TennCare Quarterly Report

January – March 2017

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Demonstration Amendment 31: Program Modifications. During the January-March 2017 quarter, the Bureau of TennCare notified the public of an amendment to the TennCare Demonstration to be submitted to the Centers for Medicare and Medicaid Services (CMS). Amendment 31 outlines program changes that would be needed if the hospital assessment fee is not renewed in 2017. These changes have also been proposed in previous years, but were made unnecessary each time by the Tennessee General Assembly's passage or renewal of a one-year hospital assessment fee. Changes to the TennCare benefit package for non-exempt adults that would be necessary if the fee were not renewed in 2017 are as follows:

- A combined annual limit of eight days per person for inpatient hospital and inpatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;
- A combined annual limit on health care practitioners' office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

The Bureau opened its public notice and comment period regarding Amendment 31 on February 23, 2017. By the conclusion of the January-March quarter, two comments had been received, each of which expressed opposition to the elimination of rehabilitative forms of therapy.

If the General Assembly renews the hospital assessment fee, Amendment 31 will be withdrawn from consideration.

Additional Proposed Modifications to the TennCare Demonstration. On December 16, 2016, CMS approved the State's application to renew the TennCare Demonstration. This approval maintained key aspects of the TennCare program (such as the managed care service delivery system, eligibility categories, and benefits package) while making modifications to others (like the supplemental payment pools for Tennessee hospitals and the manner in which the TennCare Demonstration is evaluated).

CMS's approval letter included revised versions of the materials that govern the TennCare Demonstration, namely the Waiver List, Expenditure Authorities, and Special Terms and Conditions. (The approval in its entirety is available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/tenncarewaiver.pdf.) According to the approval letter, the State had 30 days to acknowledge the approval and accept the new terms under which the TennCare Demonstration would operate. Therefore, on January 12, 2017, TennCare sent CMS written acknowledgement of the approval, as well as a request that technical corrections be made to the Waiver List, Expenditure Authorities, and Special Terms and Conditions. As of the end of the January-March 2017 quarter, CMS was still reviewing the proposed corrections.

Tennessee Eligibility Determination System. Tennessee Eligibility Determination System (or "TEDS") is the name of the system that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids. Throughout the January-March 2017 quarter, TennCare continued working with systems integrator partner Deloitte Consulting, LLP, initially on defining the State's requirements for TEDS, and subsequently on actual system design.

One feature of TEDS will be its accessibility to a wide variety of users. Entry to the system will occur via various pathways, including—

- An eligibility worker portal that processes applications for all TennCare and CoverKids eligibility categories;
- A self-service member portal that allows applicants to apply online for health coverage, create user accounts to report changes, and view notices sent to them; and
- A partner portal to be used by other State agencies (such as the Tennessee Department of Health) and provider partners to make presumptive eligibility determinations for certain TennCare populations.

As originally conceived, implementation of TEDS was to occur in two phases: one for eligibility determinations based on modified adjusted gross income (or "MAGI"), and one for eligibility determinations not based on MAGI. Given how much progress has been made on the TEDS project to date, however, TennCare and Deloitte decided that the two phases could be consolidated into a single launch, tentatively planned for late 2018.

Patient-Centered Medical Home Program. The Patient-Centered Medical Home (PCMH) program is one component of the Tennessee Health Care Innovation Initiative's strategy for primary care transformation, which assists providers in promoting better quality care, improving population health, and reducing the cost of care. Following much stakeholder input and design work, the PCMH program was launched by TennCare and the Tennessee Health Care Innovation Initiative on January 2, 2017. PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for TennCare members, the capabilities and practice standards of primary care providers, and the

overall value of health care delivered to the TennCare population. Participating providers receive training and technical assistance, quarterly reports with actionable data, and access to the state's care coordination tool. These providers are compensated with ongoing financial support and an opportunity for an annual outcome payment based on quality and efficiency performance. As of the launch date, 29 practices were participating in the PCMH program, with additional practices to be added in subsequent years.

Enhanced Respiratory Care. Effective January 1, 2017, TennCare adjusted value-based rates of reimbursement for enhanced respiratory care services provided by qualified and contracted nursing facilities (NFs). These adjustments reflect NFs' quality performance between April and September 2016. Since implementing the new, value-based reimbursement approach on July 1, 2016, TennCare has seen a marked increase in ventilator liberation, as was the goal of the quality improvement initiative. All but two facilities have increased their ventilator weaning rates, including the weaning of multiple patients who had been ventilator-dependent for more than 700 days. During the January-March 2017 quarter, TennCare also met with the Tennessee Health Care Association and with Tier 1 enhanced respiratory care providers to ensure agreement on the proposed approach for the initiative as it moves forward.

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 of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[1] 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 funding for administrative costs.

Currently, Medicaid providers may qualify for the following types of payments:

- First-year payments (through the 2016 Program Year) to 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 a 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, fourth-year, fifth-year, and sixth-year payments to providers who continue to demonstrate meaningful use of certified EHR technology.

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

Eligible practitioners who successfully attest may receive incentive payments in up to six program years. With CMS approval, TennCare chose to divide the full amount of incentive payments available to eligible hospitals among three program years. Eligible hospitals must continue to attest annually beyond the three years of payments in order to avoid Medicare payment adjustments.

EHR payments made by TennCare during the January-March 2017 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 (Jan-Mar 2017)	Cumulative Amount Paid to Date
First-year payments	109[2]	$2,651,952	$173,781,369
Second-year payments	89	$828,091	$55,606,567
Third-year payments	39	$1,169,816	$28,729,659
Fourth-year payments	48	$408,000	$3,992,175
Fifth-year payments	53	$450,500	$1,402,500
Sixth-year payments	19	$161,500	$161,500

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

- Acceptance of Program Year 2016 attestations from all new and returning providers;
- Holding 36 technical assistance calls;
- Responding to over 400 emails received in the EHR meaningful use mailbox;
- Conducting four onsite visits to physician offices in Memphis;
- Attendance at the Population Health Colloquium;
- Submission to CMS of Tennessee's State Medicaid Health Information Technology Plan (SMHP) Addendum, followed by CMS's approval of the document;
- Updates to TennCare's Provider Incentive Payment Program (or "PIPP") attestation software to enable attestations based on Meaningful Use Stage 3 measures to begin in April 2017;
- A campaign to alert eligible professionals and eligible hospitals that 2016 is the last program year in which they may enroll in the EHR program and begin attesting[3];
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Newsletters and alerts distributed by the Bureau's EHR ListServ; and
- A quarterly reminder to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

[2] Of the 109 providers receiving first-year payments in the January-March 2017 quarter, all earned their incentives by successfully attesting to adoption, implementation, or upgrading of EHR technology.
[3] Enrolled providers may continue to attest—and earn payments, if eligible—through Program Year 2021.

TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. In the coming months, the focus of outreach efforts will shift from enrolling new providers in the program to bringing back providers who attested to EHR requirements only once.

Wilson v. Gordon. *Wilson v. Gordon* is a class action lawsuit filed against the Bureau of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit, which is being heard by the U.S. District Court for the Middle District of Tennessee, alleges federal noncompliance in the Medicaid application and appeals process TennCare has been using since implementation of the Affordable Care Act.

Central to the *Wilson* suit is the issue of whether applications for TennCare coverage are being resolved in a proper and timely manner. In the fall of 2016, the State filed a Motion to Decertify the Class and Dismiss the Case. The basis of the motion was that processes used by TennCare and CMS for Medicaid applications and application appeals in Tennessee had evolved substantially. As a result of this evolution, the Motion contends, there are no remaining members in the Plaintiff class originally certified by the District Court, and any eligibility issues arising in 2016 are completely different from the issues that originally prompted the *Wilson* suit.

As reported in a previous Quarterly Report to the General Assembly, the District Court had reserved ruling on this motion in advance of a bench trial that was scheduled to take place on March 28, 2017. By order of the District Court on March 31, 2017, however, the trial was rescheduled for December 12, 2017. As of the end of the January-March 2017 quarter, oral argument on the State's Motion to Decertify the Class and Dismiss the Case was to be heard on April 27, 2017.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make EAH payments during the January-March 2017 quarter. EAH payments are made from a pool of $100 million ($35,017,500 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

The methodology for distributing these funds, as outlined in Special Term and Condition 53.a. of the TennCare Demonstration Agreement with CMS, 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 third quarter of State Fiscal Year 2017 (for dates of service during the second quarter) are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Third Quarter FY 2017
Vanderbilt University Hospital	Davidson County	$3,432,915
Regional One Health	Shelby County	$3,169,454
Erlanger Medical Center	Hamilton County	$2,588,947
University of Tennessee Memorial Hospital	Knox County	$1,542,189
Johnson City Medical Center (with Woodridge)	Washington County	$1,201,426
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$888,939
LeBonheur Children's Medical Center	Shelby County	$731,246
Metro Nashville General Hospital	Davidson County	$565,069
Jackson – Madison County General Hospital	Madison County	$554,396
East Tennessee Children's Hospital	Knox County	$518,754
TriStar Centennial Medical Center	Davidson County	$468,191
Methodist Healthcare – Memphis Hospitals	Shelby County	$467,472
Saint Jude Children's Research Hospital	Shelby County	$438,580
Methodist Healthcare – South	Shelby County	$391,029
Parkridge East Hospital	Hamilton County	$366,501
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$330,238
Parkwest Medical Center (with Peninsula)	Knox County	$313,712
Baptist Memorial Hospital – Memphis	Shelby County	$288,813
Methodist Healthcare – North	Shelby County	$279,227
University Medical Center (with McFarland)	Wilson County	$257,541
Saint Francis Hospital	Shelby County	$252,781
Saint Thomas Rutherford Hospital	Rutherford County	$238,691
Lincoln Medical Center	Lincoln County	$234,738
Baptist Memorial Hospital for Women	Shelby County	$217,868
Wellmont – Holston Valley Medical Center	Sullivan County	$213,281
Fort Sanders Regional Medical Center	Knox County	$211,885
Saint Thomas Midtown Hospital	Davidson County	$210,726
Wellmont – Bristol Regional Medical Center	Sullivan County	$207,292
Cookeville Regional Medical Center	Putnam County	$206,384
Pathways of Tennessee	Madison County	$202,851
Maury Regional Hospital	Maury County	$190,697
Ridgeview Psychiatric Hospital and Center	Anderson County	$182,023
Tennova Healthcare – Newport Medical Center	Cocke County	$174,389
TriStar StoneCrest Medical Center	Rutherford County	$152,953
Tennova Healthcare	Knox County	$151,419
Blount Memorial Hospital	Blount County	$147,676
TriStar Horizon Medical Center	Dickson County	$128,624
TriStar Summit Medical Center	Davidson County	$127,178

Hospital Name	County	EAH Third Quarter FY 2017
Gateway Medical Center	Montgomery County	$126,323
TriStar Southern Hills Medical Center	Davidson County	$125,949
Sumner Regional Medical Center	Sumner County	$124,465
Skyridge Medical Center	Bradley County	$119,741
TriStar Hendersonville Medical Center	Sumner County	$113,303
Dyersburg Regional Medical Center	Dyer County	$111,930
NorthCrest Medical Center	Robertson County	$108,170
Morristown – Hamblen Healthcare System	Hamblen County	$105,478
LeConte Medical Center	Sevier County	$101,744
Methodist Medical Center of Oak Ridge	Anderson County	$94,806
Jellico Community Hospital	Campbell County	$86,133
Takoma Regional Hospital	Greene County	$85,081
Rolling Hills Hospital	Williamson County	$79,820
Tennova Healthcare – Harton Regional Medical Center	Coffee County	$75,730
Tennova Healthcare – LaFollette Medical Center	Campbell County	$68,412
Indian Path Medical Center	Sullivan County	$64,210
Sycamore Shoals Hospital	Carter County	$61,306
Starr Regional Medical Center – Athens	McMinn County	$60,582
Skyridge Medical Center – Westside	Bradley County	$58,241
Grandview Medical Center – Jasper	Marion County	$57,058
Heritage Medical Center	Bedford County	$55,618
Bolivar General Hospital	Hardeman County	$55,228
Regional Hospital of Jackson	Madison County	$54,670
Southern Tennessee Regional Health System – Winchester	Franklin County	$54,216
Henry County Medical Center	Henry County	$50,978
Baptist Memorial Hospital – Union City	Obion County	$50,949
Henderson County Community Hospital	Henderson County	$49,708
Saint Thomas River Park Hospital	Warren County	$48,651
Hardin Medical Center	Hardin County	$46,989
Roane Medical Center	Roane County	$46,605
Lakeway Regional Hospital	Hamblen County	$46,057
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$42,438
Hillside Hospital	Giles County	$36,653
Claiborne County Hospital	Claiborne County	$36,103
PremierCare Tennessee, Inc.	Putnam County	$35,306
McKenzie Regional Hospital	Carroll County	$31,394
Erlanger Health System – East Campus	Hamilton County	$30,605
DeKalb Community Hospital	DeKalb County	$28,299
Jamestown Regional Medical Center	Fentress County	$27,258
Stones River Hospital	Cannon County	$25,669
Volunteer Community Hospital	Weakley County	$24,287

Hospital Name	County	EAH Third Quarter FY 2017
Wayne Medical Center	Wayne County	$20,338
United Regional Medical Center and Medical Center of Manchester	Coffee County	$16,973
Southern Tennessee Regional Health System – Sewanee	Franklin County	$10,431
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of March 2017, there were 1,458,637 Medicaid eligibles and 17,592 Demonstration eligibles enrolled in TennCare, for a total of 1,476,229 persons.

Estimates of TennCare spending for the third quarter of State Fiscal Year 2017 are summarized in the table below.

Spending Category	Third Quarter FY 2017*
MCO services**	$1,595,139,700
Dental services	$46,864,000
Pharmacy services	$304,464,100
Medicare "clawback"***	$56,222,200

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

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

****The Medicare Part D clawback is money that 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 Managed Care Contractors (MCCs) in the TennCare Program

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	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)
MCOs (CHOICES and ECF 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
Dental Benefits Manager (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)
Pharmacy Benefits Manager (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 claims processor (e.g., MCO, vision benefits manager, etc.). 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 and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF CHOICES claim types, by claims processor, 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 may also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau may assess applicable liquidated damages against these entities.

Net worth and company action level requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the January-March 2017 quarter, the MCOs submitted their 2016 NAIC Annual Financial Statements. As of December 31, 2016, TennCare MCOs reported net worth as indicated in the table below.[6]

[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.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,420,759	$178,196,525	$144,775,766
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$57,158,856	$434,309,068	$377,150,212
Volunteer State Health Plan (BlueCare & TennCare Select)	$46,879,872	$420,834,784	$373,954,912

During the January-March 2017 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of December 31, 2016:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$122,877,816	$178,196,525	$55,318,709
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$205,480,268	$434,309,068	$228,828,800
Volunteer State Health Plan (BlueCare & TennCare Select)	$148,059,416	$420,834,784	$272,775,368

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of December 31, 2016.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee. The OIG 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, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the third quarter of Fiscal Year 2017 are as follows:

Fraud and Abuse Complaints	Third Quarter FY 2017
Fraud Allegations	959
Abuse Allegations*	648
Arrest/Conviction/Judicial Diversion Totals	**Third Quarter FY 2017**
Arrests	21
Convictions	34
Judicial Diversions	15

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

Criminal Court Fines and Costs Imposed	Third Quarter FY 2017
Court Costs & Taxes	$2,144
Fines	$31,200
Drug Funds/Forfeitures	$3,841
Criminal Restitution Ordered	$250,598
Criminal Restitution Received[7]	$94,402
Civil Restitution/Civil Court Judgments	**Third Quarter FY 2017**
Civil Restitution Ordered[8]	$0
Civil Restitution Received[9]	$7,660

Recommendations for Review	Third Quarter FY 2017
Recommended TennCare Terminations[10]	119
Potential Savings[11]	$435,110

[7] Restitution may have been ordered in a fiscal year other than the one in which payment was actually received.

[8] 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.

[9] Restitution may have been agreed to in a fiscal year other than the one in which payment was actually received.

[10] 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. In reviewing these recommendations, TennCare must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

[11] Potential 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 estimated by TennCare to be $3,656.39).

Statewide Communication

In an effort to stay connected with local law enforcement and achieve the OIG's mission, Special Agents continue to meet in person with sheriffs and police chiefs throughout the state. These meetings further collaborative relationships and aid the mutual goal of stopping TennCare fraud and prescription drug diversion.