

**VANDERBILT HEALTH PLANS, INC.**

**For the Period  
January 1, 1995, Through December 31, 1996**

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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) Vanderbilt Health Plans, Inc., for the period January 1, 1995, through December 31, 1996.

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  
**Vanderbilt Health Plans, Inc.**  
For the Period January 1, 1995, through December 31, 1996

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## 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

### **Deficiencies in Claims Processing System**

Vanderbilt Health Plans, Inc., did not fulfill contract reporting and processing efficiency requirements. Errors were discovered in the payment and denial of medical claims. Weekly claims processing reports did not comply with TennCare contract requirements (page 6).

### **Deficiencies in Provider Agreements**

Vanderbilt Health Plans, Inc., did not include in the provider agreements all requirements specified by the TennCare contract (page 9).

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

Comptroller of the Treasury, Division of State Audit  
1500 James K. Polk Building, Nashville, TN 37243-0264  
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**Vanderbilt Health Plans, Inc.**  
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**Compliance Review  
Vanderbilt Health Plans, Inc.  
For the Period January 1, 1995, through December 31, 1996**

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**INTRODUCTION**

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**OBJECTIVES OF THE REVIEW**

This report details the results of a compliance review of the transactions, books, and accounts of Vanderbilt Health Plans, Inc. (VHP). The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if VHP 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 Contractor Risk Agreement between Vanderbilt Health Plans, 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 Vanderbilt Health Plans, Inc., for the period January 1, 1995, through December 31, 1996. 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 contracted with 12 managed care organizations to 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.

Vanderbilt Health Plans, Inc., a Tennessee corporation which is wholly owned by Vanderbilt Health Services, Inc., was incorporated on May 14, 1993, as a health maintenance organization for the purpose of providing managed health care services to residents of Tennessee, including those participating in the State of Tennessee's TennCare Program. Effective January 1, 1994, Vanderbilt Health Plans, Inc., contracted with the State of Tennessee as a health maintenance organization (HMO) to provide medical services under the newly established TennCare Program. At December 31, 1995, the enrollment in the TennCare Program for the plan was approximately 12,400 members. At December 31, 1996, the enrollment in the TennCare Program for the plan was approximately 10,300 members.

As a HMO, Vanderbilt Health Plans, Inc., 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, which differs from

generally accepted accounting principles in that “admitted” assets must be easily converted to cash to pay for outstanding claims. “Non-admitted” assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity. The plan maintained a restricted deposit of \$330,000 at December 31, 1995, to satisfy requirements of the Department of Commerce and Insurance. At December 31, 1996, the plan maintained a restricted deposit of \$365,000 to satisfy requirements of the Department of Commerce and Insurance.

The annual statement for the year ended December 31, 1995, reported \$4,790,397 in plan assets, \$4,121,214 in liabilities, and \$669,183 net worth. Vanderbilt Health Plans, Inc., reported total revenues of \$18,069,445 and total expenses of \$22,360,420, resulting in a net loss of \$4,290,975 for the period January 1 through December 31, 1995. Revenue consisted of \$20,917,860 in premiums received from TennCare, \$203,415 in investment income, \$122,985 in refund of medical incentives, and (\$3,174,815) from subsidiary operations. Expense consisted of \$18,545,130 in medical expenses and \$3,815,290 in administrative expenses.

The annual statement for the year ended December 31, 1996, reported \$6,228,212 in plan assets, \$3,442,763 in liabilities, and \$2,785,449 net worth. Vanderbilt Health Plans, Inc., reported total revenues of \$10,043,383 and total expenses of \$14,152,288, resulting in a net loss of \$4,108,905 for the period January 1 through December 31, 1996. Revenue consisted of \$15,546,377 in premiums received from TennCare, \$250,798 in investment income, and (\$5,753,792) from subsidiary operations. Expense consists of \$11,265,129 in medical expenses and \$2,887,159 in administrative expenses.

## **PRIOR REVIEW FINDING**

The previous review of Vanderbilt Health Plans, Inc., for the year ended December 31, 1994, included the following finding:

### **Weaknesses in Claims Processing**

Vanderbilt Health Plans, 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 previous finding will be repeated in the current report (see the Findings and Recommendations section of this report).

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## **RESULTS OF THE REVIEW**

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Our review of the plan revealed discrepancies in the claims processing system and in provider agreements. These discrepancies are further discussed in the Findings and Recommendations section of the report. Our review of the plan's accounting and financial data revealed no material discrepancies.

Subsequent events and review adjustments will affect the reporting on the annual statement for VHP for the period January 1 through December 31, 1996. An amended annual statement was submitted as a result of corrections in reported amounts for the value of the subsidiary's investment and non-admitted assets. The correction increases equity for VHP by \$88,925. Additionally, review testwork revealed premium tax expense was understated \$5,361 and the incentive cap pool expense was overstated \$127,763. The effect of subsequent events and review adjustments is to increase equity from \$2,785,449 to \$2,996,776 as of December 31, 1996. VHP appears to have sufficient capital to ensure uninterrupted delivery of health care.

## **FINDINGS AND RECOMMENDATIONS**

### **1. Deficiencies in claims processing system**

#### **Finding**

Vanderbilt Health Plans, Inc., has not fulfilled contract reporting and processing efficiency requirements. Fifty-five claims were judgementally selected for claims processing testing for dates of service January 1, 1995, through December 31, 1996. Our review noted the following problems:

- For three claims, VHP did not input all procedure/revenue codes and corresponding charges from the claims submitted by the provider. Instead, VHP combined multiple procedure/revenue codes into a single code. Also, VHP does not report the minimum required number of diagnoses from claims submitted by providers. Section 2-11(f) of the TennCare contract states, "Individual encounter/claim data shall be reported in a standardized format as specified by TennCare." Attachment II, Exhibit E, of the contract specifies revenue codes and a minimum of five diagnoses as data elements required for individual encounter/claims data reporting.
- For three claims, discrepancies were discovered in the date the claim was considered received. One claim had two received dates, yet the system shows the claim as being received only once. Two claims did not have a received date. Properly recording the date received is significant because of the required processing efficiency calculations of the TennCare contract.
- For three claims, the amount paid did not agree with either fee schedules or system pricing methods.
- For one emergency room claim, the claim was denied even though the diagnosis for the service met VHP's requirements of an emergency.
- For four claims, discrepancies were noted in the input of the claims or the remittance advices. VHP denied payment on one claim, yet there is no denial reason in the system. On one claim, the billed amount for a service was incorrectly entered. For two claims, all processed services did not trace to the remittance advice. A remittance advice is the written communication to the provider concerning payments and denials. Without a proper remittance advice, the provider is unable to reconcile and correct problems with claims if resubmission is necessary.
- For two claims, VHP could not locate the original claim submitted by the provider.
- VHP has not met claims processing requirements specified by the TennCare contract. Claims submitted by providers for medical services were not always processed within

the 60-day requirement. Also, VHP did not pay or deny 95% of the clean claims tested within the 30-day requirement with the remaining 5% of the clean claims to be paid or denied within ten calendar days. Of the 55 claims tested, all were clean claims with the following time lags:

- a) 17 claims within 30 days (31%)
- b) 10 claims, 31-40 day lag (18%)
- c) 14 claims, 41-60 day lag (25%)
- d) 14 claims, over 60 day lag (25%)

An additional review of claims submitted by a hospital provider was performed. This testwork included 40 claims for dates of service during 1995 and ten claims for dates of service during 1996. No problems were noted for claims with dates of service during 1996. The following problems were noted for claims with dates of service during 1995:

- For six claims, VHP did not input all procedure/revenue codes and corresponding charges from the claims submitted by the provider.
- For one claim, the hospital had obtained prior authorization, but VHP denied the claim for no authorization.
- For one emergency room claim, the claim was denied on initial processing even though the diagnosis for the service met VHP's requirements of an emergency.
- One claim has not been adjudicated and remains in the claims processing system in a hold status. The claim has exceeded the TennCare contract requirement that all claims must be processed within 60 days.

Weekly claims processing reports are not in compliance with contract requirements. Section 2-11(g) of the TennCare contract requires the plan to report to TennCare certain information on a weekly basis. The following items were not included in these weekly reports: (1) approximate waiting time for member response, and (2) number of member phone calls.

As a result of the inaccuracies and inefficiencies of the claims processing system, VHP has not fulfilled claims processing requirements of the TennCare contract.

### **Recommendation**

Vanderbilt Health Plans, Inc., should adhere to contract reporting requirements and processing efficiency requirements for claims processing. Claims should not be denied for no authorization when a valid authorization exists. The remittance advices should adequately communicate all services in order for providers to respond. Claims should be paid or denied in the time required by the TennCare contract. Claims should be paid according to the correct fee schedule or contracted pricing methodologies. All data elements required for individual

encounter/claims data reporting should be recorded from claims submitted by providers. Claims should not be denied when the service meets VHP's requirements of an emergency. The date claims are received should be properly recorded in the claims processing system. VHP should adhere to contract guidelines regarding the submission of weekly claims processing reports.

### **Management's Comment**

Examiners are required to enter claims using line-item entry method just as they are billed by the provider.

There are instances when a claim is received and rejected back to the provider outside of the claim system on a manual check-off letter. These occur mainly due to record of eligibility in the system. When the provider resubmits these claims they typically resubmit the original claim with a copy of our check-off letter and information requesting that we reconsider as they have contacted the State and have been advised of retro eligibility on the member. In these instances there will be two different received date stamps on a claim and the examiner is required to enter the most recent received date on the claim and would not deny for exceeding filing on these since they are retro eligibility issues. Every claim should be received date stamped upon receipt. In the event that an examiner receives a claim in a batch that has not been received date stamped, they are required to use the same received date that is found on all other claims in that batch and note the claim as such.

The department has a written policy on emergency care claims which is based on specific diagnosis codes. If a claim is submitted for emergency room or urgent care and has a diagnosis on Auto Payment list, authorization is waived, the claim is noted as such and paid.

Examiners are prompted by the system when entering claims to review the listing of authorizations for a member. They are required to link to appropriate authorizations when adjudicating a claim for benefits. In the event that a claim is denied, the provider appeals and a retro authorization is issued, and the denied claim is reconsidered based on retro authorization.

Held claims report is generated and worked weekly by examiners. Typically claims are not held any longer than 60 days. If additional information is needed from a provider and is not received within 60 days, the claim is rejected and the provider is advised that additional information was needed and never received.

The department is currently processing clean claims within an average of 15 days of receipt. This has been the average turnaround time since May 1997. From January through April 1997 turnaround time was between 20 and 35 days. This was due largely to a backlog of inventory which occurred when the company encountered a 30 percent reduction in staff at the end of December and a transition to new ownership in March. We are fully staffed at this time and have been since March.

## 2. Deficiencies in provider agreements

### Finding

Vanderbilt Health Plans, Inc., (VHP) did not comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements did not contain all requirements as specified in section 2-18 of the contract between TennCare and VHP.

Section 2-18 of the contract between TennCare and VHP specifies 37 (a through kk) items that provider agreements must meet. Among the items missing from some provider agreements were:

- f. Specify that the provider may not refuse to provide medically necessary or covered preventive services to a TennCare patient under this Agreement for non-medical reasons, including, but not limited to, failure to pay applicable deductibles, copayments and/or special fees. However, the provider shall not be required to accept or continue treatment of a patient with whom the provider feels he/she cannot establish and/or maintain a professional relationship;
- w. Provide for payment within thirty (30) calendar days to the provider upon receipt of a clean claim properly submitted by the provider;
- y. Specify that at all times during the term of the agreement, the provider shall indemnify and hold TENNCARE harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TENNCARE and the MCO. This indemnification may be accomplished by incorporating Section 4-19 of the TENNCARE/MCO Agreement in its entirety in the provider agreement or by use of other language developed by the MCO and approved by TENNCARE.
- ee. As of October 31, 1995, contain a provision requiring resolution of disputes by arbitration, approved by TENNCARE.
- ii. Specify that the provider must adhere to the Quality of Care Monitors included in the MCO/TENNCARE Agreement as Attachment IV. The Quality of Care Monitors shall be included as part of the provider agreement between the MCO and the provider.
- jj. Specify that a provider shall have at least one hundred and twenty (120) calendar days from the date of rendering a health care service to file a claim with the CONTRACTOR.

### **Recommendation**

Vanderbilt Health Plans, Inc., should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items as specified in section 2-18 of the TennCare contract.

### **Management's Comment**

Management did not respond to this finding.