MEMPHIS MANAGED CARE CORPORATION
D/B/A TLC FAMILY CARE HEALTHPLAN

FOR THE PERIOD
JANUARY 1 THROUGH DECEMBER 31, 1995

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October 30, 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) Memphis Managed Care Corporation, d/b/a TLC Family Care Healthplan, 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

cc: Bill Young
Theresa Clarke

State of Tennessee

Review Highlights

Comptroller of the Treasury | Division of State Audit

Compliance Review

Memphis Managed Care Corporation

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 claims payment, 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

Failure to Maintain Minimum Equity Requirements

Memphis Managed Care Corporation did not meet the minimum equity requirements of a health maintenance organization (page 6).

Deficiencies in Claims Processing System

Memphis Managed Care Corporation did not fulfill contract reporting and processing efficiency requirements. Evidence that uninsured enrollees were provided with an explanation of benefits for copayments and deductibles and that providers were given remittance advices was not provided. All diagnosis codes were not included in claims/encounter data reporting. Duplicate payments were made by the claims processing system (page 7).

"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
MEMPHIS MANAGED CARE CORPORATION
FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 1995

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COMPLIANCE REVIEW
MEMPHIS MANAGED CARE CORPORATION
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 Memphis Managed Care Corporation. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if Memphis Managed Care Corporation 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 Memphis Managed Care Corporation 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 an 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, 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 Memphis Managed Care Corporation for the period January 1 through December 31, 1995. The review included tests of insurance claims, review of 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 offered in Tennessee no later than 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.

Memphis Managed Care Corporation was organized as a nonprofit organization by its members, the Regional Medical Center at Memphis and UT Medical Group, Inc. Memphis Managed Care Corporation was incorporated on August 4, 1993. Effective January 1, 1994, Memphis Managed Care Corporation contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare program. The Memphis Managed Care Corporation's designated name for the TennCare plan is TLC Family Care Healthplan. At December 31, 1994, the enrollment for the plan was approximately 41,000 members. At December 31, 1995, the enrollment for the plan was approximately 36,000 members.

As an HMO, Memphis Managed Care Corporation files quarterly and annual statements with the Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the health maintenance organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because assets must be easily converted to cash to pay for outstanding claims. Assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should be reduced from equity. A restricted deposit is maintained by the plan in the amount of $1,190,911 to satisfy the Department of Commerce and Insurance requirements. As of December 31, 1995, the plan reported $14,168,156 in plan assets, $11,871,858 in liabilities, and $2,296,297 in equity on its annual statement. The plan reported total revenues of $53,801,661 and total expenses of $54,064,566, producing a net loss of $262,905 for the period January 1 through December 31, 1995. Revenue comprises $53,219,273 in capitation fee payments from TennCare and $582,388 in investment income and provider refunds. The plan reported $48,474,835 in medical expenses and $5,589,731 in administrative expenses.

PRIOR REVIEW FINDING

The previous review of Memphis Managed Care Corporation for the year ended December 31, 1994, contained the following finding:

Deficiencies in claims processing system

Memphis Managed Care Corporation has not fulfilled contract reporting requirements and processing efficiency requirements. Evidence that uninsured enrollees are provided with an explanation of benefits for copayments and deductibles was not provided. The claims processing system does not produce a payment history for medical payments beyond 12 months.

This finding will be repeated in the current report (see the Findings and Recommendations section of this report).

SUBSEQUENT MATERIAL EVENTS

Subsequent material events affected the reporting on the annual statement for Memphis Managed Care Corporation for the review period. A final accounting by the Bureau of TennCare in December 1996 resulted in differences for reported 1995 estimates of money to be received for adverse selection. TennCare premium revenue and TennCare receivables should be decreased by $428,485 to adjust adverse selection to the actual amount received. Also, TennCare premium revenue and TennCare receivables should be increased by $5,094 to adjust the capitation rate increase to the actual amount received for 1995. The net effect of these adjustments was to decrease TennCare premium revenue and TennCare receivables by $423,391. Also, premium tax expense and payable should be decreased by $8,468. If the 1995 annual statement were adjusted,

the net loss for the plan would be $677,828, and the total net worth for the plan would be $1,881,374. The plan does not appear to have sufficient capital to ensure uninterrupted delivery of health care since total net worth is less than the $2,100,000 required by the Department of Commerce and Insurance (see finding 1).

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.

FINDINGS AND RECOMMENDATIONS

FAILURE TO MAINTAIN MINIMUM EQUITY REQUIREMENTS

1. FINDING:

Memphis Managed Care Corporation does not meet minimum equity requirements of a health maintenance organization. The plan's adjusted equity is $1,881,374. The equity should be equal to or greater than the $2,100,000 required to satisfy Department of Commerce and Insurance requirements.

Section 2-10(e)(4) of the health maintenance organization TennCare contract states, "The CONTRACTOR shall comply with all requirements of the Tennessee Department of Commerce and Insurance applicable to risk reserves."

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

RECOMMENDATION:

Memphis Managed Care Corporation should take appropriate action to 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 Memphis Managed Care Corporation meets the minimum equity requirements.

MANAGEMENT'S COMMENT:

Our adjusted net worth as detailed in the report is $1,881,374. The statutory requirement is $2,100,000, leaving a deficiency of $218,626. It should be noted that our 1995 audited financial statements were restated by our independent auditors. The restatement has resulted in an increase to net worth of $515,448. This increase is a result of related party overpayments made in 1995 identified during the 1996 audit. The related party agrees that the overpayments are due to Memphis Managed Care Corporation. The resulting change to our 1995 audited statements is more than adequate to ensure that Memphis Managed Care Corporation meets the minimum equity requirements.

DEFICIENCIES IN CLAIMS PROCESSING SYSTEM

2. FINDING:

Memphis Managed Care Corporation has not fulfilled contract reporting requirements and processing efficiency requirements. Our review noted the following problems:

- A sample of claims processed by Memphis Managed Care Corporation revealed an average processing lag of 48.74 days from the receipt of a claim to its final adjudication. Clean claims in the sample had an average processing lag time of 50.29 days. In addition, claims returned to providers due to incomplete claims between October 1 and December 31, 1995, had an average processing lag time of 92.97 days. Section 2-18 of the TennCare contract with Memphis Managed Care Corporation states, "The CONTRACTOR shall pay within thirty (30) calendar days of receipt ninety five percent (95%) of all clean claims submitted by contract and non-contract providers . . . . The CONTRACTOR shall also process within sixty (60) calendar days of receipt all claims submitted by contract and non-contract provider." "Clean claims" are claims which do not require additional information from the medical provider before processing.

- Weekly claims processing reports are not in compliance with contract requirements. Section 2-11(g) of the TennCare contract with Memphis Managed Care Corporation defines the information to be reported on a weekly basis to TennCare. Included in the report are the following items:

  -- 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.

- The MCO was unable to provide evidence that uninsured members who are required to pay copayments and deductibles are provided an explanation of benefits. Industry practice is to provide health plan members an explanation of benefits when a copayment or deductible is required.

- The MCO was unable to provide evidence that providers were provided a remittance advice. Industry practice is to provide a remittance advice with all services submitted on the claim regardless of whether the service is covered under capitation, paid, denied, or not covered.

- The sample of claims examined revealed ten claims that did not include all diagnosis codes on the actual claim in the claims processing system. Attachment II, Exhibit E,

of the TennCare contract with Memphis Managed Care Corporation lists diagnosis codes as required data elements for claims/encounter data reporting.

- Six out-of-plan emergency claims were examined. All six claims had a processing lag exceeding 45 days with an average processing lag of 103 days. In addition, one claim examined did not meet the emergency criteria but was paid. Section 2-3(j)(1) of the TennCare contract with Memphis Managed Care Corporation states, "Payment by the CONTRACTOR for properly documented claims for emergency medical services rendered by a non-contract provider shall be made within forty-five (45) calendar days of receipt of a clean claim by the CONTRACTOR."

- During the review period, the claims processing system did not adequately identify duplicate claims. This resulted in overpayments to some providers. The annual statement for the year ended December 31, 1995, reported refunds from provider of $166,639.

RECOMMENDATION:

Memphis Managed Care Corporation should improve the efficiency of claims processing to comply with contract standards. Weekly claims processing reports submitted to TennCare should be submitted according to contract guidelines. Memphis Managed Care Corporation should maintain evidence that uninsured enrollees are provided an explanation of benefits and that providers are provided remittance advices. All diagnosis codes should be included in encounter data reporting. Memphis Managed Care Corporation should work to ensure that the claims processing system does not make duplicate payments.

MANAGEMENT COMMENT:

Memphis Managed Care Corporation has made marked improvement in the claims processing function. We have strengthened inventory procedures to ensure that aging of claims is monitored. On a daily basis, aging of claims is monitored to ensure that 95 percent of clean claims are processed within 30 days of receipt. We are submitting weekly claims progress reports in accordance with contract guidelines.

Memphis Managed Care Corporation has always provided explanation of benefits and remittance advices to uninsured members and providers, respectively. At the time of the review, neither electronic nor paper copies were maintained. MMCC now maintains electronic copies of all explanation of benefits and remittance advices.

Memphis Managed Care Corporation now captures all diagnosis codes submitted in accordance with contract requirements.

Memphis Managed Care Corporation has established system parameters for identifying potential duplicate payments for all claim types. The system will provide a warning to the claim processor of a potential duplicate at the time of adjudication. The processor then reviews the previously paid claim and determines whether there is a duplicate.