TennCare Quarterly Report

Submitted to the Members of the General Assembly

April 15, 2013

Status of TennCare Reforms and Improvements

Additional Benefit for Individuals at Risk of Institutional Placement ("Demonstration Amendment 18"). On March 7, 2013, the Bureau of TennCare submitted Demonstration Amendment 18 to the Centers for Medicare and Medicaid Services (CMS). The purpose of Amendment 18 is to expand the availability of Assisted Care Living Facility (or "ACLF") services within CHOICES, TennCare's program of long-term services and supports (LTSS) for individuals who are elderly or physically disabled.

An ACLF is a home-like setting—licensed by the Tennessee Department of Health—in which residents receive an array of services to assist with their activities of daily living. Examples of ACLF services include daily meals, homemaker services (such as sweeping, laundry, and washing dishes), and medication oversight. Currently, the ACLF benefit is available only to members of CHOICES Group 2, the portion of the CHOICES population that meets the medical criteria for placement in a Nursing Facility (NF) but that receives Home and Community Based Services (HCBS) as a safe and cost-effective alternative to institutional care.

Amendment 18 proposes to extend coverage of ACLF services to certain members of CHOICES Group 3, which consists of individuals who, in the absence of HCBS, would be "at risk" for placement in a NF. To ensure that overall LTSS expenditures remain unaffected, moreover, the benefit will be covered only when the cost of ACLF services would not exceed the amount otherwise spent on HCBS for the individual.

Additional information about Amendment 18 may be found on TennCare's website at http://www.tn.gov/tenncare/pol-notice2.shtml.

Co-Payments for Covered Generic Medications ("Demonstration Amendment 19"). On March 25, 2013, the Bureau notified the public of another proposal to be submitted to CMS. Demonstration Amendment 19 would allow a $1.50 co-payment for covered generic medications to be charged to certain groups of TennCare enrollees. This co-payment would not apply to outpatient drugs provided in an emergency situation, family planning services and supplies, and preventive services, and would not

be charged to such categories of enrollees as children in TennCare Medicaid, institutionalized adults, pregnant women, and adults who are receiving hospice services.

The request contained in Amendment 19 is an item recommended by TennCare for inclusion in its Fiscal Year 2014 budget.[1] Although the General Assembly has not yet acted on this recommendation, the Bureau must submit its request to CMS now to be able to implement the provision by October 1. Once the General Assembly has made a decision on the recommendation, the Bureau may amend or withdraw its request to CMS.

TennCare estimates that implementation of Amendment 19 would reduce State expenditures by $2,112,300 (and total expenditures by $6,122,600) during Fiscal Year 2014. The full text of the March 25 notice is available online at http://www.tn.gov/tenncare/pol-notice3.shtml.

Standard Spend Down. The TennCare Standard Spend Down (SSD) eligibility category opened to new enrollment for the sixth time on March 21, 2013 (following previous periods of open enrollment on October 4, 2010, February 22, 2011, September 12, 2011, February 21, 2012, and September 13, 2012). SSD is available through an amendment to the TennCare Waiver[2] 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.

Each open enrollment period for SSD is hosted through a dedicated, toll-free telephone line staffed by representatives of Tennessee's Department of Human Services (DHS). An individual who is interested in enrolling in the program contacts the call center and answers questions designed to ensure that he does not already have TennCare coverage. Callers who are found not to be enrolled are mailed an application that must be completed and returned within 30 days.

On March 21, 2013, DHS received 2,500 calls—the limit established by the State to ensure timely processing of applications—in 45 minutes. Because of a technical problem with the phone system, however, the application limit was raised to include individuals who had not reached a DHS representative but whose phone numbers had nonetheless been automatically recorded by the system. Updated statistics on the number of applications received and the number of individuals enrolled in the SSD program will be included in the next Quarterly Report.

***John B.* Case.** The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that has been the subject of ongoing

[1] See Page 5 of the "Health Care Finance and Administration FY 2014 Budget Presentation" document located on TennCare's website at http://www.tn.gov/tenncare/forms/HCFAbudgetFY14.pdf.

[2] 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.

litigation since 2000. In February 2012, District Judge Thomas A. Wiseman, Jr. ruled in favor of the State by dismissing the case on the grounds that TennCare had successfully established compliance with "all the binding provisions of the Consent Decree."[3] In response, the Plaintiffs filed a Notice of Appeal with the United States Court of Appeals for the Sixth Circuit on March 9, 2012.

A three-judge panel of the Sixth Circuit heard oral arguments on the appeal on October 5, 2012. Plaintiffs and Defendants subsequently filed supplemental briefs on the subject of TennCare's periodicity schedule, a timeline identifying the points in a child enrollee's life when the State must provide health screenings.[4]

On March 14, 2013, the Sixth Circuit issued a unanimous opinion upholding Judge Wiseman's decision to dismiss the *John B.* case. The 27-page ruling examined all of the arguments advanced by the Plaintiffs in their March 2012 appeal and classified each as either a "misstate[ment of] the bases of the [district] court's decision" or "simply meritless."[5] Acknowledging that Judge Wiseman had made one technical error with regard to the number of periodic screens that TennCare should have conducted during the previous year, the mistake was ultimately found to be "harmless" because TennCare had achieved full compliance with relevant federal law.[6] The concluding passage of the decision offered a definitive consideration of all of these matters:

> The district court's handling of this case after our remand last year was exemplary. The court conducted an exhaustive evidentiary hearing, reviewed 345 pages of proposed findings of fact and conclusions of law from the parties, and familiarized itself with thousands of pages of evidence already in the record. And on the basis of all of that evidence, the court found, in a thorough and carefully reasoned opinion, that TennCare had vastly improved its delivery of services to enrollees, and indeed become a national leader in its compliance with the Medicaid statute. The court's conclusions were sound. Its judgment is affirmed.[7]

The full text of the Sixth Circuit's opinion is available online at http://www.ca6.uscourts.gov/opinions.pdf/13a0068p-06.pdf.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as

[3] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.
[4] TennCare's periodicity schedule is available online at http://www.tn.gov/tenncare/tenndercare/screeningsched.shtml.
[5] John B. v. Emkes. U.S. Court of Appeals for the Sixth Circuit. Opinion, page 2. March 14, 2013.
[6] Ibid, page 23.
[7] Ibid, page 27.

its name suggests, is to provide financial incentives to Medicaid providers[8] to replace outdated, often paper-based approaches to medical record-keeping with an electronic system that meets rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

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

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

During the January to March 2013 quarter, first-year and second-year payments made by TennCare were as follows:

Payment Category	Providers Paid During the Quarter	Quarterly Amount Paid	Cumulative Amount Paid
First-year payments	330 providers (151 physicians, 122 nurse practitioners, 45 dentists, 6 hospitals, 4 physician assistants, and 2 certified nurse midwives)	$9,864,032.00	$109,836,694.97
Second-year payments	119 providers (68 physicians, 42 nurse practitioners, and 9 hospitals)	$7,244,664.00	$15,171,033.00

Outreach activities conducted during the quarter included:

- Presentation on February 19 to representatives of the Internal Health Council, a planning group dedicated to health information technology issues with members from a dozen State offices;
- Posting an online video entitled "Three Common Challenges to Achieving State 1 Meaningful Use"—available at http://www.tn.gov/tenncare/mu_prep.shtml—on February 13;

[8] 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).

- Posting an online video entitled "Timelines for the 2011 Cohort"[9]—available at http://www.tn.gov/tenncare/mu_2011timeline.shtml—on March 12;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but not at the state level.

This robust promotion of the EHR program will continue during the April-June 2013 quarter in a variety of venues, including the Fifth Annual CMS Multi-State Medicaid HITECH Conference, monthly meetings of the Internal Health Council, and provider meetings and open houses hosted by TennCare's MCOs.

Request for Proposals for Dental Benefits Management. With less than six months remaining until the contract between TennCare and its current dental benefits manager (DBM) Delta Dental of Tennessee[10] expires on September 30, 2013, the State issued a request for proposals (RFP) for dental administrative and management services on February 1, 2013.

According to the "Scope of Services" portion of the RFP document (available online at http://tn.gov/generalserv/cpo/sourcing_sub/documents/31865-00355.pdf), actual delivery of services would begin on October 1, 2013, but would be preceded by a five-month period of "readiness review." All previous contracts between TennCare and Dental Benefits Managers have been "Administrative Services Only" (or "ASO") contracts. This contract will be a partial risk-bearing contract.

The deadline for submission of a proposal to TennCare is April 2, 2013, and the successful bidder will be revealed on April 16, 2013.

New Chief Medical Officer. On January 28, 2013, Vaughn Frigon, M.D. joined TennCare's Executive Staff in the role of Chief Medical Officer. He fills the position left vacant when Dr. Wendy Long assumed a dual role as TennCare's Deputy Director and Chief of Staff.

Dr. Frigon, who is originally from Virginia, graduated from the United States Military Academy at West Point and served in the United States Army Infantry as a platoon leader during the first Persian Gulf War. After attending medical school at the University of Tennessee's College of Medicine in Memphis, he completed both an Orthopedic Surgery residency at Tulane University, and the Health Care MBA program at Vanderbilt University's Owen Graduate School of Management.

Dr. Frigon is board certified by the American Board of Orthopaedic Surgery and has practiced orthopedics for 12 years. He has also worked as the Lead Medical Director for the Unum Insurance Company in Chattanooga for the last five years. The diversity of his professional experience—military

[9] The "2011 Cohort" refers to the group of eligible professionals who attested to adoption, implementation, or upgrade of certified EHR technology and who earned a first-year incentive payment for Calendar Year 2011.
[10] Delta Dental delivers services to TennCare enrollees under the program name "TennDent."

service, providing care in rural communities with significant Medicaid populations, helping manage a corporate insurance program—should be a valuable asset for TennCare.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the January-March 2013 quarter. Essential Access Hospital payments are payments from a pool of $100 million ($34,220,000 in State dollars) appropriated by the General Assembly and funded by the Enhanced Coverage Fee.

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

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

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Third Quarter FY 2013
Regional Medical Center at Memphis	Shelby County	$3,498,038
Vanderbilt University Hospital	Davidson County	$3,262,097
Erlanger Medical Center	Hamilton County	$2,653,725
University of Tennessee Memorial Hospital	Knox County	$1,444,289
Johnson City Medical Center (with Woodridge)	Washington County	$954,982
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$733,344
LeBonheur Children's Medical Center	Shelby County	$732,329
Metro Nashville General Hospital	Davidson County	$686,869
Jackson – Madison County General Hospital	Madison County	$590,596
East Tennessee Children's Hospital	Knox County	$517,671
Methodist Healthcare – South	Shelby County	$466,418
Methodist Healthcare – Memphis Hospitals	Shelby County	$425,649
Saint Jude Children's Research Hospital	Shelby County	$351,847
Baptist Hospital	Davidson County	$314,078
Parkwest Medical Center (with Peninsula)	Knox County	$312,139
Physicians Regional Medical Center	Knox County	$292,475

Hospital Name	County	EAH Third Quarter FY 2013
University Medical Center (with McFarland)	Wilson County	$280,181
Pathways of Tennessee	Madison County	$270,713
Wellmont Holston Valley Medical Center	Sullivan County	$254,870
Saint Francis Hospital	Shelby County	$249,314
Centennial Medical Center	Davidson County	$242,912
Skyline Medical Center (with Madison Campus)	Davidson County	$237,797
Maury Regional Hospital	Maury County	$234,478
Ridgeview Psychiatric Hospital and Center	Anderson County	$229,287
Methodist Healthcare – North	Shelby County	$222,671
Middle Tennessee Medical Center	Rutherford County	$222,517
Fort Sanders Regional Medical Center	Knox County	$219,407
Delta Medical Center	Shelby County	$217,238
Cookeville Regional Medical Center	Putnam County	$183,838
Skyridge Medical Center	Bradley County	$178,717
Gateway Medical Center	Montgomery County	$176,105
Parkridge East Hospital	Hamilton County	$173,932
Wellmont Bristol Regional Medical Center	Sullivan County	$163,268
Blount Memorial Hospital	Blount County	$160,229
Baptist Memorial Hospital for Women	Shelby County	$143,622
Morristown – Hamblen Healthcare System	Hamblen County	$136,301
Baptist Memorial Hospital – Tipton	Tipton County	$132,539
Sumner Regional Medical Center	Sumner County	$124,081
StoneCrest Medical Center	Rutherford County	$118,037
NorthCrest Medical Center	Robertson County	$114,729
Tennova Healthcare – Newport Medical Center	Cocke County	$110,710
Horizon Medical Center	Dickson County	$110,585
LeConte Medical Center	Sevier County	$109,840
Southern Hills Medical Center	Davidson County	$107,302
Summit Medical Center	Davidson County	$107,033
Tennova Healthcare – LaFollette Medical Center	Campbell County	$103,041
Methodist Medical Center of Oak Ridge	Anderson County	$100,604
Takoma Regional Hospital	Greene County	$92,046
Harton Regional Medical Center	Coffee County	$91,830
Sweetwater Hospital Association	Monroe County	$89,968
Henry County Medical Center	Henry County	$86,169
Baptist Memorial Hospital – Union City	Obion County	$85,339
Dyersburg Regional Medical Center	Dyer County	$83,857
Humboldt General Hospital	Gibson County	$77,962
Wellmont Hawkins County Memorial Hospital	Hawkins County	$77,377
United Regional Medical Center	Coffee County	$76,486

Hospital Name	County	EAH Third Quarter FY 2013
Lakeway Regional Hospital	Hamblen County	$75,474
Jellico Community Hospital	Campbell County	$74,678
Grandview Medical Center	Marion County	$73,041
Skyridge Medical Center – Westside	Bradley County	$72,495
Indian Path Medical Center	Sullivan County	$72,336
Athens Regional Medical Center	McMinn County	$71,119
Heritage Medical Center	Bedford County	$68,896
Regional Hospital of Jackson	Madison County	$65,759
Crockett Hospital	Lawrence County	$62,268
River Park Hospital	Warren County	$62,139
Lincoln Medical Center	Lincoln County	$60,038
Bolivar General Hospital	Hardeman County	$59,954
Southern Tennessee Medical Center	Franklin County	$59,095
Sycamore Shoals Hospital	Carter County	$58,928
Hardin Medical Center	Hardin County	$57,602
Livingston Regional Hospital	Overton County	$51,338
Wayne Medical Center	Wayne County	$50,466
Hillside Hospital	Giles County	$45,330
Roane Medical Center	Roane County	$43,291
Claiborne County Hospital	Claiborne County	$38,162
McKenzie Regional Hospital	Carroll County	$38,001
McNairy Regional Hospital	McNairy County	$34,412
Volunteer Community Hospital	Weakley County	$31,476
Jamestown Regional Medical Center	Fentress County	$30,885
Gibson General Hospital	Gibson County	$28,863
Haywood Park Community Hospital	Haywood County	$28,841
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,915
Henderson County Community Hospital	Henderson County	$23,819
Methodist Healthcare – Fayette	Fayette County	$23,225
DeKalb Community Hospital	DeKalb County	$21,431
Decatur County General Hospital	Decatur County	$20,672
White County Community Hospital	White County	$19,787
Emerald – Hodgson Hospital	Franklin County	$14,786
TOTAL		$25,000,000

Number of Recipients on TennCare and Costs to the State

At the end of the period January 1, 2013, through March 31, 2013, there were 1,185,635 Medicaid eligibles and 20,122 Demonstration eligibles enrolled in TennCare, for a total of 1,205,757 persons.

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

Spending Category	3rd Quarter*
MCO services**	$1,281,707,700
Dental services	$31,531,800
Pharmacy services	$172,458,900
Medicare "clawback"***	$28,209,300

**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 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 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. 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.	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.
[12] 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) 2012 Annual Financial Statements. As of December 31, 2012, TennCare MCOs reported net worth as indicated in the table below.[13]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,328,549	$106,079,845	$88,751,296

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

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,481,178	$441,221,776	$376,740,598
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$217,716,730	$182,077,277

All TennCare MCOs met their minimum net worth requirements as of December 31, 2012.

Success of Fraud Detection and Prevention

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

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	3,311	148,501
Abuse Cases Received*	1,528	71,832

***** *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	$22,670.00	$708,455.00
Court Costs & Taxes	$9,529.45	$224,927.21
Court Ordered Restitution	$66,076.43	$2,131,306.45
Drug Funds/Forfeitures	$2,735.00	$435,548.56

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.

One relatively new development reflected in the "Arrest Categories" table below is OIG's participation in the Drug Enforcement Administration (DEA) Task Force. In March 2013, an OIG Special Agent assigned to the DEA Task Force made 11 felony drug arrests.

Arrest Categories

Category	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	5	528
Drug Diversion/Sale RX	18	720
Doctor Shopping	6	272
Access to Insurance	0	55
Operation FALCON III[14]	0	32
Operation FALCON 2007[15]	0	16
False Income	0	78
Ineligible Person Using Card	0	20
Living Out Of State	1	23
Asset Diversion	0	7
ID Theft	0	63
Aiding & Abetting	0	7
Failure to Appear in Court	0	3
Child Not in the Home	3	13
DEA Task Force	11	13
GRAND TOTAL	**44**	**1,850**

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[16]
Court Ordered Recoupment	$115,214.33	$4,534,879.06[17]
Recommended TennCare Terminations [18]	128	49,885

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

[15] Operation FALCON 2007, which took place from June through September of that year, was the follow-up initiative to Operation FALCON III (described in Footnote 14). Like its predecessor, Operation FALCON 2007 targeted fugitives with open warrants.

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

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

[18] 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.

	Quarter	Grand Total to Date (since February 2005)[16]
Potential Savings[19]	$468,017.92	$175,557,156.64

[19] 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).