

HEALTHSOURCE TENNESSEE PREFERRED, INC.
D/B/A TENNSOURCE

FOR THE PERIOD
JANUARY 1 THROUGH DECEMBER 31, 1995

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May 5, 1997

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
and
The Honorable Nancy Menke, Commissioner
Department of Health
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the report on the compliance review of the managed care organization (MCO) Healthsource Tennessee Preferred, Inc., d/b/a Tennsource, for the period January 1 through December 31, 1995.

The review of the operations disclosed certain deficiencies, which are detailed in the Findings and Recommendations section of this report. This report is intended to aid the Bureau of TennCare in its review to determine whether the MCO has adhered to the terms of the health maintenance organization contract. The Department of Commerce and Insurance should take whatever action it deems appropriate regarding the findings contained in this report.

Very truly yours,

W. R. Snodgrass
Comptroller of the Treasury

WRS/tp
97/023

cc: Bill Young
Theresa Clarke

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review

Healthsource Tennessee Preferred, Inc.

d/b/a Tennsource

For the Period January 1 through December 31, 1995

REVIEW OBJECTIVES

The objectives of the review were to determine if the managed care organization (MCO) is meeting its contractual obligations, including, but not limited to, proper accounting for payments from the TennCare Bureau, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

REVIEW FINDINGS

Insolvency and Failure to Meet Minimum Equity Requirements

Healthsource Tennessee Preferred, Inc., is considered insolvent and fails to meet minimum equity requirements. As of December 31, 1995, Tennsource, the TennCare operations of Healthsource Tennessee Preferred, Inc., has review-adjusted retained earnings of (\$420,905) (page 7).

Inadequate Accounting System and Deficiencies in Financial Reporting

Healthsource Tennessee Preferred, Inc., has not developed an adequate accounting system for TennCare operations. Management fee expenses are not supported by written management agreements. The annual statement reporting for the year ended December 31, 1995, contained deficiencies (page 8).

Deficiencies in Claims Processing System

Healthsource Tennessee Preferred, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements. Deductibles and copayments for certain claims for medical services were incorrectly computed. Providers were not notified of the status of suspended claims. Also, weekly claims processing reports are not in compliance with contract requirements (page 9).

Deficiencies in Provider Contract Language

Healthsource Tennessee Preferred, Inc., has not complied with the TennCare contract requirements for provider contracts. The contracts do not contain specific language regarding timeliness of claims and processing and submission of claims (page 12).

"Review Highlights" is a summary of the report. To obtain the complete review report which contains all findings, recommendations, and management comments, please contact

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COMPLIANCE REVIEW
HEALTHSOURCE TENNESSEE PREFERRED, INC.
d/b/a TENNSOURCE
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1995

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COMPLIANCE REVIEW
HEALTHSOURCE TENNESSEE PREFERRED, INC.
d/b/a TENNSOURCE
THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1995

INTRODUCTION

PURPOSE OF THE REVIEW

This report details the results of a compliance review of the transactions, books, and accounts of Healthsource Tennessee Preferred, Inc. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if the Healthsource Tennessee Preferred, Inc., plan was administered in accordance with the requirements of *Tennessee Code Annotated* and the contracts between the state and the MCO. The objectives of the review were:

1. to determine whether the MCO is meeting its contractual obligations under the TennCare agreement with the state;
2. to determine whether the MCO has properly adjudicated claims from service providers and has made payments in a timely manner;
3. to determine whether enrollment counts and categories are accurate and whether monthly payments and withhold amounts from TennCare to the MCO are accurate;
4. to determine if the MCO has sufficient financial capital to ensure uninterrupted delivery of health care;
5. to determine if records maintained by the MCO are adequate to determine compliance with the rules and contract requirements of the Bureau of TennCare; and
6. to recommend appropriate actions to correct any deficiencies.

POST-AUDIT AUTHORITY

This review was conducted pursuant to Section 2-14 of the Contractor Risk Agreement between Healthsource Tennessee, Inc., and the State of Tennessee which states:

The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees for

the purposes of audit requirements. Records other than medical records may be kept in original paper state, or preserved on micromedia or electronic format. Medical records shall be maintained in their original form. These records, books, documents, etc., shall be available for review by authorized federal, state, and Comptroller personnel during the Agreement period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved in which case records shall be kept until all tasks are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR and subcontractor or provider records must be requested and approved by TENNCARE.

SCOPE OF THE REVIEW

The review examined the records, transactions, and contract provisions of Healthsource Tennessee Preferred, Inc., for the period January 1 through December 31, 1995. The review included tests of insurance claims, accounting records, and other auditing procedures considered necessary.

BACKGROUND INFORMATION

Effective January 1, 1994, the State of Tennessee received approval from the U.S. Department of Health and Human Services to begin a five-year Medicaid waiver project which changed most services covered under the Medicaid program to a managed care capitated system. Under the waiver program, known as TennCare, the state contracts with 12 managed care organizations that manage and provide care for enrollees for a stated monthly capitation fee. In addition to recipients eligible under Medicaid criteria, certain uninsured or uninsurable persons may enroll in the TennCare Program. The managed care organizations in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan.

The Tennessee Department of Health is the state agency responsible for administration of the managed care program in Tennessee. The department is authorized to contract with MCOs to provide specified services to people who are or would have been eligible for Medicaid as it was administered during fiscal year 1992-93 and to other Tennesseans who are eligible for and are enrolled in the TennCare system. The managed care organization must

1. be appropriately licensed to operate within the State of Tennessee;

2. demonstrate the existence of a network of health care providers capable of providing comprehensive health care services throughout the community where the plan is offered;
3. clearly demonstrate the capability and intent to provide case management services;
4. assure the availability of service providers outside the community service network for covered services that are not commonly provided in that particular community area;
5. demonstrate sufficient financial capital to ensure uninterrupted delivery of health care on an ongoing basis;
6. demonstrate sufficient financial capital, network capability, and a willingness to accept a reasonable number of enrollees from any failed health plan operating in the community;
7. agree to move to electronic billing for all of its TennCare plans within three years of the effective date of the agreement;
8. unanimously agree with other MCOs in the TennCare system for the provision of pharmacy services to TennCare enrollees who reside in long-term care facilities so that only one pharmacy shall be responsible for their pharmacy services;
9. agree not to require service providers to accept TennCare reimbursement amounts for services provided under any non-TennCare plan operated or administered by the managed care organization; and
10. mutually agree to such other requirements as may be reasonably established by TennCare.

Effective January 1, 1994, Healthsource Tennessee, Inc., contracted with the state as a preferred provider organization (PPO) to provide medical services under the newly established TennCare program. From January 1 through July 31, 1994, TennCare operations, d/b/a Tennsource, was a separate component and was managed through Healthsource Tennessee, Inc. Effective August 1, 1994, the TennCare operations and other business operations of Healthsource Tennessee, Inc., were spun off into an affiliated company, Healthsource Tennessee Preferred, Inc. Healthsource Tennessee, Inc., serves as the management company of Healthsource Tennessee Preferred, Inc. The contract with the state remains in the name of the original company, Healthsource Tennessee, Inc. Healthsource Tennessee, Inc., and Healthsource Tennessee Preferred, Inc., are wholly owned subsidiaries of Healthsource Management, Inc. Healthsource Management, Inc., is a wholly owned subsidiary of Healthsource, Inc., a publicly traded corporation. At December 31, 1995, the enrollment in the TennCare program for Tennsource was approximately 4,000 members.

As a PPO, Tennsource, the TennCare operations of Healthsource Tennessee Preferred, Inc., must establish risk reserves in an amount equal to what would have been required by the Tennessee Department of Commerce and Insurance if Tennsource had been a health maintenance organization licensed by the state. Also, Tennsource is allowed to retain up to 10 percent of the monthly capitation amount paid by TennCare as a management fee, with the remainder of the monthly capitation payment available for the payment of covered benefits. TennCare is not liable for any excess benefit costs. Any and all excess administrative costs are borne by Tennsource. In the event of savings, Tennsource, as provided for in Section 2-10(e)(2) of the TennCare contract, is required to share with TennCare a portion of such savings after medical benefits and allowable administrative expenses are paid. The contractor is permitted to share 5 percent of the savings with the providers and is allowed to retain 5 percent for the contractor's efficiency. The remainder of the savings are returned to TennCare.

PRIOR REVIEW FINDINGS:

The previous review of Healthsource Tennessee Preferred, Inc., for the year ended December 31, 1994, included the following findings:

Inadequate accounting system and deficiencies in financial reporting

Healthsource Tennessee, Inc., has not developed an adequate accounting system for TennCare operations. The accounting system should produce a general ledger composed of journal entries supported by documentation of payments. The general ledger balances at fiscal year-end should be reported on a trial balance.

Deficiencies in claims processing system

Healthsource Tennessee, Inc., has not fulfilled contract reporting and processing efficiency requirements for TennCare operations. Deductibles and copayments for certain claims for medical services were incorrectly computed. Also, weekly claims processing reports are not in compliance with contract requirements.

All previous findings will be repeated in the current report (see the Findings and Recommendations section of this report).

SUBSEQUENT MATERIAL EVENT

The TennCare enrollees of Healthsource Tennessee, Inc., d/b/a Tennsource, were transferred January 1, 1997, to Phoenix Health Care of Tennessee, Inc.

RESULTS OF THE REVIEW

Our review of the plan's claims processing system and accounting and financial data revealed discrepancies which are further discussed in the Findings and Recommendations section of the report.

Based on our review of the capitation payments by TennCare and the payments by Tennsource, we have computed a final plan savings of \$535,124 for the year ended December 31, 1994, and a tentative plan savings of \$84,584 for the year ended December 31, 1995. Schedule 1 shows the final settlement calculation for the year ended December 31, 1994, and schedule 2 shows the tentative settlement calculation for the year ended December 31, 1995. A final settlement will be determined for the year ended December 31, 1995, when all transactions for the period under review have been completed.

Healthsource Tennessee Preferred, Inc., made an interim payment on October 4, 1996, of \$508,311 based on a previous tentative settlement calculation for the year ended December 31, 1994. The overpayment of \$26,699 resulting from the final settlement calculation for December 31, 1994, has been applied as a credit to the December 31, 1995, tentative settlement calculation. The savings calculation for December 31, 1995, is a tentative settlement because the Division of State Audit could not rely on the accuracy of computer-processed payments for medical services by Healthsource Tennessee Preferred, Inc., after July 31, 1996. Healthsource Tennessee Preferred, Inc., converted to a new software package in August 1996. The Division of State Audit has found that the new software incorrectly overpaid a significant number of claims (see finding 3). Medical services payments processed after July 31, 1996, will not be included in the savings calculation until the overpayments are corrected.

The Department of Commerce and Insurance should take appropriate action to collect the savings due to the state.

The annual statement filed by Healthsource Tennessee Preferred, Inc., for Tennsource for the year ended December 31, 1995, was inadequate. The balance sheet and the statement of revenue, expenses, and net worth reports on the annual statement could not be supported (see finding 2). When the adjusted trial balance and supplementary schedule of TennCare operating information prepared by the independent accountant were used, the statement of operations reported total revenues of \$5,451,419, health care expenses of \$5,235,426, administrative expenses of \$829,323, and an operating loss of (\$613,330) for the period January 1 through December 31, 1995. The balance sheet reported total assets of \$1,659,076, total liabilities of \$2,600,688, and a retained earnings of (\$941,612).

Subsequent material events and error corrections for 1994 and 1995 revenues and expenses affected the reporting of the operations of Tennsource. The balance sheet and the income statement for Tennsource were adjusted by the Division of State Audit as follows:

- Withholds released by the Bureau of TennCare during 1996 for eligibility dates in 1994 and 1995 were included.
- Retroactive receivables were adjusted to actual payments. The net increase to accounts receivable was \$263,118.
- Pharmacy expenses of \$88,885 paid in 1996 were accrued as an expense and a payable as of December 31, 1995.
- From the savings calculations for 1994 and 1995, revenue and health care expenses were adjusted to actual. Additionally, an expense and a payable were recorded as savings due to the State of Tennessee and to medical providers. Medical payables were also adjusted to actual payments as determined by the savings calculations.
- Premium taxes payable and expense were adjusted to actual revenue after applying the appropriate rate.
- Administrative withholds payables were converted to intercompany payables.
- Administrative expenses were adjusted for unrecorded auditing expenses.

The effect of review adjustments on the retained earnings for TennCare operations is to decrease the deficit from (\$941,613) to (\$420,905) as of December 31, 1995. A review-adjusted balance sheet and statement of operations is shown on schedule 3.

FINDINGS AND RECOMMENDATIONS

INSOLVENCY AND FAILURE TO MEET MINIMUM EQUITY REQUIREMENTS

1. FINDING:

Tennsource, the TennCare operations of Healthsource Tennessee Preferred Inc., is considered insolvent as of December 31, 1995, with a review-adjusted equity of (\$420,905). The plan does not meet the minimum financial reserve requirement specified in the TennCare contract and in *Tennessee Code Annotated*.

Section 2-10(e)(4) of the TennCare contract for preferred provider organizations states, "The Contractor shall establish risk reserves in an amount equal to the amount that would have been required by Tennessee Department of Commerce and Insurance if the Contractor had been a health maintenance organization licensed by the State of Tennessee."

Section 56-32-201, et seq., *Tennessee Code Annotated*, addresses the statutory requirements for health maintenance organizations.

RECOMMENDATION:

Healthsource Tennessee Preferred, Inc., should take appropriate action to achieve positive equity and meet the minimum risk reserve requirements for TennCare operations. The Tennessee Department of Commerce and Insurance should take whatever action deemed necessary to ensure that Healthsource Tennessee Preferred, Inc., meets the minimum equity requirements.

MANAGEMENT'S COMMENT:

We concur with the finding noted in the report. To correct the situation, Healthsource Inc. issued a surplus note for \$750,000 in September of 1996. At December 31, 1996, the total net worth for Healthsource Tennessee Preferred was \$2,755,071.

INADEQUATE ACCOUNTING SYSTEM AND DEFICIENCIES IN
FINANCIAL REPORTING

2. FINDING:

Healthsource Tennessee Preferred, Inc., has not developed an adequate accounting system for TennCare operations. The following deficiencies were noted with the accounting system and financial and annual statement reporting for TennCare operations:

- The general ledger accounts do not segregate cash and medical expenses for TennCare operations from other lines of business. Healthsource Tennessee Preferred, Inc., reported TennCare operations by manually accumulating cash receipts and payments for the period January 1 through December 31, 1995, and then adjusting cash transactions for unpaid withholds from TennCare and unpaid expenses at December 31, 1995.
- The annual statement filed by Healthsource Tennessee Preferred, Inc., for Tennsource for the year ended December 31, 1995, was inadequate. The balance sheet and statement of revenue, expenses, and net worth reports on the annual statement are not supported by a general ledger or trial balance.
- Charges for administrative expenses by Healthsource Tennessee, Inc., the management company, and Healthsource, Inc., the parent, are not supported by a written management agreement. Management expense allocations could not be verified.
- Expenses and payables were not recognized for savings due to the state and medical providers.
- Expenses and payables were not recognized for pharmacy expenses incurred in 1995 but not paid until 1996.

Section 2-12 of the TennCare contract with Healthsource Tennessee, Inc., states, “The Contractor shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this Agreement and any other costs and expenditures made under the Agreement.”

As a result of the inadequate accounting system and unsupported annual statement reporting, the financial operations of the TennCare operations have been incorrectly reported. The effect of review adjustments on the retained earnings for TennCare operations is to decrease the deficit from (\$941,613) to (\$420,905) as of December 31, 1995. A review-adjusted balance sheet and statement of operations is exhibited on schedule 3.

RECOMMENDATION:

Healthsource Tennessee Preferred, Inc., should develop an adequate accounting system for TennCare operations. An acceptable accounting system should produce a trial balance at fiscal year-end supported by a general ledger. The general ledger accounts should separate TennCare transactions from other lines of business. Revenues should be reported in the year earned. A written management agreement should be executed between Healthsource Tennessee Preferred, Inc., and related parties performing management services. Management fee expenses should be adequately supported. Expenses and payables should be recognized according to generally accepted accounting principles.

MANAGEMENT'S COMMENT:

We concur with the findings noted in the report. Since the audit, we have segregated cash and medical expenses for Tennsource in the general ledger from other lines of business. The annual statement for the year ended December 31, 1996, is supported with the general ledger and reconciliations. At this point in time, we have not taken any action to obtain a written management agreement between Healthsource Tennessee and Healthsource Tennessee Preferred and do not plan to do so due to the sale of the Tennsource business at December 31, 1996. Furthermore, we are in the process of determining expenses and payable for savings due to the state and medical providers.

DEFICIENCIES IN CLAIMS PROCESSING SYSTEM

3. FINDING

Healthsource Tennessee Preferred, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements for TennCare operations. Our review noted the following problems:

- a. Healthsource Tennessee Preferred, Inc., did not comply with the TennCare Bureau's requirements regarding encounter data. Healthsource Tennessee Preferred, Inc., submitted encounter data that was considered unacceptable. As a result, the TennCare Bureau notified Healthsource Tennessee Preferred, Inc., that the 10% capitation withhold amounts totaling \$126,078.56 for October, November, and December 1996 would be permanently retained. Encounter data, a record of the medical services provided to enrollees, is necessary for evaluation of quality of care and access to TennCare services. The claims processing system did not record all revenue codes and charges from claims for medical services. Section 2-

11(f) of the contract between TennCare and Healthsource Tennessee, Inc., requires that encounter data be reported in a format specified by TennCare. Additionally, Attachment II, Exhibit E, of the contract lists revenue codes as a required data element for claims/encounter data reporting.

- b. Healthsource Tennessee Preferred, Inc., converted to a new software package in August 1996. The Division of State Audit has discovered that the new software incorrectly overpaid a significant number of claims. The payments were determined unacceptable for savings and loss calculations. As of the end of fieldwork, Healthsource Tennessee Preferred, Inc., had suspended all payments until errors can be corrected. The following payment errors were discovered:
- Payments were made at full charge without applying a negotiated fee amount or the appropriate withhold amount.
 - Certain claims for inpatient stays paid a per diem but also incorrectly paid ancillaries at full charges.
 - Certain claims for inpatient stays denied room and board charges but paid ancillaries at full charges.
- c. Healthsource Tennessee Preferred, Inc., incorrectly calculated deductibles and copayments for certain TennCare claims paid. The deductibles and copayments were computed based on the charges for medical services instead of on the negotiated rate between medical providers and Healthsource Tennessee Preferred, Inc. Section 2-3(h) of the TennCare contract states, "Deductibles and copayments charged the enrollee shall be based upon the negotiated rate between the MCO and the provider." As a result of the incorrect calculation, deductibles and copayments were overstated, and medical providers were underpaid. This finding has been repeated from the prior review. No action has been taken by Healthsource Tennessee Preferred, Inc., to correct over-stated copayments and deductibles and underpayments to medical providers.
- d. A sample of TennCare claims processed by Healthsource Tennessee Preferred, Inc., revealed an average processing lag of 51 days from receipt claim to final adjudication. Section 2-18 of the TennCare contract with Healthsource Tennessee, Inc., states, "The Contractor agrees to make payments within thirty calendar days of receipt for at least ninety-five percent of all clean claims." "Clean claims" are claims which do not require additional information from the medical provider before processing.
- e. Medical providers were not notified through remittance advice by Healthsource Tennessee Preferred, Inc., when claims were placed indefinitely in

suspended status by the claims processing system. As a result, medical providers will not be able to determine the final status of all claims filed with Healthsource Tennessee Preferred, Inc.

- f. Weekly claims processing reports are not in compliance with contract requirements. Section 2-11(g) of the TennCare contract with Healthsource Tennessee, Inc., defines the information to be reported on a weekly basis to TennCare. The following items should be included in the reports:
- number of unpaid claims in inventory by service type;
 - aging of unpaid claims by service type;
 - average time from receipt to final payment of claim by service type;
 - approximate value of unpaid claims by service type;
 - number of member phone calls; and
 - approximate waiting time for member response.

RECOMMENDATION:

Healthsource Tennessee Preferred, Inc., should submit encounter data in the format specified by the Bureau of TennCare. All revenue codes and charges should be included in encounter data reporting. Healthsource Tennessee Preferred, Inc., should correct payment errors caused by the new software package installed in August 1996. Copayments and deductibles should be computed based on the negotiated rate between Healthsource Tennessee Preferred, Inc., and the medical providers. Incorrectly computed claims paid should be recomputed to correctly compute deductibles and copayments based on the negotiated rates. Healthsource Tennessee Preferred, Inc., should notify providers of the corrected computations and ensure that they properly adjust patient accounts for the overstated deductibles and copayments. Healthsource Tennessee Preferred, Inc., should adhere to contract guidelines regarding claims processing efficiency and the submission of weekly claims processing reports.

MANAGEMENT'S COMMENT:

We concur with the findings noted in the report. Encounter data for years 1994 through 1996 has been supplied to the TennCare Bureau. Furthermore, efforts to correct the claims paid incorrectly are under way. In response to the finding related to claim lag, we are currently in a run-out phase and are in the process of evaluating the remaining monies available and claims payable for 1996. Furthermore, some of the reports listed in

the audit are available but, since we are in a run-out phase, the results will not give a clear picture of the activity.

DEFICIENCIES IN PROVIDER CONTRACT LANGUAGE

4. FINDING:

Healthsource Tennessee Preferred, Inc., has not complied with the TennCare contract requirements for provider contracts. Language describing the following requirements is excluded or deficient in contracts between Healthsource Tennessee Preferred, Inc., and medical providers:

- The managed care organization is to pay the provider within 30 days of receipt of a properly submitted clean claim;
- A provider shall have at least 120 calendar days from the date of service to file a claim with the managed care organization. The specific language of Healthsource Tennessee Preferred, Inc., provider contracts allows only 90 calendar days to file a claim.

All requirements for provider contracts are specified in section 2-18 of the TennCare contract with Healthsource Tennessee, Inc.

RECOMMENDATION:

Healthsource Tennessee Preferred, Inc., should comply with TennCare contract requirements for provider contracts.

MANAGEMENT'S COMMENT:

We concur with the findings noted in the report. However, no action is planned to correct the contracts due to the sale of the TennCare business at December 31, 1996.

