

**Healthsource Tennessee Preferred, Inc.
d/b/a Tennsource**

**For The Period
January 1 Through December 31, 1996**

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April 24, 1998

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
and
The Honorable Nancy Menke, Commissioner
Department of Health
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the report on the compliance review of the managed care organization (MCO) Healthsource Tennessee Preferred, Inc., d/b/a Tennsource, for the period January 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 Bureau of TennCare in its review to determine whether the MCO has adhered to the terms of the health maintenance organization contract. The Department of Commerce and Insurance should take whatever action it deems appropriate regarding the findings contained in this report.

Very truly yours,

W. R. Snodgrass
Comptroller of the Treasury

WRS/pn
98/030

cc: Bill Young
Theresa Clarke

State of Tennessee

Review Highlights

Comptroller of the Treasury

Division of State Audit

Compliance Review

Healthsource Tennessee Preferred, Inc.

d/b/a Tennsource

For the Period January 1 through December 31, 1996

REVIEW OBJECTIVES

The objectives of the review were to determine if the managed care organization (MCO) is meeting its contractual obligations, including, but not limited to, proper accounting for payments from the TennCare Bureau, proper enrollment counts, maintenance of sufficient financial reserves, and recordkeeping sufficient to meet program requirements.

REVIEW FINDINGS

Deficiencies in Claims Processing System

Healthsource Tennessee Preferred, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements. Deductibles and copayments for certain claims for medical services were incorrectly computed and overcharged. Conversion by Healthsource Tennessee Preferred, Inc., to new claims processing software resulted in overpayments. Also, weekly claims processing reports are not in compliance with contract requirements (page 7).

Deficiencies in Financial Reporting and Failure to Maintain Minimum Equity Requirements

Healthsource Tennessee Preferred, Inc., failed to maintain minimum equity requirements. As of December 31, 1996, Tennsource, the TennCare operations of Healthsource Tennessee Preferred, Inc., had a review-adjusted retained earnings of negative \$1,401,165. Management fee expenses are not supported by written management agreements. The annual statement reporting for the year ended December 31, 1996, contained deficiencies (page 10).

Deficiencies in Provider Contract Language

Healthsource Tennessee Preferred, Inc., has not complied with the TennCare contract requirements for provider contracts. The contracts do not contain specific language regarding timeliness of claims and processing and submission of claims (page 12).

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

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Compliance Review
Healthsource Tennessee Preferred, Inc.
d/b/a Tennsource
For The Period January 1 Through December 31, 1996

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**Compliance Review
Healthsource Tennessee Preferred, Inc.
d/b/a Tennsource
For The Period January 1 Through December 31, 1996**

INTRODUCTION

PURPOSE OF THE REVIEW

This report details the results of a compliance review of the transactions, books, and accounts of Healthsource Tennessee Preferred, Inc. The purpose of this review was to evaluate the programmatic operations of the managed care organization (MCO) and to determine if the Healthsource Tennessee Preferred, Inc., plan was administered in accordance with the requirements of *Tennessee Code Annotated* and the contracts between the state and the MCO. The objectives of the review were

1. to determine whether the MCO is meeting its contractual obligations under the TennCare agreement with the state;
2. to determine whether the MCO has properly adjudicated claims from service providers and has made payments in a timely manner;
3. to determine whether enrollment counts and categories are accurate and whether monthly payments and withhold amounts from TennCare to the MCO are accurate;
4. to determine if the MCO has sufficient financial capital to ensure uninterrupted delivery of health care;
5. to determine if records maintained by the MCO are adequate to determine compliance with the rules and contract requirements of the Bureau of TennCare; and
6. to recommend appropriate actions to correct any deficiencies.

POST-AUDIT AUTHORITY

This review was conducted pursuant to Section 2-14 of the Provider Risk Agreement between Healthsource Tennessee, Inc., and the State of Tennessee which states:

The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred pursuant to this Agreement as well as medical information relating to the individual enrollees for

the purposes of audit requirements. Records other than medical records may be kept in original paper state, or preserved on micromedia or electronic format. Medical records shall be maintained in their original form. These records, books, documents, etc., shall be available for review by authorized federal, state, and Comptroller personnel during the Agreement period and five (5) years thereafter, except if an audit is in progress or audit findings are yet unresolved in which case records shall be kept until all tasks are completed. During the Agreement period, these records shall be available at the CONTRACTOR's chosen location subject to the approval of TENNCARE. If the records need to be sent to TENNCARE, the CONTRACTOR shall bear the expense of delivery. Prior approval of the disposition of CONTRACTOR and subcontractor or provider records must be requested and approved by TENNCARE.

SCOPE OF THE REVIEW

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

BACKGROUND INFORMATION

Effective January 1, 1994, the State of Tennessee received approval from the U.S. Department of Health and Human Services to begin a five-year Medicaid waiver project which changed most services covered under the Medicaid program to a managed care capitated system. Under the waiver program, known as TennCare, the state contracts with ten managed care organizations that manage and provide care for enrollees for a stated monthly capitation fee. In addition to recipients eligible under Medicaid criteria, certain uninsured or uninsurable persons may enroll in the TennCare Program. The managed care organizations in turn arrange for a network of hospitals, doctors, and other health care providers to furnish health care services for persons enrolled in the plan.

The Tennessee Department of Health is the state agency responsible for administration of the managed care program in Tennessee. The department is authorized to contract with MCOs to provide specified services to people who are or would have been eligible for Medicaid as it was administered during fiscal year 1992-93 and to other Tennesseans who are eligible for and are enrolled in the TennCare system. The managed care organization must

1. be appropriately licensed to operate within the State of Tennessee;

2. demonstrate the existence of a network of health care providers capable of providing comprehensive health care services throughout the community where the plan is offered;
3. clearly demonstrate the capability and intent to provide case management services;
4. ensure the availability of service providers outside the community service network for covered services that are not commonly provided in that particular community area;
5. demonstrate sufficient financial capital to ensure uninterrupted delivery of health care on an ongoing basis;
6. demonstrate sufficient financial capital, network capability, and a willingness to accept a reasonable number of enrollees from any failed health plan operating in the community;
7. agree to move to electronic billing for all of its TennCare plans within three years of the effective date of the agreement;
8. unanimously agree with other MCOs in the TennCare system for the provision of pharmacy services to TennCare enrollees who reside in long-term care facilities so that only one pharmacy shall be responsible for their pharmacy services;
9. agree not to require service providers to accept TennCare reimbursement amounts for services provided under any non-TennCare plan operated or administered by the managed care organization; and
10. mutually agree to such other requirements as may be reasonably established by TennCare.

Effective January 1, 1994, Healthsource Tennessee, Inc., contracted with the state as a preferred provider organization (PPO) to provide medical services under the newly established TennCare program. From January 1 through July 31, 1994, TennCare operations, d/b/a Tennsource, was a separate component and was managed through Healthsource Tennessee, Inc. Effective August 1, 1994, the TennCare operations and other business operations of Healthsource Tennessee, Inc., were spun off into an affiliated company, Healthsource Tennessee Preferred, Inc. Healthsource Tennessee, Inc., serves as the management company of Healthsource Tennessee Preferred, Inc. The contract with the state remains in the name of the original company, Healthsource Tennessee, Inc. Healthsource Tennessee, Inc., and Healthsource Tennessee Preferred, Inc., are wholly owned subsidiaries of Healthsource Management, Inc. Healthsource Management, Inc., is a wholly owned subsidiary of Healthsource, Inc., a publicly traded corporation. At December 31, 1996, the enrollment in the TennCare program for Tennsource was approximately 4,100 members.

As a PPO, Tennsource, the TennCare operations of Healthsource Tennessee Preferred, Inc., must establish risk reserves in an amount equal to what would have been required by the Tennessee Department of Commerce and Insurance if Tennsource had been a health maintenance organization licensed by the state. Also, Tennsource is allowed to retain up to 10 percent of the monthly capitation amount paid by TennCare as a management fee, with the remainder of the monthly capitation payment available for the payment of covered benefits. TennCare is not liable for any excess benefit costs. Any and all excess administrative costs are borne by Tennsource. In the event of savings, Tennsource, as provided for in Section 2-10(e)(2) of the TennCare contract, is required to share with TennCare a portion of such savings after medical benefits and allowable administrative expenses are paid. The contractor is permitted to share 5 percent of the savings with the providers and is allowed to retain 5 percent for the contractor's efficiency. The remainder of the savings are returned to TennCare.

Healthsource Tennessee Preferred, Inc., files quarterly and annual statements with the Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the plan meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting, which differs from generally accepted accounting principles in that "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity. The plan maintained a restricted deposit with a market value of \$379,551 as of December 31, 1996. The reported equity for Healthsource Tennessee Preferred, Inc., as of December 31, 1996, was \$1,161,082. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1996, reported TennCare premium revenues of \$5,102,543, medical expenses of \$3,546,967, and administrative expenses of \$836,954, resulting in net income of \$718,622. A separate balance sheet for TennCare operations not required for annual statement purposes reported assets of \$1,737,910, liabilities of \$1,709,114, and retained earnings of \$59,621.

PRIOR REVIEW FINDINGS

The previous review of Healthsource Tennessee Preferred, Inc., for the year ended December 31, 1995, included the following findings:

Insolvency and Failure to Meet Minimum Equity Requirements

Healthsource Tennessee Preferred, Inc., is considered insolvent and fails to meet minimum equity requirements. As of December 31, 1995, Tennsource, the TennCare operations of Healthsource Tennessee Preferred, Inc., has review-adjusted retained earnings of negative \$420,905.

Inadequate Accounting System and Deficiencies in Financial Reporting

Healthsource Tennessee Preferred, Inc., has not developed an adequate accounting system for TennCare operations. Management fee expenses are not supported by written management agreements. The annual statement reporting for the year ended December 31, 1995, contained deficiencies.

Deficiencies in Claims Processing System

Healthsource Tennessee Preferred, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements. Deductibles and copayments for certain claims for medical services were incorrectly computed. Providers were not notified of the status of suspended claims. Also, weekly claims processing reports are not in compliance with contract requirements.

Deficiencies in Provider Contract Language

Healthsource Tennessee Preferred, Inc., has not complied with the TennCare contract requirements for provider contracts. The contracts do not contain specific language regarding timeliness of claims and processing and submission of claims.

All previous findings will be repeated in the current report (see the Findings and Recommendations section of this report).

SUBSEQUENT MATERIAL EVENT

TennCare enrollment of Healthsource Tennessee Preferred, Inc., d/b/a Tennsource, was sold to Phoenix Health Care of Tennessee, Inc., for \$1,829,500. The contract between Healthsource Tennessee, Inc., and TennCare terminated on December 31, 1996. The TennCare enrollees in Healthsource Tennessee Preferred, Inc., d/b/a Tennsource, became members of Phoenix Health Care of Tennessee, Inc., effective January 1, 1997.

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.

The prior review report computed savings of \$535,124 and \$84,584 for the plan years of 1994 and 1995, respectively. Also, the report noted that Healthsource Tennessee Preferred, Inc., had converted to a new software package which resulted in significant overpayments of medical claims. Healthsource Tennessee Preferred, Inc., has attempted to correct the overpayments and release claims payments which remained unpaid. See finding 1 for further discussion of problems noted in the claims processing system. Based on our review of the capitation payments by TennCare and the payments by Healthsource Tennessee Preferred, Inc., we have computed an updated plan savings of \$481,206, for the year ended December 31, 1994. Losses of \$11,714 and \$718,554 have been computed for the plan years 1995 and 1996, respectively. Schedules 1, 2, and 3 show the final settlement calculation for the plan years 1994, 1995, and 1996.

Subsequent material events and correction of errors discovered by the Division of State Audit for 1994, 1995, and 1996 revenues and expenses will affect the reporting of the TennCare operations of Healthsource Tennessee Preferred, Inc. The balance sheet and the statement of revenue, expenses, and net worth were adjusted by the Division of State Audit as follows:

- From the savings calculations for 1994, 1995, and 1996, health care expenses were adjusted to actual. Additionally, savings due to providers were adjusted, and accounts receivable was recorded because of the updated savings calculations for 1994 and 1995.
- Overpayments of \$69,280 resulting from a software conversion in August 1996 have been adjusted from medical expense and reflected as an accounts receivable.
- Pharmacy expenses of \$15,290 paid in 1997 were accrued as an expense and a payable as of December 31, 1996.
- Premium taxes payable and expense have been adjusted for the effect of savings and loss calculation.
- Administrative expenses were adjusted for unrecorded auditing expenses of \$14,500.

The effect of review adjustments on the retained earnings for Tenncare, the TennCare operations of Healthsource Tennessee Preferred, Inc., is to increase the deficit from \$59,621 to (\$1,401,165) as of December 31, 1996. A review-adjusted balance sheet and statement of revenue, expenses, and net worth is shown on schedule 4.

FINDINGS AND RECOMMENDATIONS

1. Deficiencies in the claims processing system

Finding

Healthsource Tennessee Preferred, Inc., has not fulfilled contract reporting requirements and processing efficiency requirements for TennCare operations. Our review noted the following problems:

- a. The TennCare Bureau has retained \$179,105 of the 10% capitation withhold amounts from 1996 capitation payments for deficiencies in encounter data submissions. Encounter data, a record of the medical services provided to enrollees, is necessary for evaluation of quality of care and access to TennCare services. For two of the claims sampled, the claims processing system did not record all revenue codes, charges, and minimum number of diagnosis codes from claims for medical services. Section 2-11(f) of the contract between TennCare and Healthsource Tennessee, Inc., requires that encounter data be reported in a format specified by TennCare. Additionally, Attachment II, Exhibit E, of the contract lists revenue codes as a required data element for claims/encounter data reporting.
- b. Healthsource Tennessee Preferred, Inc., converted to a new software package in August 1996. The Division of State Audit had discovered during the prior review that the new software incorrectly overpaid a significant number of claims. The payments were determined unacceptable for savings and loss calculations. The following payment errors were discovered:
 - Payments were made at full charge without applying a negotiated fee amount or the appropriate withhold amount.
 - Certain claims for inpatient stays paid a per diem but also incorrectly paid ancillaries at full charges.
 - Certain claims for inpatient stays denied room and board charges but paid ancillaries at full charges.

In the claims processing system, Healthsource Tennessee Preferred, Inc., had corrected overpayments of \$512,077 as of November 19, 1997, for claims with dates of service in 1994, 1995, and 1996. Healthsource Tennessee Preferred, Inc., had not attempted to recoup these overpayments as of November 19, 1997. Also, the current year's review noted that in December 1996 Healthsource Tennessee Preferred, Inc., stopped paying claims filed by medical providers. In the claims

processing system, these claims were denied with the explanation reason that “Tennsource funds exhausted,” but a remittance advice denying these claims was not sent to the medical providers. A remittance advice is the written communication to the provider concerning payments and denials. The Division of State Audit and the Department of Commerce and Insurance concluded that Healthsource Tennessee Preferred, Inc., had prematurely stopped paying claims because Tennsource funds were not exhausted. We calculated that medical payments were less than 90% of TennCare capitation received, resulting in a savings of \$763,597. In January 1998, at the request of the Department of Commerce and Insurance, Healthsource Tennessee Preferred, Inc., reprocessed all claims previously denied as “Tennsource funds exhausted.” The reprocessing resulted in overpayments applied to specific providers and additional cash payments of \$1,206,049 by Healthsource Tennessee Preferred, Inc. The result of the reprocessing was to reduce savings previously computed for plan year 1994 to \$481,206, and losses to occur for the plan years 1995 and 1996 of \$11,714 and \$718,554, respectively (see schedules 1, 2, and 3).

- c. Healthsource Tennessee Preferred, Inc., incorrectly calculated deductibles and copayments for certain TennCare claims paid. The deductibles and copayments were computed based on the charges for medical services instead of on the negotiated rate between medical providers and Healthsource Tennessee Preferred, Inc. Section 2-3(h) of the TennCare contract states, “Deductibles and copayments charged the enrollee shall be based upon the negotiated rate between the MCO and the provider.” As a result of the incorrect calculation, deductibles and copayments were overstated, and medical providers were underpaid.
- d. Healthsource Tennessee Preferred, Inc., incorrectly applied a \$6 copayment to Medicaid recipients for non-emergency use of the emergency room. Section 2-3(h) of the TennCare contract states, “The CONTRACTOR shall not require any deductibles, copayments, and/or special fees for covered services except to the extent that deductibles, copayments, and/or special fees are required for those services by TENNCARE.” The only special fee that can be applied is a \$25 fee for non-emergency use of hospital emergency rooms by non-Medicaid enrollees.
- e. Healthsource Tennessee Preferred, Inc., incorrectly exceeded deductible limits for enrollees with deductible requirements. In a sample of 13 enrollees with deductible requirements, four enrollees were incorrectly assessed deductible payments beyond their required limits. The errors resulted in reduction of payments to medical providers and overcharges to non-Medicaid eligible enrollees ranging from \$34.40 to \$233.00 for the sampled enrollees.
- f. Healthsource Tennessee Preferred, Inc., has not met claims processing requirements specified by the TennCare contract. Healthsource Tennessee Preferred, Inc., 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. All 40 claims tested were clean claims with the following time lags:

- five within 30 days (13%)
- six within the next ten days (15%)
- seven within 41-60 days (17%)
- four were not completely processed until after 60 days (10%)
- The remaining 18 (45%) in our sample were received between October 28, 1996, and July 14, 1997, but not completely processed as of November 19, 1997. Seventeen of these claims have been denied “Tennsource funds exhausted” and one claim remained unpaid. As previously mentioned, Healthsource Tennessee Preferred, Inc., had not notified providers through a remittance advice the status of these claims; therefore, we considered these claims as not completely processed. In January 1998, all of these claims were reprocessed and remittance advices sent.

The TennCare contract states, “The CONTRACTOR shall pay within thirty (30) calendar days of receipt ninety five percent (95%) of all clean claims submitted by contract and non-contract providers. 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. The term "process" means that the CONTRACTOR must pay the claim or advise the provider that a submitted claim is (1) a "denied claim" and specify all reasons for denial or (2) a claim that cannot be denied or specify in detail all information and/or documentation that is needed from the provider in order to allow or deny the claim.”

- g. The original hardcopy claim was not provided by Healthsource Tennessee Preferred, Inc., for six of the 40 claims in the sample.
- h. Weekly claims processing reports are not in compliance with contract requirements. Section 2-11(g) of the TennCare contract with Healthsource Tennessee, Inc., defines the information to be reported on a weekly basis to TennCare. The following items should be included in the reports:
 - number of unpaid claims in inventory by service type
 - aging of unpaid claims by service type
 - average time from receipt to final payment of claim by service type
 - approximate value of unpaid claims by service type
 - number of member phone calls
 - approximate waiting time for member response

Recommendation

Healthsource Tennessee Preferred, Inc., should submit encounter data in the format specified by the Bureau of TennCare. All revenue codes and charges should be included in encounter data reporting. Copayments and deductibles should be computed based on the negotiated rate between Healthsource Tennessee Preferred, Inc., and the medical providers. (Deductibles should not exceed annual limitations.) Healthsource Tennessee Preferred, Inc., should notify providers of the corrected computations and ensure that they properly adjust patient accounts for the overstated deductibles and copayments. No action is required regarding claims processing efficiency and submission of weekly claims processing reports since the plan was sold and the contract with TennCare ceased December 31, 1996.

Management's Comment

We concur.

2. Deficiencies in financial reporting and failure to maintain minimum equity requirements

Finding

The following deficiencies were noted with the financial and annual statement reporting for TennCare operations:

- Medical expenses were underreported by \$1,763,874. As noted in finding 1, Tennsource, the TennCare operations of Healthsource Tennessee Preferred, Inc., stopped paying medical claims in December 1996 and no payable was established at December 31, 1996, because Tennsource funds were considered exhausted. In January 1998, the reprocessing of previously denied and overpaid claims increased medical expenses. Also, an expense and payable was not recognized for pharmacy expenses of \$15,290 incurred in 1996 but not paid until 1997.
- Charges for administrative expenses by Healthsource Tennessee, Inc., the management company, and Healthsource, Inc., the parent, are not supported by a written management agreement.
- An expense for audit fees of \$14,500 was not reported.

Section 2-12 of the TennCare contract with Healthsource Tennessee, Inc., states, "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 Agreement and any other costs and expenditures made under the Agreement.”

As a result of the deficiencies in the financial reporting and adjustments as a result of the savings and loss calculations, the separate balance sheet and statement of revenue, expenses, and net worth for Tennsource, the TennCare operations of Healthsource Tennessee Preferred, Inc., has been adjusted. The effect of review adjustments on the retained earnings for TennCare operations is to increase the deficit from \$59,621 to (\$1,401,165) as of December 31, 1996. A review-adjusted balance sheet and statement of revenue, expenses, and net worth for TennCare operations is exhibited on schedule 4. The adjustments to TennCare operations will reduce the equity for Healthsource Tennessee Preferred, Inc., from \$1,161,082 to (\$299,704). The plan did not meet the minimum financial reserve requirement equal to the statutory deposit as of December 31, 1996, specified in the TennCare Contract and in *Tennessee Code Annotated*.

Section 2-10(e)(4) of the TennCare contract for preferred provider organizations states, “The Contractor shall establish risk reserves in an amount equal to the amount that would have been required by Tennessee Department of Commerce and Insurance if the Contractor had been a health maintenance organization licensed by the State of Tennessee.”

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

Recommendation

No action is required since the plan was sold and the contract between Healthsource Tennessee, Inc., and TennCare ceased December 31, 1996.

Management’s Comment

We concur.

3. Deficiencies in provider contract language

Finding

Healthsource Tennessee Preferred, Inc., has not complied with the TennCare contract requirements for provider contracts. Language describing the following requirements is excluded or deficient in contracts between Healthsource Tennessee Preferred, Inc., and medical providers:

- The managed care organization is to pay the provider within 30 days of receipt of a properly submitted clean claim; and
- A provider shall have at least 120 calendar days from the date of service to file a claim with the managed care organization. The specific language of Health-source Tennessee Preferred, Inc., provider contracts allows only 90 calendar days to file a claim.

All requirements for provider contracts are specified in section 2-18 of the TennCare contract with Healthsource Tennessee, Inc.

Recommendation

No action is required since the plan was sold and the contract between Healthsource Tennessee, Inc., and TennCare ceased December 31, 1996.

Management's Comment

We concur.