

Premier Behavioral Systems of Tennessee, LLC

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

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October 13, 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) Premier Behavioral Systems of Tennessee, LLC, 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
97/098

cc: Bill Young
Theresa Clarke
Ben Dishman

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review

Premier Behavioral Systems of Tennessee, LLC

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

Premier Behavioral Systems of Tennessee, LLC (Premier), failed to meet minimum equity and working capital requirements. As of December 31, 1996, Premier had a review adjusted equity of (\$2,216,828) (page 9).

Incorrect Payment Calculation to Community Mental Health Centers

Premier did not correctly apply all of the compensation terms of their contract with the Community Mental Health Centers (CMHCs). Case management expense was understated \$604,070 because Premier's statewide enrollment for priority participants

was not adjusted as of December 31, 1996. Consequently, the enrollment for priority participants for each CMHC had not been adjusted (page 9).

Inaccurate Annual Statement Reporting

Net income was overstated \$46,559 and total liabilities were understated \$51,040 on the annual statement reporting for the period July 1 through December 31, 1996 (page 12).

Judicial Claims Denied

Premier inappropriately denied court ordered services for individuals who were not participants in the TennCare Partners Program (page 14).

Deficiencies in the Authorization System

Premier has invalidly denied claims for “no authorization” when a valid authorization exists. Premier’s authorization system failed to properly transfer all authorizations to the claims processing subcontractors (page 15).

Deficiencies in Claims Processing

Premier did not fulfill contract reporting and processing efficiency requirements. Errors were discovered in the payment and denial of mental health and substance abuse claims. Remittance advices did not adequately communicate all denial reasons in order for providers to respond (page 16).

Deficiencies in Encounter Data Reporting

Premier inadequately reported encounter data required by contract: the encounter data did not include all revenue, procedure, and diagnosis codes (page 22).

Excessive Rates Paid to Affiliated Providers

Rates paid to providers affiliated with Premier were higher than the rates paid to non-affiliated providers, in violation of the TennCare Partners Program contract (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
Premier Behavioral Systems Of Tennessee, LLC
For The Period July 1 Through December 31, 1996**

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**Compliance Review
Premier Behavioral Systems Of Tennessee, LLC
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 Premier Behavioral Systems of Tennessee, LLC (Premier). 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 Premier. The objectives of the review were

1. to determine whether Premier is meeting its contractual obligations under the TennCare agreement with the state;
2. to determine whether Premier 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 Premier are accurate;
4. to determine if Premier has sufficient financial capital to ensure uninterrupted delivery of mental health and substance abuse services;
5. to determine if records maintained by Premier 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 Premier Behavioral Systems of Tennessee, LLC, 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

We examined the records, transactions, and contract provisions of Premier Behavioral Systems of Tennessee, LLC, 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 695,000 participants assigned to Premier are as follows:

- HealthNet
- Blue Cross/Blue Shield (excluding East Tennessee*)
- John Deere Health Care
- OmniCare Health Plan
- Phoenix Healthcare
- VHP Community Care

*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 482,000 participants are assigned to TBH.

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 is judicials. These individuals are not considered enrollees or participants 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 statewide 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 identifications with treatment plans and re-assessments 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;
11. Mutually agree to such other requirements as may be reasonably established by TennCare, TDCI, and TDMHMR.

Premier 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 Premier. If the actual accrued amount paid by Premier for covered services and premium tax is less than 90% of the amounts paid by the Bureau of TennCare, then Premier shall remit to TDMHMR 100% of the difference.

ADMINISTRATIVE ORGANIZATION OF PREMIER

Premier Behavioral Systems of Tennessee, LLC, is a membership established in May 1996 for the purpose of delivering mental health services under the TennCare Partners Program. The members consisted of Premier Holdings, Inc. (PH), Columbia Behavioral Health of Tennessee, LLC (CBHT), and Managed Health Network, Inc. (Foundation). PH is a wholly-owned subsidiary of Magellan Health Services, Inc.; CBHT is jointly owned by Columbia/HCA and First Health Corporation; and Foundation is a wholly-owned subsidiary of Foundation Health Corporation. Magellan Health Services, Inc., is a majority owner of Advocare of Tennessee, Inc. (Advocare). Premier contracts with the three related parties to provide specific administrative and mental health and substance abuse services through service agreements. Advocare is to provide general administrative services as well as care services for basic and priority outpatient, case management, and grant and crisis payments. Administrative services are paid to Advocare on per member per month (PMPM) fixed amount. Payments for care services to Advocare are based upon negotiated payments with Community Mental Health Centers (CMHCs) or other providers with no risk assumption by Advocare. CBHT is to provide care services for inpatient, intensive outpatient, partial hospitalization, and regional mental health institutes. CBHT is paid a per member per month PMPM capitation by Premier with risk or benefit depending on whether actual cost of care remains within 3% of the actual PMPM amounts paid to CBHT. Foundation is to provide claims processing administrative services as well as care services for pharmacy, lab, transportation, and primary care provider visits capitation. Payments to Foundation are based upon PMPM capitation amounts. On September 1, 1996, Foundation terminated its service agreement with Premier. Premier contracted with other providers to deliver care services previously provided by Foundation. Foundation continued to provide claims processing administrative services for dates of service through November 30, 1996. Effective for dates of service beginning December 1, 1996, Premier contracted with FHC Options, Inc., a 50% owner of Columbia Behavioral Health of Tennessee, LLC, to provide claims processing administrative services.

The officers and board of directors for Premier as of December 31, 1996, are as follows:

Officers for Premier

Dick Orndoff, Chief Manager
Donnie Pennington, Secretary

Board of Directors for Premier

Henry Harbin, M.D.
Don Fowls, M.D.

Bob Osburn
Chuck Kanach

PROVIDER CONTRACTS AND SUBCONTRACTS

Premier must obtain written approval from TDMHMR for all of its provider contracts and subcontracts. The contract between TDMHMR and Premier requires that Premier contract with the State of Tennessee's five regional mental health institutes. These institutes provide essential inpatient mental health services to the priority population. Premier has contracted with the regional mental health institutes on a per diem basis. Inpatient, intensive outpatient, and partial hospitalization services are also provided by hospitals across Tennessee on a per diem basis.

In addition, the contract encourages Premier 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. Premier originally contracted with 29 CMHCs to provide medically/psychologically necessary designated covered services. The CMHCs act as care coordinators responsible for arranging the behavioral health care needs of their assigned participants. All of the centers except three have a contractual arrangement with Premier which specifies a certain per priority member per month rate to be used in the calculation of the monthly priority case rate paid to those centers. Premier calculates the monthly case rate for each of these centers by multiplying the number of priority participants reported by a center by the specified per member per month rate, then dividing that number by the total priority cases reported for all centers. The other three centers' contractual arrangements specify a fixed case rate. The assignment of the priority population to the CMHCs at the effective date of the contracts, July 1, 1996, is based on a comparison between the CMHC's enrollment records with MCO or BHO enrollment data. Assignment of newly assigned priority members will be determined by member's choice. If the assigned members elect to receive services from other providers, then the CMHC's monthly case rate payments will be reduced on a percentage basis according to the services received. Other providers include physicians, psychiatrists, licensed social workers, and hospitals and are paid based upon a fee schedule for the procedures provided. Each CMHC also receives grant payments at the same funding levels for the prior fiscal year based on Premier's percentage of total TennCare Partners enrollment. Grants represent payments for non-clinical adult services, psychosocial services, and crisis teams provided by the CMHCs. In addition to the case rate payments, the CMHCs are eligible to receive additional compensation based on the amount of inpatient savings that is realized for the priority population that the CMHC serves.

Five TennCare managed care organizations (MCOs) have been contracted and paid by Premier a subcapitation based upon number of members enrolled in the MCOs. The MCOs have contracted with primary care physicians who provide a portion of the mental health services for Premier. Also, the MCOs provide some of the lab, transportation, and pharmacy services that are the responsibility of Premier. Additionally, Premier has contracted with Quality Transportation,

Inc., to provide transportation services. RxCare and ProMark were contracted by Premier to provide pharmacy services from July 1 through December 29, 1996, and PCS Health Systems, Inc., effective December 30, 1996.

ANNUAL STATEMENT REPORTING

As a BHO, Premier Behavioral Systems of Tennessee, LLC (the plan), 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 outstanding claims. “Non-admitted” 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. As of December 31, 1996, the plan reported \$17,129,756 in admitted plan assets, \$19,300,025 in liabilities, and (\$2,170,269) in equity on its annual statement. The plan reported total revenues of \$91,379,880 and total expenses of \$101,382,576, producing a net income of (\$10,002,695) for the period July 1 through December 31, 1996. Revenue comprises \$91,276,628 in capitation fee payments from TennCare and \$103,252 in investment income. The plan reported \$91,313,395 in medical expenses and \$10,069,181 in administrative expenses. A restricted deposit is currently maintained by the plan in the amount of \$1,200,000 to satisfy requirements of the TennCare Partners Program contract.

This is the first review of Premier Behavioral Systems of Tennessee, LLC’s compliance with the provisions of its contract with the Tennessee Department of Mental Health and Mental Retardation.

Premier Behavioral Systems of Tennessee, LLC, has informed the state of its intent to terminate its agreement with the state effective October 31, 1997. The state has taken action to monitor the termination.

RESULTS OF THE REVIEW

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

Based on our review of the capitation payments by the Bureau of TennCare and the payments and accrued amounts for mental health and substance abuse services, the actual accrued amount paid by Premier for covered services and premium tax is greater than 90 percent 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 Premier Behavioral Systems of Tennessee, LLC, for the period July 1 through December 31, 1996. The balance sheet and income statement for Premier were adjusted by the Division of State Audit (see finding 3). The effect of review adjustments is to decrease net income \$46,559 and increase total liabilities \$51,040. Equity was decreased from (\$2,170,269) to (\$2,216,828) 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

Premier Behavioral Systems of Tennessee, LLC, did not meet minimum equity requirements of a behavioral health organization with a review-adjusted equity of negative \$2,216,828 for the period July 1 through December 31, 1996. The equity should have been equal to or greater than the \$4,563,831 as required in Section 3.3.2.1 of the TennCare Partners contract. Premier did not maintain positive working capital (current assets in excess of current liabilities) as required by Section 3.3.2.2 of the TennCare Partners contract.

Premier informed the Department of Commerce and Insurance that loans and withholds in the amount of \$7,663,459 due to Advocare and Columbia were converted to additional paid-in capital. The conversion of the loans and withholds will satisfy the equity and positive working capital requirements of the TennCare Partners Program contract as of March 3, 1997.

Recommendation

Premier Behavioral Systems of Tennessee, LLC, should maintain the minimum equity requirements and positive working capital requirements of the TennCare Partners Program contract.

Management's Comment (Premier)

As is stated in the finding, Premier's LLC members corrected the December 1996 equity and working capital deficiencies by March 1997.

2. Incorrect payment calculations to the community mental health centers

Finding

Premier did not correctly apply all of the compensation terms of their contracts with the CMHCs. Our review noted the following problems with the calculated payments by Premier to the CMHCs:

- Case management expense as of December 31, 1996, was understated. Premier requested from the CMHCs the number of priority participants serviced at July 1996.

Since certain CMHCs did not relay their priority participants until several months later, Premier's statewide priority participants was understated. A retroactive application of the corrected statewide enrollment increases the case management expense by \$604,070 for the period July 1 through December 31, 1996.

- The enrollment of priority participants per CMHC used in the calculation of the case rate payments had not been adjusted for changes since July 1996. Premier had based the calculation of payments for case management from July to December, 1996, on the initial enrollments provided by the CMHCs. However, the number of priority participants serviced by the CMHCs had changed for this same period. Premier linked the adjustment of the priority participant enrollments to the correct submission of intake and assessment files. These files are reported by CMHCs to Premier in an electronic format and are required to pass edits established by the state. Delays and confusion in the electronic connections and the inability to pass edit requirements made the enrollment data from the intakes and assessment files unreliable. Premier intends to retroactively adjust the calculation of payments for case management when the intakes and assessment files have been corrected. Although the eventual correction of enrollments will not have a material effect to case management expenses for Premier, the adjustment of enrollment may significantly affect the individual amounts owed to or due from each CMHC.
- Payments were not reduced from the CMHCs' monthly capitation when the assigned priority participants choose to receive services from other CMHCs or other mental health and substance abuse providers. Specific percentage reductions are defined in the CMHC contracts for case management, medication management, and all other outpatient services given by other providers. In order to compute the percentage reductions, Premier must first obtain reliable enrollment data from the CMHCs and compare this data to the paid claims file. Also, significant problems have been noted in the paid claims and must be corrected before applying the percentage reductions (see finding 6). The eventual application of percentage reductions could significantly affect the individual amounts owed to or due from each CMHC.

The Division of State Audit performed a separate review of the status of the CMHCs under the TennCare Partners Program at June 1997. The following problems were noted by the CMHCs during the review:

Claims Payment Difficulties

Although fee-for-service revenue generally represents a small percentage of a center's revenue, a number of the mental health centers have reported claims processing difficulties with fee-for-service claims filed with Premier. Case rate payments from Premier, while timely, have been all but impossible for the CMHCs to reconcile with their case count.

Transportation

Most of the CMHCs in the state report difficulty with the transportation service provided through Premier. Premier has contracted with Quality Transportation, Inc., to provide transportation for the CMHCs. The transition to the new transportation contractor was problematic. Many centers 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 centers report poor service from Premier's transportation subcontractor. Problems ranged from late pick-up and return rides to failed pick-ups resulting in missed appointments. Premier 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.

Premier 10% Withhold

In November 1996, Premier sent each CMHC a contract amendment which specified that 10% of the monthly case rate would be withheld from each center. The purpose of the withholding was to ensure Premier would have sufficient funds to meet its obligations. The contracts between Premier and the CMHCs contain a provision that such amendments would be effective unless the center chose to terminate the contract. None of the CMHCs chose to terminate. The CMHCs indicate that Premier has not properly responded to their questions on the withhold. The centers do not know if the withhold is permanent or if it represents an actual reduction in monthly case rate payments.

Inpatient Hospitalization Savings

The contracts between Premier and the CMHCs contain financial incentives for demonstrating lower inpatient costs. The CMHCs claim that Premier has made no attempt to evaluate these goals, and some of the CMHCs indicate they are entitled to savings under this provision. However, according to Premier, the determination of inpatient savings is dependent on the CMHCs' successful submission of intake data.

Recommendation

Premier should correctly apply all of the compensation terms of their contracts with the CMHCs. Premier should properly report case management expense based upon updated statewide Premier enrollment of priority participants. When satisfactory enrollment amounts for each CMHC are obtained, Premier should retroactively calculate

case rate payments for each CMHC. Inpatient savings and percentage reductions terms of the contracts between Premier and the CMHCs should be computed when errors noted in the claims processing system are corrected. Premier should review and monitor the adequacy of the services provided by the transportation subcontractor. Premier should resolve the disputes for transportation service failures of Quality Transportation, Inc.

Management's Comment (Premier)

Premier corrected reported case management expense in its February 1997 financial statements (and the quarterly statutory filing for March 1997). Premier converted its case rate payment methodology in July 1997 and now bases the payments on CMHC-reported priority population caseloads which have passed State edits for the State mental health intake system, validated by applicable CMHC-reported encounter data which has also passed State edits. Premier is providing CMHCs with transition cash flow where the validated, reported caseloads are significantly below expectations. In September 1997, Premier will provide CMHCs the initial reconciliation of case rate payments for the twelve months ending June 1997. Following an opportunity to respond to the reconciliation or provide additional validating data, Premier will provide a final reconciliation and assess the financial impact to each individual CMHC. The final reconciliation will include the impact of inpatient incentive and multiple provider reductions. Premier shares concerns about Quality Transportation, monitors their complaints and grievances on a weekly basis, and has worked through numerous corrective action plans with them. Premier also works on a daily basis expediting solutions to transportation difficulties encountered by Premier consumers. Premier has already mediated several disputes between Quality Transportation and CMHCs. Premier contracts directly with Quality for transportation service; no CMHC is under any obligation to provide transportation for Premier. Organizations who desire to provide services for Quality Transportation must negotiate contracts directly with Quality.

3. Inaccurate annual statement reporting

Finding

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

- Premium tax expense was underreported \$50,619 because actual revenue was not applied to the appropriate rate.
- Unrecorded interest received, service charges, and an error in the general ledger overstated cash by \$11,879. The restricted cash account was understated \$15,141 for interest earned but not recorded. Interest income was understated \$66,840, and

interest receivable was understated \$1,219 for the unrecorded interest payments and interest earned as of December 31, 1996.

- Because of discrepancies discovered in the calculation of payments to the CMHCs, case rate expense was understated \$604,077 (see finding 2). Also, adjustments are required to pharmacy, inpatient, professional fees, and transportation expenses based upon corrected estimates and enrollments. Medical expenses other than case rates are overstated \$402,716.
- Administrative expenses are overstated \$138,574 because estimates were applied at December 31, 1996.
- Withhold payables to the three partners have been recorded based upon 10% of cash payments to the partners. The withhold payables were understated by \$156,991.

Section 3.13.1 of the TennCare Partners Program contract with Premier states that

The CONTRACTOR shall establish and maintain an accounting system in accordance with generally accepted accounting principles. The accounting system shall maintain records pertaining to the tasks defined in this CONTRACT and any other costs and expenditures made under the CONTRACT.

As a result of the inaccurate annual statement reporting, net income is overstated \$46,559, and total liabilities is understated \$51,040. Equity should be decreased from (\$2,170,269) to (\$2,216,828) as of December 31, 1996. A review-adjusted balance sheet and statement of revenue, expenses, and net worth is shown on schedules 1 and 2. The Department of Commerce and Insurance and the Department of Mental Health and Mental Retardation cannot adequately assess the effectiveness of TennCare Partner program due to the inaccuracies in annual statement reporting.

Recommendation

Premier should accurately file the annual statement. Expenses should be properly reported according to generally accepted accounting principles. Premium tax expense should be reported by applying the appropriate rate to premium revenue. Interest income should reflect interest earned as of the filing period of the annual statement. Case rate expense should be reported based upon adjusted statewide Premier enrollment for priority participants.

Management's Comment (Premier)

In total the identified issues amount to 1.2% of Premier's reported loss for 1996 and are considered immaterial by Premier's external auditors. Premier recorded the corresponding

corrections in February and March 1997. The new CMHC payment methodology implemented in July 1997 (see finding #2) makes adjustment for payment purposes to Premier's statewide caseload totals for CMHCs whose reported and validated caseloads fall short of expectations.

4. Inability to process judicial claims

Finding

Premier has not processed claims for court ordered mental health and substance abuse services as specified in the contract with the TennCare Partners Program. The 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 Premier 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

Premier 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.

Comments of Premier

TDMHMR now provides Premier with special eligibility records for "presumptive" cases which includes "judicials." Premier passes this eligibility to its claim processor along with the regular eligibility updates. Therefore, where TDMHMR has processed this special eligibility, claims submitted for judicials need not deny for lack of eligibility.

Comments of Foundation

With respect to the Judicials services, Managed Health Network, Inc., (Foundation) processed all of the regional mental health institute claims submitted to it for dates of service from July 1, 1996, through November 30, 1996. Of those claims included in the random sample, those for regional mental health institutes were all paid with the exception of four, one of which was denied because Foundation was advised by AdvoCare the member had Medicare as primary insurance. The other three claims did not have authorizations for the confinement, and we were advised by Premier that all inpatient confinements required authorizations in order to be paid. All of the other regional mental health institute claims received by Foundation did have authorizations.

5. Deficiencies in the authorization system

Finding

Premier improperly denied claims for “no authorization” when a valid authorization exists. Premier is responsible for the preauthorizations. Premier’s authorization system failed to properly communicate all authorizations obtained by providers to the claims processing subcontractors. As of May 29, 1997, 11,104 authorizations had not been successfully communicated to the current claims processing subcontractor.

As a result of the deficiencies in the authorization system, claims are improperly denied because they are received and processed before Premier communicates the authorizations to the claims processing subcontractors.

Recommendation

Premier should not deny claims for “no authorization” when a valid authorization exists. Authorizations should be made available to Premier’s claims processing subcontractors in a timely manner. Claims previously denied for no authorization should be reviewed to determine if a valid authorization exists.

Management’s Comment (Premier)

Premier provides authorizations to its claims processor on a daily basis. Premier has now adjusted and resubmitted the referenced authorizations which its claims processor rejected through an edit process. To protect providers when the claims processor’s system is unable to accept certain authorizations, Premier now allows providers to submit claims with Premier’s authorization letter(s) attached manually. Also, the claims processor now routinely inspects claims which deny for no authorization.

6. Deficiencies in claims processing

Finding

Premier Behavioral Systems of Tennessee, LLC, has not fulfilled contract reporting and processing efficiency requirements. Two hundred claims for mental health and substance abuse services were randomly selected for claims processing testing. Our review noted several problems. For ease of referral, we are including the response from Foundation, Inc., where applicable, in italics after each cited error. Since Foundation is no longer a member of Premier and thus no longer participates in the TennCare Partners Program, we have not addressed their comments.

- a. The following errors were discovered for 100 sampled claims processed by the subcontractor Foundation for dates of service July 1 through November 31, 1996:

- For four claims, Foundation did not input all dates of service and corresponding procedures and charges from the claims submitted by the provider.

All claims were entered according to Foundation system requirements and included revenue and/or CPT code, diagnosis code, and billed charges. For inpatient claims the admit date is used with the corresponding revenue code.

- For three claims submitted by providers, Foundation never processed the claims.

These claims were not received in Foundation's San Rafael, California office.

- For three claims, Foundation denied partial or full payment and communicated to the provider that no prior authorization was granted. However, an authorization had been granted on two of the claims for all services, and the other was a judicial claim which requires no authorization (see finding 4).

According to information provided to Foundation by Premier all regional mental health institute claims required authorization. The other two claims did not have an authorization in the Foundation system.

- Foundation denied a claim for "member not eligible," but according to the TennCare eligibility system, the person was eligible during the dates of service on the claim.

This claim was denied due to Medicare being the primary insurer. AdvoCare advised Foundation that no claims were to be processed when the member was eligible for Medicare.

- A claim in the sample was paid twice. The duplicate payment was the result of claims adjudicator error.

Examiner error.

- Foundation priced and/or paid five claims incorrectly. Four of these claims were paid at rates other than the contractually agreed-upon rates. One claim was paid incorrectly because the procedure code was incorrectly entered into the claims processing system.

One of the claims was paid incorrectly due to examiner error. Three of the claims were paid incorrectly (were corrected) due to an AdvoCare provider database problem.

- Charges were paid for a claim for which prior authorizations were required, but none had been requested.

This claim represents professional fees for an inpatient confinement which was authorized.

- A claim was denied by Foundation using the denial code “member not eligible.” Instead, the actual reason for denial was that the recipient’s primary coverage was Medicare.

Claim was processed correctly. Member eligibility shows Medicare is the primary insurer.

- Foundation 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. Also, the denial and adjustment codes reported on the remittance advice cannot be deciphered using the legend included with the remittance advice. For example, according to the remittance advice legend, the adjustment code for the letter “A” was represented as five different denial and/or adjustment reasons.

b. The following errors were discovered for 100 sampled claims processed by the subcontractor Options Health Care, Inc. (Options), for dates of service after November 30, 1996:

- For 21 claims, Options denied payment for lack of tax identification number. During the transition period of claims processing subcontractors from Foundation, Premier notified contracted providers that the new claims processing subcontractor, Options, would require the submission of a form W-9. The form reports the taxpayer identification number and certification from the Internal

Revenue Service. Options denied all claims submitted by providers that did not first submit the W-9. This requirement and subsequent denials are considered inappropriate. Providers contracted in good faith with either one of the Premier members, Advocare or Columbia, in July 1996 but have not directly contracted with Options. If Premier elects to have a subcontractor perform its responsibility for claims processing, then Premier should have obtained an updated W-9 from all contracted providers before Options began processing claims.

- For four claims, Options denied payment and communicated to the provider that no prior authorization was granted. Due to the deficiencies in the authorization system, an authorization had been granted but not recognized on the claims processing system (see finding 5).
 - Options denied a judicial claim because no prior authorization was granted. However, judicial claims do not require prior authorization (see finding 4).
 - A claim was denied by Options for “no prior authorization” for all dates of service on the claim. However, an authorization had been granted for at least one date of service on the claim.
 - Options denied two lab claims. The claims were considered by Options to be medical claims instead of mental health and substance abuse claims. However, the primary diagnosis on each of the claims was related to mental health and substance abuse, and the lab procedures on the claims did not require preauthorization.
 - Options processed a claim under the wrong participant’s name.
 - Options denied a claim as “outside the members effective” date when the TennCare eligibility system shows the member was eligible at the time of service.
 - A keying error by Options caused the denial of a claim for January 17, 1997, date of service which was input as January 17, 1996.
 - The remittance advices for Options are not sufficient to communicate to the provider the status of claims payments and denials. Options’ remittance advices report only two denial codes for each claim submitted, but some claims can be denied for more than two reasons. This process does not allow the provider to properly correct all deficiencies when the claim is resubmitted.
- c. Premier 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, Premier 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, 177 were clean claims with the following time lags:

- 99 claims within 30 days (56%),
- 34 claims, 31-40 day lag (19%),
- 42 claims, 41-60 day lag (24%), and
- 2 claims, over 60 day lag (1%)

Of the remaining 23 claims, 11 (92%) were processed within 60 days and one was processed over 60 days. The last 11 of these 23 claims have no time lag because ten were never processed and one was reversed.

Section 3.13.2 of the TennCare Partners Program contract with Premier states

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.

Foundation has, during the period it processed claims for Premier, made every effort to comply with the requirements of the State of Tennessee with respect to claim turnaround time. However, Foundation had many problems over the course of the processing which precluded it from meeting required turnaround times on a consistent basis because certain information needed from members of the Premier organization, such as prior authorizations for services, was incomplete or inaccurate.

An additional review of claims submitted by a psychiatrist group and a hospital provider was performed. For eight claims tested for the psychiatrist group, three claims were denied for “no authorization” but a valid authorization exists on Premier’s authorization system. For the hospital provider, 67 claims were tested. Of the 67 claims, 24 have dates of service July 1 through November 30, 1996, and the remaining 43 claims have dates of service after November 30, 1996. The results are as follows:

- a. Regarding the 24 claims with dates of services July 1 through November 30, 1996:
 - Twelve claims were submitted by the provider but could not be found through a name search of Foundation’s and Options’ processed claims data file.

Twelve claims were submitted by the provider for members who do not appear in the eligibility file provided to Foundation by AdvoCare.

- Three names could not be found on either the Foundation or Options system. However, according to the TennCare eligibility system, two names are current TennCare enrollees assigned to Premier.

Three claims were for members who did not appear in the eligibility file based on information provided by the provider (lack of social security number and/or date of birth).

- Four claims were denied for “no authorization.” Two lab claims were invalidly denied for no prior authorization. Lab services do not require prior authorization.

Of the four claims denied for lack of authorizations, one was paid on 3/12/97 and two were correctly denied based on information available at the time, and one incorrectly denied. Claims denied on 5/8/97 were denied by Options (past the runout period for Foundation).

- One claim denied for no authorization had billed services different from the services authorized. One claim had no authorization associated with the dates of service and was also denied for timely filing.
- One claim was invalidly denied because the service date was before the enrollee’s effective date. According to the TennCare eligibility system, this enrollee was eligible during the date of service. One claim was invalidly denied for being outside the timely filing limit. Through a conversation with a Premier representative, Options has been informed that claims should not be denied for untimely filing.

One claim was denied because the service date was prior to the enrollee’s effective date. Denial was based on eligibility data provided by AdvoCare. One claim was denied for being outside the timely filing limit. Denial was based on information available at the time.

- The remaining three claims were handled correctly.

One claim was correctly paid on 3/13/97. Another claim was never received.

b. Regarding the 43 claims with dates of service after November 30, 1996:

- Fourteen claims could not be found on the Options system through a name search of enrollee claim history. According to a review by Options, nine claims were not found on the system, four claims had been denied, and one claim was paid. The denials were not tested for validity.
- Sixteen claims were denied for no authorization:

- a) One claim was authorized with a date of service effective one day after the billed date of service. This denial is questionable.
 - b) Two claims had no authorizations that could be found on Options' system.
 - c) Eight claims were incorrectly denied for "no authorization" when a valid authorization existed.
 - d) Two claims had authorizations on the Options system matching the date of service but not the service code.
 - e) Three claims were incorrectly denied for "no authorization" because Premier incorrectly authorized the services to a different hospital.
- Two claims were denied because of the use of a specific revenue code for hospital psychiatric intensive care unit. Options had previously accepted and paid a claim filed by the hospital using the revenue code in question.
 - The 11 remaining claims were paid.

As a result of the inaccuracies and inefficiencies of the authorization and claims processing systems, Premier 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. Mental health and substance abuse providers have experienced significant financial and administrative problems caused by Premier's inability to process claims correctly.

Recommendation

Premier Behavioral Systems of Tennessee, LLC, 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 denial reasons in order for providers to respond. Claims should be paid or denied in the time required by the TennCare Partners Program contract. All claims submitted by providers should be entered and processed by the claims processing subcontractors. If contracted providers have not submitted a form W-9 to Options, Premier must ensure that the form is obtained. Premier should ensure duplicate payments never occur. Claims should be paid according to the correct fee schedule. For all claims submitted, all dates of service and corresponding procedures and charges must be entered. Lab claims submitted with the proper procedure and diagnosis codes for mental health and substance abuse should not be denied. Because of the significant errors in claims processing, claims should not be denied for timely filing until these issues are corrected. Premier should reprocess all previously paid claims for the errors noted.

Management's Comment (Premier)

In addition to the steps taken in response to finding #5, above, concerning authorizations, Premier does now waive the timely filing requirement in order to expedite reprocessing of claims. Premier has worked aggressively to obtain form W-9 where needed and this issue is now substantially resolved. Premier is establishing a claim audit group which will begin work in September 1997 to examine claims paid to date and will initiate reprocessing of claims where needed. In conjunction with the claim audit, Premier will reassess the current claims processing vendor to determine whether that vendor can in fact meet State requirements and whether benefit can be obtained by again changing vendors. Premier works with any provider reporting claim processing difficulties to get authorized claims paid correctly. Properly filed lab claims are not now denied for authorization.

7. Deficiencies in encounter data reporting

Finding

Premier Behavioral Systems of Tennessee, LLC, 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 following deficiencies were noted from the claims sample for each of the claims processing subcontractors:

- Foundation did not enter all revenue codes, procedure codes, diagnosis codes, and charges from claims submitted by mental health and substance abuse providers. For inpatient hospital claims, all revenue codes and charges were combined in order to pay on a per diem. For encounter data purposes, all revenue codes and charges must be detailed.
- Options did not always enter all of the diagnosis codes from the claims submitted by mental health and substance abuse providers. Required encounter data elements include the primary and other diagnosis codes.

Additionally, the state informed Premier 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 May 2, 1997, totaled \$315,000.

Section 3.12.5 of the TennCare Partners Program contract with Premier states

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 of the TennCare Partners Program contract with Premier 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

Premier should correctly report encounter data as specified in the TennCare Partners Program contract.

Management's Comment (Premier)

Since notification from TDMHMR earlier this year that they were shifting TennCare Partners data reporting priorities from the State mental health intake system to TennCare encounter reporting, Premier has devoted significant and substantial resources to obtaining encounter files from its vendors and contractors, including CMHCs, and formatting that data for State use. As a result, Premier is now in substantial compliance on encounter reporting, despite TDMHMR's timeliness requirements which far exceed the standards TennCare sets for its MCOs. Correspondence provided under separate cover will document this achievement.

8. Excessive rates paid to affiliated providers

Finding

Rates paid to providers affiliated with Columbia Behavioral Health of Tennessee, LLC, and Advocare of Tennessee, Inc., members of Premier Behavioral Systems of Tennessee, LLC, are higher than rates paid to non-affiliated providers. Section 6.16 of the contract between the TDMHMR and Premier stipulates that the rates paid for each unit of service to subcontractors in which Premier has an ownership, control interest, or indirect ownership interest, shall not exceed the average of the payments for each unit of service to non-related subcontractors. Whenever the rate contracted to an affiliated provider is greater than the highest rate contracted with a non-affiliated provider, the amount paid to affiliated providers exceeds the average paid to non-affiliated providers. For 19 inpatient, intensive outpatient, and partial hospitalization services, the per diem rates contracted to affiliated providers for 13 of the services were higher than per diem

rates contracted with non-affiliated hospitals. For example the highest per diem contracted for inpatient substance abuse service to an affiliated hospital was \$280, while the highest per diem contracted to a non-affiliated hospital for the same service was \$157. In addition, the affiliated hospital rate excludes physician fees while the non-affiliated hospital rate includes physician fees.

Recommendation

Premier should not pay affiliated providers at rates higher than those paid to non-affiliated providers.

Management's Comment (Premier)

Premier recognizes that some rates for some affiliate facilities were higher than those for non-affiliated facilities. To bring all rates in line and to recoup monies paid to affiliates with higher rates the following steps will be taken:

- Amend contracts of any affiliate facility who has rates that are higher than the contracted rates of any non-affiliated facility.
- Claims vendors will change all rate files for affiliate facilities to reflect lower rates. These changes will be retroactive back to July 1, 1996.
- The claims history of each facility whose rates are being lowered will be investigated to determine the number of days or units that were paid at the higher rate. This data will be used to determine the amount to be refunded by each facility.
- Each facility will be formally notified of the number of days or units that were overpaid and the refund amount due.
- The Comptroller's office will be provided copies of all correspondence to facilities as well as proof of rate changes and refunds.