TennCare Quarterly Report

Submitted to the TennCare Oversight Committee and the Fiscal Review Committee

April 16, 2007

Status of TennCare Reforms and Improvements

New MCOs in Middle Tennessee

The January-March quarter culminated in a major achievement for the Bureau of TennCare. Effective April 1, 2007, two new health plans began serving enrollees in the Middle Tennessee Region. The two new plans are AmeriChoice and AmeriGROUP.

Enrollees in Middle Tennessee, other than some of those who live in Davidson County, have not had a choice of health plans in a number of years. The two new health plans offer, in addition to new choices, a new model of service delivery. They were designed to integrate medical and behavioral services in order to provide better coordination of care for enrollees.

During the quarter, the Bureau continued its focus on the readiness review process to assure that the new plans were ready to begin serving enrollees in Middle Tennessee effective April 1, 2007. The Bureau devoted attention during this quarter to reviewing and monitoring provider network development, conducting systems testing of critical interfaces, conducting Round 2 of On-site reviews (in which both TennCare and the Tennessee Department of Commerce and Insurance (TDCI) participated), and carrying out multiple transition activities to assure a smooth move for TennCare enrollees.

In November, provider network activity was reported every other week. Beginning in February, network reporting schedules were moved to weekly, then twice weekly, and then to a daily submission. Geo Access reports were run on the submissions and reviewed by TennCare and the Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD). Meetings were scheduled two to three times per week among the new plans, TennCare, TDMHDD, and TDCI to assure that minimum requirements were met prior to implementation on April 1, 2007.

During this quarter, the TennCare Information Technology (IT) team met with the new MCOs several times a week to discuss the daily interfaces of systems testing. All major milestones for each major test area were met to support the April 1 implementation date. Test areas included, but were not limited to, enrollment data, encounter data, and capitation data. Also, the Bureau's Claims/IT team conducted a second TennCare On-site at each local MCO location in addition to the TDCI On-site that occurred during this

quarter. Follow-up responses were requested and reviewed to assure that TennCare specific requirements were understood and would be met for April 1st.

In February, TennCare prepared and disseminated communication materials consisting of a Policy Brief, Fact Sheet, and Frequently Asked Questions (FAQs) to advocates, providers, and legislators in order to assist with any questions or issues that might be encountered during the transition. Letters were sent to all enrollees informing them of the upcoming changes. TennCare created a team within the Bureau, as well as requiring transition teams within each plan, to assist enrollees and providers during the transition period.

While this is not an exhaustive listing, below are several of the activities included as a part of the transition plan:

- Provision of a prepared transition plan to existing Managed Care Contractors (MCCs) (TennCare Select, VHP and Magellan) and the new Middle Tennessee Managed Care Organizations (MCOs)
- Conduct of multiple meetings with exiting MCCs, the new Middle Tennessee MCOs, and the Department of Children's Services (DCS) to discuss possible issues and needs for enrollees, providers, and plans during transition
- Transmission of enrollee files from exiting MCCs to new Middle Tennessee MCOs through TennCare, including private duty nursing cases, primary care provider (PCP) files, case management information, prior authorization files, disease management information, recent surgeries, prenatal cases, chronic high risk cases, etc.
- Connection of Case Managers between exiting MCCs and Middle Tennessee MCOs for transition of care purposes.

Implementation of "soft limits"

On February 1, 2007, TennCare implemented a modification to the pharmacy program. A new process, originally called "soft limits" and now called the "Prescriber Attestation Process," was put in place to allow enrollees who are subject to a limit on outpatient drugs to obtain additional prescriptions in urgent circumstances.

TennCare Medicaid adults are limited to five prescriptions per month, of which two must be generic drugs. This limit applies to all adults aged 21 and older except for those who are in Nursing Facilities and those who are being served in Home and Community Based Services (HCBS) waiver programs.

Over 600 medications have been identified for the "Prescriber Attestation Process." Under this process, when an enrollee has reached a benefit limit and his prescriber contacts TennCare and attests that the enrollee has an urgent need for one of these drugs, TennCare will provide coverage for it.

The State already had an "Auto Exemption Process," formerly called the "Short List." The Auto Exemption Process is a list of over 500 drugs that do not count against an enrollee's benefit limit.

Consolidation of Elderly and Disabled Home and Community Based Services (HCBS) waiver programs

Upon receiving relief in *Ware v. Goetz* this quarter, the State proceeded with the consolidation of the three Elderly and Disabled Home and Community Based Services (HCBS) waivers. Enrollees participating in the ADAPT waivers in Davidson, Hamilton, and Knox Counties and enrollees participating in the Shelby County HCBS waiver are in the process of transitioning into the statewide HCBS waiver, where they will have access to an expanded array of services including Personal Care Attendant, Adult Day Care, and In-Home Respite. This transition is proceeding in accordance with a protocol developed by the State and approved by the Court to assure the health, safety, and welfare of all enrollees.

Waiver extension

Bureau staff spent a great deal of time this quarter reformatting the waiver documents in an effort to secure CMS approval of an extension of the TennCare waiver.

As mentioned in the last quarterly report, the current TennCare waiver ("TennCare II") was granted in 2002 for a period of five years (July 1, 2002, through June 30, 2007). It is a Section 1115(a) demonstration waiver. In June 2006 the State sent CMS a letter asking for a three-year extension of the waiver under the Section 1115(e) authority. In November 2006 CMS denied the State's request for an extension under the Section 1115(e) authority and directed the State to submit a waiver extension request under the Section 1115(a) authority. This process required a reworking of the waiver documents. Once approved, the new Section 1115(a) extension is expected to be effective from July 1, 2007, through June 30, 2010. It is not envisioned that the waiver extension will involve any substantial changes in the programmatic aspects of the original waiver.

Weekly conference calls were held with CMS during this quarter, and the Bureau responded to all requests from CMS. Data runs were done on multiple occasions, and details regarding the programmatic aspects of the waiver were reworked and refined.

CMS submitted the revised waiver documents to the federal Office of Management and Budget (OMB) for their review on April 4, 2007.

Standard Spend Down (SSD) program

In the last quarterly report, we indicated that CMS had approved the proposed Standard Spend Down (SSD) program, which would enable the State to add up to 100,000 adults who are aged, blind, disabled, or caretaker relatives of Medicaid-eligible dependent children and who have incurred unpaid medical bills of a sufficient size to "spend down" to the income level used in the Medicaid Medically Needy program for pregnant women and children. This new population is to be a demonstration population and not a Medicaid population.

One of the Special Terms and Conditions of the TennCare waiver is a commitment not to enroll demonstration eligibles during the last six months of the waiver. Since the

requested extension of the waiver has not yet been approved (see above section), the State does not believe it is in a position to implement the amendment until agreement has been reached on the terms, conditions, and budgetary authority under which the demonstration will be extended as of July 1, 2007. The State has therefore requested that CMS move expeditiously to approve the request for waiver extension so that it may implement the SSD amendment.

Essential Access Hospital (EAH) payments

The TennCare Bureau continued to make Essential Access Hospital payments during this period. Essential Access Hospital payments are payments from a pool of $100 million ($35,292,500 in state dollars) appropriated by the General Assembly.

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 five state mental health institutes.

Essential Access Hospital payments for the third quarter of State Fiscal Year 2007 are shown in the following table.

Hospital Name	FY 2007 3rd Qtr EAH
Methodist Medical Center of Oak Ridge	$167,155
Ridgeview Psychiatric Hospital and Center	$51,327
Bedford County Medical Center	$70,552
Blount Memorial Hospital	$122,068
Bradley Memorial Hospital	$111,455
Cleveland Community Hospital	$123,243
Saint Mary's Medical Center of Campbell County	$73,691
Jellico Community Hospital	$131,125
Stones River Hospital	$51,649
Baptist Memorial Hospital-Huntingdon	$32,449
McKenzie Regional Hospital	$ 40,463
Sycamore Shoals Hospital	$61,720
Claiborne County Hospital	$110,871
Cumberland River Hospital	$15,920
Baptist Hospital of Cocke County	$186,795
United Regional Medical Center	$126,006
Harton Regional Medical Center	$92,811

Hospital Name	FY 2007 3rd Qtr EAH
Cumberland Medical Center	$115,185
Southern Hills Medical Center	$122,459
Tennessee Christian Medical Center	$444,082
Metro Nashville General Hospital	$1,033,500
Baptist Hospital	$200,741
Vanderbilt University Hospital	$2,742,194
Centennial Medical Center	$247,535
Summit Medical Center	$138,816
Baptist Women's Treatment Center	$2,784
Vanderbilt Stallworth Rehabilitation Hospital	$32,700
Decatur County General Hospital	$26,182
Baptist DeKalb Hospital	$30,267
Horizon Medical Center	$102,164
Dyersburg Regional Medical Center	$117,548
Methodist Healthcare Fayette	$41,069
Jamestown Regional Medical Center	$76,889
Emerald Hodgson Hospital	$21,585
Southern Tennessee Medical Center	$72,544
Gibson General Hospital	$36,391
Humboldt General Hospital	$75,356
Hillside Hospital	$81,743
Laughlin Memorial Hospital	$70,706
Takoma Adventist Hospital	$60,368
Morristown Hamblen Healthcare System	$152,515
Lakeway Regional Hospital	$123,693
Erlanger Medical Center	$1,655,839
Erlanger North Hospital	$32,447
Parkridge Medical Center	$75,688
East Ridge Hospital	$137,939
Valley Hospital	$143,235
Bolivar General Hospital	$36,901
Hardin County General Hospital	$108,295
Wellmont Hawkins County Memorial Hospital	$67,615
Haywood Park Community Hospital	$48,253
Henderson County Community Hospital	$23,863
Henry County Medical Center	$92,719
Jefferson Memorial Hospital	$49,177
Fort Sanders Regional Medical Center	$276,516
Saint Mary's Health System	$175,577
Baptist Hospital of East Tennessee	$100,907
University of Tennessee Memorial Hospital	$1,713,397
East Tennessee Children's Hospital	$445,851
Fort Sanders Parkwest Medical Center	$98,622
Crockett Hospital	$62,465
Lincoln Medical Center	$41,525

Hospital Name	FY 2007 3rd Qtr EAH
Fort Sanders Loudon Medical Center	$45,364
Woods Memorial Hospital	$35,419
Athens Regional Medical Center	$51,964
McNairy Regional Hospital	$38,967
Jackson Madison County General Hospital	$634,000
Regional Hospital of Jackson	$113,707
Pathways of Tennessee	$104,651
Grandview Medical Center	$53,157
Maury Regional Hospital	$183,819
Sweetwater Hospital Association	$147,976
Gateway Medical Center	$153,099
Baptist Memorial Hospital Union City	$97,605
Livingston Regional Hospital	$52,232
Cookeville Regional Medical Center	$122,818
Roane Medical Center	$60,204
Northcrest Medical Center	$146,323
Middle Tennessee Medical Center	$219,841
Baptist Treatment Center of Murfreesboro	$7,451
Stonecrest Medical Center	$65,321
Scott County Hospital	$84,586
Fort Sanders Sevier Medical Center	$153,984
Regional Medical Center (The Med)	$4,641,856
Saint Jude Children's Research	$258,933
Methodist Healthcare South	$135,974
Methodist University Healthcare	$409,874
Methodist Healthcare North	$142,149
Methodist Healthcare Lebonheur	$804,149
Delta Medical Center	$150,581
Saint Francis Hospital	$409,364
Community Behavioral Health	$74,206
Smith County Memorial Hospital	$25,737
Wellmont Bristol Regional Medical Center	$237,628
Wellmont Holston Valley Medical Center	$245,112
Indian Path Pavilion	$35,848
Tennessee Christian Medical Center-Portland	$39,629
Sumner Regional Medical Center	$159,594
Hendersonville Medical Center	$57,045
Baptist Memorial Hospital-Tipton	$101,829
Unicoi County Memorial Hospital	$25,312
River Park Hospital	$58,559
North Side Hospital	$52,606
Johnson City Specialty Hospital	$13,241
Johnson City Medical Center Hospital	$713,213
Woodridge Psychiatric Hospital	$90,733
Wayne Medical Center	$24,573

Hospital Name	FY 2007 3rd Qtr EAH
Volunteer Community Hospital	$31,715
White County Community Hospital	$36,248
University Medical Center	$326,657
TOTAL	**$25,000,000**

Reverification Status

Reverification of demonstration eligibles continued to be on hold during this quarter but will begin soon.

Status of Filling Top Leadership Positions in the Bureau

Four key appointments were made during this quarter.

Patti Killingsworth was appointed January 1, 2007, as Chief of Long Term Care Operations. Ms. Killingsworth will oversee and direct the Long Term Care and Developmental Disability Services Divisions, with responsibility for all activities related to long-term care facilities, including nursing homes and oversight of Section 1915 Home and Community Based Waiver projects for persons who are elderly and/or disabled and persons who are mentally retarded. Prior to this appointment, Ms. Killingsworth was Director of Member Services for the Bureau of TennCare.

Tracy Purcell was appointed January 1, 2007, as Director of Member Services. Ms. Purcell oversees the processing of all TennCare medical, behavioral health, pharmacy, and dental appeals filed by TennCare enrollees. She supervises the TennCare Solutions Unit, as well as the Administrative Solutions Unit, the Valid Factual Dispute Unit, the Medical Solutions Unit, the Directives Solutions Unit, the Legal Solutions Unit, and the Single State Agency Unit. In addition to the above responsibilities, Ms. Purcell coordinates communications with members and directs eligibility policy. Prior to this appointment, Ms. Purcell served as Director of Eligibility Services for the Bureau of TennCare.

Jeanne Jordan, M.D. was appointed February 1, 2007, as Associate Medical Director. Dr. Jordan provides input on all aspects of medical policy and medical decision making related to children enrolled in the TennCare program. Dr. Jordan has previously served as Chief Medical Officer, Tulane University Hospital and Clinic; Assistant Dean, Tulane University Hospital and Clinic Affairs; and, Assistant Professor of Pediatrics at both Tulane University and the University of Alabama, Tuscaloosa.

Judy Womack was appointed February 1, 2007, as the Director of Quality Oversight. Ms. Womack is responsible for monitoring the quality of care delivered through the TennCare program's Managed Care Contractors (MCCs). Ms. Womack previously served in the Bureau of TennCare as Managed Care Director, Quality Oversight

Division. In addition, Ms. Womack has more than 20 years of experience managing and directing a broad array of public health programs.

Number of Recipients on TennCare and Costs to the State

Number of recipients. As of the end of the quarter, there were 1,204,852 enrollees on TennCare: 1,170,056 Medicaid eligibles and 34,796 Uninsureds and Uninsurables (Medically Eligibles).

TennCare spending. During the first quarter of calendar year 2007 (January through March), TennCare spent $718,907,500 for managed care organization (MCO) services, $107,212,100 for behavioral health organization (BHO) services, $35,977,100 for dental benefit manager (DBM) services, and $172,637,400 for pharmacy benefits manager (PBM) services. The State's Medicare clawback payment was $54,083,300.[1] (The "clawback" refers to the payment required under the Medicare program's new Part D pharmacy program. Pharmacy benefits for Medicaid/Medicare dual eligibles, which had formerly been provided by TennCare, were shifted to the Medicare program on January 1, 2006. The "clawback" payment is intended to be roughly the amount of state funds that the state Medicaid program would have paid if it had continued to pay for outpatient prescription drugs for persons dually eligible for Medicare and Medicaid.)

Viability of MCOs in the TennCare Program

Claims payment analysis

The prompt pay requirements of T.C.A. § 56-32-226(b) mandate that each health maintenance organization and behavioral health organization ensure that 90% of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and 99.5% of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefit Manager (DBM) requires that the DBM also process claims in accordance with this statutory standard.

TennCare's contract with its Pharmacy Benefits Manager (PBM) requires that the PBM must pay 95% of all clean claims within 20 calendar days of receipt and the remaining 5% of clean claims within the following 10 calendar days.

TDCI requested data files of all TennCare processed claims from TennCare Managed Care Organizations (MCOs), Behavioral Health Organizations (BHOs), the DBM, and the PBM for the months of November and December 2006 and January 2007. TDCI also requested data files of pended TennCare claims and a paid claims triangle from November 1, 2005 through January 31, 2007.

[1] These figures are unaudited as of April 9, 2007.

Except for Preferred Health Partnership of Tennessee ("PHP") and UAHC Health Plan of Tennessee ("UAHC") all MCOs, BHOs and the PBM were in compliance with the prompt pay requirements for November and December 2006 and January 2007. PHP was out of compliance for December 2006 and January 2007. In December, PHP processed only 85% of clean claims within 30 calendar days of receipt. In January, PHP processed only 78% of clean claims within 30 calendar days of receipt. Because of its non-compliance, PHP has been required to submit claims data files monthly until PHP processes claims timely for three consecutive months. Tests of PHP's monthly data file for February found that PHP remained out of compliance, processing only 86% of clean claims within 30 calendar days of receipt. PHP has failed to meet the prompt pay requirements for seven of the last 12 months tested. TDCI will levy an administrative penalty for PHP's failure to timely process claims in accordance with the prompt pay statute.

UAHC was out of compliance with the prompt pay requirements for the months of November and December 2006 and January 2007. In November UAHC processed only 85% of clean claims within 30 calendar days of receipt. In December UAHC processed only 76% of clean claims within 30 calendar days of receipt. In January, UAHC processed only 86% of clean claims within 30 calendar days of receipt. Because of its non-compliance, UAHC has been required to submit monthly data files until UAHC processes claims timely for three consecutive months. Tests of UAHC's monthly data file for February found that UAHC was in compliance with the prompt pay requirements. If UAHC remains in compliance for March and April 2007, it will return to quarterly submission of data files and TDCI will not assess an administrative penalty against UAHC.

Net worth requirement

As of December 31, 2006, TennCare MCOs/BHOs reported net worth as indicated in the table below. TDCI has not adjusted the net worth reported on the NAIC annual statements. TDCI's calculations for the net worth requirement reflect payments made for the calendar year ending December 31, 2006, including payments made under the "stabilization plan."

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (formerly John Deere)	17,339431	157,938,399	140,598,968
Memphis Managed Care	8,777,597	30,480,574	21,702,977
Preferred Health Partnership	6,583,291	33,552,547	26,969,256
UAHC Health Plan	7,230,835	11,699,216	4,468,381
Unison Health Plan	3,746,386	5,451,597	1,705,211
Volunteer (BlueCare & Select)	25,703,132	30,758,110	5,054,978
Windsor Health Plan	6,291,309	8,182,072	1,890,763
Premier Behavioral Systems	7,026,272	27,493,548	20,467,276
Tennessee Behavioral Health	6,606,592	19,290,585	12,683,993

FINANCIAL ISSUES:

Xantus Healthplan of Tennessee, Inc. (Xantus)

No change.

Tennessee Coordinated Care Network d/b/a Access MedPlus (TCCN)

No change.

Universal Care of Tennessee (Universal)

On February 16, 2007, Universal received $20,000,000 from TennCare in compromise and settlement of the $75,000,000 claim filed against the State of Tennessee in the Claims Commission by Universal prior to it being placed in liquidation.

Success of Fraud Detection and Prevention

The Office of Inspector General (OIG) was established 2 1/2 years ago (July 1, 2004). The mission of the OIG is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program.* The OIG staff receives case information from a variety of sources including: local law enforcement, the Tennessee Bureau of Investigation (TBI), the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCCs), OIG data mining, and the general public via the OIG web site, faxes, letters, and phone calls to the OIG hotline. The statistics for the third quarter of the 2006 - 2007 fiscal year are as follows:

***NOTE**: Included are the fiscal year totals (FYT) and the grand totals to date (TD) -- since the OIG was created (July 2004)*

Summary of Enrollee Cases

	Quarter	FYT	Grand Total
Cases Received	4,505	16,607	73,294
Cases Closed*	3,525	15,393	73,714

***Cases are closed when there is inadequate information provided to investigate the complaint, the information has been researched and determined to be unfounded, the case was referred to another agency (as per appropriate jurisdiction), or prosecuted by the OIG and closed. This number also includes reports the OIG runs for the TennCare Bureau regarding potential fraud or abuse.*

Summary of Enrollee Abuse Cases

	Quarter	FYT
Abuse Cases Received	2,769	14,248
Abuse Cases Closed	911	4,641
Abuse Cases Referred [1]	1,894	10,434

[1] Abuse cases may be referred to the appropriate Managed Care Organization (MCO), the TennCare Bureau, or DHS for further review.

Summary of Provider Cases

	Quarter	FYT	Grand Total
Cases opened	66	228	870
Cases closed	32	137	746
Cases referred to TBI*	3	16	74
Cases referred to HRBs**	5	23	66

***The OIG refers **provider cases** to the TBI Medicaid Fraud Unit (as per state and federal law) and assists with these investigations as requested.*
***Health Related Boards*

Summary of Arrests & Convictions

	Quarter	FYT	Grand Total
Arrests	32	131	397
Convictions	5	46	129
Diversions*	4	16	45

Note: *Special Agents were not in the field making arrests until February 2005.*
***Judicial Diversion**: A guilty plea or verdict subject to expungement following successful completion of probation. Tennessee Code Annotated § 40-35-313*
***Pre-trial Diversion**: Prosecution was suspended and if probation is successfully completed, the charge will be dismissed. Tennessee Code Annotated § 40-15-105*

Court Fines & Costs Imposed

	QUARTER	FYT	GRAND TOTAL
Fines	**$6,000.00**	**$20,600.00**	**$52,125.00**
Court Costs & Taxes	**$1,798.50**	**$12,255.30**	**$27,070.80**
Drug Funds	**$132.50**	**$1,266.50**	**$3,276.00**
Restitution	**$60,822.06**	**$238,329.25**	**$729,563.77**

There is an aggressive push to pursue enrollees who have committed fraud or abuse against the TennCare program. The primary criminal cases types are: drug cases (drug diversion, drug seekers, and forged prescriptions), reporting a false income, access to insurance, and living outside of the State of Tennessee.

Arrest Categories

Drug Diversion/Forged Prescription	258
Access to Insurance	48
Operation Falcon III	32
False Income	20
Ineligible Person Using Card	16
Living Out Of State	8
Asset Diversion	6
Theft of Services	6
ID Theft	3
GRAND TOTAL	**397**

TennCare Referrals & Recoupments

	Quarter	FYT	Grand Total
Pharmacy Lock-in **(1)**	32	137	810
Recoupment **(2)**	$109,247.97	$296,163.83	$646,394.12
Recommended TennCare Terminations **(3)**	1,695	9,756	20,216
Potential Savings **(4)**	$5,593,500	$32,395,200	$75,928,477

Footnotes for the *TennCare Referral and Recoupments* table

(1) The total in the last column is for the time period of September 2004 through March 31, 2007. Pharmacy lock-in referrals are sent to the TennCare Bureau for consideration.

(2) The total in the last column reflects dollars collected by the OIG and sent to the TennCare Bureau from February 15, 2005, (when a Fiscal Manager and an attorney joined the OIG staff to facilitate and document this process) through March 31, 2007.

(3) Enrollee recommendations sent to the TennCare Bureau for consideration based on reports run from *file net* (i.e. Prisoner Report, State Wage Report, the Deceased Report, and the PARIS Report). Reports are run upon availability on *file net*.

(4) There were 1,695 enrollee terminations recommended for the third quarter. The TennCare Bureau uses $3,592.32 as the average annual cost per enrollee for Medical, Pharmacy Services, BHO, and Dental, and $3,082.44 for Medical and Pharmacy Services only (an average of $3,300 was used for this total figure). [NOTE: Previous reports reflected the number $4,181.04 as the average annual cost per enrollee.]

Investigative Sources

	Quarter	FYT	Grand Total
OIG Hot Line	996	2,867	12,038
OIG Mail Tips	83	270	2,665
OIG Web Site	414	1,327	4,091
OIG Email Tips	108	318	1,907

The OIG staff provided presentations or attended meetings for the following organizations/contacts during this quarter:

a Meetings with local law enforcement officials:
- *2 of the Judicial Task Forces
- *7 District Attorneys
- *27 Sheriffs and Chiefs of Police

b. Demonstrations:
- Shared Health
- Prescription Monitoring Program
- CoverTenn electronic interface system

c. Presentations:
- Middle Tennessee Medical Group Management Association
- Murfreesboro Dental Association
- Girl Scouts

d. Meetings:
- Law Enforcement Committee Monthly Meeting (Brentwood, Tn)
- Franklin Rotary Club
- MCC Roundtable
- Institute of Internal Auditors
- CoverTn/Kids/RX & Access Tennessee

Legislative hearings
Nursing Home Roundtable

The OIG started working with Medicaid fraud units within states that touch Tennessee: Mississippi, Alabama, Kentucky, Virginia, Arkansas, Georgia, Missouri, and North Carolina. This sharing of data has been extremely valuable to the mission of the OIG.

The OIG staff continues to work with the State's contractor, Medstat, to develop the fraud and abuse detection software system. The OIG is working with this vendor to initiate proactive reports for identifying TennCare fraud. Targeted queries are generated on a routine basis. The goal behind these reports and queries is to assist with a successful OIG investigation and prosecution of individuals who have violated the law as it pertains to TennCare fraud.

Four employee vacancies were created during this quarter due to two transfers to other state agencies, one termination, and one promotion to a vacancy. There will be an evaluation of these vacancies to ensure they will be filled appropriately.

Training continued for OIG personnel during this quarter. The Special Agents began completing an annual In-Service training that includes POST required courses, new policies and procedures, all qualifications with approved weapons, a legal update, etc. All continuing education hours have begun for OIG "professional" staff members, i.e., attorneys, accountant, registered nurses, and information technology personnel.

The OIG Legal Division has assisted OIG staff members by providing legal advice on issues including how to meet the requirements of various statutes and drafting and reviewing documents that have legal implications. The Legal Division facilitates the case preparation process and works closely with various District Attorneys toward a successful prosecution of OIG cases. They review all legal matters of the OIG and advise on pending legislative issues.

The Inspector General and the Deputy Inspector General over Criminal Investigations have continued visits to various Tennessee counties. In each jurisdiction visited, there is a courtesy call to the Sheriff and Chief of Police. The goal is to continue to solidify the collaboration between local law enforcement and the OIG. More visits are planned for the next quarter.

The OIG continues to maintain accredited status by complying with the standards of the Commission on Accreditation for Law Enforcement Agencies (CALEA). The OIG was accredited in November 2006. The State of Tennessee OIG is the only Inspector General agency to achieve law enforcement accreditation both nationally and internationally.

The OIG website was implemented during the second quarter. This will be helpful with the "Tips for Cash" Program by providing updates on the resolution of cases as they occur.

An OIG Special Agent has been selected to attend the summer session of the FBI National Academy in Quantico, Virginia. This is a very prestigious school that is often referred to as the Harvard of law enforcement. The State of Tennessee only receives about 12 slots a year so the competition in the law

enforcement community is keen. Once SA John Morgan graduates, the OIG will have seven NA graduates.

Plans for next quarter:

a. Continue to exchange information with local, state, and federal government agencies.
b. Continue to work with Medstat to improve reports that would assist with the data mining function of the OIG.
c. Provide presentations and training for interested parties regarding TennCare fraud and the role of the OIG.
d. Continue staff training and develop best practices.
e. Track the newly created pay incentive program for tips that lead to a successful conviction for TennCare fraud. This program is a result of legislation from the 104th General Assembly and is a law.
f. Continue to review information for possible fraud and abuse of the newly created programs: CoverTn, Cover Kids, CoverRX, and Access Tennessee -- as they link to TennCare cases.
g. Continue to implement legislated programs pertaining to the OIG (last session): data mining and providing administrative hearings for the recovery of money owed to the TennCare program.
h. Continue the process for re-accreditation (a three year process). The OIG was accredited in November 2006.