TennCare Quarterly Report

Submitted to the Members of the General Assembly

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Status of TennCare Reforms and Improvements

Application to Renew the TennCare Waiver. Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. In exchange for a waiver of certain federal statutes and regulations governing Medicaid, TennCare "demonstrates" the principle that a managed care approach to health care can result in a more efficient use of resources, thereby allowing the state to extend coverage to people who would not otherwise be eligible for Medicaid. One limitation imposed on demonstration projects, however, is that they may operate only for finite periods of time (referred to as "approval periods") before having to be renewed.

Although the TennCare demonstration does not expire until June 30, 2013, the Bureau filed its renewal application with the Centers for Medicare and Medicaid Services (CMS) on June 29, 2012, to comply with provisions in federal regulation and the Waiver agreement requiring submission a year in advance.[1] Following extensive negotiations between the two parties throughout the second half of 2012, CMS notified the Bureau on December 31, 2012, that a three-year renewal of the TennCare Waiver had been approved. Bureau staff members are currently reviewing the terms and conditions of the new Waiver agreement and will work with CMS throughout January 2013 to finalize the details of the renewal.

Dual Demonstration Proposal. On May 17, 2012, TennCare submitted a proposal to the Medicare Medicaid Coordination Office to consolidate services for individuals who are dually eligible for Medicare and Medicaid. During the months that followed, Bureau management developed several concerns about the project, including the methodology by which Tennessee health plans would be reimbursed, key policy decisions that could impede the effectiveness of the project, and delays that would make it difficult, if not impossible, for the State to achieve success within the prescribed timeframes. On December 21, 2012, therefore, the Bureau withdrew its proposal. However, TennCare remains committed to improving the quality and cost-effectiveness of care for dual eligibles in Tennessee and is moving forward on plans to improve coordination of care within the existing Medicare Part C authority.

[1] See 42 C.F.R. § 431.412(c) and Special Term and Condition #8 of the TennCare Waiver.

Budget Presentation. On November 13, 2012, three members of TennCare's executive staff—Director Darin Gordon, Chief Medical Officer Wendy Long, and Chief Financial Officer Casey Dungan—made a budget presentation regarding Fiscal Year 2014 to Governor Bill Haslam, Finance and Administration Commissioner Mark Emkes, and Budget Director David Thurman. The presentation addressed not only TennCare's budget, but also those of the other divisions within the Health Care Finance and Administration (HCFA) umbrella overseen by Director Gordon: the Office of eHealth Initiatives, Cover Tennessee, and the Insurance Exchange Planning Initiative.

The presentation document itself, which remains available on the Bureau's website at http://www.tn.gov/tenncare/forms/HCFAbudgetFY14.pdf, concisely summarizes the manner in which TennCare has been able to deliver quality care and achieve high levels of patient satisfaction within the context of limited revenues and a sluggish economic recovery. Of particular note in this regard is the program's success at controlling inflation: from 2004 through 2010, TennCare provided care for each of its enrollees at a cost roughly one-and-a-half to two-and-a-half times less than the national average. Projections from accounting firm PricewaterhouseCoopers included within the presentation indicate that this trend will continue: in Fiscal Year 2014, inflation of medical costs under TennCare is expected to be held to 3.5 percent, as compared with a 7.5 percent inflation rate for commercial insurance programs.

As Governor Haslam had requested of all State agencies, TennCare included within its proposed budget a hypothetical plan for reducing expenditures by 5 percent. Potential cost-controlling measures put forward by the Bureau ranged from benefit and reimbursement rate reductions to integration strategies (such as absorbing the Children's Health Insurance Program within TennCare and bringing an element of the pharmacy benefit into managed care) and beyond.

Concluding with an overview of the challenges, opportunities, and costs associated with the Affordable Care Act (Medicaid expansion and the Insurance Exchange in particular), the presentation laid out the concerns that TennCare, Tennessee, and the entire nation will face in the arena of health care in the years ahead. The budget hearing may be viewed at http://nowuseeit.state.tn.us/mediasite5/Viewer/?peid=b9cbafd633344aaabd819043e56b9fcc1d.

Possible Changes to TennCare Benefits ("Amendment 17"). In late December 2012, TennCare issued public notice of its intention to file Waiver Amendment 17 with CMS. Amendment 17 repeats several changes proposed in each of the last three years that were made unnecessary each time by the General Assembly's passage of a one-year Enhanced Coverage Fee. Changes to the TennCare benefit package for adults that would be necessary if the one-year Enhanced Coverage Fee were not renewed this year are as follows:

- Elimination of physical therapy, speech therapy, and occupational therapy for all adults
- Benefit limits on certain hospital services, lab and x-ray services, and health practitioners' office visits for non-pregnant adults and non-institutionalized adults

Additional information about Amendment 17 is available online at http://www.tn.gov/tenncare/pol-notice.shtml.

***John B.* Case.** The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that has been the subject of ongoing litigation since 2000. In February 2012, Judge Thomas A. Wiseman, Jr. ruled in favor of the State by dismissing the case on the grounds that TennCare had successfully established compliance with "all the binding provisions of the Consent Decree." [2] In response, the Plaintiffs filed a Notice of Appeal with the United States Court of Appeals for the Sixth Circuit on March 9, 2012.

A three-judge panel of the Sixth Circuit heard oral arguments on the appeal on October 5, 2012. Plaintiffs and Defendants subsequently filed supplemental briefs on the subject of TennCare's periodicity schedule, a timeline identifying the points in a child enrollee's life when the State must provide screenings and diagnostic and treatment services.[3] To date, the Sixth Circuit has not rendered a decision on the appeal.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[4] to replace outdated, often paper-based approaches to medical record-keeping with an electronic system that meets rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

Currently, Medicaid providers may qualify for two types of payments:

- First-year payments to providers who adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards; and
- Second-year payments to providers who earned first-year payments in calendar year 2011 and achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2012 (for eligible hospitals) or calendar year 2012 (for eligible professionals).

[2] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.

[3] TennCare's periodicity schedule is available online at http://www.tn.gov/tenncare/tenndercare/screeningsched.shtml.

[4] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and certain kinds of physician assistants) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

During the October to December 2012 quarter, first-year and second-year payments made by TennCare were as follows:

Payment Category	Providers Paid During the Quarter	Quarterly Amount Paid	Cumulative Amount Paid
First-year payments	99 providers (43 physicians, 29 nurse practitioners, 18 dentists, 8 hospitals, and 1 physician assistant)	$5,832,603.00	$99,972,662.97
Second-year payments	111 providers (64 physicians, 31 nurse practitioners, 15 hospitals, and 1 certified nurse midwife)	$5,821,506.00	$7,926,369.00

Outreach activities conducted during the quarter included:

- Participation in the MeHarry Medical/Dental Conference on October 12;
- Presentation to more than 250 providers at the Tennessee Academy of Family Physicians Conference (October 30-November 2);
- Activities at the UHC Community Plan Provider Information Fair on November 7;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but not at the state level.

The conclusion of Calendar Year 2012 marked two years since Tennessee's EHR program began accepting attestations from providers. Only ten other states can claim this achievement.

New Pharmacy Benefits Manager. Following a competitive bidding process in which three companies submitted proposals, TennCare named Magellan Health Services the program's new Pharmacy Benefits Manager (PBM) on November 6, 2012. Magellan will replace Catamaran (formerly SXC Health Solutions), which has held the role since 2008.

Although Magellan will not start processing claims for TennCare until June 1, 2013, the company began preparations in December 2012. Priorities during this period of transition include the following:

- Establishing a pharmacy network
- Building a claims processing system and loading it with enrollee information and with edits specific to TennCare's preferred drug list, prior authorization program, and clinical/quantity requirements
- Creating a call center and a website to assist patients and providers
- Contracting with drug manufacturers for supplemental rebates

Although these tasks are sizable, Magellan's experience managing pharmacy benefits for eight million individuals is a positive indication of the company's ability to succeed with projects of similar scope. TennCare's contract with Magellan lasts through May 31, 2016, and contains an option for two one-year extensions.

Eligibility Determination System. On May 8, 2012, TennCare issued a Request for Proposal (RFP) to design, develop, and implement a new eligibility determination system for Tennessee's Medicaid and CHIP programs. The RFP, which remains available online at http://tn.gov/generalserv/purchasing/ocr/documents/31865-00345-2.pdf, invited qualified businesses to submit proposals for a system that could ensure the State's continued compliance with federal law and regulations.

One of the central benefits envisioned in the new system is that historically paper-based and/or in-person transactions—such as applications for benefits and the reporting of status changes—will be conducted through an online portal. Although a basic online application currently exists, the new system will contain a rules engine capable of making eligibility determinations in real time or near real time.

After receiving and reviewing five proposals, TennCare awarded the contract to the Northrop Grumman Corporation on November 9, 2012. Collaboration between the Bureau and Northrop Grumman on the project has already begun, as the eligibility determination system must be deployed no later than January 1, 2014.

Catalyst for Payment Reform. On December 19, 2012, TennCare announced its decision to join Catalyst for Payment Reform (CPR). CPR is a national independent organization led by large purchasers of health insurance with active involvement of providers, health plans, consumers, and labor groups working to improve health care quality and reduce costs by identifying and coordinating workable solutions to improve how health care is paid for in the United States.

TennCare joins more than 20 other large purchasers of health insurance in this effort. This includes companies such as FedEx, GE, Intel, Verizon, Xerox, 3M and Walmart, as well as Medicaid programs in South Carolina and Ohio. Purchasing partners interact on a regular basis with major health insurance companies such as Aetna, CIGNA, UnitedHealthcare, and WellPoint to discuss progress in advancing innovations, paying for value, and aligning payments with purchaser goals.

CPR provides member organizations with resources such as market assessment tools, model health plan contract language, action briefs, a payment framework, and opportunities to collaborate and share best practices with other CPR member organizations. The members of CPR share a common interest in designing payment methodologies that cut waste and reflect performance, create alignment between purchasers and federal organizations such as CMS and the Department of Health and Human Services, and implement price transparency and value pricing.

TennCare's commitment to CPR includes performing a self-assessment of capabilities and coordination with current plans, using CPR model health plan contract language when appropriate, and participating in coordinated initiatives with other purchasers.

Additional information about the Catalyst for Payment Reform may be found at http://www.catalyzepaymentreform.org.

Award for Chief Information Officer. On December 11, 2012, the Information Technology Management Association (ITMA) honored TennCare Chief Information Officer Brent Antony as Outstanding IT Director for 2012.

The ITMA is an organization whose stated mission is to "provide a forum for . . . Information Systems Management professionals to share information relating to their environment and State government" with the ultimate goal of "identifying common concerns, arriving at a consensus, and working toward their resolution."[5] In bestowing the award, ITMA recognized Mr. Antony for having made the most significant contribution to the organization based on the agency's strategic plan.

Antony, who joined TennCare in 2005 and holds dual masters degrees—an MBA and a masters of public health—in health systems management, oversees all aspects of the Bureau's information technology systems management. He has been distinguished twice within the field of information technology in as many years. In June 2011, he was named by eMids Technologies and Healthcare Payer News as one of eleven top executives and thought leaders in the healthcare information technology industry.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the October-December 2012 quarter. Essential Access Hospital payments are payments from a pool of $100 million ($34,220,000 in State dollars) appropriated by the General Assembly and funded by the Enhanced Coverage Fee.

The methodology for distributing these funds specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which receive cost-based reimbursement from the TennCare program and, therefore, do not have unreimbursed TennCare costs, and the four State mental health institutes.

[5] See the "Information Technology Management Association" profile contained within The State of Tennessee 2009-2010 Information Systems Statewide Plan, an online document located at http://www.state.tn.us/finance/oir/prd/stplan.pdf.

The Essential Access Hospital payments made during the second quarter of State Fiscal Year 2013 for dates of service during the first quarter of State Fiscal Year 2013 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Second Quarter FY 2013
Regional Medical Center at Memphis	Shelby County	$3,498,038
Vanderbilt University Hospital	Davidson County	$3,262,097
Erlanger Medical Center	Hamilton County	$2,653,725
University of Tennessee Memorial Hospital	Knox County	$1,444,289
Johnson City Medical Center (with Woodridge)	Washington County	$954,982
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$732,568
LeBonheur Children's Medical Center	Shelby County	$732,329
Metro Nashville General Hospital	Davidson County	$686,869
Jackson – Madison County General Hospital	Madison County	$589,973
East Tennessee Children's Hospital	Knox County	$517,671
Methodist Healthcare – South	Shelby County	$465,926
Methodist Healthcare – Memphis Hospitals	Shelby County	$425,200
Saint Jude Children's Research Hospital	Shelby County	$351,476
Baptist Hospital	Davidson County	$313,746
Parkwest Medical Center (with Peninsula)	Knox County	$311,810
Physicians Regional Medical Center	Knox County	$292,166
University Medical Center (with McFarland)	Wilson County	$279,886
Pathways of Tennessee	Madison County	$270,713
Wellmont Holston Valley Medical Center	Sullivan County	$254,601
Saint Francis Hospital	Shelby County	$249,050
Centennial Medical Center	Davidson County	$242,656
Skyline Medical Center (with Madison Campus)	Davidson County	$237,546
Maury Regional Hospital	Maury County	$234,231
Ridgeview Psychiatric Hospital and Center	Anderson County	$229,287
Methodist Healthcare – North	Shelby County	$222,436
Middle Tennessee Medical Center	Rutherford County	$222,282
Fort Sanders Regional Medical Center	Knox County	$219,176
Delta Medical Center	Shelby County	$217,009
Cookeville Regional Medical Center	Putnam County	$183,644
Skyridge Medical Center	Bradley County	$178,528
Gateway Medical Center	Montgomery County	$175,920
Parkridge East Hospital	Hamilton County	$173,748
Wellmont Bristol Regional Medical Center	Sullivan County	$163,096
Blount Memorial Hospital	Blount County	$160,060

Hospital Name	County	EAH Second Quarter FY 2013
Baptist Memorial Hospital for Women	Shelby County	$143,470
Morristown – Hamblen Healthcare System	Hamblen County	$136,158
Baptist Memorial Hospital – Tipton	Tipton County	$132,399
Sumner Regional Medical Center	Sumner County	$123,950
StoneCrest Medical Center	Rutherford County	$117,912
NorthCrest Medical Center	Robertson County	$114,608
Tennova Healthcare – Newport Medical Center	Cocke County	$110,593
Horizon Medical Center	Dickson County	$110,468
LeConte Medical Center	Sevier County	$109,724
Southern Hills Medical Center	Davidson County	$107,189
Summit Medical Center	Davidson County	$106,920
Tennova Healthcare – LaFollette Medical Center	Campbell County	$102,932
Methodist Medical Center of Oak Ridge	Anderson County	$100,498
Takoma Regional Hospital	Greene County	$91,949
Harton Regional Medical Center	Coffee County	$91,733
Sweetwater Hospital Association	Monroe County	$89,873
Henry County Medical Center	Henry County	$86,078
Baptist Memorial Hospital – Union City	Obion County	$85,249
Dyersburg Regional Medical Center	Dyer County	$83,768
Humboldt General Hospital	Gibson County	$77,879
Wellmont Hawkins County Memorial Hospital	Hawkins County	$77,295
United Regional Medical Center	Coffee County	$76,405
Lakeway Regional Hospital	Hamblen County	$75,394
Jellico Community Hospital	Campbell County	$74,599
Grandview Medical Center	Marion County	$72,964
Skyridge Medical Center – Westside	Bradley County	$72,418
Indian Path Medical Center	Sullivan County	$72,260
Athens Regional Medical Center	McMinn County	$71,044
Heritage Medical Center	Bedford County	$68,823
Regional Hospital of Jackson	Madison County	$65,689
Crockett Hospital	Lawrence County	$62,203
River Park Hospital	Warren County	$62,073
Lincoln Medical Center	Lincoln County	$59,974
Bolivar General Hospital	Hardeman County	$59,891
Southern Tennessee Medical Center	Franklin County	$59,033
Sycamore Shoals Hospital	Carter County	$58,866
Hardin Medical Center	Hardin County	$57,541
Livingston Regional Hospital	Overton County	$51,284
Wayne Medical Center	Wayne County	$50,413
Hillside Hospital	Giles County	$45,282
Roane Medical Center	Roane County	$43,246
Claiborne County Hospital	Claiborne County	$38,122

Hospital Name	County	EAH Second Quarter FY 2013
McKenzie Regional Hospital	Carroll County	$37,961
McNairy Regional Hospital	McNairy County	$34,375
Volunteer Community Hospital	Weakley County	$31,443
Jamestown Regional Medical Center	Fentress County	$30,853
Gibson General Hospital	Gibson County	$28,833
Haywood Park Community Hospital	Haywood County	$28,810
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,886
Henderson County Community Hospital	Henderson County	$23,794
Methodist Healthcare – Fayette	Fayette County	$23,200
DeKalb Community Hospital	DeKalb County	$21,408
Decatur County General Hospital	Decatur County	$20,650
White County Community Hospital	White County	$19,766
Emerald – Hodgson Hospital	Franklin County	$14,771
Riverview Regional Medical Center – North	Smith County	$11,347
TOTAL		$25,000,000

Number of Recipients on TennCare and Costs to the State

At the end of the period October 1, 2012, through December 31, 2012, there were 1,217,020 Medicaid eligibles and 20,017 Demonstration eligibles enrolled in TennCare, for a total of 1,237,037 persons.

Estimates of TennCare spending for the second quarter are summarized in the table below.

Spending Category	2nd Quarter*
MCO services**	$1,315,878,900
Dental services	$43,372,500
Pharmacy services	$196,754,400
Medicare "clawback"***	$42,305,100

**These figures are cash basis as of December 31 and are unaudited.*

***This figure includes Integrated Managed Care MCO expenditures.*

****The Medicare Part D clawback is money states pay to the federal government to help offset costs the federal government incurs by covering the prescription benefit for enrollees who have both Medicare and Medicaid.*

Viability of MCCs in the TennCare Program

Claims payment analysis. TennCare's prompt pay requirements may be summarized as shown below.

Entity	Standard	Authority
MCOs (non-CHOICES services)	90% of clean claims for payment for services delivered to TennCare enrollees are paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	T.C.A. § 56-32-126(b)
MCOs (CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[6] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[7] are processed and paid within 21 calendar days of receipt.	TennCare contract

[6] Excludes Personal Emergency Response Systems (PERS), assistive technology, minor home modifications, and pest control claims. Claims for delivery of these services are handled like general MCO claims.

[7] Ibid.

Entity	Standard	Authority
DBM	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
PBM	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by TennCare Contract (i.e., East, Middle, or West Grand Region) and by subcontractor (e.g., claims processed by a vision benefits manager). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by TennCare contract, and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The TennCare Bureau can also assess liquidated damages pursuant to the terms of the Contractor Risk Agreement. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

Net worth requirement. By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) Third Quarter 2012 Financial Statements. As of September 30, 2012, TennCare MCOs reported net worth as indicated in the table below.[8]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,551,988	$101,682,118	$84,130,130

[8] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations. Amerigroup, for instance, operates a Medicare Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, operates solely on TennCare's behalf.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$62,651,284	$457,732,244	$395,080,960
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,832,427	$203,694,016	$168,861,589

All TennCare MCOs met their minimum net worth requirements as of September 30, 2012.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee.* The OIG staff receives case information from a variety of sources including: local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCCs), and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the second quarter of the 2012 - 2013 fiscal year are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	2,958	145,190
Abuse Cases Received*	969	70,304

***** *Abuse cases may be referred to the appropriate Managed Care Organization (MCO), the TennCare Bureau, or DHS for further review/action.*

Court Fines & Costs Imposed

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Fines	$13,275.00	$685,785.00
Court Costs & Taxes	$4,099.15	$215,397.76
Court Ordered Restitution	$17,520.46	$2,065,230.02
Drug Funds/Forfeitures	$461.50	$432,813.56[9]

The OIG aggressively pursues enrollees who have apparently committed fraud or abuse against the TennCare program. The primary criminal case types are: prescription drug cases (drug diversion, drug

[9] This figure has been revised from the total of $434,364.22 reported last quarter.

seekers, doctor shopping, and forging prescriptions), reporting a false income, access to other insurance when one is enrolled in an "uninsured" category, and ineligible individuals using a TennCare card.

One new development reflected in the "Arrest Categories" table below is OIG's participation in the Drug Enforcement Administration (DEA) Task Force. In December 2012, an OIG Special Agent assigned to the DEA Task Force made two felony drug arrests that resulted in the confiscation of $1,029 in cash and 850 pills (576 Hydrocodone, 150 Oxycodone, 50 Opana, 46 Xanax, and 28 unidentified).

Arrest Categories

Category	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	2	523
Drug Diversion/Sale RX	27	702
Doctor Shopping	16	266
Access to Insurance	0	55
Operation FALCON III[10]	0	32
Operation FALCON 2007[11]	0	16
False Income	2	78
Ineligible Person Using Card	0	20
Living Out Of State	1	22
Asset Diversion	0	7
ID Theft	3	63
Aiding & Abetting	2	7
Failure to Appear in Court	0	3
Child Not in the Home	5	10
DEA Task Force	2	2
GRAND TOTAL	**60**	**1,806**

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[12]
Court Ordered Recoupment	$371,670.41	$4,419,664.73[13]

[10] Operation FALCON ("Federal and Local Cops Organized Nationally") III—conducted October 22-28, 2006—was a joint mission among federal, state, city, and county law enforcement agencies to arrest fugitives, including individuals facing narcotics charges. Additional information about all of the Operation FALCON initiatives is available on the website of the United States Marshals Service at http://www.usmarshals.gov/falcon/index.html.

[11] Operation FALCON 2007, which took place from June through September of that year, was the follow-up initiative to Operation FALCON III (described in Footnote 10). Like its predecessor, Operation FALCON 2007 targeted fugitives with open warrants.

[12] On February 15, 2005, a Fiscal Manager and an attorney joined the OIG staff to facilitate and document recoupment and recommended terminations.

[13] This total reflects dollars collected by the OIG and sent to the TennCare Bureau.

	Quarter	Grand Total to Date (since February 2005)[12]
Recommended TennCare Terminations [14]	114	49,757
Potential Savings[15]	$416,828.46	$175,089,138.72

In addition, OIG embarked on a new collaboration with the Office of the Attorney General to recover TennCare funds by bringing civil cases against providers. During the October-December 2012 quarter, the initiative yielded two successes: a settlement of $12,636.59 in a case of overbilling, and a settlement of $325,000.00 in a case of "upcoding", or billing for a higher level of services than one actually provides.

[14] Recommendations that enrollees' TennCare coverage should be terminated are sent to the TennCare Bureau for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. The Bureau determines whether these referrals meet the criteria for termination.

[15] Savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).