

Tennessee Behavioral Health, Inc.

**For the Period
July 1 Through December 31, 1996**

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July 23, 1997

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
and
The Honorable Nancy Menke, Commissioner
Department of Health
3rd Floor Cordell Hull Building
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the report on the financial and compliance review of the behavioral health organization (BHO) Tennessee Behavioral Health, Inc., for the period July 1 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 Department of Mental Health and Mental Retardation in its review to determine whether the BHO has adhered to the terms of the behavioral health organization contract. The Tennessee Department of Mental Health and Mental Retardation 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/cr
97/086

cc: Bill Young
Theresa Clarke
Ben Dishman

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review
Tennessee Behavioral Health, Inc.
For the Period July 1 through December 31, 1996

REVIEW OBJECTIVES

The objectives of the review were to determine if the behavioral health organization (BHO) is meeting its contractual obligations, including, but not limited to, proper claims payment, proper accounting for payments from the state, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

REVIEW FINDINGS

Failure to Maintain Minimum Equity Requirements and Positive Working Capital

Tennessee Behavioral Health, Inc. (TBH), failed to meet minimum equity and working capital requirements. As of December 31, 1996, TBH had a review-adjusted equity of \$253,279 (page 9).

Errors in Payments and Contractual Discrepancies With Community Mental Health Centers

Errors were discovered in the calculation of payments to the Community Mental Health Centers (CMHCs). Also, the community mental health centers are charged for services rendered to their assigned recipients even though they have little input in directing that care (page 9).

Deficiencies in Annual Statement Reporting

TBH did not file its annual statement in the requested format. Administrative expenses were improperly reported on the annual statement. Receivables over 90 days were incorrectly reported as assets readily turned to cash (page 12).

Improper Denial of Priority Member Benefits

TBH improperly denied priority members mental health and substance abuse services. Copayments were incorrectly calculated for enhanced members (page 14).

Judicial Claims Are Denied

TBH inappropriately denied court ordered services for individuals who are not participants in the TennCare Partners Program (page 15).

Deficiencies in the Authorization System

TBH's method of transferring authorizations from a subcontractor causes delays in the availability of authorizations on TBH's claims processing system. TBH has improperly denied claims for "no authorization" when a valid authorization exists (page 16).

Deficiencies in Claims Processing

TBH has not fulfilled contract reporting and processing efficiency requirements. Errors were discovered in the payment, denial, and copayment calculation of mental health and substance abuse claims. An explanation of benefits was not provided to uninsured mem-

bers when a copayment calculation was required. TBH does not track outpatient mental health benefits for basic participants in order to perform reassessments (page 17).

Deficiencies in Encounter Data Reporting

TBH inadequately reported encounter data required by contract: the encounter data did not include all claims payments, and monthly summary reports were not submitted timely (page 22).

Lack of Coordination With TennCare Managed Care Organizations

TBH has not coordinated with the TennCare managed care organizations as required under their coordination agreements. No action has been taken to address upper limits on coinsurance due from recipients (page 23).

"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
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**Compliance Review
Tennessee Behavioral Health, Inc.
For the Period July 1 Through December 31, 1996**

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**Compliance Review
Tennessee Behavioral Health, Inc.
For the Period July 1 Through December 31, 1996**

INTRODUCTION

OBJECTIVES OF THE REVIEW

This report details the results of a compliance review of the transactions, books, and accounts of Tennessee Behavioral Health, Inc. (TBH). The purpose of this review was to evaluate the programmatic operations of the behavioral health organization (BHO) and to determine if the plan was administered in accordance with the requirements of *Tennessee Code Annotated* and the contract between the state and TBH. The objectives of the review were

1. to determine whether TBH is meeting its contractual obligations under the TennCare agreement with the state;
2. to determine whether TBH 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 the state to TBH are accurate;
4. to determine if TBH has sufficient financial capital to ensure uninterrupted delivery of mental health and substance abuse services;
5. to determine if records maintained by TBH are adequate to determine compliance with the rules and contract requirements of the Tennessee Department of Mental Health and Mental Retardation; and
6. to recommend appropriate actions to correct any deficiencies.

POST-AUDIT AUTHORITY

This review was conducted pursuant to Section 3.14.2 of the Provider Risk Contract between the State of Tennessee Department of Mental Health and Mental Retardation and Tennessee Behavioral Health, Inc. which states:

The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred under this CONTRACT as well as medical information relating to the individual Participants

for the purpose 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 CONTRACT 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 CONTRACT period, these records shall be available at the CONTRACTOR's chosen location subject to the approval of TDMHMR. If the records need to be sent to TDMHMR, 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 TDMHMR if the CONTRACT or subcontract is continuous.

SCOPE OF THE REVIEW

The review examined the records, transactions, and contract provisions of Tennessee Behavioral Health, Inc., for the period July 1 through December 31, 1996. The review included tests of insurance claims, review of accounting records, and other review procedures considered necessary.

BACKGROUND INFORMATION

The TennCare Partners Program, a managed care capitation program for mental health and substance abuse services, was initiated on July 1, 1996, and is designed to function in a manner similar to the TennCare Program. TennCare replaced the existing Medicaid Program on January 1, 1994, with a program of managed health care providing traditional medical services. Prior to July 1, 1996, mental health and substance abuse services were generally funded by grants or fee-for-service payments from the state. Although some grant payments, such as contracts with the Department of Children's Services, to the community mental health centers are unaffected by the TennCare Partners Program, funding for most of the services has shifted to the TennCare Partners Program. Each month, the state pays a capitation rate for each TennCare Partners Program participant to one of the two managed care organizations, referred to as behavioral health organizations (BHOs), that contract with the state to provide mental health and substance abuse services. Previously five BHOs were approved to provide mental health and substance abuse services for the TennCare Partners Program. A consolidation occurred to form two BHOs instead of the original five. The BHOs are Premier Behavioral Systems of Tennessee, LLC, located in Nashville, and Tennessee Behavioral Health Inc. (TBH), located in Knoxville.

TENNCARE PARTNERS PROGRAM PARTICIPANTS

The assignment of 1,177,000 TennCare Partners Program participants to the two BHOs is based upon the participants' enrollment in the TennCare managed care organizations. The managed care organizations and their approximately 482,000 participants assigned to TBH are as follows:

- Access . . . Med Plus
- Blue Cross/Blue Shield (East Tennessee*)
- TennSource (terminated December 31, 1996, with participants transferred to Phoenix Health Plan)
- Preferred Health Partnership
- Prudential Community Care
- TLC Family Care Healthplan
- Blue Care (in Knoxville, formerly Total Health Plus)

*East Tennessee includes the counties Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, Union.

The remaining managed care organizations and their approximately 695,000 participants are assigned to Premier Behavioral Systems of Tennessee, LLC.

There are two categories of participants in the TennCare Partners Program: priority participants and basic participants. Priority participants include individuals diagnosed as Severely and/or Persistently Mentally Ill (SPMI) aged 18 years or older and individuals diagnosed as Severe Emotional Disturbance (SED) under the age of 18. TennCare Partners participants who are not priority participants are referred to as basic participants. Services covered for both the priority and basic participants include inpatient psychiatric hospitalization, outpatient mental health services, substance abuse treatment, psychiatric pharmacy and lab-related services, transportation to mental health and substance abuse services, and specialized crisis services. Additional services covered for the priority population include mental health case management, 24-hour residential treatment, housing/residential care, specialized outpatient and symptom management, and psychiatric rehabilitation services. Approximately 52,000 of the total TennCare Partners Program participants are in the priority population.

An additional category of individuals for which mental health and substance abuse services are covered by the BHOs are judicials. These individuals are not considered enrollees or partici-

pants in the BHO plan but are entitled to coverage for services required by the statute or court order under which the individual was referred.

RESPONSIBILITIES OF CONTRACTED PARTIES

The Tennessee Department of Mental Health and Mental Retardation (TDMHMR) is the state agency responsible for administration of the TennCare Partners Program. TDMHMR and the Bureau of TennCare are responsible for verifying the eligibility of participants and for assigning them to and disenrolling them from the TennCare Partners Program.

Specific qualifications and responsibilities with which the behavioral health organization must comply include:

1. Maintain service accessibility and availability through the existence of a current state-wide network of appropriately licensed and credentialed mental health and substance abuse providers capable of providing 24-hour comprehensive mental health and substance abuse care;
2. Pay or appropriately deny 95% of the total number of clean claims from both contract and noncontract providers within 30 calendar days of receipt, pay or appropriately deny the remaining 5% of the total number of clean claims within the next ten days, and process all claims submitted by contract and noncontract providers within 60 calendar days of receipt;
3. Provide mental health case management in accordance with standards set by TDMHMR;
4. Identify persons in need of clinical related group/target population group assessments, provide these assessments promptly and accurately, and follow up on identifications with treatment plans and reassessments as necessary;
5. Manage mental health and substance abuse provider networks: recruit, credential, enroll, train, and manage providers and maintain positive provider relationships;
6. Provide a responsive grievance and appeals process, both formal and informal;
7. Meet and maintain the administrative requirements of the Tennessee Department of Commerce and Insurance (TDCI) as specifically set forth in the PROVIDER RISK CONTRACT or applicable statute;
8. Establish and maintain adequate risk reserves;

9. Have adequate and appropriate general liability, professional liability, and workers compensation insurance for the protection of clients, staff, facilities, and the general public;
10. Measure and report utilization, cost, quality, and patient satisfaction data through a management information system that supports the specific administrative and clinical decision making required for delivery of mental health and substance abuse services; and
11. Mutually agree to such other requirements as may be reasonably established by TennCare, TDCI, and TDMHMR.

TBH is allowed to retain up to 10% of the monthly capitation amount paid by the Bureau of TennCare as a management fee, with the remainder of the monthly capitation payment available for the payment of covered direct mental health and substance abuse services and premium taxes. Any and all excess administrative costs are borne by TBH. If the actual accrued amount paid by TBH for covered services and premium tax is less than 90% of the amounts paid by the Bureau of TennCare, then TBH shall remit to TDMHMR 100% of the difference.

ADMINISTRATIVE ORGANIZATION OF TBH

Tennessee Behavioral Health, Inc. (TBH), is a wholly owned subsidiary of Preferred Health Partnership Companies, Inc., which is a wholly owned subsidiary of Covenant. TBH sub-contracts with Merit Behavioral Companies of Tennessee (MBCT) to provide administrative services. The subcontract specifies a distribution of 51% of the profits to MBCT. Profits are determined by deducting agreed-upon direct administrative expenses from 10% of the premiums paid by the Bureau of TennCare. The officers and board of directors for TBH and the board of directors of MBCT are as follows:

Officers for TBH

David B. Patterson, President
 William T. Rust, Chief Executive Officer
 Karen N. Ellis, CPA, Assistant Secretary and Chief Financial Officer

Board of Directors for TBH

Randolph Lowery, M.D.	William H. Rachels, Sr.
Kenneth Luckmann, M.D.	Marvin Eichorn
Ralph G. Lillard, Jr.	Winfield Dunn
Richard Stooksbury, Jr.	Joseph N. McDonald
John Milner	

Board of Directors for MBCT

Henry Kravis

George Roberts

Edward Gilhuly

Todd Fisher

Albert Waxman

Arthur Halper

Ronald Geraty

Terry Thompson

PROVIDER CONTRACTS AND SUBCONTRACTS

TBH must obtain written approval from TDMHMR for all of its provider contracts and subcontracts. The contract between TDMHMR and TBH requires that TBH contract with the State of Tennessee's five regional mental health institutes. These institutes provide essential in-patient mental health services to the priority population. TBH has contracted with the regional mental health institutes on a per diem basis. In addition, the contract encourages TBH to contract with community mental health centers (CMHCs). The primary providers of outpatient mental health services for the priority population are the CMHCs located across the state. TBH originally contracted with 29 CMHCs to provide medically/psychologically necessary designated covered services. The CMHCs are compensated based on the following language from the provider agreement between TBH and the CMHCs:

For Enrollees assigned to Provider (CMHC), payment will be 100% of net premium, defined as gross premium received by TBH from Payor Plan (TennCare Partners Program) less premium tax and administration fees, less any payments for fee-for-service care, subcapitation arrangements, or direct funding agreements for services provided to Enrollees assigned to Provider and eligible for payment under Payor Plan. . . . For Enrollees not assigned to Provider, but eligible for payment under Payor Plan, Provider will be reimbursed in accordance with fee schedule.

Under this contracted methodology, the CMHCs act as care coordinators responsible for arranging the behavioral health care needs of their assigned participants. The CMHCs' assignment of priority and basic participants and their associated monthly capitation received from TBH is determined by each enrollee's zip code. From the assigned participants' capitation, premium tax of 1.75% payable to the State of Tennessee and 10% administration fees payable to TBH and MBCT are subtracted. The remaining 88.25% of net capitation is available for the payment of medical services. The CMHCs' monthly payment for participants is dependent on the behavioral services used by the assigned participants for fee-for-service items, subcapitation arrangements contracted by TBH, and grant payments.

Fee-for-service items include behavioral health claims submitted by providers. The claims are paid by TBH based on either a fee schedule or per diem rate. Because there is a delay between the service and the submission and payment of claims, estimates are used to determine the incurred but not reported claims (IBNR) for each month. TBH calculates the IBNR for all enrollees and then allocates the amount to the individual CMHCs based on their percentage of enroll-

ment. The IBNR amounts directly reduce the monthly payments to the CMHC for assigned participants.

Subcapitation arrangements include payments to a TennCare managed care organization and the University of Tennessee Medical Group. The managed care organization has contracted with primary care physicians who provide a portion of mental health services for the BHO. Additionally, TBH has contracted with Quality Transportation, Inc., to provide transportation services and with RxCare and Promark to provide pharmacy services to participants statewide. TBH contracts with Behavioral Health Group, Inc., to provide medical management and utilization review services. TBH reduces the CMHCs' assigned participants' capitation by a per member per month amount for subcapitation arrangements.

ANNUAL STATEMENT REPORTING

As a BHO, Tennessee Behavioral Health, Inc., files quarterly and annual statements with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the behavioral health 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 "admitted" assets must be easily converted to cash to pay for "nonadmitted" outstanding claims. Assets such as furniture, equipment, and prepaid expenses are not to be 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 \$1,000,000 to satisfy requirements of the TennCare Partner Program contract. As of December 31, 1996, the plan re-reported \$20,915,421 in admitted plan assets, \$20,283,809 in liabilities, and \$631,612 in equity on its annual statement. The plan reported total revenues of \$64,731,150 and total expenses of \$64,407,909 producing a net income of \$323,241 for the period July 1 through December 31, 1996. Revenue comprises \$64,139,087 in capitation fee payments from TennCare and \$592,063 in interest income and miscellaneous income. The plan reported \$57,665,720 in medical expenses and \$6,742,189 in administrative expenses.

This is the first review of Tennessee Behavioral Health, Inc.'s compliance with the provisions of its contract with the Tennessee Department of Mental Health and Mental Retardation and Tennessee Behavioral Health, 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.

Our review of the capitation payments by the Bureau of TennCare and the payments and accrued amounts for mental health and substance abuse services revealed that the actual accrued amount paid by TBH for covered services and premium tax is greater than 90% of the amounts paid by the Bureau of TennCare. A savings calculation as defined in the TennCare Partners contract is not considered necessary.

Subsequent material events and review adjustments will affect the reporting on the annual statement for Tennessee Behavioral Health, Inc., for the period July 1 through December 31, 1996. The balance sheet and income statement for TBH were adjusted by the Division of State Audit as follows:

- Retroactive receivables were adjusted to actual payments. The net increase to retroactive accounts receivable and premium revenue was \$211,862.
- Premium tax expense and payable were adjusted to actual revenue after applying the appropriate rate. The net increase to both premium tax expense and premium tax payable was \$96,766.
- Mental health and substance abuse services was adjusted to a percentage of actual revenue using the methodology established by TBH. Additionally, administrative expense was improperly classified on the annual statement as mental health and substance abuse services (see finding 3). The net increase to mental health and substance abuse expenses was \$153,369, and the increase to claims payable was \$990,366.
- The reclassification of expenses as administrative will increase management expenses and reduce amounts expensed as franchise and excise taxes and income taxes. The net increase to administrative expenses was \$406,449, and the net decrease to income tax expense and payable was \$109,782. The net decrease to accounts payable affiliates was \$416,063, and the net decrease to franchise and excise tax payable was \$14,485.
- Accounts receivable was adjusted as nonadmitted assets (see finding 3). The decrease to accounts receivable and equity was \$43,393.

The effect of review adjustments is to decrease equity from \$631,612 to \$253,279 as of December 31, 1996. Review-adjusted equity fails to meet the minimum requirement of the TennCare Partners Program contract (see finding 1). A review-adjusted balance sheet and statement of revenue, expenses, and net worth is shown on schedules 1 and 2.

FINDINGS AND RECOMMENDATIONS

1. Failure to maintain minimum equity requirements and positive working capital

Finding

Tennessee Behavioral Health, Inc., does not meet minimum equity requirements of a behavioral health organization with a review-adjusted equity of \$253,279 for the period July 1 through December 31, 1996. The equity should be equal to or greater than the \$3,217,548 required in Section 3.3.2.1 of the TennCare Partners contract. TBH has not maintained positive working capital (current assets in excess of current liabilities) as required by Section 3.3.2.2 of the TennCare Partners contract. Review-adjusted working capital for the period July 1 through December 31, 1996, is (\$3,043,601).

Recommendation

Tennessee Behavioral Health, Inc., should take the appropriate action to meet minimum equity requirements and achieve a positive working capital position. The Tennessee Department of Commerce and Insurance should take whatever action deemed necessary to ensure that Tennessee Behavioral Health, Inc., meets the equity and working capital requirements of the TennCare Partners contract.

Management's Comment

To address this issue, TBH originally submitted a letter of credit. Subsequent to June 1, 1997, we invested the appropriate amount of cash in TBH to address the minimum equity and positive working capital requirements.

2. Errors in payments and contractual discrepancies with community mental health centers

Finding

TBH made errors in the calculation of payments to the community mental health centers. Also, the contract with the CMHCs does not allow them to manage care, but they assume the burden of the financial risk. Our review noted the following problems with the calculations and payments by TBH to the CMHCs:

- Fee-for-service payments are not reduced from the CMHCs' monthly capitation for assigned enrollees. Instead, TBH computes the reduction of the monthly capitation for fee-for-services payments by applying each CMHC's percentage of enrollment to total fee-for-service payments by TBH. This is contradictory to the contracts between the CMHCs and TBH and results in overpayments and underpayments to CMHCs.
- Incurred but not reported (IBNR) calculations are based on budgeted amounts established in July 1996. IBNR is a reduction of the monthly capitation payment to the CMHCs because it estimates claims to be ultimately paid. TBH's inability to base IBNR calculations on actual experience instead of on a budget is due in part to delays by TBH in processing regional mental health institute claims and to deficiencies noted in the claims processing system. Inaccuracy of the IBNR calculation may have an adverse financial effect on the CMHCs.
- TBH reduces the capitation to CMHCs for monthly payments to a managed care organization and the University of Tennessee Medical Group. These subcapitation arrangements were established in recognition that some mental health and substance abuse services are provided through the managed care organizations' contracts with primary care physicians. No controls exist in TBH's claims processing system to prevent primary care physicians covered under these subcapitation arrangements from being paid twice. The CMHCs' monthly payments are reduced once for the subcapitation arrangement and again for the fee-for-service payment for the same service if any are paid.

The contractual arrangement between CMHCs and TBH jeopardized the stability of services to the priority population. The contracts between the CMHCs and TBH assign the risk of medical costs to the CMHCs. TBH's only risk is administrative: no risk is assumed as long as management expenses are 10% or less of the monthly capitation payments from the Bureau of TennCare. These contracts assume that the CMHCs have the ability to manage all types of care although the CMHCs provide only outpatient services for the priority population. The centers actually have a limited ability to manage care for their patients. Additional areas and factors which unduly places risk on the CMHCs include the following:

- Participants are allowed to choose any provider in TBH's network per the TennCare Partners contract. A gatekeeper system similar to a managed care organization is not allowed.
- The CMHCs are dependent upon TBH's negotiations for contract payments for other services such as inpatient, pharmacy, transportation, and primary care subcapitation payments. These payments reduce the CMHCs' monthly capitation, yet the CMHCs do not participate in the contract negotiations for these payments.
- The CMHCs are dependent upon TBH's ability to properly process fee-for-service claims. Deficiencies have been discovered in the claims processing system, including

duplicate payments (see finding 7). Any overpayments to providers for fee-for-service claims ultimately reduce the amount paid to the CMHCs.

- Since TBH reduced each CMHC's payments for fee-for-service payments based on percentage of enrollment instead of on the actual fee-for-service payments for their assigned participants, the CMHCs are not given credit for their ability to manage care.

As part of a separate review by the Division of State Audit regarding the status of the CMHCs under the TennCare Partners program, the CMHCs cited the inability to manage the care of TBH-enrolled recipients as a major problem. According to the centers, they were aware the TBH contract put them at significant risk, but they believed and continue to believe that the contract gives them the right to manage the care of enrolled patients. The CMHCs, however, were not given that opportunity and thus believe their inability to manage care has resulted in excessive use of high-cost services, such as inpatient, at their expense. The CMHCs have experienced a revenue reduction under the TennCare Partners program as compared to previous fee-for-service arrangements for comparable services. One community mental health center has closed since the inception of the TennCare Partners program. An additional problem noted is complaints regarding the transportation vendor, Quality Transportation, Inc. Quality Transportation, Inc., is paid a per member per month capitation by TBH for all transportation services connected with mental health and substance abuse services. Many CMHCs continued to provide transportation using their own resources with the understanding that Quality Transportation, Inc., would reimburse them. However, in most cases they have received no reimbursement. Many of the CMHCs report poor service from the transportation subcontractor. Problems ranged from late pick-up and return rides to failed pick-ups leading to missed appointments. TBH will not pay for unreimbursed transportation services billed by the CMHCs and expects the CMHCs to resolve payment and failed service disputes with Quality Transportation, Inc.

As of December 31, 1996, TBH computed that the CMHCs have been overpaid \$3,589,325 and has reported this amount as an accounts receivable due from the CMHCs. This amount represents the estimated expenses beyond 88.25% of the monthly amounts paid by the Bureau of TennCare for the period July 1 through December 31, 1996. The collection of the CMHC receivable is considered questionable and has been excluded from admitted assets by the Tennessee Department of Commerce and Insurance in the determination of statutory equity. Any additional amounts accrued to IBNR would result in similar increases to the receivable but would not continue to affect statutory equity.

The state informed TBH on April 18, 1997, that risk contracts with the CMHCs, although assumed to be allowable through a contractual process, leave in doubt the stability of the services required by the priority population which the TennCare Partners program is designed to serve. The state has prepared amendments to the TennCare Partners program contract with TBH to prohibit the passing of total financial risk to contractors or subcontractors without giving them commensurate management and control opportunities.

Recommendation

TBH should accurately calculate CMHC payments according to the CMHC contract language. Fee-for-service payments should be applied to the CMHC payments based on assigned participants and not on a percentage-of-enrollment basis. IBNR calculations should be updated based on historical payments when sufficient payments for regional mental health institute claims are processed as well as when errors noted in the claims processing system are corrected. Coordination should be established with the managed care organizations to prevent the payment of fee-for-service claims covered under capitation arrangements. Contracts with CMHCs should be amended so that total financial risk is not assumed by the CMHCs. The contractual risk applied to the CMHCs should be for services in which the CMHCs have an ability to effectively manage care and costs associated with those services. TBH should review and monitor the adequacy of the services provided by the transportation subcontractor. TBH should resolve the disputes for transportation service failures of Quality Transportation, Inc.

Management's Comment

We have been unable to establish individual IBNR reserves for each CMHC due to the fact that sufficient payments have not been made for prior periods. As a result, we do not have an actuarially sound basis for developing the individual IBNR pools. Once we have established individual pools, we will true-up the medical expenses incurred by each CMHC. Fee for services payments will be allocated based upon the member's CMHC vs. enrollment to the extent possible.

TBH's new contract model offers CMHCs the opportunity to manage the care provided to Partners members assigned to them under a capitated arrangement. The model does not allow CMHCs to accept risk for services which they cannot manage directly or indirectly. The implementation of the model considers the consumer's right to choose providers. TBH feels that this new contract increases the likelihood for success at the CMHC level.

TBH will increase oversight of its transportation vendors. Financial disputes between the CMHCs and QTS are being addressed at this time. QTS must resolve these reimbursement problems to TBH and CMHC satisfaction within a designated time frame.

3. Deficiencies in annual statement reporting

Finding

The following deficiencies were noted in the annual statement reporting for the period July 1 through December 31, 1996:

- The Department of Commerce and Insurance requested that TBH submit revenue and expenses on an updated format of the annual statement which provides a more accu-

rate classification of mental health and substance abuse services. TBH filed the annual statement on the previous format. Mental health and substance abuse services were inadequately classified either as other professional services or inpatient.

- Premium taxes are improperly classified as medical expenses. The updated format of the annual statement provides for the proper classification of premium tax expense as an administrative expense.
- Administrative expenses related to a contract with Behavioral Health Group, Inc., are incorrectly classified as a medical expense. The improper classification reduces the amount available for mental health and substance abuse expenses and increase the amount available for profit distribution between TBH and Merit Behavioral Companies.
- Administrative expenses were not properly classified in the required format of the annual statement.
- Receivables of \$43,393 are considered nonadmitted assets for statutory basis accounting. Receivables are considered nonadmitted if they are over 90 days old.

The Department of Commerce and Insurance and the Department of Mental Health and Mental Retardation cannot adequately assess the effectiveness of TennCare Partners Program because of the deficiencies in annual statement reporting.

Recommendation

TBH should file the annual statement on the format requested by the Department of Commerce and Insurance. Expenses should be properly classified according to the required format. Administrative expenses should not be classified as mental health and substance abuse services. Receivables over 90 days should be reported as nonadmitted assets.

Management's Comment

TBH will file the schedules for 1996 in the format requested by the Department of Commerce and Insurance. This format will address the first four items in finding 3. With respect to the receivables of \$43,393, we still consider them admitted assets. These receivables represent the advance of grant payments in the beginning of the program to the CMHCs. While they could have easily been collected within 90 days, it would have been a hardship on the CMHCs. The decision was made to collect it over a longer period to lessen the impact on the CMHCs.

4. Improper denial of priority member benefits

Finding

Tennessee Behavioral Health, Inc., has improperly denied mental health and substance abuse services for priority members for exceeding benefit limits although priority members have no benefit limits. Also, copayments are improperly charged to priority members on a 75%, 50%, 25% rule based on a number of visits instead of on a participant's income basis for outpatient mental health visits.

Section 2.6 of the TennCare Partners Program contract with TBH states that priority members do not have a maximum amount of outpatient visits or a lifetime dollar limit. Priority members are to receive all mental health and substance abuse services "as medically necessary."

Schedule E of Attachment G of the TennCare Partners Program contract with TBH states that the 75%, 50%, 25% rule for copayments applies only for persons who are not in the priority population. For priority participants, copayments are based upon income.

Recommendation

Tennessee Behavioral Health, Inc., should not limit member benefits for priority participants and should not charge the 75%, 50%, 25% rule for copayments for outpatient mental health visits. All previous claims improperly denied for exceeding member benefits for the priority population and any claims where a sliding scale basis of copayment was charged for outpatient mental health visits should be reprocessed.

Management's Comment

TBH incorrectly denied benefits to priority population members erroneously acting as if benefits limitations existed. We are aware that no such ceiling was applicable. Our error was procedural and was not the policy of the company. TBH reconfigured the benefits table in our claims payment system effective January 1, 1997, and presently there are no limits applied electronically to services for the priority population.

During the first six months of the Partners Program, TBH applied the wrong copayment schedule to services provided to priority population members. Since that error was identified, TBH applies the (correct) copayment schedule which is based upon family size and household income. This sliding fee scale results in a percentage payment expected from the patient. Copayments from the priority population range from 0% to 10% and are assessed at the point of service. TBH then deducts the copayment from the amount rendered to the provider upon claim payment.

TBH will reprocess all claims previously denied for exceeding member benefits for the priority population. In addition, prior claims adjudication which applied incorrect copayments to priority members will be reviewed for correction.

5. Inability to process judicial claims

Finding

Tennessee Behavioral Health, Inc., has not processed claims for court ordered mental health and substance abuse services as specified in the contract with the TennCare Partners Program. TBH's claims processing system denies court ordered services for individuals who are not participants in the TennCare Partners Program.

Section 2.2.3 of the TennCare Partners Program contract with TBH states that

The CONTRACTOR shall provide court-ordered mental health evaluation and treatment services to Judicials who are individuals identified by TDMHMR and who are not Participants in the TennCare Partners Program. Services which are included in this category are identified in Section 2.6.5. Individuals receiving Judicial Services who are not enrolled in TennCare or participate in the BHO plan by TDMHMR determination are defined as Judicials. Judicials are entitled only to coverage of those mental health evaluation and treatment services required by the statute or court order under which the individual was referred.

Recommendation

Tennessee Behavioral Health, Inc., should update the claims processing system so that it is able to process claims for court ordered mental health and substance abuse claims for individuals identified by TDMHMR as judicials and who are not participants in the TennCare Partners Program.

Management's Comment

TBH acknowledges its contractual responsibility to pay for court-ordered services. However, the mechanical reality is that our claims payment system guards against illegitimate payment for services to non-eligible individuals. Using Medicaid funds to pay claims for services to individuals whose eligibility is unconfirmed would violate Medicaid regulations and could place TBH in a somewhat questionable position. Inasmuch as we would prefer to adhere to federal guidelines and regulations, TBH remains hesitant to use TennCare funds to pay for court-ordered services until we can be sure that we are operating within the boundaries of this Medicaid funded program (paying for services to eligible participants). Payment for court-ordered services is de-

pendent upon confirmation from the Bureau of TennCare that those services/members are covered under the Partners Program. Rarely, if ever, do providers attach court orders to these claims. Therefore, it is imperative that court-ordered service recipients be included on the eligibility tapes we receive from TennCare. When we can match a claim with confirmed eligibility, our claims payment system will adjudicate. When there is no match, because the service recipient has not been confirmed as eligible by the Bureau, TBH cannot pay the claim without violating contractual guidelines set down by the Partners Program contract. If we pay claims for individuals who are not confirmed eligible by the Bureau, the encounter data we later submit to the department will flag the contradiction and TBH will be held financially accountable for abusing the guidelines.

Only recently have those court-ordered individuals been placed on TennCare eligibility tapes. When a court-ordered individual is not listed on the eligibility tape, TBH holds the claim for 30 days, meanwhile checking daily for a match. If the claim has been in the queue for 30 days and the individual's eligibility is still not confirmed by the TennCare Bureau eligibility file, TBH will return the claim to the provider.

Rebuttal

The contract between TDMHMR and TBH clearly defines judicials as individuals identified by TDMHMR who are not participants in the TennCare Partners Program. TBH should update the claims processing system so that it is able to process claims for judicials, regardless of whether the individuals are included on the TennCare recipient files sent to TBH.

6. Deficiencies in the authorization system

Finding

TBH has improperly denied claims for no authorization when a valid authorization exists. TBH's method of transferring authorizations from a subcontractor causes delays in the availability of authorizations on TBH's claims processing system.

Behavioral Health Group, Inc. (BHG), provides TBH with preauthorization services. BHG is electronically connected to TBH's claims processing system and software, but BHG does not utilize the connection. Instead, they record authorizations on a separate system. TBH's claims processors did not have access to authorizations until January 1997. TBH receives the authorizations on a printout from which they have to be manually entered into the claims processing system. There is a considerable lag time from when BHG enters the authorizations to when TBH loads them into their claims processing system.

Because of the deficiencies in the authorization system, claims are denied because they are received and processed before TBH ever loads the authorizations from BHG.

Recommendation

Tennessee Behavioral Health, Inc., should not deny claims for no authorization when a valid authorization exists. Authorizations should be made available to TBH's claims processing system in a timely manner: TBH should require BHG to use the electronic authorization connection.

Management's Comment

All Tennessee Behavioral Health Utilization Management functions are currently on-line and interfacing with the Knoxville IS facility. In March 1997, TBH eliminated multiple electronic pre-authorization systems. All TBH authorizations for behavioral health services are now recorded through a single system. Provider claims are adjudicated against this system. TBH anticipates that the accuracy and efficiency of this unified approach will limit invalid denials to providers.

In addition, TBH mounted an intense effort to assure that all authorizations since July 1, 1996, issued by the BHG vendor are correctly entered into TBH's electronic authorization system. This project is very near completion.

7. Deficiencies in claims processing

Finding

Tennessee Behavioral Health, Inc., has not fulfilled contract reporting and processing efficiency requirements. Two hundred claims were randomly selected for claims processing testing. Our review noted the following problems:

- a. Nine claims in the sample were paid twice. These duplicate payments were the result of TBH's using two different provider files. Also, TBH's claims system cannot recognize as duplicates resubmitted claims with "Y" and "Z" procedure codes. The overpayments will ultimately decrease amounts paid to the CMHCs.
- b. The following errors were discovered in the application of coinsurance for the "uninsured" participants:
 - A claim was denied, yet TBH charged the member a copayment.

- For three claims, TBH incorrectly applied a percentage of income copayment on an outpatient mental health visit rather than correctly applying a sliding scale basis copayment.
 - For two claims, TBH did not apply a copayment for outpatient mental health visits in which a sliding scale basis copayment should have been applied.
 - For one claim, TBH applied a sliding scale basis copayment to a service that was not subject to a copayment, and TBH incorrectly paid the provider for services which fell under capitation paid to a CMHC. Services under capitation do not require further payment.
- c. TBH does not provide uninsured members who are required to pay copayments an explanation of benefits (EOB). It is industry practice to provide health plan members with an EOB when a copayment is required.
- d. For five claims, TBH priced and/or paid incorrectly. Errors in TBH's claims processing system's provider files caused these discrepancies by matching claims to the wrong fee schedules. Also, claims were incorrectly paid because individual procedures on the claim were incorrectly denied. A claim with a missing data element was paid but should have been denied. This data element is required information for reporting encounter data to the state.
- e. The other claims were incorrectly denied for the following reasons:
- A basic member is eligible for 45 outpatient mental health visits per year. Four claims were incorrectly denied for a basic member when only 41 visits were paid.
 - TBH denied all emergency room (ER) and emergency room physician claims with an explanation code that the ER record must be attached. When the ER record is received, the claim is paid without review of the ER record. The attachment of the ER record is not a requirement of TBH's provider manual. ER claims that were denied for no ER record attachment were improperly denied.
 - Two claims were correctly denied, but the explanation communicated to the mental health and substance abuse provider was incorrect.
- f. TBH was unable to produce all of the remittance advices requested from the sample. A remittance advice is the written communication to the provider concerning payments and denials.
- g. TBH has not met claims processing requirements specified by the TennCare Partners Program contract. Claims submitted by providers for mental health and substance abuse services were not always processed within the 60 day requirement. Also, TBH 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 200 claims tested, 161 were clean claims with the following time lags:

- 100 claims within 30 days (62%)
- 23 claims, 31-40 day lag (14%)
- 33 claims, 41-60 day lag (21%), and
- five claims, more than 60 day lag (3%)

Of the remaining 39 claims, 34 (97%) were processed within 60 days and one was processed over 60 days. During claims testwork, five other claims were found that were still pending adjudication after 60 days. For the remaining four claims, a lag was not computed since they were in a pended status.

Section 3.13.2 of the TennCare Partners Program contract with TBH states that

The CONTRACTOR shall pay or appropriately deny within thirty (30) calendar days of receipt ninety five percent (95%) of all clean claims submitted by contract and non-contract providers. . . . Thereafter, the CONTRACTOR shall pay the remaining five percent (5%) of clean claims within ten (10) calendar days. The CONTRACTOR shall also process within sixty (60) calendar days of receipt all claims submitted by contract and non-contract providers.

TBH does not track outpatient visits for basic participants for purposes of reassessments as required by Section 2.2.2.2.3 of the contract. Reassessments are required when a basic participant reaches 40 outpatient mental health benefits in a calendar year. TBH also does not perform reassessments for children/adolescents admitted to a psychiatric unit. TBH relies upon the CMHCs to perform reassessments. The CMHCs cannot be expected to track all outpatient visits since participants may access more than one mental health and substance abuse provider.

Mental health and substance abuse providers stated that they have submitted claims to TBH but have never received a payment or denial. A sample of these claims was provided by an emergency room physicians group. These claims could not be found on TBH's claims processing system. It was discovered that TBH was returning claims to providers without entering the claims into the system. An additional review of a hospital provider was performed in which 35 additional claims were tested. The results are as follows:

- three of the claims submitted by the provider were not found on the TBH claims system
- one claim was suspended

- one claim was paid
- 30 claims were denied

TBH says that the 30 denied claims were denied for several reasons. However, not all reasons were valid:

- some were invalidly denied for missing ER records
- seven were denied for member not eligible when the member was eligible
- one was denied for patient not found because the member's name was misspelled by one letter
- 19 claims did not have enough information to make a determination as to whether the claims were denied validly.

As a result of the inaccuracies and inefficiencies of the claims processing system, TBH has not fulfilled claims processing requirements of the TennCare Partners Program contract. The errors and delays in claims processing have jeopardized the stability of the TennCare Partners Program. Duplicate payments ultimately decrease the amounts available to be paid to the CMHCs. Mental health and substance abuse providers have experienced significant financial and administrative problems caused by TBH's inability to process claims correctly.

Recommendation

Tennessee Behavioral Health, Inc., should adhere to contract reporting and processing efficiency requirements for claims processing. TBH should update the claims processing system to ensure duplicate payments do not occur. Copayments should be computed according to the TennCare Partners Program contract. Services covered under capitation should not be paid additionally as fee-for-service. An explanation of benefits should be provided to uninsured participants when a copayment is required. Claims should be paid according to the correct fee schedule. Basic participants should be allowed 45 outpatient mental health visits annually. Emergency room claims should not be denied for lack of ER record attachment. Denial reasons should appropriately reflect the reason for a claims denial. Remittance advices should be maintained to support provider payments and denials. Claims should be paid or denied in the time required by the TennCare Partners Program contract. TBH should track outpatient mental health benefits for basic participants in order to perform reassessments. All claims submitted by providers should be entered and processed in TBH's claims processing system. TBH should reprocess all previously paid claims for the errors noted.

Management's Comment

- a. Currently, TBH is processing all claims under one provider file. We are generating a report to capture all duplicate claims paid in order to recover overpayments.
- b. Since December of 1996, TBH has undergone a reconfiguration for our claims payment system. Processes that required manual manipulation in 1996 have been reconfigured for the system to automatically apply benefits to each claim. All claims that have been processed incorrectly are being reversed or recovered.
- c. The current EOB utilized for Preferred Health Partnership, Inc.'s (PHP's) TennCare medical/surgical population was approved by the state, and PHP is currently sending their members this EOB. This same EOB was not approved for the Partners Program. To date, TBH does not have an approved EOB from the state to send to its members. We are developing a plan to address the lack of an approved EOB. Our objective would be to have a single EOB approved by the TennCare Bureau for our PHP TennCare product and approved by the TennCare Partners Program for TBH.
- d. TBH has corrected provider files effective January of 1997. With the reconfiguration of our claims payment system, the Benefit Analyst no longer manually manipulates a claim to process. This has eliminated claims being processed incorrectly.
- e. With the reconfiguration of our claims payment system, outpatient mental health visits track automatically for paid visits only.

Emergency Room claims for dates of service in 1996 were paid without reviewing the ER notes. Now, the claim is checked for an authorization code indicating the ER called TBH Utilization Management within 24 hours as stated in the Provider Reference Guide. If an authorization is found, the UM documentation is reviewed to determine if coordination with the member's MCO is needed. If there is no authorization, ER records are requested. Any claims denied as MCO Responsibility are checked for a prior MCO denial. If found, the claim is referred to the MCO Claims Coordination Committee. Any ER claim denied for medical reason (i.e., medical necessity not apparent, procedure not related to diagnosis, diagnosis not substantiated by documentation, etc.) is first reviewed by a clinician.

- f. TBH feels confident that a remittance advice was mailed to all providers. However, due to system problems, we were unable to identify in our imaging system one remittance advice during the State audit.
- g. TBH's plan for tracking Basic Participant benefits utilization so that clinically related group/target population group (CRG/TPG) reassessments are referred to their Care Coordinator (CMHCs) is complete and will be implemented by August. Benefits utilization by non-severely and/or persistently mentally ill (SPMI) members is tracked and when 40 outpatient services are accumulated, that member is referred to their Care

Coordinator for a CRG/TPG reassessment. If the new CRG/TPG results in an SPMI or seriously emotionally disturbed (SED) categorization, then the member becomes eligible for the Enhanced Benefits package. If the reassessment does not result in an SPMI or SED categorization, then the member's benefits package would remain Basic and benefits limits would be applied.

- h. TBH recognizes that we were not processing claims in a timely fashion. However, after we reconfigured our claims payment system, we added temporary employees to our regular full time to employees processing claims. We have meet the standards for the last several months.

In December of 1996, we realized that claims were being returned to providers for lack of information. This procedure was halted immediately and claims were put through the normal claim process. If information was missing on the claims to be processed, we deferred the claims through the system and attached an adjustment code requesting the additional information. The only claims we currently return to the providers are those where the member does not appear in our eligibility file after 30 days.

8. Deficiencies in encounter data reporting

Finding

Tennessee Behavioral Health, Inc., inadequately reported encounter data required by the TennCare Partners Program contract. Encounter data, a record of mental health and substance abuse service provided to enrollees, is necessary for evaluation of quality of care and access to TennCare Partners services.

The encounter data does not include payments to the subcontractors Mental Health Cooperative and Case Management, Inc. The claims submitted by these providers were not submitted on standard claim forms and were not entered into TBH's claims processing system. Additionally, the state informed TBH that liquidated damages would be assessed for inadequate encounter data reporting. Liquidated damages for inadequate encounter data reporting assessed for the period February 22 through June 1, 1997, totaled \$630,000.

Section 3.12.5 of the TennCare Partners Program contract with TBH states that

The CONTRACTOR shall furnish to TennCare information regarding individual encounters (individual units of service provided to Participants). Encounter information will be submitted for all covered services as listed in Section 2.6. This information shall be reported in a standardized format as specified by TDMHMR and transmitted electronically to TennCare on a basis specified by TDMHMR and the Bureau of TennCare. The minimum

data elements required to be provided are identified in Attachment E.5 of this CONTRACT.

Section 3.12.7 states, “The CONTRACTOR shall report to TDMHMR monthly summary reports of encounter data and annually the average cost and accumulative average cost of providing each definable unit of services for which encounter data will be reported in accordance with Section 3.12.5.”

Recommendation

Tennessee Behavioral Health, Inc., should correctly report encounter data as specified in the TennCare Partners Program contract. Claims for all mental health and substance abuse services processed or paid should be included in encounter data reporting.

Management’s Comment

While, in the past, TBH experienced difficulty submitting encounter data in a timely fashion, we have recently made significant strides toward compliance with department expectations. Encounter data for inpatient and outpatient care, pharmacy services, clinical information, case management and transportation are presently forwarded to the department as quickly as possible once they are collected from the providers/vendors. Some gaps and inadequacies remain and are of as great concern to us as they are the department. We are working diligently to rectify these.

9. Lack of coordination with TennCare managed care organizations

Finding

Tennessee Behavioral Health, Inc., has not coordinated with the TennCare managed care organizations (MCOs) for the treatment of participants and for out-of-pocket limitations. Claims have been submitted and denied by both TBH and the MCOs because neither party will accept the claims as mental health and substance abuse or medical/surgical. TBH has not coordinated with the MCOs to split the cost of service pending the resolution of such disputes.

Section 3.4.3.3.1 of the TennCare Partners Program contract with TBH states

When disputes arise between the Participant’s MCO and his or her BHO regarding responsibility for a particular medically necessary covered service, the BHO and the MCO shall coordinate to insure that the service will be delivered to the Participant and the MCO and the BHO must split the cost of the service pending resolution of any dispute between the BHO and the MCO. . . . Services to the Participant must not be delayed because

there is a dispute between the MCO and BHO over who is responsible over delivering the service. The Participant's MCO and his or her BHO are jointly responsible for the Participant, and the State will hold the MCO and the BHO jointly accountable for the quality of care the Participant receives.

TBH has not coordinated with the TennCare MCOs for out-of-pocket limits for their participants. This could cause TennCare members to exceed their annual out-of-pocket limit because both the MCO and BHO can charge a copayment. Schedule A of Attachment G of the TennCare Partners Program contract defines the out-of-pocket limits for participants.

Recommendation

Tennessee Behavioral Health, Inc., should coordinate with TennCare MCOs when a dispute arises as to whether TBH or the MCO is to pay a claim. TBH must coordinate with the MCOs for annual out-of-pocket limits for TennCare participants to ensure limits are not exceeded.

Management's Comment

TBH is currently reviewing claims denied as "MCO Responsibility" and will ask its collaborative MCOs to do the same with regard to claims denied as "BHO Responsibility." We will then review each claim for appropriateness of denial and reverse accordingly.

The reality of tracking the out-of-pocket expenditures maximum for members has been discussed with three of our collaborating MCOs. Out-of-pocket expenditures include deductibles and copayments. Since TBH does not require members to pay deductibles, this is not a coordination issue with our MCOs. Our largest MCO correlate, Access . . . Med Plus, does not require copayments. The others do. Since we also require copayments for some members, this is a major coordination challenge. From the earliest discussions regarding contracting with the Partners Program, TBH was aware that this coordination of expenditures requirement would be extremely difficult, if not impossible, to implement. To date, we have not been successful in our efforts to get our four correlated MCOs requiring copayments of their members to cooperate with us sufficiently to be able to coordinate tracking the accumulation of out-of-pocket expenditures. Since there appears to be little hope of resolving this issue, TBH is presently assessing the potential impact of eliminating the copayment requirement from its plan. If that becomes the case, then TBH will not require deductibles nor copayments and there will be no coordination of out-of-pocket expenditures.

