

OmniCare Health Plan, Inc.
For the Period
January 1 Through December 31, 1995

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June 10, 1998

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) OmniCare Health Plan, Inc., 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 preferred provider 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/pn

cc: Bill Young
Theresa Clarke

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review
OmniCare Health Plan, Inc.
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 Bureau of TennCare, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

REVIEW FINDINGS

Deficiencies in Financial Reporting

OmniCare Health Plan, Inc., did not include an actuarial certification of its estimated incurred but not reported medical liabilities in the annual statement reporting. Medical expenses were not properly reported in the appropriate period (page 6).

Deficiencies in Claims Processing System

OmniCare Health Plan, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements. Errors were discovered in the payment and denial of medical claims. An explanation of benefits was not provided to enrollees who were required to make copayments. Also, weekly claims processing reports are not in compliance with contract requirements (page 7).

Deficiencies in Provider Contract Language

OmniCare Health Plan, Inc., did not include in the provider agreements all requirements specified by the TennCare contract (page 10).

"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
OmniCare Health Plan, Inc.,
For the Period January 1 Through December 31, 1995**

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**Compliance Review
OmniCare Health Plan, Inc.,
For the Period January 1 Through December 31, 1995**

INTRODUCTION

OBJECTIVES OF THE REVIEW

This report details the results of a compliance review of the transactions, books, and accounts of OmniCare Health Plan, Inc. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if OmniCare Health Plan, Inc., 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-REVIEW AUTHORITY

This review was conducted pursuant to Section 2-14 of the Provider Risk Agreement between OmniCare Health Plan, 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 OmniCare Health Plan, 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 ten 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. ensure 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.

OmniCare Health Plan, Inc., formerly Affordable Healthcare, was chartered in the State of Tennessee in October 1993. Effective January 1, 1994, OmniCare Health Plan, Inc., contracted with the state as a preferred provider organization (PPO) to provide medical services under the newly established TennCare program. As of December 31, 1995, the ownership of OmniCare Health Plan, Inc., consisted of a 75% controlling interest by United American of Tennessee (UAT) and a 25% interest held by Mr. Alvin King. UAT is a wholly owned subsidiary of United American Healthcare Corporation (UAHC).

At December 31, 1994, the enrollment in the TennCare program for OmniCare Health Plan, Inc., was approximately 79,000 members. At December 31, 1995, the enrollment in the TennCare program for OmniCare Health Plan, Inc., was approximately 47,900 members.

As a PPO, OmniCare Health Plan, Inc., must establish risk reserves in an amount equal to what would have been required by the Tennessee Department of Commerce and Insurance if OmniCare Health Plan, Inc., had been a health maintenance organization licensed by the state. Also, OmniCare Health Plan, Inc. 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 OmniCare Health Plan, Inc. In the event of savings, OmniCare Health Plan, Inc., 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.

OmniCare Health Plan, Inc., files quarterly and annual statements with the Department of Commerce and Insurance. The statements are filed on a statutory basis of accounting. As of December 31, 1995, the plan reported \$27,265,924 in plan assets, \$24,627,924 in liabilities, and \$2,638,000 in equity on its annual statement. The plan reported total revenues of \$75,717,289 and total expenses of \$67,852,763, producing net income of \$7,864,526 for the period January 1 through December 31, 1995. Revenue comprises \$73,997,347 in capitation fee payments from TennCare and \$1,719,942 in investment income. The plan reported \$55,555,609 in medical expenses and \$12,297,154 in administrative expenses.

PRIOR REVIEW FINDINGS

The previous review of OmniCare Health Plan, Inc., for the year ended December 31, 1994, included the following findings:

- 1. Questionable Marketing and Enrollment Practices**
Individuals described by and retained by OmniCare Health Plan, Inc., as independent marketing agents engaged in questionable marketing practices in which applications for ineligible and fictitious persons were submitted to the state. Identified capitation payments of \$78,206 were made to OmniCare for improperly enrolled individuals from January 1994 through July 1995.
- 2. Insolvency and Deficiencies in Financial Reporting**
OmniCare Health Plan, Inc., is considered insolvent as of December 31, 1994, with an adjusted equity of negative \$6,075,154.
- 3. Deficiencies in Claims Processing System**
OmniCare Health Plan, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements. Uninsured members are not provided an explanation of benefits for copayments and deductibles paid.

The questionable marketing and enrollment practices noted in the previous report ceased in November 1994. The current report shows the plan is no longer insolvent, but deficiencies in financial reporting and in the claims processing system have continued (see the Findings and Recommendations section of this report).

RESULTS OF THE REVIEW

Our review of the plan revealed discrepancies in the claims processing system, provider agreements, accounting, and financial data. These discrepancies 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 OmniCare Health Plan, Inc., we have computed a final plan savings for the contract year 1995 of \$8,668,799 with \$7,801,919 determined payable to the State of Tennessee. Schedule 1 shows the final settlement calculation as determined by the Division of State Audit for the contract year 1995. The Tennessee Department of Finance and Administration and the Tennessee Department of Health reached a settlement with OmniCare Health Plan, Inc., reducing the payable to \$6,305,304.

Subsequent material events and error corrections affected the reporting of the operations of OmniCare Health Plan, Inc., for the year ended December 31, 1995. The balance sheet and the income statement for OmniCare Health Plan, Inc., were adjusted by the Division of State Audit as follows:

- Revenue and receivables were adjusted for additional retroactive capitation increase and adverse selection payments by TennCare of \$740,909 and \$621,246 during 1996 for 1995 eligibility. Also, the TennCare Bureau has retained \$1,026,845 of the 10% capitation withhold amounts from 1995 capitation payments for deficiencies in encounter data submissions (see finding 2). The net increase to accounts receivable was \$335,310.
- Medical expense and claims liability were increased \$3,526,314 based on actual payments. Additionally, the expenses and a payable for the savings and loss calculation for the contract year 1995 were adjusted to the settlement reached with the State of Tennessee. Accounts payable state and state expense were reduced \$4,350,314, and accounts payable providers and provider expense were reduced \$276,714.
- Prepaid insurance of \$1,949 was adjusted as a non-admitted asset.
- Premium taxes payable and expense of \$40,692 were adjusted to actual revenue after applying the appropriate rate.

The effect of review adjustments on equity for OmniCare Health Plan, Inc., as of December 31, 1995, is to increase equity from \$2,638,000 to \$4,031,383. OmniCare Health Plan, Inc., is in compliance with minimum equity requirements as of December 31, 1995. A summary of review adjustments to statutory equity is shown on schedule 2.

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in financial reporting

Finding

The following deficiencies were noted in the financial reporting for OmniCare Health Plan, Inc., (OmniCare) for the review period:

- OmniCare did not include an actuarial certification for its IBNR (incurred but not reported) estimate for medical claims liabilities on the annual statement for the year ended December 31, 1995. Section 2-11(i) of the TennCare contract with OmniCare requires the annual statement to be filed on the form prescribed by the National Association of Insurance Commissioners. The form requires the inclusion of an actuarial certification of IBNR.
- Medical expenses were not properly reported in the appropriate period. The claims processing system produces lag reports which segregate medical costs by plan month and year based upon the dates of service. These reports are used to determine medical expenses by plan year for the TennCare contract savings and loss calculation. The lag reports were determined inaccurate because of a variance between the lag reports and cash payments. OmniCare could not offer an explanation for the errors in the lag reports. Because the variance included medical expenses from other years, we determined that the variance unacceptably affected the calculation of savings and loss. Therefore, OmniCare had to manually segregate costs by plan year on a check-by-check basis when the lag report was incorrect. The manual segregation was determined acceptable. Section 2-12 of the TennCare contract states that OmniCare shall establish and maintain an accounting system in accordance with generally accepted accounting principles, which require that costs be reported in the year in which they were incurred.

As a result of the deficiencies noted in financial reporting, the medical claims liability and expenses were understated \$3,526,314 for the year ended December 31, 1995.

Recommendation

OmniCare should include in the annual statement reporting an actuarial certification for the IBNR estimate for medical claims liabilities. OmniCare should maintain a general ledger system that accurately reports medical costs in the year incurred. OmniCare should determine why the claims processing software produces inaccurate lag reports and take the appropriate action to correct the software.

Management's Comment

Our independent auditors, Ernst & Young, performed audits for years ended December 31, 1995; December 31, 1996; and the six months ended June 30, 1997. Extensive actuarial work was performed by their national actuary department located in Atlanta, Georgia. Their findings were that our reserves were sufficient. Subsequently, OmniCare has retained the services of and received an actuarial opinion by Towers Perrin for the years ended December 31, 1996, and 1997. OmniCare will provide actuarial certifications in its future annual statement filings with the State of Tennessee.

OmniCare had recently installed Healthtrek, a newly developed claims processing system, during the reviewers' visit. The lag report function was new and still under development. OmniCare has revamped the claims lag report generated from Healthtrek and is satisfied with the results. OmniCare reconciles this claims lag report monthly to ensure accuracy.

2. Deficiencies in claims processing

Finding

OmniCare Health Plan, Inc., (OmniCare) has not fulfilled contract reporting requirements and processing efficiency requirements for TennCare operations. Sixty claims were randomly selected for claims processing testing. Our review noted the following problems:

- a. The Bureau of TennCare has retained \$1,026,845 of the 10% capitation withhold amounts from 1995 capitation payments for deficiencies in encounter data submissions. Encounter data, a record of the medical services provided to enrollees, is necessary for evaluating quality of care and access to TennCare services. The following encounter data deficiencies were discovered in our sample:
 - The claims processing system did not record all revenue codes and charges for three of the claims for medical services. Attachment II, Exhibit E, of the contract lists revenue codes and charges as required data elements for claims/encounter data reporting.
 - For 13 claims, only the primary diagnosis was entered. For one claim, the secondary diagnosis was incorrectly entered as the primary diagnosis. Attachment II, Exhibit E, of the contract specifies the primary diagnosis, as well as other diagnoses, as a required data element for individual encounter/data reporting.
 - For 14 of the claims tested, the total amount of the claim was entered as an additional claim line, therefore doubling the total amount of the claim.

- b. Three claims tested were incorrectly denied by OmniCare. A claim for ambulance services related to an emergency was denied for “no prior authorization.” A claim related to emergency room services was denied by OmniCare with the explanation to “submit with ER record.” Both of these claims reported diagnosis codes that were considered emergencies according to OmniCare’s criteria and therefore should not have been denied or pended. A claim was incorrectly denied because the member was not considered eligible by OmniCare at the date of service. The member was confirmed eligible according to OmniCare’s system and TennCare’s system for the date of service.
- c. Uninsured members who are required to pay copayments are not provided an explanation of benefits. It is industry practice to provide members an explanation of benefits when a copayment is required.
- d. The original hardcopy claim was not provided by OmniCare for two of the 60 claims in the sample.
- e. Seven claims were priced and paid wrong according to contract terms between OmniCare and medical providers. The errors resulted in a total underpayment of \$1,317.65 to medical providers.
- f. For one claim in the sample, the claims processing system processed the claim but did not show that a check has been released. As previously noted in finding 1, deficiencies were discovered in the claims processing system’s reporting of payments for medical services.
- g. As claims are received by mail from medical providers, OmniCare date-stamps the received date on the claim. One claim in our sample was paid before the date stamped on the claim, indicating that the date stamp is not always the received date. The application of the correct received date to claims is critical to establishing compliance with contract processing efficiency requirements.
- h. OmniCare has not met claims processing requirements specified by the TennCare contract. OmniCare did not pay or deny 95% of the clean claims tested within 30 days and process all claims within 60 days. Of the 60 claims tested, only 15 (25%) were processed within 30 days, 18 (30%) within 31-60 days, and 26 (43%) were not completely processed until after 60 days of receipt of claim. For one claim, we were unable to determine the process days because, as previously mentioned, the reported received date was after the paid date. The TennCare contract 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 contract also states, The CONTRACTOR shall also process within sixty (60) calendar days

of receipt of all claims submitted by contract and non-contract providers.

- i. Weekly claims processing reports are not in compliance with contract requirements. Section 2-11(g) of the TennCare contract with OmniCare 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
 - approximate waiting time for member response

Recommendation

OmniCare Health Plan, Inc., should adhere to contract reporting requirements and processing efficiency requirements for claims processing. OmniCare should submit encounter data in the format specified by the Bureau of TennCare. An explanation of benefits should be provided to uninsured participants when a copayment is required. Claims should be paid according to contracts between OmniCare and medical providers. OmniCare should accurately record the date claims are received. OmniCare should adhere to contract guidelines regarding the submission of weekly claims processing reports.

Management's Comment

- a. The new claims system records all revenue codes and charges.

We are now entering all diagnoses listed on the claim up to the amount for which our system provides spaces, which is five.

We have corrected the problem through better training and claims processing system.

- b. The first two claims were incorrectly denied. The third claim, however, was correctly denied because the member was not eligible at the time of service, which was July 6, 1995. The claim was processed on August 2, 1995. TennCare updated eligibility on January 1, 1996, after which the claim was processed. The providers in all three of the cases would have an opportunity to appeal the denials. At that time, OmniCare would review the denial reasons and reprocess the claim correctly.
- c. OmniCare has not required the members to pay copayments. We are now able to provide an explanation of benefits to those members who are required to pay copayments.

- d. In our research of the claim, we found that one of the original claims was sent to Premier, our behavioral health provider for our members. We do on occasion receive claims which are billed to other MCOs. Many times our providers will call to verify receipt of their claims and upon notification to them that we have not received them, they will fax the claim in order to meet the timely filing deadline. We believe this to have been the case in the second claim.
- e. We have corrected the problem through better training and claims processing system.
- f. This is usually the case when OmniCare issues an advance payment to a provider. The payment is made on account and when the claim is processed, no check is issued to that provider until the advance payment is applied.
- g. We believe this to have been a clerical error in the setting of the dock machine. We have provided better training and claims processing system.
- h. OmniCare is continuously working to improve the claims processing procedure/system. Currently, we believe the percentage of claims meeting the processing requirement has improved.
- i. Currently the weekly claims processing reports are in compliance except for the information regarding the average turnaround time. We have worked with our MIS department and will be including that information on future reports.

Rebuttal

- c. The application of copays and deductibles was clearly evident through our testwork of the claims system and provider remittance advices.
- d. Since both of the hard copy original claims not provided by OmniCare from our sample were processed by OmniCare, the original claims should have been maintained.

3. Deficiencies in provider contract language

Finding

OmniCare Health Plan, Inc., (OmniCare) did not comply with the Bureau of TennCare's requirements for provider agreements. The provider agreements did not contain all requirements as specified in Section 2-18 of the contract between TennCare and OmniCare.

Section 2-18 of the contract between TennCare and OmniCare specifies 36 items that provider agreements must meet. Among the items missing from some provider agreements were the following:

- The managed care organization is to pay the provider within 30 days of receiving 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 the OmniCare provider contracts allows only 90 calendar days to file a claim.
- At all times during the agreement, the provider shall indemnify and hold TennCare harmless from all claims, losses, or suits relating to activities under the agreement.

Recommendation

OmniCare Health Plan, Inc., should comply with the Bureau of TennCare's requirements for provider agreements. The provider agreements should contain all items as specified in Section 2-18 of the TennCare contract.

Management's Comment

OmniCare currently incorporates in the provider contract an exhibit, "Billing and Payment Procedures," which defines a clean claim, informs the provider of our obligation to process the claim within 30 days, and their obligation to file the clean claim within 120 days from the date of service. We are currently updating our provider contracts to include a statement to hold TennCare harmless from all claims, losses, or suits relating to activities under the agreement.