TennCare Quarterly Report

Submitted to the Members of the General Assembly

April 2014

Status of TennCare Reforms and Improvements

Commitment Award from the Tennessee Center for Performance Excellence. On February 19, 2014, TennCare Director Darin Gordon attended the Excellence in Tennessee Awards Banquet hosted by the Tennessee Center for Performance Excellence (TNCPE). During the event, Director Gordon accepted TNCPE's "Commitment Award," which recognizes organizations that are "beginning to demonstrate serious commitment to, and implementation of, performance improvement principles." The award was the culmination of a cycle in which TennCare examined its principles, processes, and achievements; summarized them in a 20-page application to TNCPE; and hosted a day-long site visit for a team of examiners who offered the Bureau feedback on its operations.

TNCPE is a nonprofit organization whose stated mission is "to drive organizational excellence in Tennessee."[1] Since 1993, TNCPE has reviewed applications from more than 1,200 organizations across the state, including such government agencies as the Tennessee Department of Health, the Tennessee Department of Environment and Conservation, and the City of Germantown. The support of former Tennessee Governor Ned McWherter was an essential element to the formation of both TNCPE and TennCare in the early 1990s.

Additional information about TennCare's receipt of the Commitment Award is available at http://news.tn.gov/node/11758. TNCPE's website is located at https://www.tncpe.org/index.php.

Proposal Concerning CHOICES Program and Supplemental Pools ("Demonstration Amendment 20"). On December 17, 2013, the Bureau submitted Demonstration Amendment 20 to the Centers for Medicare and Medicaid Services (CMS). Amendment 20 proposed three modifications to the TennCare program:

- Continuing, through June 30, 2015, to offer new enrollment in the At Risk Demonstration Eligibility Category. Without approval by CMS of the changes proposed in Amendment 20, this category would have been closed to new enrollment on December 31, 2013. To be eligible in

[1] See TNCPE's "What We Do" page, located online at https://www.tncpe.org/what_we_do/index.php.

this category, individuals must be adults who are financially eligible for Long-Term Services and Supports (LTSS), who meet the Level of Care criteria for LTSS that existed in Tennessee on June 30, 2012, but not the criteria that went into effect on July 1, 2012, and who are at risk for institutionalization in the absence of Home and Community Based Services (HCBS) that are available to them through the CHOICES Program;

- Expanding the State's Essential Access Hospital (EAH) Pool to address the fact that Tennessee is now the only state in the country without a Disproportionate Share Hospital (DSH) allotment specified in federal statute. Under Amendment 20, funds previously associated with DSH payments in Tennessee would be added to the EAH Pool; and
- Increasing the State's Public Hospital Supplemental Payment (PHSP) Pool and adding Erlanger Medical Center in Chattanooga to the list of hospitals eligible for these special payments.

Following CMS's approval on December 30, 2013, of the component of Amendment 20 concerning the At Risk Demonstration Eligibility Category, negotiations on the components pertaining to the EAH Pool and the PHSP Pool were conducted throughout the January-March 2014 quarter. CMS issued written approval of the remaining provisions of Amendment 20 on March 28, 2014. As of this writing, the state is in discussions with CMS regarding the exact wording of the revised Special Terms and Conditions of the TennCare Demonstration agreement.

Possible Changes to TennCare Benefits ("Demonstration Amendment 21"). On January 27, 2014, TennCare submitted Demonstration Amendment 21 to CMS. Amendment 21 repeats several changes proposed in each of the last four years that 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 adults that would be necessary if the fee were not renewed in 2014 are as follows:

- Elimination of physical therapy, speech therapy, and occupational therapy for all adults
- Benefit limits on certain hospital services, lab and X-ray services, and health practitioners' office visits for non-pregnant adults and non-institutionalized adults

As of the end of the January-March 2014 quarter, negotiations between the State and CMS on Amendment 21 had not commenced. If the General Assembly extends the fee for State Fiscal Year 2014-2015 by passing House Bill 1950 / Senate Bill 1908, then the Bureau will withdraw Amendment 21.

Managed Care Organization (MCO) Contracts. After issuing a Request for Proposals (RFP) for three MCOs to furnish managed care services to the TennCare population, the Bureau announced on December 16, 2013, that successful bids had been submitted by Amerigroup, BlueCare, and UnitedHealthcare, the companies already comprising TennCare's managed care network. The new contracts, which became effective on January 1, 2014, require delivery of physical health services,

behavioral health services, and Long-Term Services and Supports (LTSS) in all three of Tennessee's grand regions. Each of the previous contracts, by contrast, was limited to only one grand region. [2]

During the January-March 2014 quarter, TennCare began work with each contractor to ensure a seamless transition to the statewide service delivery model scheduled for implementation on January 1, 2015. Although a phased-in approach had originally been envisioned (with implementation in Middle Tennessee on January 1, 2015, and in East and West Tennessee later that calendar year), the MCOs' level of preparedness indicated that delivery of services could begin in all three grand regions simultaneously. In addition, the Bureau and the MCOs are coordinating their efforts to minimize the impact of the transition on enrollees: preliminary estimates are that only one-third of the enrollee population will be reassigned from one health plan to another.

"Flat File" Option. Since January 1, 2014, the Federally-Facilitated Marketplace (FFM) has been conducting eligibility determinations for the MAGI categories of Medicaid and CoverKids in Tennessee. (MAGI categories are those Medicaid categories for which financial eligibility is determined according to a new methodology set out in the Affordable Care Act called "MAGI," for Modified Adjusted Gross Income. Most Medicaid categories are MAGI categories.) The FFM reports to the state on individuals whom it has found eligible for Medicaid or CoverKids, and the state enrolls these persons accordingly. For several months now, the federal government has been transmitting applicant information to the states through a mechanism called "Account Transfers (ATs)" which are intended to provide information on a near-real time basis. Because the AT transmissions from the FFM to states were not ready to be implemented by January 1st, the federal government requested that states use AT flat files, which are static weekly data transmittals, to enroll persons whom the FFM has determined to be eligible. Tennessee has accepted this option, and received approval to implement a "flat file option" to be able to use data from the flat files to enroll persons in TennCare and CoverKids.

Extension of the Eligibility Renewal Process. In 2013 CMS sent out a letter (SHO #13-003) offering certain options to State Medicaid agencies in order for them to implement targeted enrollment strategies to facilitate Medicaid and CHIP enrollment and renewal in 2014. Five specific strategies were proposed and discussed in detail.

By far the most popular strategy among states has been Strategy 2, "Delayed Renewals and Date of Completion." Implementation of this strategy would relieve the state from having to operate two sets of eligibility rules during a period of time and would, instead, allow the state to process renewals on an alternative schedule. As of March 5, 2014, 35 states had received approval to implement this strategy, with more requests pending. TennCare has elected to pursue Strategy 2 and is awaiting approval.

[2] Under the previous arrangement, a single entity could hold more than one contract. BlueCare, for instance, had managed care contracts in East and West Tennessee. Amerigroup, by contrast, held a managed care contract only in Middle Tennessee.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[3] to replace outdated, often paper-based approaches to medical record-keeping with electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

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

- First-year payments to providers who either adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards, or who achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who subsequently achieved meaningful use of certified EHR technology for any period of 90 consecutive days;
- Third-year payments to providers who continue to demonstrate meaningful use of certified EHR technology.

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

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2014)	Cumulative Amount Paid to Date
First-year payments	125 providers[4] (54 nurse practitioners, 50 physicians, 13 dentists, 7 certified nurse midwives, and 1 physician assistant)	$2,656,250	$135,125,690[5]
Second-year payments	185 providers (112 physicians, 56 nurse practitioners, and 17	$8,815,266	$36,008,454

[3] 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).

[4] Of the 125 providers receiving first-year payments in the January-March 2014 quarter, 4 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

[5] TennCare's previous Quarterly Report to the General Assembly identified the cumulative total of first-year EHR payments as $132,790,952. This total was subsequently revised to $132,469,440 based on corrections made by Maximus, the company with which TennCare contracts to maintain its Provider Incentive Payment Program system.

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Jan-Mar 2014)	Cumulative Amount Paid to Date
	hospitals)		
Third-year payments	60 providers (44 physicians, 14 nurse practitioners, 1 certified nurse midwife, and 1 hospital)	$704,531	$704,531

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

- Participation throughout the quarter in five Southeast Regional Collaboration for HIT/HIE (SERCH) calls, in which government officials from 11 states pool knowledge and resources to address areas of common concern within the field of Health Information Technology;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use;
- Hosting a Meaningful Use webinar on January 27;
- Attending a demonstration on March 11 of the Immunization Registry electronic transmissions system at Vanderbilt University Medical Center, an application that allows Vanderbilt clinics to exchange information related to routine immunizations with the Tennessee Department of Health;
- Conducting a conference call on March 12 to aid a children's hospital with Meaningful Use attestation;
- Meeting with tnREC (Tennessee's regional extension center for health information technology) on March 27 to improve alignment between the information that providers include in their attestations and the requirements of the EHR program;
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but who have not registered or attested at the state level.

Several projects are being planned for—or are culminating in—the upcoming months. Workshops for providers throughout the state, for instance, are being arranged for the April-June 2014 quarter. In addition, TennCare will submit an annual report of EHR incentive activity to CMS by the conclusion of April, the same month in which a semi-automated tool for evaluating Stage 2 Meaningful Use attestations is expected to be finalized.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the January-March 2014 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, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the third quarter of State Fiscal Year 2014 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 2014
Vanderbilt University Hospital	Davidson County	$3,275,631
Regional Medical Center at Memphis	Shelby County	$3,072,008
Erlanger Medical Center	Hamilton County	$2,618,413
University of Tennessee Memorial Hospital	Knox County	$1,498,746
Johnson City Medical Center (with Woodridge)	Washington County	$1,259,775
Metro Nashville General Hospital	Davidson County	$775,427
LeBonheur Children's Medical Center	Shelby County	$715,777
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$653,989
East Tennessee Children's Hospital	Knox County	$534,223
Jackson – Madison County General Hospital	Madison County	$528,354
Methodist Healthcare – South	Shelby County	$443,711
Methodist Healthcare – Memphis Hospitals	Shelby County	$413,340
Saint Jude Children's Research Hospital	Shelby County	$408,108
University Medical Center (with McFarland)	Wilson County	$389,627
Saint Thomas Midtown Hospital	Davidson County	$381,325
Centennial Medical Center	Davidson County	$288,040
Physicians Regional Medical Center	Knox County	$284,354
Methodist Healthcare – North	Shelby County	$274,578
Skyline Medical Center (with Madison Campus)	Davidson County	$266,243
Saint Francis Hospital	Shelby County	$246,950
Saint Thomas Rutherford Hospital	Rutherford County	$244,441

Hospital Name	County	EAH Third Quarter FY 2014
Parkwest Medical Center (with Peninsula)	Knox County	$240,097
Wellmont Holston Valley Medical Center	Sullivan County	$235,084
Maury Regional Hospital	Maury County	$228,572
Fort Sanders Regional Medical Center	Knox County	$210,243
Pathways of Tennessee	Madison County	$206,684
Skyridge Medical Center	Bradley County	$190,095
Ridgeview Psychiatric Hospital and Center	Anderson County	$186,980
Gateway Medical Center	Montgomery County	$173,333
Cookeville Regional Medical Center	Putnam County	$172,102
Delta Medical Center	Shelby County	$167,817
Parkridge East Hospital	Hamilton County	$162,909
Methodist Hospital – Germantown	Shelby County	$161,496
Blount Memorial Hospital	Blount County	$151,337
Wellmont Bristol Regional Medical Center	Sullivan County	$149,288
Baptist Memorial Hospital for Women	Shelby County	$143,694
Haywood Park Community Hospital	Haywood County	$139,898
NorthCrest Medical Center	Robertson County	$132,607
Southern Hills Medical Center	Davidson County	$116,743
LeConte Medical Center	Sevier County	$114,442
Horizon Medical Center	Dickson County	$113,659
Sumner Regional Medical Center	Sumner County	$111,091
Tennova Healthcare – Newport Medical Center	Cocke County	$107,325
Rolling Hills Hospital	Williamson County	$106,336
Takoma Regional Hospital	Greene County	$101,875
Methodist Medical Center of Oak Ridge	Anderson County	$100,374
Heritage Medical Center	Bedford County	$100,115
Baptist Memorial Hospital – Tipton	Tipton County	$96,590
StoneCrest Medical Center	Rutherford County	$96,173
Summit Medical Center	Davidson County	$95,154
Tennova Healthcare – LaFollette Medical Center	Campbell County	$95,007
Dyersburg Regional Medical Center	Dyer County	$91,340
Morristown – Hamblen Healthcare System	Hamblen County	$90,703
Henry County Medical Center	Henry County	$88,269
Sweetwater Hospital Association	Monroe County	$75,388
Sycamore Shoals Hospital	Carter County	$74,430
Harton Regional Medical Center	Coffee County	$72,489
Grandview Medical Center	Marion County	$70,389
Indian Path Medical Center	Sullivan County	$69,889
Humboldt General Hospital	Gibson County	$69,722
Regional Hospital of Jackson	Madison County	$67,394
Baptist Memorial Hospital – Union City	Obion County	$64,853

Hospital Name	County	EAH Third Quarter FY 2014
Lakeway Regional Hospital	Hamblen County	$63,581
Jellico Community Hospital	Campbell County	$63,061
Wellmont Hawkins County Memorial Hospital	Hawkins County	$62,662
Hardin Medical Center	Hardin County	$57,850
Crockett Hospital	Lawrence County	$57,727
Athens Regional Medical Center	McMinn County	$56,895
River Park Hospital	Warren County	$56,164
Southern Tennessee Medical Center	Franklin County	$54,845
Livingston Regional Hospital	Overton County	$54,382
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$52,578
Henderson County Community Hospital	Henderson County	$43,890
McNairy Regional Hospital	McNairy County	$42,263
Roane Medical Center	Roane County	$42,150
Skyridge Medical Center – Westside	Bradley County	$41,596
Bolivar General Hospital	Hardeman County	$36,846
McKenzie Regional Hospital	Carroll County	$36,658
Claiborne County Hospital	Claiborne County	$36,244
Hillside Hospital	Giles County	$35,736
Volunteer Community Hospital	Weakley County	$33,058
Gibson General Hospital	Gibson County	$32,282
United Regional Medical Center	Coffee County	$32,045
Jamestown Regional Medical Center	Fentress County	$30,327
Wayne Medical Center	Wayne County	$28,309
Methodist Healthcare – Fayette	Fayette County	$28,166
Erlanger Health System – East Campus	Hamilton County	$27,381
DeKalb Community Hospital	DeKalb County	$25,765
Baptist Memorial Hospital – Huntingdon	Carroll County	$20,365
White County Community Hospital	White County	$16,800
Emerald – Hodgson Hospital	Franklin County	$15,328
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of March 2014, there were 1,211,320 Medicaid eligibles and 19,488 Demonstration eligibles enrolled in TennCare, for a total of 1,230,808 persons.

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

Spending Category	3rd Quarter*
MCO services**	$966,070,400
Dental services	$27,220,400
Pharmacy services	$214,630,000
Medicare "clawback"***	$27,842,600

**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[6] 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[7] are processed and paid within 21 calendar days of receipt.	TennCare contract

[6] 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.

[7] 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 2013 National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of December 31, 2013, TennCare MCOs reported net worth as indicated in the table below.[8]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$108,075,136	$90,524,144

[8] 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, conducts only TennCare business.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,885,278	$513,401,130	$448,515,852
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$256,869,320	$221,927,282

All TennCare MCOs met their minimum net worth requirements as of December 31, 2013.

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 Fiscal Year 2014 are as follows:

TennCare Fraud & Abuse: Cases Received[9]

	Quarter
TennCare Fraud Cases	3,147
TennCare Abuse Cases*	2,995

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

Criminal Court: Fines & Costs Imposed

	Quarter
Court Fines	$20,550
Court Costs & Taxes	$6,041
Court Ordered Restitution	$68,354 (a 116% increase from last quarter)
Drug Funds/Forfeitures	$4,094

[9] The substantial rise in the number of fraud cases (a 24% increase) and abuse cases (a 273% increase) received during the January-March 2014 quarter coincides with a variety of networking and outreach efforts initiated by the OIG, including the letters to law enforcement described below, distribution of electronic and paper posters throughout the state, and collaboration with the Tennessee Department of Human Services on cases involving food stamp fraud.

The OIG aggressively pursues enrollees who have 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), child not in the home, reporting a false income, access to other insurance when one is enrolled in an "uninsured" category, and ineligible individuals using a TennCare card. The 50 individuals arrested during the January-March 2014 quarter were charged with a total of 169 criminal counts via Grand Jury indictments.

Arrest Totals

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Individuals Arrested	50	2,076
Criminal Counts / Charges	169	6,527

OIG Case Recoupment & Civil Court Judgments

	Quarter
Consent Orders & Civil Judgments[10]	$205,077

Recommendations for Review

	Quarter
Recommended TennCare Terminations[11]	19
Potential Savings[12]	$69,471

During the January-March 2014 quarter, the OIG had two Special Agents working with the Social Security Administration's (SSA's) Cooperative Disability Investigations (CDI) Unit. CDI's mission is to combat fraud by investigating questionable statements and activities of claimants, medical providers, interpreters, or other service providers who facilitate or promote disability fraud at the state and/or federal level. The work of the CDI Unit supports the strategic goal of ensuring the integrity of Social Security programs with a zero tolerance for fraud and abuse. This work ties in closely with the OIG's mission of stopping TennCare fraud. In February, the two OIG Special Agents received a commendation and plaque for the OIG CDI Case of the Month Award based on "an outstanding case that is a tribute to your excellent work in preventing SSA fraud, waste, and abuse."

[10] 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.

[11] Recommendations that enrollees' TennCare coverage should be terminated are sent to the TennCare Bureau for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. The Bureau determines whether these referrals meet the criteria for termination.

[12] Savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).

OIG/CDI Unit Statistics

	Quarter
Allegations Received	38
Cases Opened	29
Cases Closed	25
Claims Denied or Ceased	27
SSA Savings	$2,364,848
Non-SSA Savings	$1,767,188
Total Savings	$4,132,036

In a continuing effort to remain connected with local law enforcement and thereby aid the OIG's mission of stopping TennCare fraud, letters were mailed to every police chief, sheriff, and judicial drug task force in Tennessee during the quarter. Each letter (more than 400 of which were sent) provided the name and telephone number of the OIG Special Agent assigned to the law enforcement agency's county, and highlighted the cooperation, partnership, and support between the OIG and local law enforcement in combatting TennCare fraud (prescription drug diversion and doctor shopping, in particular).