

**Blue Cross and Blue Shield of Tennessee
TennCare Operations
For the Period
January 1, 1996, Through December 31, 1996**

**Volunteer State Health Plan – Eastern Tennessee, Inc.
For the Period
January 1, 1996, Through December 31, 1997**

**Volunteer State Health Plan, Inc.
For the Period
November 1, 1996, Through December 31, 1998**

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March 3, 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 Blue Cross and Blue Shield of Tennessee, TennCare Operations, for the period January 1, 1996, through December 31, 1996; Volunteer State Health Plan – Eastern Tennessee, Inc., for the period January 1, 1996, through December 31, 1997; and Volunteer State Health Plan, Inc., for the period November 1, 1996, through December 31, 1998.

Sincerely,

John G. Morgan
Comptroller of the Treasury

cc: Joe Keane
John Tighe

State of Tennessee

A u d i t H i g h l i g h t s

Comptroller of the Treasury

Division of State Audit

TennCare Report

Blue Cross and Blue Shield of Tennessee

TennCare Operations

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

Volunteer State Health Plan – Eastern Tennessee, Inc.

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Volunteer State Health Plan, Inc.

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

Finding

Deficiencies in Claims Processing

Volunteer State Health Plan, Inc., did not fulfill claims processing requirements as specified by the TennCare contract (page 9).

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

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TennCare Report
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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 must 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 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 MCOs provide 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.

Since the inception of the TennCare program on January 1, 1994, Blue Cross and Blue Shield of Tennessee, Inc. (BCBST), has participated as a preferred provider organization. On December 31, 1995, BCBST purchased the University of Tennessee Health Plan, a licensed health maintenance organization, and its 4,600 members for \$1,825,000. These members were transferred on January 1, 1996, to a newly created subsidiary of BCBST, Volunteer State Health Plan – Eastern Tennessee, Inc. (VSHP-ET). On June 1, 1996, BCBST transferred its TennCare members living in Knox County and East Tennessee community service areas (CSAs) to VSHP-ET. Also, effective June 1, 1996, VSHP-ET entered into a risk agreement with Tennessee Health Partnership, Inc. (THP), in which THP agreed to manage, provide, and pay for covered medical services to all of VSHP-ET members in exchange for 90% of the total premiums received by VSHP-ET from the state. VSHP-ET retained 10% of the premiums received from the state for administrative services, including the processing of claims submitted by THP providers for services rendered to VSHP-ET members.

On November 1, 1996, the remaining members of BCBST were transferred into another BCBST subsidiary and a licensed health maintenance organization, Volunteer State Health Plan, Inc. (VSHP). VSHP markets its services under the "BlueCare" tradename. VSHP pays for substantially all claims on a fee-for-service basis. Effective October 1, 1997, VSHP pays BCBST a stop-loss premium equal to 2% of premiums for only VHSP enrollees. Stop-loss insurance reported for the year ended December 31, 1997, and for the year ended December 31, 1998, was \$3,213,653 and \$12,908,577, respectively. Terms of the stop-loss coverage require recoveries if the plan has incurred medical expenses beyond 86% of the premium received by the plan during the calendar year. Premiums are defined by the stop-loss agreement as the total amount received from the State pursuant to the TennCare agreement, less applicable premium taxes, and other premiums such as subcapitation payments received from behavioral health organizations. No claim has been filed against the stop-loss insurance for the calendar year 1997 nor for the calendar year 1998. Beginning December 31, 1996, VSHP provided services through a primary care manager network. On January 1, 1998, VSHP-ET assigned its rights and substantially all of its assets and delegated its obligations to VSHP. VSHP agreed to provide all required TennCare services to VSHP-ET's former members and to be responsible for resolving all unresolved grievances, contract disputes, and medical services appeals that were pending at the time of assignment. VSHP continued the risk agreement with THP for members living in Knox County and East Tennessee CSAs.

VSHP and VSHP-ET have administrative contracts under which BCBST provides administrative services. For 1996 and 1997, the companies reimburse BCBST for administrative costs based on direct and indirect cost allocations. For 1998, the reimbursement was similar, with an additional \$1,884,266 return on investment charged to VSHP beyond the direct and indirect cost allocations.

At December 31, 1996, the enrollment in VSHP-ET was approximately 129,000 members. At December 31, 1997, the enrollment in VSHP-ET was approximately 112,000 members.

At December 31, 1996, the enrollment in VSHP was approximately 477,000 members. At December 31, 1997, the enrollment in VSHP was approximately 437,000 members. At December 31, 1998, the enrollment in VSHP was approximately 571,000 members.

VSHP-ET and VSHP file quarterly and annual statements with the Tennessee Department of Commerce and Insurance. This 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. Statutory accounting 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.

Since BCBST operated as a PPO until October 31, 1996, a final savings and loss calculation is required per the TennCare contract, section 2-10. The plan is allowed to retain up to 10% 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 shall not be liable for any excess benefit costs. Any and all excess administrative costs will be borne by Blue Cross and Blue Shield of Tennessee. In the event of savings, the plan, 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 shall be permitted to share five percent of the savings with providers. The contractor shall be allowed to retain five percent for the contractor's efficiency. The remainder of the savings shall be returned to TennCare. BCBST reported a loss of \$10,575,248 through the run-out of claims payments through May 31, 1997, for calendar year 1996.

The annual statement for VSHP-ET for the year ended December 31, 1996, reported \$14,824,351 in plan assets; \$5,918,187 in liabilities; and \$8,906,164 net worth. The plan maintained a restricted deposit of \$8,500,000 as of December 31, 1996. A statement of revenue, expenses, and net worth for the year ended December 31, 1996, reported total revenues of \$113,758,659, medical expenses of \$102,483,700, administrative expenses of \$12,173,908, and provision for federal income taxes of \$(315,000), resulting in a net loss of \$583,949. Revenue comprises \$112,579,834 in capitation fee payments from TennCare; \$702,158 in behavioral health organization (BHO) capitation payments; and \$476,667 in investment income. Medical expense includes \$5,087,133 of administrative and net income of THP which will be reclassified as administrative expense. Premium taxes incurred to the state were reported as \$2,262,168. Medical expenses less administrative expense and net income of THP represents 86% of capitation fee payments from TennCare, and administrative expenses less premium taxes plus administrative expense and net income of THP represents 13.2% of capitation fee payments from TennCare.

The annual statement for VSHP-ET for the year ended December 31, 1997, reported \$15,494,593 in plan assets; \$5,981,904 in liabilities; and \$9,512,689 net worth. The plan maintained a restricted deposit of \$7,781,181 as of December 31, 1997. A statement of revenue, expenses, and net worth for the year ended December 31, 1997, reported total revenues of \$166,566,433, medical expenses of \$144,302,197, administrative expenses of \$22,380,281, and

provision for federal income taxes of \$(40,616), resulting in a net loss of \$75,429. Revenue comprises \$164,630,709 in capitation fee payments from TennCare; \$1,261,023 in BHO capitation payments; and \$674,701 in investment income. Premium taxes incurred to the state were reported as \$3,292,814. Medical expenses represent 87% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 11.5% of capitation fee payments from TennCare.

The annual statement for VSHP for the year ended December 31, 1996, reported \$83,059,477 in plan assets; \$67,785,145 in liabilities; and \$15,274,332 net worth. The plan maintained a restricted deposit of \$2,100,000 as of December 31, 1996. A statement of revenue, expenses, and net worth for the year ended December 31, 1996, reported total revenues of \$108,836,541, medical expenses of \$95,312,914, administrative expenses of \$14,228,270, and provision for federal income taxes of \$(246,000), resulting in a net loss of \$458,643. Revenue comprises \$107,412,084 in capitation fee payments from TennCare; \$926,147 in BHO capitation payments; and \$498,310 in investment income. Premium taxes incurred to the state were reported as \$2,148,242. Medical expenses represent 88% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 11.2% of capitation fee payments from TennCare.

The annual statement for VSHP for the year ended December 31, 1997, reported \$143,399,600 in plan assets; \$104,073,252 in liabilities; and \$39,326,348 net worth. The plan maintained a restricted deposit of \$1,752,879 as of December 31, 1997. A statement of revenue, expenses, and net worth for the year ended December 31, 1997, reported total revenues of \$637,687,795, medical expenses of \$541,272,637, administrative expenses of \$78,781,821, and provision for federal income taxes of \$6,171,668, resulting in net income of \$11,461,669. Revenue comprises \$628,985,078 in capitation fee payments from TennCare; \$3,119,357 in BHO capitation payments; and \$5,583,360 in investment income. Premium taxes incurred to the state were reported as \$12,579,902. Medical expenses represent 85.6% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 10.5% of capitation fee payments from TennCare.

The annual statement for VSHP for the year ended December 31, 1998, reported \$193,920,306 in plan assets; \$122,552,673 in liabilities; and \$71,367,633 net worth. The plan has a depository agreement with the Department of Commerce and Insurance in the amount of \$11,200,000 as of December 31, 1998. A statement of revenue, expenses, and net worth for the year ended December 31, 1998, reported total revenues of \$831,994,353, medical expenses of \$693,266,321, administrative expenses of \$100,724,723, and provision for federal income taxes of \$13,301,158, resulting in net income of \$24,702,151. Revenue comprises \$818,911,573 in capitation fee payments from TennCare; \$3,826,700 in BHO capitation payments; and \$9,256,080 in investment income. Premium taxes incurred to the state were reported as \$16,374,085. Medical expenses represent 84.3% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 10.3% of capitation fee payments from TennCare.

SCOPE OF THE EXAMINATION

Our examination covers certain financial related requirements of the contract between the state and Blue Cross and Blue Shield of Tennessee, TennCare Operations, for the period January 1, 1996, through December 31, 1996; Volunteer State Health Plan – Eastern Tennessee, Inc., for the period January 1, 1996, through December 31, 1997; and Volunteer State Health Plan, Inc., for the period November 1, 1996, through 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, clinical, and medical requirements.

PRIOR EXAMINATION FINDINGS

The previous examination of Blue Cross and Blue Shield of Tennessee, TennCare Operations, for the period January 1 through December 31, 1995, included the following findings:

Deficiencies in Claims Processing System

Blue Cross and Blue Shield of Tennessee needs stronger controls over record retention. Payments to medical providers are not always based on the negotiated rate.

Deficiencies in Provider Agreements

Blue Cross and Blue Shield of Tennessee did not include in its provider agreements all requirements specified by the TennCare contract.

Finding 2 has been satisfactorily remedied. Finding 1 will be repeated in the current report (see the Finding and Recommendation section of this report).

RESULTS OF THE EXAMINATION

Our examination of the plans revealed discrepancies in the claims processing system. These discrepancies are further discussed in the Finding and Recommendation section of the report. The plans were in compliance with minimum equity requirements of the contract with the state. No adjustments were considered necessary for annual statement reporting purposes for any of the companies for the period January 1, 1996, through December 31, 1997. Subsequent late payments by TennCare for adverse selection were not reported on VSHP's annual statement for the year ended December 31, 1998. VSHP has received an additional adverse selection payment of \$2,253,007 for the year ended December 31, 1998. Additionally, VSHP is to receive a 2% retroactive rate increase for 1998 capitation payments. The effect of these adjustments would increase equity, and therefore VSHP would remain in compliance with minimum equity requirements.

Independent Accountant's Report

September 23, 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 August 25, 1999, that Blue Cross and Blue Shield of Tennessee, TennCare Operations, for the period January 1, 1996, through December 31, 1996; Volunteer State Health Plan – Eastern Tennessee, Inc., for the period January 1, 1996, through December 31, 1997; and Volunteer State Health Plan, Inc., for the period November 1, 1996, through December 31, 1998, complied with the following requirements during the period January 1, 1996, through December 31, 1998:

- The organizations are in compliance with the minimum equity requirements as specified in the contract with the state.
- The organizations have complied with their contractual duty to provide certain member services to their enrollees such as membership cards, provider directories, assignment of a primary care provider, and information on filing grievances.
- The organizations have complied with the processing efficiency requirements for claims processing.
- The organizations have complied with contractual reporting requirements.

- The organizations have complied with contractual requirements concerning their agreements with subcontractors and providers.
- The organizations have properly filed their quarterly and annual statements with the state according to National Association of Insurance Commissioners (NAIC) guidelines.

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 Blue Cross and Blue Shield of Tennessee, TennCare Operations; Volunteer State Health Plan – Eastern Tennessee, Inc.; and Volunteer State Health Plan, Inc., 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 companies' compliance with specified requirements.

Our examination disclosed the following material noncompliance:

- The organization is not in compliance with contractual claims processing requirements.

In our opinion, except for the material noncompliance described in the above paragraph, management's assertions that it has complied with the aforementioned requirements for Blue Cross and Blue Shield of Tennessee, TennCare Operations, for the period January 1, 1996, through December 31, 1996; Volunteer State Health Plan – Eastern Tennessee, Inc., for the period January 1, 1996, through December 31, 1997; and Volunteer State Health Plan, Inc., for the period November 1, 1996, through December 31, 1998, are 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

FINDING AND RECOMMENDATION

Deficiencies in claims processing

Finding

Volunteer State Health Plan – Eastern Tennessee, Inc., and Volunteer State Health Plan, Inc., (VSHP-ET/VSHP) did not fulfill contractual claims processing requirements. A review of 192 claims for services provided from January 1, 1996, through December 31, 1998, revealed the following:

- a. VSHP-ET/VSHP's denial of six claims was improper:
 - Three claims were denied because the provider had not obtained a prior authorization. VSHP-ET/VSHP's authorization system confirmed a prior authorization had been granted for two of the claims and the services on the other claim did not require a prior authorization. VSHP-ET/VSHP reprocessed the claims correctly.
 - Two claims were denied because the enrollee had other insurance which was considered primary. The other insurance had expired before the date of service of the claim. VSHP-ET/VSHP has correctly reprocessed the claims.
 - One claim for vision services was denied because the service is not covered for enrollees age 21 or over. The diagnosis for the vision service was covered since it was medical in nature. VSHP-ET/VSHP reprocessed and paid the claim and responded that the claims system was reconfigured to look at a specific list of vision diagnosis codes categorized as vision but considered medical.
- b. One claim was incorrectly processed under the wrong provider number. VSHP-ET/VSHP has set up the claim for adjustment under the correct provider number.
- c. One claim resulted in an incorrect payment because the procedure code was keyed incorrectly. VSHP-ET/VSHP has set up the claim for adjustment under the correct procedure code.
- d. VSHP-ET/VSHP inadequately reported encounter data required by the TennCare contract for one of 192 claims tested. Encounter data, a record of medical services provided to enrollees, is necessary for evaluation of quality of care and access to TennCare services.
- e. The following deficiencies were discovered in the calculation of deductibles and coinsurance:

- For four claims, VSHP-ET/VSHP calculated and accumulated \$175 in enrollee deductible instead of the plan requirements of \$250. VSHP-ET/VSHP responded, "In an effort to prevent over applying the deductible and disadvantaging our members when we are working with a subcontractor, BlueCare established a designated amount to be applied for medical and pharmacy deductible. On this particular claim the medical portion of the deductible was satisfied, therefore, the system computed the co-insurance correctly."
- For one claim, the coinsurance was computed before the deductible was satisfied. VSHP-ET/VSHP responded, "It appears the system did not handle this claim properly. In April 1999, we converted to a Y2K compliant system, which is not the same as the system that was used at the time this claim was originally adjudicated. We will review the current system to insure we don't have this issue. Our intent is not to disadvantage our members by adjusting this claim if it was due to a past system problem."

Recommendation

VSHP should not deny claims for no prior authorization when the provider has obtained an authorization. Claims should not be denied for other insurance if the dates of service are after the expiration of the other insurance. Claims for vision services which are considered medical in nature should not be denied for age appropriateness. VSHP should correctly report encounter data as specified in the TennCare contract. Deductibles and coinsurance should be computed as specified in the TennCare contract.

Management's Comment

The errors regarding the improper denial of claims for enrollees with other insurance appear to have resulted from keying errors. However, due to the unique procedures associated with the processing of TPL claims, and the loading of TPL information received from the State, BlueCare consolidated the processing of this claim type into one department in 1998. This consolidation has resulted in more efficient and accurate processing as claims associates receive TPL specific training.

Due to the system limitations of our pharmacy vendor, we developed a deductible split based on historical cost-sharing data. The process was developed due to the timing and coordination involved between two systems to minimize or eliminate the potential of over-applying deductible amounts. We were aware this was not a perfect process but in all instances the member would not be disadvantaged. This process is monitored and tracked on a daily basis to ensure members are not overcharged.