

**Tennessee Managed Care Network
D/b/a Access...*MedPLUS***

**For the Period
January 1, 1996, Through December 31, 1998**

Arthur A. Hayes, Jr., CPA, JD, CFE
Director

Ronald M. Paolini, CPA
Assistant Director

Clare A. Tucker, CPA
Audit Manager

Karen Degges
In-Charge Auditor

John Mattingly, CPA
Beth Pugh
Staff Auditors

Amy Brack
Editor

January 14, 2000

The Honorable Don Sundquist, Governor
and

Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

and

The Honorable John Ferguson, Commissioner
Department of Finance and Administration
First Floor, State Capitol
Nashville, Tennessee 37243-0285

Ladies and Gentlemen:

Pursuant to the agreement between the Comptroller of the Treasury and the Department of Health, the Division of State Audit performs examinations of managed care organizations participating in the Tennessee TennCare Program under Title XIX of the Social Security Act.

Submitted herewith is the report of the examination of Tennessee Managed Care Network, d/b/a Access...*MedPLUS*, for the period January 1, 1996, through December 31, 1998.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/pn
99/075

cc: Joe Keane
Theresa Clarke-Lindsey
John Tighe

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

TennCare Report
Tennessee Managed Care Network
D/b/a Access...MedPLUS

For the Period January 1, 1996, Through December 31, 1998

- 1. Management Did Not Provide Requested Information**
TMCN did not cooperate fully with Comptroller of Treasury personnel and provide information necessary to conduct the audit in a timely manner (page 9).
- 2. Failure to Maintain Minimum Equity Requirements**
TMCN did not meet the minimum equity requirements of a health maintenance organization (page 10).
- 3. Deficiencies in Claims Processing System**
TMCN has not fulfilled contract reporting requirements and processing efficiency requirements specified by the TennCare contract (page 11).
- 4. Weaknesses in Management Oversight and Internal Controls**
TMCN did not provide documentation of internal audit function or an organizational chart (page 18).
- 5. Deficiencies in Provider Contract Language**
TMCN did not include in the provider agreements all requirements specified by the TennCare contract (page 19).
- 6. Failure to File Audited Financial Statements**
TMCN did not file audited financial statements for the year ended December 31, 1998, as required by the TennCare contract (page 22).

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

Comptroller of the Treasury, Division of State Audit
1500 James K. Polk Building, Nashville, TN 37243-0264
(615) 741-3697

TennCare Report
Tennessee Managed Care Network
D/b/a Access...MedPLUS
For the Period January 1, 1996, Through December 31, 1998

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
Purpose and Authority of the Examination	1
Background	1
Scope of the Examination	5
Prior Examination Findings	5
Results of the Examination	5
Independent Accountant's Report	7
FINDINGS AND RECOMMENDATIONS	9
1. Management did not provide requested information	9
2. Failure to maintain minimum equity requirements	10
3. Deficiencies in claims processing system	11
4. Weaknesses in management oversight and internal controls	18
5. Deficiencies in provider contract language	19
6. Failure to file audited financial statements	22

**Tennessee Managed Care Network
D/b/a Access...MedPLUS
For the Period January 1, 1996, Through December 31, 1998**

INTRODUCTION

PURPOSE AND AUTHORITY OF THE EXAMINATION

The terms and conditions for authorizing the TennCare Program, as well as the contracts between the state of Tennessee and the managed care organizations (MCOs) require that audits of the managed care organizations be conducted by the Tennessee Comptroller's Office. The contract between the Tennessee Department of Health and the State Comptroller's Office also contains a provision requiring the audits.

Under their contract with the state, the MCOs have asserted to comply with stated requirements regarding their provision of services to TennCare enrollees. The purpose of our examination is to render an opinion on the MCOs' assertions that they have complied with certain financial related requirements of their contract with the state.

BACKGROUND

The Tennessee Department of Health is the single state agency responsible for administering the TennCare Program and the TennCare Partners Program. On January 1, 1994, the TennCare Program began as an approved federal waiver replacing the then existing Medicaid Program. TennCare encompasses all services other than mental health and long-term care. On July 1, 1996, the TennCare Partners Program was initiated. TennCare Partners, which functions in the same manner as the regular TennCare Program, covers mental health services. Long-term care continues to be excluded from all TennCare waivers. The state contracts with private health maintenance organizations to provide TennCare services to beneficiaries. The health maintenance organizations (HMOs) are referred to as "managed care organizations" (MCOs).

Recipients who meet Medicaid eligibility standards are enrolled in the TennCare Program and TennCare Partners Program. In addition, certain uninsured and uninsurable individuals are eligible for enrollment. Uninsured persons may be required to pay a monthly premium. The contracting MCO provides care for TennCare enrollees for a stated monthly capitation fee. The MCOs 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. Essentially, the program functions much the same as a conventional health care delivery system under managed care.

Prior to TennCare, Tennessee Managed Care Network (TMCN), a nonprofit corporation, coordinated medical services for approximately 35,000 Aid to Families with Dependent Children (AFDC) Medicaid recipients in the State of Tennessee. Effective January 1, 1994, the plan contracted with the State of Tennessee as an HMO to provide medical services under the newly established TennCare program. The TMCN designated name for the TennCare plan is Access...MedPLUS. Effective March 1, 1996, Tennessee Managed Care Network sold investments in subsidiaries and all fixed assets to Medical Care Management Company (MCMC), a for-profit corporation. The management agreement between TMCN and MCMC grants MCMC the authority to supervise and manage the day-to-day operations of the plan. MCMC is paid a management fee, based on a declining scale, from 12% TO 8% of annual premium revenue plus a performance incentive of 50% of the plan's net profit.

At December 31, 1996, the enrollment in the TennCare program for TMCN was approximately 254,000 members. At December 31, 1997, the enrollment in the TennCare program for TMCN was approximately 291,000 members. At December 31, 1998, the enrollment in the TennCare program for TMCN was approximately 296,000 members.

TMCN files quarterly and annual statements with the Tennessee Department of Commerce and Insurance. This department uses the information filed in 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. "Nonadmitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and are reduced from equity.

The annual statement for the year ended December 31, 1996, reported \$85,371,239 in plan assets; \$66,103,726 in liabilities; and \$19,267,513 net worth. The plan maintained a restricted deposit of \$6,537,675 as of December 31, 1996. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1996, reported total revenues of \$363,316,586; medical expenses of \$298,500,420; and administrative expenses of \$51,535,232, resulting in net income of \$13,280,934. Revenue comprises \$358,162,465 in capitation fee payments from TennCare; \$3,666,861 in investment income; and \$1,487,260 in gain on sale of assets. Included in the medical expenses reported on the NAIC is \$4,775,271 for Health Education outreach expense. This amount includes payments for salaries, consultants, travel, and public relations.

For the year ended December 31, 1996, the general ledger for MCMC provided by TMCN reports total expenses of \$28,087,271.31 and total revenue of \$36,187,169.03. Management fee expense and profit share revenue paid to MCMC by TMCN is \$36,072,867.65. Medical expenses represent 82.01 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 13.72 percent of capitation fee payments from TennCare.

The annual statement for the year ended December 31, 1997, reported \$84,667,101 in plan assets; \$62,976,946 in liabilities; and \$21,690,155 net worth. The plan maintained a

restricted deposit of \$3,435,555 as of December 31, 1997. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1997, reported total revenues of \$400,487,724; medical expenses of \$341,991,906; and administrative expenses of \$50,423,752, resulting in net income of \$8,072,066. Revenue comprises \$395,703,695 in capitation fee payments from TennCare; \$4,223,052 in investment income; and \$560,977 in miscellaneous income. Included in the medical expenses reported on the NAIC is \$6,152,830 for Health Education outreach expense. This amount includes payments for salaries, consultants, travel, public relations, contributions, and donations.

For the year ended December 31, 1997, the general ledger for MCMC provided by TMCN reports total expenses of \$28,971,794.10 and total revenue of \$41,573,709.59. Management fee expense and profit share revenue paid to MCMC by TMCN is also \$41,573,709.59. Medical expenses represent 84.87 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 12.3 percent of capitation fee payments from TennCare.

The annual statement for the year ended December 31, 1998, reported \$73,290,255 in plan assets; \$56,847,085 in liabilities; and \$16,443,170 net worth. The plan maintained a restricted deposit of \$3,515,615 as of December 31, 1998. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of \$444,571,182; medical expenses of \$393,921,933; and administrative expenses of \$52,285,518, resulting in a net loss of \$1,636,269. Revenue comprises \$440,430,160 in capitation fee payments from TennCare, and \$4,141,022 in investment income. Included in the medical expenses reported on the NAIC is \$4,988,888 for Health Education outreach expense. This amount includes payments for salaries, consultants, travel, auto lease payments, advertising, contributions, and donations. Medical expenses represent 88.31 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 11 percent of capitation fee payments from TennCare.

For the year ended December 31, 1998, the general ledger for MCMC provided by TMCN reports total revenue of \$43,414,589.31 and total expenses of \$38,123,323.70. Of this expense amount, \$20,502,918.05 is reported by TMCN as being actual costs incurred for TMCN. The remaining amount consists of \$13,743,273.61 Access Health Systems (AHS) corporate cost allocation, \$3,485,277.94 in state and federal income taxes, and \$391,857.10 in miscellaneous expense. Management fee expense paid to the MCMC by TMCN and reported as revenue by the MCMC is \$42,462,812.84. State auditors requested information concerning TMCN's relationship with AHS and ownership information for AHS. However, TMCN has not provided any information concerning Access Health Systems.

TMCN was required by the Department of Commerce and Insurance to amend the 1998 NAIC annual statement. The amended annual statement for the year ended December 31, 1998, reported \$71,600,290 in plan assets; \$65,585,191 in liabilities; and \$6,015,099 in net worth. The plan maintained a restricted deposit of \$3,515,615 as of December 31, 1998. A separate balance sheet for TennCare operations is not required for annual statement purposes. A separate

statement of revenues, expenses, and net worth for TennCare operations for the year ended December 31, 1998, reported total revenues of \$437,013,685; medical expenses of \$401,657,657; and administrative expenses of \$51,281,260, resulting in a net loss of \$15,925,232. Revenue comprises \$432,609,463 in capitation fee payments from TennCare, and \$4,404,222 in investment income. Included in the medical expenses reported on the NAIC is \$4,988,888 for Health Education outreach expense. This amount includes expenses of \$1,438,649 for salaries and benefits; \$807,482 for consulting fees; \$745,140 for advertising and promotion; \$718,631 for health education; \$504,450 for contributions and donations; \$503,432 for mom-to-be program; \$94,931 for office supplies; \$82,367 for travel; \$66,014 for training; \$19,774 for auto lease expense; and \$8,018 for other expenses. Medical expenses represent 91.69 percent of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 11 percent of capitation fee payments from TennCare.

The amended annual statement included the following changes:

- Investments were increased by \$263,200 to adjust for fair market value.
- Pharmacy rebate was increased by \$47,620 to adjust for actual receipt.
- Claims payable was increased by \$9,000,000 to adjust for the outside accountant's actuary review.
- TennCare premium revenue and receivables were decreased by \$10,944,118 to adjust the adverse selection amount to actual received in 1999. Originally, the receivable had been booked under criteria permitted by the Department of Commerce and Insurance. The decrease was necessary when the amount received for adverse selection turned out to be much less than expected.
- TennCare premium revenue and receivables were increased by \$4,340,076 to adjust for a retroactive rate increase.
- Premium taxes of \$131,411 and management fee expenses of \$872,848 were decreased to reflect the adjustments made to revenue.

The amendments made to the annual statement increase the loss from \$3,222,500 to \$14,288,963. Also, the equity decreases from \$16,443,170 on the original filing to \$6,015,099 on the amended filing. See finding one for equity deficiency.

SCOPE OF THE EXAMINATION

Our examination covers certain financial related requirements of the contract between the state and Tennessee Managed Care Network, for the period January 1, 1996, to December 31,

1998. The requirements covered are referred to under management's assertions specified later in the Independent Accountant's Report. Our examination does not cover those portions of the contract concerning quality of care and clinical and medical requirements.

PRIOR EXAMINATION FINDINGS

The previous examination of Tennessee Managed Care Network, for the year ended December 31, 1995, included the following findings:

Denial of access to records

Medical Care Management Company, the management company for Tennessee Managed Care Network (the plan), has denied state auditors access to records regarding material events subsequent to the period under review.

Understatement of trade accounts payable and errors in computation of unpaid claims liabilities

Tennessee Managed Care Network has underreported plan liabilities by \$130,253. Errors were discovered in the calculation of IBNR (incurred but not reported) claims liability. Total unpaid claims liabilities reported by the plan were adequate.

Weaknesses in management oversight and internal control

Tennessee Managed Care Network has no internal audit function. Also, a current organizational chart was not provided. In addition, checks from the manual register were not accounted for properly.

Deficiency in claims processing system

Tennessee Managed Care Network has not fulfilled contract reporting requirements regarding encounter data. Also, weekly claims processing reports do not include all information required by the contract. The policy of issuing advance payments continued for the period under review.

The findings concerning weaknesses in management oversight and internal control and deficiency in claims processing system will be repeated in the current report (see the Findings and Recommendations section of this report).

RESULTS OF THE EXAMINATION

Our examination of the plan revealed discrepancies in the claims processing system, provider agreements, accounting, and financial data. These discrepancies are further discussed in the Findings and Recommendations section of the report.

No adjustments were considered necessary for reporting purposes for the period January 1, 1996, through December 31, 1997. Subsequent material events and corrections affected the reporting of the operations of TMCN for the period January 1 through December 31, 1998.

Except for the adjustment that follows, State Audit adjustments were made by TMCN on the amended statement. TMCN's equity was adjusted by the Division of State Audit as follows:

- Receivables for pharmacy in the amount of \$641,675, and reinsurance in the amount of \$60,984 that were over 90 days were reclassified as nonadmitted.

The effect of examination adjustments on the net income for the TennCare operations of TMCN is to increase net loss from \$15,925,232 to \$16,627,891 as of December 31, 1998. The effect of review adjustments will decrease equity by \$702,659.

The claims payable amount on the original filing of the 1998 NAIC annual statement of \$53,622,722 was certified by an independent actuary. This amount was increased by \$9,000,000 on the amended statement and was certified by the independent actuary. During fieldwork, auditors received summaries of claims paid in January 1999 and February 1999. Summaries for March through May 1999 were requested by auditors but were not received.

Independent Accountant's Report

July 30, 1999

The Honorable Don Sundquist, Governor
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Fredia Wadley, M.D., Commissioner
Department of Health
344 Cordell Hull
Nashville, Tennessee 37247

Ladies and Gentlemen:

We have examined management's assertions included in its representation letter dated May 14, 1999, that Tennessee Managed Care Network complied with the following requirements during the period January 1, 1996, through December 31, 1998.

The organization has complied with its contractual duty to provide certain member services to its enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.

As discussed in management's representation letter, management is responsible for ensuring compliance with those requirements. Our responsibility is to express an opinion on management's assertions about the organization's compliance based on our examination.

Our examination was made in accordance with standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence about the compliance of Tennessee Managed Care Network, d/b/a Access...*MedPLUS* with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion. Our

examination does not provide a legal determination on the compliance of Tennessee Managed Care Network, d/b/a Access...*MedPLUS* with specified requirements.

Our examination disclosed the following material noncompliance applicable to Tennessee Managed Care Network, d/b/a Access...*MedPLUS*:

- Agreements with subcontractors and with medical providers do not contain the required provisions as specified in the contract with the state.
- Assets and liabilities are not properly classified as "admitted" or "nonadmitted" on the annual National Association of Insurance Commissioners (NAIC) report which is completed on a "statutory basis of accounting" and filed with the state.
- The organization is not in compliance with the minimum equity requirements as specified in the contract with the state.
- The organization is not in compliance with contractual claims processing requirements.
- The organization is not in compliance with contractual reporting requirements.

In our opinion, except for the material noncompliance described in the above paragraph, management's assertions that Tennessee Managed Care Network complied with the aforementioned requirements for the period January 1, 1996, through December 31, 1998, is fairly stated, in all material respects.

This report is intended solely for the use of the Tennessee General Assembly and the Tennessee Department of Health. However, this report is a matter of public record and its distribution is not limited.

Sincerely,

Arthur A. Hayes, Jr., CPA, Director
Division of State Audit

AAH/pn

FINDINGS AND RECOMMENDATIONS

1. Management did not provide requested information

Finding

TMCN has not always provided the auditors with requested information. In addition, information received was often incomplete or was not what had been requested. During the audit, it appeared that management's primary objective was to restrict the flow of information to the auditors rather than provide a free flow of information. Auditors encountered communication problems as well. Frequently telephone calls were not returned or were not returned timely. Management did not take reasonable measures to seek clarification when uncertain of exact information requested in writing. As a result, no information was received, or it had to be requested several times, resulting in additional delays.

Section 2-13 of the contract between the plan and the state specifies that "the CONTRACTOR shall make all records available at the CONTRACTOR's expense for review, audit, or evaluation by authorized federal, state, and Comptroller of Treasury personnel." Also, Section 2-16 of the contract specifies that "the CONTRACTOR shall make available to TennCare or its representatives and other authorized state and federal personnel . . . all records, books, documents, and other evidence pertaining to this Agreement, as well as appropriate administrative and/or management personnel who administer the plan." When information is not received timely, unnecessary delays in field work and reporting can occur. Unnecessary delays drive up audit costs.

Recommendation

Management should cooperate fully with Comptroller of Treasury personnel and provide information necessary to conduct the audit in a timely manner.

Management's Comment

TMCN responded timely and completely to requests for information. Based on our understanding of the requests made, complete information was provided to the auditors in an expeditious manner. It is virtually impossible to respond to broad generalizations as reflected in the finding. TMCN did not restrict the flow of information to the auditors, but instead sought to assure the provision of accurate and complete data.

During the time of the audit fieldwork, a new Information System was being implemented. We fully expect upon completion, response time in the future will be significantly improved.

Rebuttal

TMCN did not respond timely and completely to requests for information. As noted in the background information and in the responses to finding 2, auditors were not provided with requested information.

2. Failure to maintain minimum equity requirements

Finding

Tennessee Managed Care Network does not meet the minimum equity requirements of a health maintenance organization. The minimum equity requirement at December 31, 1998, is \$10,262,289. The plan's adjusted equity at December 31, 1998, is \$5,312,440, which results in a deficiency of \$4,949,849.

Section 2-10(e)(4) of the health maintenance organization TennCare contract states, "The CONTRACTOR shall comply with all requirements of the Tennessee Department of Commerce and Insurance applicable to risk reserves."

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

Recommendation

Tennessee Managed Care Network should take appropriate action to meet the minimum risk reserve requirements for TennCare operations. The Tennessee Department of Commerce and Insurance should take whatever action deemed necessary to ensure that Tennessee Managed Care Network meets the minimum equity requirements.

Management's Comment

We concur with the finding that TMCN does not meet minimum equity requirements. TMCN is in discussion with TDOCI regarding correcting this deficiency.

3. Deficiencies in claims processing system

(Items in italics are management responses. Rebuttals, where necessary, are in bold following the response.)

Finding

Tennessee Managed Care Network did not fulfill contract reporting requirements and processing efficiency requirements. A review of 195 claims for services provided from January 1, 1996, through December 31, 1998, revealed the following:

- a) TMCN did not meet the claims processing requirements specified by the TennCare contract. Clean claims submitted by providers for medical services were not always processed within the 40-day requirement. The processing lags include an adjustment to the adjudication date. TMCN's final adjudication date used to calculate the lag is the date that checks and remittance advices are printed. The processing lag has been adjusted to calculate the lag using the date the checks and remittance advices are mailed. Of the 195 claims examined, all were clean claims with the following time lags:

187 claims within 30 days (96%)
2 claims within 40 days (1%)
6 claims within 41 to 60 days (3%)

- b) Seven claims did not pay amounts in agreement with negotiated rates.

- (1) One claim was underpaid according to fee schedule provided for anesthesia claims.
- (1) *The system was not recognizing the physical status codes, which resulted in the claim paying incorrect units. This was brought to the attention of the MCIS department and the error corrected.*
- (2) For one claim, agreement with the negotiated rate could not be determined based on the transportation fee schedules.
- (2) *All conventional transportation claims are paid as billed. All claims are submitted for processing by the CSA. The CSA is responsible for making sure that the bill submitted is at the contracted rate. Paid correctly.*
- (2) **Rebuttal: During fieldwork, TMCN failed to provide the details requested for this claim.**
- (3) For two claims, agreement with the negotiated rate could not be determined based on information provided.

- (3) *For the first claim, when defra labs are billed, payment is calculated at 62% of defra price. All other lines are paid at the outpatient contracted percentage rate. All lines paid correctly. No errors. The second claim was paid correctly.*
 - (3) **Rebuttal: During fieldwork, TMCN failed to provide the details requested for these claims.**
 - (4) Three claims were overpaid according to the contract with the dental provider.
 - (4) *Two claims did not pay. Both denied correctly. One claim: ICN incorrect (only 12 digits). We are unable to identify the claim for comment.*
 - (4) **Rebuttal: The claims did not deny in the entirety. Some of the lines were paid. Correct ICN previously provided.**
- c) Twenty-six claims did not have all common and provider specific data elements recorded.
- (5) Two of these did not have revenue/procedure codes recorded in system.
 - (5) *Rev. Codes 300-319 must report specific lab codes for defra pricing. Only the lab code is maintained to reflect pricing methodology.*
 - (5) **Rebuttal: Neither code was found in system.**
 - (5) *Procedure Code 00170 is invalid for dental. This code is restricted for Anesthesiologist and CRNA's. Codes that are invalid for specific provider types do not appear on the procedure/formulary file. This claim denied appropriately with EC-232 (procedure not on procedure formulary file).*
 - (5) **Rebuttal: Procedure 00170 was incorrectly keyed. The correct procedure code was 00130.**
 - (6) Two claims recorded the incorrect provider or no provider.
 - (6) *This claim was batched incorrectly, as claim type should have been 06 (physician). Claims incorrectly batched are denied to the 9's with error code 350 to be reprocessed in the correct batch. This claim was reprocessed and the provider received payment on the 7/11/97 remittance.*
 - (6) *Provider number submitted on the claim is for BMH Lauderdale. The claim paid correctly to BMH Lauderdale.*
 - (6) **Rebuttal: The provider on the claim is Cleveland Pediatrics, P.C.**
 - (7) For one claim, a charge recorded in the system was not the charge on the claim.

- (7) *The billed charge on line 3 is \$40.00. This amount was entered correctly.*
- (7) **Rebuttal: The billed charge on line 4 was \$30 and \$20 was entered into the claims system.**
- (8) The remaining 21 claims did not have third, fourth, and/or fifth diagnosis codes recorded in the system.
- (8) *Twenty-one claims that did not have third and fourth diagnosis recorded: The data entry vendor was keying one diagnosis. Instructions and specifications were given to the vendor to key all diagnosis indicated on the claim.*
- d) The denial codes for eight claims were incomplete or inaccurate.
- (9) Four claims did not deny for all possible denial codes.
- (9) *Denial codes: The online inquiry indicates up to three denial codes. Ten denial codes are indicated on the remittance that the provider receives. Also, if claims deny for edits that are set in daily cycle it cannot set the edits that are in the weekly cycle. Dependent on the error set in daily some errors cannot set. (Example: Invalid member ID). If this error is set the system cannot check prior authorization, pre-cert and eligibility.*
- (9) **Rebuttal: Examples of denials not reported include untimely filing and duplicate claim paid.**
- (10) One denied claim was denied with the wrong denial code.
- (10) *Claim denied correctly with EC-568. If component Y3000 has already paid, the per diem cannot be billed.*
- (10) **Rebuttal: According to claims processing manager, this claim should have been denied for untimely filing.**
- (11) Two claims had error/denial codes for "capitated procedure/zero payment" even though procedure codes were not on the capitated list.
- (11) *Error code denial for capitation procedure: The providers identified are capitated specialists. Capitated specialists are paid according to their contractual agreement. Therefore, the claims "0" paid appropriately.*
- (11) **Rebuttal: During fieldwork, TMCN failed to provide the details requested for this claim.**

e) Seven claims denied in error.

(12) One claim denied in error as a result of a keypunch error that caused a previous submission to be paid to a wrong provider. The claim should have been corrected and payment made to the correct provider.

(12) Invalid ICN. Please supply correct ICN.

(12) Rebuttal: The correct ICN was previously provided.

(13) One claim denied for "provider not eligible on date of service" even though the provider was eligible.

(13) When this claim was submitted for payment the provider had an end date of 7/1/98, which resulted in the claim denying appropriately.

(13) Rebuttal: The claim was later paid. The provider was eligible.

(14) One claim denied in error as a result of a keypunch error. The admission date was keyed as 03/03/98 when it should have been keyed as 03/13/98. This resulted in the claim being denied in error for "pre-cert does not match admit date on claim."

(14) Keying error agreed.

(15) One claim had a line item to deny in error due to a keypunch error of the procedure code.

(15) Procedure code submitted was illegible. Data Entry clerk entered procedure as best as she or he could.

(16) One claim denied in error as a result of a keypunch error. The beginning date of service was incorrectly keypunched.

(16) Agree - keypunch error.

(17) One claim was a resubmission. The claim denied for "claim exceeds timely filing limit." A resubmission does not hit timely filing limits until after 165 days. This claim's received lag was 133 days.

(17) TMCN's policy is once a claim is denied the provider must resubmit within 45 days or timely filing is applied.

(17) Rebuttal: TMCN did not provide this information during fieldwork.

(18) One claim denied for "non-covered." This claim should have paid as capitated procedure.

(18) *Diagnosis code V2541 (contraceptive pill) is a non-covered diagnosis. The denial was based on the diagnosis and not the procedure codes. Therefore, the claim denied correctly.*

(18) Rebuttal: The provider should have been notified that the procedure was covered under capitation. This was done upon reprocessing.

f) (19) For four claims, no documentation was provided to substantiate denial code.

(19) *Claim denied as a result of keypunch error made in the units.*

(19) *The system was not recognizing the servicing number as an anesthesiologist. This error identified and corrected. All claims previously denied with EC-231 were system reprocessed and the provider received payment.*

(19) *Claim was submitted electronically. No information was loaded on the consent file. The claim denied on 10/09/98. The consent file was updated after the claim denied.*

(19) *Invalid ICN. Please supply correct ICN.*

(19) Rebuttal: The correct ICN was provided.

g) Four claims paid in error.

(20) One claim should have denied for "recipient has Medicare B."

(20) *Invalid ICN. Please supply correct ICN.*

(20) Rebuttal: Previously TMCN had been provided the correct ICN and had agreed the claim was paid in error.

(21) One claim should have denied for "claim exceeds one dental exam per six months."

(21) *Error code 670 is informational only and does not restrict visits.*

(21) Rebuttal: Regardless of the information given, the claim should have denied.

(22) One claim should have denied for "claim exceeds timely filing limit." No requests were found to bypass timely filing limits.

- (22) *Agree, bypassed timely filing.*
- (23) One claim should have denied with explanation to "bill BHO." The primary diagnosis for this claim was behavioral.
- (23) *Agree, claim was special batched and paid.*
- h) For nine claims, the appropriate paid status of the claims could not be determined by auditors due to TMCN's failure to provide requested documentation.
- (24) *Invalid ICN. Please supply correct ICN.*
- (24) Rebuttal: Correct ICN was provided.**
- (25) *Provider paid at outpatient rate of 75%. (two claims)*
- (25) Rebuttal: During fieldwork, TMCN failed to provide the details requested for this claim.**
- (26) *Invalid, please supply correct ICN.*
- (26) Rebuttal: Correct ICN was provided.**
- (27) *All conventional transportation claims are paid as billed. All claims are submitted for processing by the CSA. The CSA is responsible for making sure that the bill submitted is at the contracted rate. Paid correctly.*
- (28) *The system was not recognizing the servicing provider number as an anesthesiologist. This error was identified and corrected. All claims previously denied with EC-231 were system reprocessed and the provider received payment.*
- (29) *Claim denied as a result of a keypunch error made in the units.*
- (30) *Error code 461 is informational only and does not deny the claim.*
- (31) *Error code 670 is informational only.*

(27) through (31) Rebuttal: During fieldwork, TMCN failed to provide the details requested for these claims.

In addition to the 195 claims examined, 69 claims were selected from provider complaints filed with the Department of Commerce and Insurance. These claims were examined to determine if they were correctly adjudicated. The following was determined:

a) TMCN's denial of four claims was improper:

- (32) Three claims were denied because the claim does not match the authorization. The claims agreed with the authorization from TMCN.
- (32) *At the time claim was processed, incorrect data was on file. File was corrected in July.*
- (32) *Authorization was corrected in December. Until then, the claim did not have an authorization match on file.*
- (32) *Prior authorization not on file. Referral corrected to reflect a proper provider specialty in July.*
- (33) One claim denied because the claim was not submitted within 120 days. A keying error by TMCN resulted in the inappropriate denial.
- (33) *Date keyed as 3/02/98, should have been 9/2/98. Agreed, keying error.*

b) TMCN paid five claims incorrectly:

- (34) Four claims were underpaid on first submission by the medical provider. TMCN reprocessed the claims and paid the appropriate amount.
- (34) *These claims were initially submitted without instructions to pay according to special arrangements. Therefore, the claims had to be adjusted to pay according to agreed arrangement.*
- (35) One claim was overpaid since the payment by the recipient's primary insurer and the subsequent payment by TMCN as the secondary carrier exceed the total charges on the claim.
- (35) *Key punch error. TPL amount not keyed.*

c) TMCN's denial of 56 claims was considered appropriate.

d) TMCN's processing and payment of four claims were considered appropriate.

The inaccuracies and inefficiencies in the claims processing system indicate TMCN's failure to fulfill the claims processing requirements of the TennCare contract.

Recommendation

TMCN should adhere to contract reporting requirements and processing efficiency requirements for claims processing. Claims should be paid according to the correct fee schedule or contract pricing methodologies. All data elements required for individual encounter/claims data reporting should be recorded from claims submitted by providers. All possible reasons for denial should be communicated to the provider. Claims should be paid or denied in the time required by the TennCare contract.

Management's Comment

We do not concur with the finding that TMCN has failed to fulfill the claims processing requirements of the TennCare contract. TMCN processes approximately 2,400,000 claims per year, which equates to approximately 7,200,000 claims processed during the three years covered by this audit report. We agree that there were some errors as indicated above, but strongly disagree with the above conclusions that TMCN failed to fulfill the claims processing requirements of the TennCare contract.

Of the 62 claims that the auditors used to conclude that TMCN failed to fulfill the claim processing requirements, twenty-four (24) of the claims were processed correctly, 10 were not processed correctly mainly due to key punch errors, 7 did not have accurate claim identification numbers provided by the auditors to research the claims, and 21 had enough data to process the claims and did not impact the processing of the claims.

Rebuttal

The contract with the state requires all claims to be processed correctly.

4. Weaknesses in management oversight and internal controls

Finding

For the period under review and for the prior examination, several management weaknesses were noted:

- TMCN does not appear to have an internal audit function. Although the plan has a contract with an external organization to serve in this function and in questionnaires management states that the internal auditing staff conducts examinations, management did not provide documentation of work performed by the internal auditors when requested in writing by the auditors.

- The plan could not provide a current organizational chart of the operation of the company. Management has stated on several occasions that they were working on the chart and would provide it to the auditors.

Recommendation

TMCN should provide auditors with documentation of work performed by the organization hired to perform the internal auditing function. Organizational charts should be updated to reflect the responsibilities and authorities of management and staff.

Management's Comment

Tennessee Managed Care Network maintains that the internal controls established to safeguard the assets of the company are in place and are functioning properly.

Organizational charts have been provided to the Department of Commerce and Insurance.

Rebuttal

Internal audit reports were not provided. An organizational chart requested several times was not provided during fieldwork.

5. Deficiencies in provider contract language

Finding

Tennessee Managed Care Network did not comply with the TennCare contract requirements for provider agreements. The contracts did not contain all requirements as specified in Section 2-18 of the contract between TennCare and Tennessee Managed Care Network. Language describing the following requirements is excluded or deficient in contracts between TMCN and its providers:

- Specify in the provider agreement that the provider agreement and its attachments contain all the terms and conditions agreed upon by the parties.
- The provider shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the provider agreement without TMCN's approval.
- An adequate record system must be maintained for recording services, servicing providers, charges, dates, and all other commonly accepted information elements for services rendered to enrollees pursuant to the agreement. Enrollees and their representatives shall be given access to the enrollees' medical records, to the extent and in the manner provided by *Tennessee Code*

Annotated Sections 63-2-101 and 63-2-102, and, subject to reasonable charges, be given copies thereof upon request. When a patient-provider relationship with a TennCare primary care provider ends and the enrollee requests that medical records be sent to a second TennCare provider who will be the enrollee's primary care case manager or gatekeeper, the first provider shall not charge the enrollee or the second provider for providing the medical records.

- The provider shall indemnify and hold TennCare harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Agreement between TennCare and the MCO.
- The provider shall secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the enrollees and TMCN under the agreement. The provider shall provide such insurance coverage at all times during the agreement and upon execution of the provider agreement furnish TMCN with written verification of the existence of such coverage.
- TMCN and the provider agree to recognize and abide by all state and federal laws, regulations and guidelines applicable to the health plan.
- The agreement incorporates by reference all applicable federal and state laws or regulations, and that revision of such laws or regulations shall automatically be incorporated into the agreement, as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, TMCN and the provider agree to negotiate such further amendments as may be necessary to correct any inequities.
- Specify that both parties recognize that in the event of termination of the agreement between the MCO and TennCare, the provider agreement shall terminate immediately and the provider shall immediately make available, to TennCare, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the MCO/provider agreement. The provision of such records shall be at no expense to TennCare.
- The Contractor shall submit the proposed arbitration procedure, existing alternative arbitration procedure, or any subsequent modification to the arbitration procedure to the Tennessee Department of Commerce and Insurance, TennCare Division, for review and approval/denial within 30 calendar days after receipt. If a modification to the arbitration procedure is sent, it shall be sent Certified Mail-Return Receipt Requested.
- Include a conflict of interest clause as stated in Section 4-7 of the agreement between the MCO and TennCare.

- The provider shall have at least 120 calendar days from the date of rendering a health care service to file a claim and no more than 180 calendar days to file an initial claim with the MCO.
- Enrollees have the right to appeal adverse decisions that affect services. Notices of the right to appeal adverse decisions shall be displayed by the provider in public areas of facilities.

In addition, the subcontract with Vision Service Plan Insurance Co. was not approved by the Bureau of TennCare as required in Section 2-10 of the contract between TennCare and TMCN.

Recommendation

TMCN should comply with the TennCare Bureau's requirements regarding provider agreements. The provider agreements should contain all items as specified in Section 2-18 of the TennCare contract. All subcontracts should be approved by the TennCare Bureau.

Management's Comment

Tennessee Managed Care Network has submitted to TennCare and the Department of Insurance for approval during the existence of TennCare, contracts at three different times: with the initiation of TennCare prior to January 1, 1994; in 1996 in compliance with the Contractor Risk Agreement entered into with the State of Tennessee dated September 1995; and again in 1998 incorporating various amendments to the Contractor Risk Agreement.

In each instance, when Tennessee Managed Care Network submitted a provider agreement format, the agreement was approved by both the Tennessee Department of Commerce and Insurance and the Bureau of TennCare as required by the Contractor Risk Agreement.

Specifically, in 1999 the Tennessee Department of Commerce and Insurance and the Bureau of TennCare approved the following new provider agreements:

Primary Care Provider
 Specialist Physician
 Hospital
 Pharmacy
 Ancillary Service Provider
 Conventional Transportation
 Ambulance
 Community Service Agency

Therefore, the Tennessee Department of Commerce and Insurance and the Bureau of TennCare have approved as being compliant with the TennCare Contractor Risk Agreement and the laws of Tennessee all new provider agreements for use by Tennessee Managed Care Network.

Approved contracts are ready to be distributed to all providers.

Rebuttal

Executed contracts that we reviewed did not contain all of the required elements.

6. Failure to file audited financial statements

Finding

TMCN failed to file audited financial statements. Section 2-11.i of the contract between TMCN and TennCare states that audited financial statements covering the previous calendar year must be submitted by May 1 of each calendar year. TMCN requested and was granted two extensions. The first extension of the deadline was to May 28, 1999, and the second extension was to June 9, 1999. A third extension of the deadline has not been requested or granted. As a result of the failure to file audited financial statements, TMCN is not in compliance with the TennCare contract and timely information is not available.

Recommendation

TMCN should comply with the TennCare contract and file audited financial statements.

Management's Comment

We concur. TMCN has kept the Department of Commerce and Insurance and the Bureau of TennCare updated on the filing of audited financial statements. TMCN has taken the policy position that any filing of financial statements should be as accurate as possible and that any significant event that could change an opinion on the statement should be reported. This position has been shared with both the Department of Commerce and Insurance and the Bureau of TennCare.