TennCare Quarterly Report

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Status of TennCare Reforms and Improvements

Insure Tennessee. On December 15, 2014, Governor Haslam announced the Insure Tennessee plan, a two-year pilot program to provide health care coverage to Tennesseans who currently lack access to health insurance or who have limited options in that regard. The program rewards healthy behaviors, prepares members to transition to private coverage, promotes personal responsibility, and incentivizes choosing preventative and routine care instead of unnecessary use of emergency rooms.

Five key elements of the proposal are:

- A fiscally sound and sustainable program that will not create any new taxes for Tennesseans and will not add any State cost to the budget;
- The provision of two new private market choices for Tennesseans;
- Shifting the delivery model and payment of health care in Tennessee from fee-for-service to outcomes-based;
- Incentivizing Tennesseans to be more engaged and to take more personal responsibility in their health; and
- Preparing participants for eventual transition to commercial health coverage.

The Insure Tennessee plan stems from Governor Haslam's announcement in March 2013 that he would not expand the traditional Medicaid program but that he would work with the federal government on a plan for Tennessee that would take into consideration program cost, patient engagement, payment reform, and health outcomes.

Managed Care Organization (MCO) Readiness. In December 2013, the Bureau of TennCare announced that the three health plans already comprising TennCare's managed care network—Amerigroup, BlueCare, and UnitedHealthcare—had submitted successful bids to deliver physical health services,

behavioral health services, and Long-Term Services and Supports (LTSS)[1] in all three of Tennessee's grand regions beginning on January 1, 2015. During the October-December 2014 quarter, TennCare continued to coordinate with the MCOs to ensure a seamless transition to this statewide service delivery model.

One of the most important elements of this preparation was the mailing of notification letters to individuals (approximately one-third of the TennCare population) who would be transferred from one MCO to another beginning on January 1, 2015. The notices, which were mailed on November 14, 2014, provided enrollees both the name of the new plan and instructions for remaining with their current plan if preferred. Complementing this effort were joint TennCare-MCO workgroups tasked with ensuring that the transfer of enrollee data—such as treatment histories, claims histories, scheduled (including re-occurring) non-emergent transportation trips, and impending surgery dates—that accompanied MCO reassignments was managed properly. TennCare carefully monitored the MCOs' activity to ensure that all applicable standards regarding data transfers were met and that all appropriate safeguards were observed.

Additionally, the Bureau conducted a total of six site visits in November and December to evaluate each plan's readiness to deliver behavioral health services and long-term services and supports in all three regions. Findings from the visits confirmed that the MCOs were adequately prepared for statewide implementation on January 1, 2015.

Budget Presentation. On December 5, 2014, three members of TennCare's executive staff—Director Darin Gordon, Deputy Director and Chief of Staff Dr. Wendy Long, and Chief Financial Officer Casey Dungan—presented the Fiscal Year 2016 proposed budget for the Division of Health Care Finance and Administration (HCFA) to Governor Bill Haslam, Finance and Administration Commissioner Larry Martin, Budget Director David Thurman, and Chief Operating Officer Greg Adams.

The presentation document itself, which is available on HCFA's website at http://tn.gov/tenncare/forms/HCFAbudgetFY16.pdf, concisely summarizes the manner in which TennCare has been able to deliver quality care and achieve high levels of member satisfaction while continuing to control inflationary growth. Evidence of these achievements as highlighted by the presentation includes the following:

- Improvement in 81 percent of the 47 HEDIS (Healthcare Effectiveness Data and Information Set) measures tracked since 2007;
- High rankings for TennCare health plans at regional and national levels;

[1] It should be noted that there is more than one type of LTSS program. LTSS programs serving persons who are elderly or who have physical disabilities are included in the menu of services offered by the MCOs. LTSS programs serving persons who have intellectual or developmental disabilities are operated outside the TennCare Demonstration, although the persons who receive these services are also members of TennCare and receive their physical health and behavioral health services through the MCOs.

- Enrollee satisfaction levels above 90 percent for several years in a row (including 93 percent in 2014); and
- Medical inflation levels less than half of those of commercial insurance programs and of Medicaid programs nationally.

A portion of the presentation was devoted to the opportunities and challenges faced by Tennessee as a result of Medicaid eligibility changes instituted by the Affordable Care Act. Despite the ongoing difficulties in development of the Tennessee Eligibility Determination System (TEDS) and in enrollment of eligible individuals through the Federally Facilitated Marketplace (FFM), HCFA successfully added more than 120,000 people to the TennCare program during Calendar Year 2014. (As detailed below under the heading of "Number of Recipients on TennCare and Costs to the State," total enrollment as of December 2014 stood at 1,345,574 individuals.)

As Governor Haslam had requested of all State agencies, HCFA included within its budget presentation a proposal for reducing expenditures by seven percent. Potential cost-controlling measures ranged from reduced provider reimbursement rates and implementation of a limit on enrollment in CHOICES Group 3 to elimination of the hospice benefit, discretionary hospital grants, and the perinatal grant program.

Touching on the system of payment and delivery system reform that TennCare is pursuing, as well as the challenges posed by various cost drivers, the presentation laid out the environment in which HCFA will operate for years to come.

Beneficiary Survey. Every year since 1993, the Center for Business and Economic Research (CBER) at the University of Tennessee in Knoxville has conducted a survey of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—to assess their opinions about health care. Respondents provide feedback on a range of topics, including demographics (age, household income, family size, etc.), perceptions of quality of care received, and behavior relevant to health care (the type of provider from whom an individual is most likely to seek initial care, the frequency with which care is sought, etc.).

On November 17, 2014, CBER published a summary of the results of the most recent survey entitled "The Impact of TennCare: A Survey of Recipients 2014." Although the findings of a single survey must be viewed in context of long-term trends, a number of results from the report were noteworthy:

- 93 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction—the sixth straight year above 90 percent—is tied for the third highest in the program's history.
- The percentage of respondents classifying themselves as uninsured fell to 7.2 percent, a 25 percent decline from 2013's result. Likewise, the percentage of respondents classifying their children as uninsured fell to 2.4 percent, a 35 percent decline from 2013's result.
- Only 1 percent of respondents covered by TennCare reported that they sought initial medical care for their children at the hospital instead of at a doctor's office or clinic. This figure is

significant because seeking initial care at the emergency room (in the absence of an emergency) is less cost-effective than seeking this care at a doctor's office or clinic. Redirection of enrollees to the most cost-effective source of care is a primary objective of a managed care program, and the evidence suggests that TennCare has been successful in meeting this goal.

In summary, the report notes, "TennCare continues to receive positive feedback from its recipients, with 93 percent reporting satisfaction with the program, indicating TennCare is providing medical care in a satisfactory manner and up to the expectations of those it serves." The report is available online at http://cber.bus.utk.edu/tncare/tncare14.pdf.

Wilson v. Gordon. In July 2014, attorneys with the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program filed a class action lawsuit against TennCare, the Tennessee Department of Finance and Administration, and the Tennessee Department of Human Services. The suit alleged a variety of flaws in the enrollment process TennCare had been using since January 1, 2014. Attorneys representing the State, however, pointed out that this process had been approved by the federal government and that more than 125,000 applications for TennCare coverage had been approved in the first eight months of 2014 alone.

These arguments were heard in the U.S. District Court for the Middle District of Tennessee by Judge Todd Campbell, who subsequently granted class action status to the suit and issued a preliminary injunction requiring the State to provide an opportunity for a fair hearing on any delayed adjudications. These "delay hearings" are required to be held within 45 days (or 90 days in disability cases) after a class member requests such a hearing and provides proof that an application was filed. TennCare took immediate action to comply with Judge Campbell's rulings but also filed an appeal with the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

During the October-December 2014 quarter, two additional developments in the case occurred. At the District Court level, Magistrate Judge John Bryant entered a Protective Order on November 3, 2014, based on a joint motion by Plaintiffs and Defendants. The purpose of the Order was to ensure that any confidential information regarding TennCare applicants used within the course of the *Wilson* matter be protected. At the Court of Appeals level, the State filed its Opening Brief on November 26, 2014 (followed by the filing of a corrected Opening Brief on December 2, 2014). The brief outlined the State's position in the *Wilson* suit, including the basis for vacating or reversing Judge Campbell's preliminary injunction.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (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 is

to provide financial incentives to Medicaid providers[2] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet 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 the following types of payments:

- First-year payments to providers (eligible hospitals or practitioners) who either—
  - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
  - Achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year and fourth-year payments to providers who continue to demonstrate meaningful use.

EHR payments made by TennCare during the October-December 2014 quarter as compared with payments made throughout the life of the program appear in the table below:

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2014)	Cumulative Amount Paid to Date
First-year payments	146[3]	$4,208,453	$148,051,502
Second-year payments	68	$5,222,234	$46,047,222
Third-year payments	53	$749,349	$5,143,483
Fourth-year payments	8	$68,000	$68,000

Technical assistance activities, outreach efforts, and other EHR-related projects conducted by Bureau staff during the quarter included:

- Participation throughout the quarter in three Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use (with particular emphasis on the EHR final rule that took effect on October 1, 2014);

[2] 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).

[3] Of the 146 providers receiving first-year payments in the October-December 2014 quarter, 6 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

- Attendance at six Tennessee Medical Association workshops in October 2014, during which information was furnished to providers from the Chattanooga, Jackson, Kingsport, Knoxville, Memphis, and Nashville areas;
- Hosting an information booth at the Tennessee Academy of Family Physicians Conference in Gatlinburg in October 2014;
- Hosting a webinar entitled "CMS 2014 CEHRT Flexibility Rule Implementation in Tennessee" on December 18, 2014 (a pdf version of which is available online at http://www.tnrec.org/wp-content/uploads/Final-2014Rule-Change-in-PIPP.pdf);
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- 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 who have not registered or attested at the state level.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program.

Public Forum on the TennCare Demonstration. In compliance with the federal regulation at 42 CFR § 431.420(c) and the terms of its Demonstration agreement with CMS, TennCare hosted a public forum in the downtown branch of the Nashville Public Library on December 17, 2014. The purpose of the forum was to provide members of the public an opportunity to comment on the progress of the TennCare Demonstration project, which has delivered Medicaid services to eligible Tennesseans under a managed care model since 1994.

The December 17 open meeting was not the only avenue through which feedback could be offered. Notice of the forum, which appeared on the TennCare website, included an email address, a physical address, and a dedicated phone line at which comments would be accepted. Although the Bureau received no comments through any of these outlets, additional opportunities to assess the TennCare Demonstration will be available, as TennCare is required to convene a forum on this subject each year for the foreseeable future.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make EAH payments during the October-December 2014 quarter. EAH payments are made from a pool of $100 million ($34,935,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment 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, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the second quarter of State Fiscal Year 2015 for dates of service during the first quarter are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Second Quarter FY 2015
Regional Medical Center at Memphis	Shelby County	$3,363,349
Vanderbilt University Hospital	Davidson County	$3,180,780
Erlanger Medical Center	Hamilton County	$2,696,914
University of Tennessee Memorial Hospital	Knox County	$1,447,794
Johnson City Medical Center (with Woodridge)	Washington County	$1,211,056
LeBonheur Children's Medical Center	Shelby County	$711,392
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$683,452
Metro Nashville General Hospital	Davidson County	$600,107
Jackson – Madison County General Hospital	Madison County	$543,086
East Tennessee Children's Hospital	Knox County	$538,608
Methodist Healthcare – Memphis Hospitals	Shelby County	$510,521
Methodist Healthcare – South	Shelby County	$490,173
Saint Jude Children's Research Hospital	Shelby County	$417,035
University Medical Center (with McFarland)	Wilson County	$384,958
Saint Thomas Midtown Hospital	Davidson County	$353,475
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$336,518
Wellmont – Holston Valley Medical Center	Sullivan County	$303,633
Fort Sanders Regional Medical Center	Knox County	$294,879
TriStar Centennial Medical Center	Davidson County	$270,886
Methodist Healthcare – North	Shelby County	$252,167
Saint Francis Hospital	Shelby County	$244,781
Parkridge East Hospital	Hamilton County	$229,155
Maury Regional Hospital	Maury County	$228,346
Parkwest Medical Center (with Peninsula)	Knox County	$222,830
Saint Thomas Rutherford Hospital	Rutherford County	$222,814
Pathways of Tennessee	Madison County	$216,560
Wellmont – Bristol Regional Medical Center	Sullivan County	$209,676
Cookeville Regional Medical Center	Putnam County	$193,294
Ridgeview Psychiatric Hospital and Center	Anderson County	$193,264

Hospital Name	County	EAH Second Quarter FY 2015
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$189,938
Methodist Hospital – Germantown	Shelby County	$173,248
Baptist Memorial Hospital for Women	Shelby County	$151,570
Skyridge Medical Center	Bradley County	$140,976
Blount Memorial Hospital	Blount County	$132,558
Gateway Medical Center	Montgomery County	$130,914
TriStar Horizon Medical Center	Dickson County	$128,908
TriStar StoneCrest Medical Center	Rutherford County	$120,823
TriStar Summit Medical Center	Davidson County	$119,564
NorthCrest Medical Center	Robertson County	$119,304
Delta Medical Center	Shelby County	$118,496
Dyersburg Regional Medical Center	Dyer County	$115,578
LeConte Medical Center	Sevier County	$113,800
Morristown – Hamblen Healthcare System	Hamblen County	$112,403
Southern Hills Medical Center	Davidson County	$111,027
Heritage Medical Center	Bedford County	$108,399
Sumner Regional Medical Center	Sumner County	$103,399
Takoma Regional Hospital	Greene County	$97,516
Tennova Healthcare – Newport Medical Center	Cocke County	$92,871
Sweetwater Hospital Association	Monroe County	$91,655
Laughlin Memorial Hospital	Greene County	$91,180
Rolling Hills Hospital	Williamson County	$90,176
Methodist Medical Center of Oak Ridge	Anderson County	$88,050
TriStar Hendersonville Medical Center	Sumner County	$83,023
Harton Regional Medical Center	Coffee County	$81,853
Henry County Medical Center	Henry County	$80,948
Tennova Healthcare – LaFollette Medical Center	Campbell County	$79,205
Grandview Medical Center	Marion County	$77,642
Sycamore Shoals Hospital	Carter County	$76,200
Skyridge Medical Center – Westside	Bradley County	$74,929
Regional Hospital of Jackson	Madison County	$73,277
Baptist Memorial Hospital – Union City	Obion County	$71,360
Lakeway Regional Hospital	Hamblen County	$70,905
Indian Path Medical Center	Sullivan County	$62,939
Wellmont Hawkins County Memorial Hospital	Hawkins County	$60,217
Jellico Community Hospital	Campbell County	$60,177
Hardin Medical Center	Hardin County	$59,025
McNairy Regional Hospital	McNairy County	$58,104
Starr Regional Medical Center – Athens	McMinn County	$57,413
River Park Hospital	Warren County	$54,449

Hospital Name	County	EAH Second Quarter FY 2015
Henderson County Community Hospital	Henderson County	$46,884
Roane Medical Center	Roane County	$43,619
United Regional Medical Center	Coffee County	$41,621
Hillside Hospital	Giles County	$39,947
Crockett Hospital	Lawrence County	$39,751
Livingston Regional Hospital	Overton County	$37,206
McKenzie Regional Hospital	Carroll County	$35,515
Haywood Park Community Hospital	Haywood County	$35,107
Volunteer Community Hospital	Weakley County	$33,309
Bolivar General Hospital	Hardeman County	$30,941
Wayne Medical Center	Wayne County	$29,982
Erlanger Health System – East Campus	Hamilton County	$27,219
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,076
DeKalb Community Hospital	DeKalb County	$24,157
Methodist Healthcare – Fayette	Fayette County	$22,069
Emerald Hodgson Hospital	Franklin County	$10,075
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of December 2014, there were 1,326,199 Medicaid eligibles and 19,375 Demonstration eligibles enrolled in TennCare, for a total of 1,345,574 persons.

Estimates of TennCare spending for the second quarter of State Fiscal Year 2015 are summarized in the table below.

Spending Category	2nd Quarter*
MCO services**	$1,661,999,500
Dental services	$37,861,900
Pharmacy services	$242,010,400
Medicare "clawback"***	$41,614,200

**These figures are cash basis as of December 29 and are unaudited.*

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

****The Medicare Part D clawback is money states are required to 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 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.	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[4] 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[5] are processed and paid within 21 calendar days of receipt.	TennCare contract

[4] 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.

[5] 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 2014 Financial Statements. As of September 30, 2014, TennCare MCOs reported net worth as indicated in the table below.[6]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$150,780,558	$133,229,566

[6] 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 and Volunteer State Health Plan, for instance, operate Medicare Advantage Plans, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,885,278	$520,961,787	$456,076,509
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$310,096,757	$275,154,719

All TennCare MCOs met their minimum net worth requirements as of September 30, 2014.

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 Fiscal Year 2015 are as follows:

TennCare Fraud & Abuse: Cases Received

	Quarter
TennCare Fraud Cases	1,486
TennCare Abuse Cases*	738

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

Criminal Court: Fines & Costs Imposed

	Quarter
Court Fines	$23,800
Court Costs & Taxes	$3,247
Court Ordered Restitution	$114,797[7]
Court Ordered Restitution Received[8]	$52,615
Drug Funds/Forfeitures	$666

[7] This total represents a 147 percent increase over court ordered restitution achieved during the July-September 2014 quarter and a 255 percent increase over restitution achieved during the October-December 2013 quarter. The rise in court ordered restitution coincides with the OIG's greater focus on eligibility cases (e.g., false reporting of income or household composition, living out of state while continuing to draw TennCare benefits, etc.), which involve greater sums of money because of associated medical and pharmacy costs.

[8] Restitution may have been ordered in a quarter earlier than the quarter in which payment was actually received.

The OIG aggressively pursues enrollees who are alleged to have committed fraud or abuse against the TennCare program. The primary criminal case types are: prescription drug cases (illegal sale of prescription medication, drug seekers, doctor shopping, and forging prescriptions), gaining TennCare eligibility by claiming a child who does not actually live in the home, and ineligible individuals using TennCare recipients' benefits.

Arrest Totals

	Quarter	FY 15 to Date
Individuals Arrested	63	117
Criminal Counts / Charges	204	413

OIG Case Recoupment & Civil Court Judgments

	Quarter
Consent Orders & Civil Judgments[9]	$34,254
Recoupments Received[10]	$44,615

Recommendations for Review

	Quarter
Recommended TennCare Terminations[11]	231
Potential Savings[12]	$844,626.09

During the October-December 2014 quarter, two OIG Special Agents collaborated with the Social Security Administration's Cooperative Disability Investigations (CDI) Unit. This Unit's mission is to combat fraud by investigating questionable statements and activities of claimants, medical providers, interpreters, or other service providers who facilitate or promote disability fraud at the state and federal levels. The work of the CDI Unit supports the strategic goal of ensuring the integrity of Social Security programs with zero tolerance for fraud and abuse. This work ties in closely with OIG's mission of stopping TennCare fraud.

[9] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

[10] A recoupment may be received in a quarter other than the one in which it is ordered.

[11] 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.

[12] 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).

OIG/CDI Unit Statistics

	Quarter
Allegations Received	27
Cases Opened	18
Cases Closed	23
Claims Denied or Ceased	27
SSA Savings	$1,454,496
Medicaid/Medicare Savings	$1,807,527
Total Savings	$3,262,023

In a continued effort to stay connected with local law enforcement and to enhance the OIG's mission of stopping TennCare fraud, a total of 426 letters were mailed during October 2014 to police chiefs, sheriffs, judicial drug task forces, and District Attorneys General in Tennessee. The letters advised each agency CEO of the name and phone number of the OIG Special Agent assigned to the jurisdiction and provided notice that agents would visit the CEOs in their respective jurisdictions in the near future. The letters also highlighted the already established cooperation, partnership, and support between the OIG and each agency in their collective efforts to combat TennCare fraud, prescription drug diversion, and doctor shopping.

In addition, on October 1, 2014, two OIG Special Agents participated in the Tennessee Bureau of Investigation's State Agency Networking Day as part of a training curriculum to familiarize State law enforcement agents with all of the resources available to them in State government. OIG agents provided officers in training the history and mission of the OIG and explained how joint efforts could more effectively combat TennCare fraud and prescription drug diversion.