TennCare Quarterly Report

Submitted to the Members of the General Assembly

April 13, 2012

Status of TennCare Reforms and Improvements

Standard Spend Down. The TennCare Standard Spend Down (SSD) eligibility category opened to new enrollment for the fourth time on February 21, 2012 (following previous rounds on October 4, 2010, February 22, 2011, and September 12, 2011). SSD is available through an amendment to the TennCare Waiver[1] and is designed to serve a limited number of persons who are not otherwise eligible for Medicaid but who are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and who have enough unreimbursed medical bills to allow them to "spend down" their income to a low level known as the Medically Needy Income Standard (MNIS). The MNIS for a family of three in Tennessee is $317 per month.

During the open enrollment period, the Department of Human Services (DHS) received 2,934 calls in just over one hour. As a result, 2,790 callers not already covered by TennCare were invited to apply for SSD, and, by March 23, 1,213 individuals had returned their applications. As of the end of the quarter, the announced deadline for submitting an application was April 5, 2012.

Long-Term Services and Supports Webpage. In January 2012, TennCare's Division of Long-Term Services and Supports (LTSS) updated its dedicated page on the Bureau's website. The refurbished site—located online at http://www.tn.gov/tenncare/longtermcare.shtml—provides a wealth of information, including:

- An overview of the meaning and function of long-term services and supports
- Descriptions of all LTSS programs, including CHOICES, the "Money Follows the Person" (or "MFP") grant, services for individuals with intellectual disabilities, and the Program of All-inclusive Care for the Elderly (or "PACE")
- Instructions for applying for LTSS programs
- Links to the websites of State agencies and managed care organizations that have a role in delivering long-term care to TennCare enrollees

[1] See Expenditure Authority 7.b.ii and Special Term and Condition #21.a of the TennCare Waiver, a copy of which is available online at http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf.

- Contact information for TennCare's LTSS Division

As TennCare continues its efforts to rebalance long-term care toward increased use of home and community based services, the upgraded webpage is expected to serve an important function in delivering updates and furnishing resources to the public.

Proposed Change in CHOICES Membership ("Amendment 14"). On March 1, 2012, TennCare asked permission from the Centers for Medicare and Medicaid Services (CMS) to open the "Interim CHOICES 3" category for CHOICES, TennCare's program of long-term services and supports for individuals who are elderly or physically disabled. The CHOICES 3 category will have no enrollment target and will be composed of persons who meet the State's Level of Care (LOC) criteria for Nursing Facility (NF) care today but who would not meet those criteria if they are revised. These individuals will be eligible for a package of home and community based services (HCBS), as well as all TennCare services. The purpose of opening the new category is to maximize the availability of HCBS while simultaneously complying with the "Maintenance of Effort" (MOE) requirements contained in the Affordable Care Act. Once the category is in place, persons who meet the criteria for NF care today would still have a "pathway to eligibility" when the LOC criteria are revised. The State's intention is to open the category on July 1, 2012, and close it on December 31, 2013, when the MOE requirements for adults expire.

TennCare projects that implementation of this measure would result in cost avoidance of nearly $16 million in Fiscal Year 2012-2013. These savings would be achieved by placing greater emphasis on cost-effective home and community based services within the Bureau's system of long-term services and supports.

Proposed Removal of Cap on Hospital Payments ("Amendment 16"). On March 8, 2012, the Bureau notified the public of another proposal to be submitted to CMS. The purpose of Amendment #16 is to enable TennCare to take full advantage of the Medicaid Disproportionate Share Hospital (DSH) allotment appropriated to the State by Congress for Federal Fiscal Year 2012.

According to the Special Terms and Conditions of the TennCare Demonstration, certain payments made to hospitals by TennCare are subject to an annual cap of $540 million. This cap was developed on the basis of the amount of DSH funding appropriated by Congress when the current Demonstration was approved. It will not be possible for the State to make use of the entire new DSH allotment appropriated by Congress and still stay within the cap.

Therefore, the State is proposing in Amendment #16 to reconfigure the current Special Terms and Conditions of the Demonstration so that the State will always have the capacity to make use of any DSH allotments made by Congress to Tennessee.

TennCare estimates that implementation of Amendment #16 will result in an increase in aggregate annual expenditures of up to $28 million in State funds in the fiscal year. The State funds will be supported by revenues generated from the annual hospital assessment fee.

The full text of the March 8 notice is available online at http://www.tn.gov/tenncare/forms/amendment16.pdf.

***John B.* Trial.** The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that has been the subject of ongoing litigation since 2000. Shortly after assuming responsibility for the case last year, Judge Thomas A. Wiseman, Jr. issued a Case Management Order, which identified current substantial compliance with the requirements of the consent decree as the primary issue to be resolved at trial. The Order also provided a schedule for discovery and set a trial date of October 31, 2011. The trial began as scheduled and lasted exactly one month, concluding on November 30.

On February 14, 2012, almost 14 years to the day after the suit was filed, Judge Wiseman ruled that TennCare had successfully established its compliance with "all the binding provisions of the Consent Decree" and, consequently, that the consent decree was vacated and the case dismissed.[2] In his 38-page Memorandum Opinion, Judge Wiseman not only outlined in extensive detail all of the components of TennCare's early and periodic screening, diagnosis and treatment ("EPSDT") program for children—including outreach efforts, screening, diagnosis and treatment, and monitoring and oversight—but also documented the manner in which the State had achieved "substantial compliance with virtually every operative paragraph of the Consent Decree."[3] In addition, the Plaintiffs and Defendants alike were praised for presenting proof in a manner that was both "highly professional" and "completely devoid of acrimony."[4]

On March 9, 2012, the Plaintiffs filed a Notice of Appeal with the United States Court of Appeals for the Sixth Circuit.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program makes first-year payments to Medicaid providers[5] who have adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards. TennCare administers Tennessee's Medicaid EHR program, the vast majority of funding for which is provided by the federal government.[6] During the January-March quarter, TennCare continued to distribute first-year payments, while simultaneously finalizing the attestation process through which providers may earn second-year payments.

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[2] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.
[3] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Memorandum Opinion, page 24. February 14, 2012.
[4] Ibid, page 38.
[5] 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).
[6] The federal government covers 90% of administrative costs and 100% of the incentive payments.

Building on the substantial accomplishments achieved during calendar year 2011, the Bureau opened calendar year 2012 at an even brisker pace. From January through March 2012, TennCare issued over $26 million of EHR payments to a total of 568 providers, including 289 physicians, 206 nurse practitioners, 28 pediatricians, 19 hospitals, 16 dentists, 8 certified nurse midwives, and 2 physician assistants. Given that the total amount of payments issued to providers from May through December 2011 was approximately $22 million, the momentum of the program appears to be accelerating. This progress is attributable in no small part to TennCare's ever evolving communications network related to the EHR program, some facets of which are a dedicated webpage (the introductory segment of which is located at http://www.tn.gov/tenncare/ehr_intro.shtml), newsletters distributed by the Bureau's EHR ListServ (subscriptions to which are available at http://www.tn.gov/tenncare/medicaidhitemail.html), and the TennCare Provider Incentive Payment Program ("PIPP") portal that became operational in November 2011.

As the quarter concluded, TennCare made final preparations for the next phase of the program. In early April 2012, the Bureau was to open the attestation process for second-year payments to providers who had adopted, implemented, or upgraded to certified EHR technology during 2011, and who had made meaningful use of the technology from January 1 through March 30, 2012. By the end of March, therefore, a new attestation web portal was being put in place to enable providers to complete this process online. In addition, because the criteria for determining whether meaningful use has been achieved are highly technical, TennCare posted an overview of the subject on its website at http://www.tn.gov/tenncare/mu.shtml. The site offers a wealth of information and resources to providers—whether eligible professionals or eligible hospitals—engaged in attestation.

Award for Chief Financial Officer. At its recent President's Dinner, the Tennessee Primary Care Association (TPCA) gave TennCare Chief Financial Officer Casey Dungan the William V. Corr Award of Excellence. This honor recognizes "outstanding leadership resulting in health policy development or innovative program implementation in Tennessee."[7]

TPCA's stated goal is "maximizing access to health services for all Tennesseans with emphasis on the working poor, the uninsured, TennCare patients, and others most in need."[8] In bestowing the Corr Award on Dungan, TPCA recognized the work that Casey had done with the Prospective Payment System workgroup to streamline TennCare's reimbursement policies.

Dungan, who joined TennCare in 2006, has degrees from Duke University and the University of Georgia. His duties as the Bureau's Chief Financial Officer began on October 1, 2011, following terms as a budget analyst and the Deputy CFO.

Recognition of Executive Staff Members. On March 20, 2012, the March of Dimes and its advocacy partner the Tennessee Initiative for Perinatal Quality Care (TIPQC) honored three members of

[7] This and additional information about the award is available on TPCA's website at http://www.tnpca.org/displaycommon.cfm?an=1&subarticlenbr=133.
[8] See TPCA's "Our History" page, located online at http://www.tnpca.org/displaycommon.cfm?an=1&subarticlenbr=38.

TennCare's executive staff. At the Healthy Babies Legislative Reception, Director Darin Gordon, Chief Medical Officer Wendy Long, and Medical Director Jeanne James were recognized for their "work to protect women and babies."

The mission of the Tennessee Chapter of the March of Dimes is to "improve the health of babies by preventing birth defects, premature birth and infant mortality,"[9] while TIPQC strives to "improve health outcomes for mothers and infants in Tennessee."[10]

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 ($34,220,000 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, do not have unreimbursed TennCare costs, and the five State mental health institutes.

The Essential Access Hospital payments for the third quarter of State Fiscal Year 2012 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Third Quarter FY 2012
Regional Medical Center at Memphis	Shelby County	$3,918,611
Erlanger Medical Center	Hamilton County	$2,815,559
Vanderbilt University Hospital	Davidson County	$2,471,141
University of Tennessee Memorial Hospital	Knox County	$1,369,701
Johnson City Medical Center (with Woodridge)	Washington County	$1,173,395
LeBonheur Children's Medical Center	Shelby County	$768,520
Metro Nashville General Hospital	Davidson County	$751,593

[9] See the organization's "Mission Programs" page, which is located at http://www.marchofdimes.com/tennessee/4727.asp.

[10] TIPQC's full mission statement, as well as more information about the organization, is available online at http://www.tipqc.org/.

Hospital Name	County	EAH Third Quarter FY 2012
Jackson - Madison County General Hospital	Madison County	$630,757
Methodist Healthcare - South	Shelby County	$567,179
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$497,192
East Tennessee Children's Hospital	Knox County	$481,480
Parkwest Medical Center (with Peninsula)	Knox County	$442,401
Methodist University Healthcare	Shelby County	$408,488
Saint Jude Children's Research Hospital	Shelby County	$345,034
Centennial Medical Center	Davidson County	$304,488
Saint Francis Hospital	Shelby County	$298,022
Delta Medical Center	Shelby County	$273,699
University Medical Center	Wilson County	$249,878
Skyline Medical Center (with Madison Campus)	Davidson County	$249,155
Wellmont Holston Valley Medical Center	Sullivan County	$244,410
Maury Regional Hospital	Maury County	$242,257
Mercy Medical Center	Knox County	$238,950
Pathways of Tennessee	Madison County	$222,372
Fort Sanders Regional Medical Center	Knox County	$213,117
Ridgeview Psychiatric Hospital and Center	Anderson County	$199,927
Middle Tennessee Medical Center	Rutherford County	$177,312
Methodist Healthcare - North	Shelby County	$174,868
Gateway Medical Center	Montgomery County	$173,520
Cookeville Regional Medical Center	Putnam County	$171,153
Baptist Hospital	Davidson County	$171,065
Wellmont Bristol Regional Medical Center	Sullivan County	$169,781
Skyridge Medical Center	Bradley County	$161,171
Baptist Memorial Hospital for Women	Shelby County	$144,904
Parkridge East Hospital	Hamilton County	$144,815
Morristown - Hamblen Healthcare System	Hamblen County	$139,812
NorthCrest Medical Center	Robertson County	$139,054
Summit Medical Center	Davidson County	$126,383
Regional Hospital of Jackson	Madison County	$115,342
LeConte Medical Center	Sevier County	$113,715
Sweetwater Hospital Association	Monroe County	$113,290
Sumner Regional Medical Center	Sumner County	$112,687
StoneCrest Medical Center	Rutherford County	$110,156
Baptist Hospital of Cocke County	Cocke County	$110,053
Dyersburg Regional Medical Center	Dyer County	$109,390
Methodist Medical Center of Oak Ridge	Anderson County	$106,850
Southern Hills Medical Center	Davidson County	$106,607
Baptist Memorial Hospital - Tipton	Tipton County	$106,255
Horizon Medical Center	Dickson County	$103,811

Hospital Name	County	EAH Third Quarter FY 2012
Blount Memorial Hospital	Blount County	$103,801
United Regional Medical Center	Coffee County	$98,623
Saint Mary's Medical Center of Campbell County	Campbell County	$98,351
Takoma Regional Hospital	Greene County	$84,088
Harton Regional Medical Center	Coffee County	$84,015
Jellico Community Hospital	Campbell County	$83,928
Hendersonville Medical Center	Sumner County	$83,885
Sycamore Shoals Hospital	Carter County	$81,178
Community Behavioral Health	Shelby County	$77,701
Athens Regional Medical Center	McMinn County	$72,868
Lakeway Regional Hospital	Hamblen County	$71,774
Hardin Medical Center	Hardin County	$71,737
Heritage Medical Center	Bedford County	$70,122
Henry County Medical Center	Henry County	$69,531
Indian Path Medical Center	Sullivan County	$68,522
Crockett Hospital	Lawrence County	$64,484
Saint Mary's Jefferson Memorial Hospital	Jefferson County	$61,910
River Park Hospital	Warren County	$61,016
Humboldt General Hospital	Gibson County	$60,755
Southern Tennessee Medical Center	Franklin County	$59,347
Grandview Medical Center	Marion County	$58,710
Bolivar General Hospital	Hardeman County	$58,263
Claiborne County Hospital	Claiborne County	$58,010
Lincoln Medical Center	Lincoln County	$56,893
Wellmont Hawkins County Memorial Hospital	Hawkins County	$53,605
Baptist Memorial Hospital - Union City	Obion County	$52,893
Jamestown Regional Medical Center	Fentress County	$50,293
Roane Medical Center	Roane County	$48,738
Hillside Hospital	Giles County	$47,564
Skyridge Medical Center - West	Bradley County	$46,619
Riverview Regional Medical Center - North	Smith County	$41,536
Livingston Regional Hospital	Overton County	$41,506
Volunteer Community Hospital	Weakley County	$38,195
Methodist Healthcare - Fayette	Fayette County	$35,737
McKenzie Regional Hospital	Carroll County	$34,407
Wayne Medical Center	Wayne County	$32,724
McNairy Regional Hospital	McNairy County	$29,037
Henderson County Community Hospital	Henderson County	$28,381
Haywood Park Community Hospital	Haywood County	$26,979
Baptist Memorial Hospital - Huntingdon	Carroll County	$26,526
Erlanger East Hospital	Hamilton County	$24,153
Gibson General Hospital	Gibson County	$23,949
Johnson City Specialty Hospital	Washington County	$21,465

Hospital Name	County	EAH Third Quarter FY 2012
White County Community Hospital	White County	$20,329
Decatur County General Hospital	Decatur County	$20,029
Emerald Hodgson Hospital	Franklin County	$16,503
TOTAL		$25,000,000

Number of Recipients on TennCare and Costs to the State

At the end of the period January 1, 2012, through March 31, 2012, there were 1,197,824 Medicaid eligibles and 18,825 Demonstration eligibles enrolled in TennCare, for a total of 1,216,649 persons.

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

	3rd Quarter*
Spending on MCO services**	$1,362,869,800
Spending on dental services	$39,930,100
Spending on pharmacy services	$206,927,500
Medicare "clawback"***	$27,522,800

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

Viability of MCCs in the TennCare Program

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

Entity	Standard	Authority
MCOs (non-CHOICES services)	90% of clean claims for payment for services delivered to TennCare enrollees are paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	T.C.A . § 56-32-126(b)
MCOs (CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[11] are processed and paid within 14 calendar days of receipt.	TennCare contract

[11] 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.

Entity	Standard	Authority
	99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[12] are processed and paid within 21 calendar days of receipt.	
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 (i.e., 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 the 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 TennCare Contract. 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.

TDCI's calculations for the net worth requirement reflect payments made for the calendar year ended December 31, 2011. During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) 2011 Annual Financial Statement. As of December 31, 2011, TennCare MCOs reported net worth as indicated in the table below.[13]

[12] Ibid.

[13] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations. AmeriGroup, for instance, operates a Medicare

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
AmeriGroup Tennessee	$17,551,988	$144,193,492	$126,641,504
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$62,651,284	$452,776,017	$390,124,733
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,651,682	$159,450,400	$124,798,718

All TennCare MCOs met their minimum net worth requirements as of December 31, 2011.

Success of Fraud Detection and Prevention

The mission of the 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 web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the third quarter of the 2011 - 2012 fiscal year are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	1,480	138,635
Abuse Cases Received*	1,692	67,107

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

Court Fines & Costs Imposed

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Fines	$33,400.00	$538,342.00
Court Costs & Taxes	$4,623.59	$199,206.49
Court Ordered Restitution	$66,196.77	$1,904,108.74
Drug Funds/Forfeitures	$403.00	$419,107.40

Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, operates solely on TennCare's behalf.

The OIG aggressively pursues enrollees who have apparently committed fraud or abuse against the TennCare program. The primary criminal case types are: prescription drug cases (drug diversion, drug seekers, doctor shopping, and forging prescriptions), reporting a false income, access to other insurance when one is enrolled in an "uninsured" category, and ineligible individuals using a TennCare card.

Arrest Categories

Category	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	16	501
Drug Diversion/Sale RX	23	622
Doctor Shopping	11	212
Access to Insurance	0	55
Operation Falcon III	0	32
Operation Falcon IV	0	16
False Income	1	76
Ineligible Person Using Card	0	20
Living Out Of State	0	19
Asset Diversion	0	7
ID Theft	1	50
Aiding & Abetting	0	5
Failure to Appear in Court	1	3
GRAND TOTAL	**53**	**1,618**

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[14]
Court Ordered Recoupment	$37,403.00	$3,865,724.42[15]
Recommended TennCare Terminations [16]	32	49,487
Potential Savings[17]	$117,004.48	$174,101,913.26

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

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

[16] 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.

[17] Savings are determined by multiplying the number of enrollees whose coverage would be terminated by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).