TennCare Quarterly Report

Submitted to the Members of the General Assembly

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Status of TennCare Reforms and Improvements

Insure Tennessee. On December 15, 2014, Governor Haslam announced the Insure Tennessee plan, a two-year pilot program to provide health care coverage to Tennesseans who currently lack access to health insurance or who have limited options in that regard. The program is designed to reward healthy behaviors, prepare members to transition to private coverage, promote personal responsibility, and incentivize choosing preventative and routine care instead of unnecessary use of emergency rooms. The Insure Tennessee plan evolved from Governor Haslam's announcement in March 2013 that he would not expand the traditional Medicaid program but that he would work with the federal government on an alternative plan for Tennessee that would take into consideration program cost, patient engagement, payment reform, and health outcomes.

On January 8, 2015, Governor Haslam issued a proclamation convening a special session of the General Assembly to consider a joint resolution on Insure Tennessee. The session began on February 2 with the governor outlining his proposal to a joint convention of the Senate and the House of Representatives. Following hearings on Insure Tennessee over the next two days, the Tennessee Senate Health and Welfare Committee effectively ended the special session on February 4 by voting 7-4 against Insure Tennessee.

Several weeks after this development, Insure Tennessee was temporarily revived in the regular session of the 109th General Assembly. Senate Joint Resolution 93, which "authorizes the Governor to do all that is necessary to implement Insure Tennessee," passed the Senate Health and Welfare Committee by a 6-2-1 vote on March 25. On March 31, however, the Senate Commerce and Labor Committee defeated the measure by a 6-2-1 vote.

Wilson v. Gordon. *Wilson v. Gordon* is a class action lawsuit filed against the Bureau of TennCare by the Tennessee Justice Center, the Southern Poverty Law Center, and the National Health Law Program. The suit alleges a variety of flaws in the enrollment process TennCare has been using since January 1, 2014.

Currently, two separate courts are hearing arguments in the case. The first is the U.S. District Court for the Middle District of Tennessee, where Plaintiffs originally filed suit in July 2014. The District Court

granted class action status to the case and issued a preliminary injunction requiring the Defendants (specifically, TennCare) to provide an opportunity for a fair hearing on any delayed adjudications of applications for TennCare coverage. TennCare took immediate action to comply with these rulings but also filed an appeal with a second court, the U.S. Court of Appeals for the Sixth Circuit in Cincinnati.

The Defendants filed a motion at the District Court level on February 25, 2015, requesting that the process of discovery in *Wilson v. Gordon* be suspended until the case had been adjudicated by the Court of Appeals. The basis for this request was that any resources devoted to discovery would be wasted if the Court of Appeals ultimately dismissed the matter altogether. The District Court denied this request on March 20, 2015, but did encourage the parties to prioritize discovery requests in such a way as not to interfere with TennCare's efforts to adjudicate applications in a timely manner.

Tennessee Eligibility Determination System. On January 12, 2015, TennCare announced plans to select a new vendor for the continued development of the Tennessee Eligibility Determination System (TEDS). The purpose of TEDS is to review applications for health care assistance and identify which persons are eligible for an "insurance affordability program," meaning TennCare, CoverKids, or subsidized insurance under the Health Insurance Marketplace.

After months of delays and missed benchmarks, the State had decided in 2014 to hire an independent international consulting firm, KPMG LLP, to perform an assessment of TEDS. The assessment was to provide—

- A review of progress to date by then-vendor Northrop Grumman Systems Corporation;
- Identification of project deficiencies;
- Determination of potential risks to the TennCare program; and
- Options for resuming development of the TEDS project and leading it to a successful outcome.

In late 2014, KPMG LLP released a comprehensive report to the State. As a result of the detailed findings within the report, TennCare and Northrop Grumman mutually decided it to be in their respective best interests to terminate their contract early. The State will move forward with the process for selecting a new vendor.

Statewide Managed Care Organizations (MCOs). On January 1, 2015, following months of intensive preparations, TennCare MCOs Amerigroup, BlueCare, and UnitedHealthcare began delivering physical health services, behavioral health services, and Long-Term Services and Supports (LTSS)[1] to enrollees in all three of Tennessee's grand regions. Previously, only two MCOs had operated in each grand region, and only UnitedHealthcare had served all three regions.

[1] It should be noted that there is more than one type of LTSS program. LTSS programs serving persons who are elderly or who have physical disabilities are included in the menu of services offered by the MCOs. LTSS programs serving persons who have intellectual or developmental disabilities are operated outside the TennCare Demonstration, although the persons who receive these services are also members of TennCare and receive their physical health and behavioral health services through the MCOs.

Coinciding with this January 1 implementation date was the transfer of approximately 411,000 TennCare members to different health plans to ensure a more even distribution of enrollment among the three statewide MCOs. Two enrollee notices mailed during the previous quarter aided this transition.

- The first notice was directed to affected members of CHOICES, TennCare's program of long-term services and supports (LTSS) for individuals who are elderly or who have physical disabilities. The letter alerted recipients to the impending transfer, so that each recipient's new MCO could introduce itself and provide assurances that plans of care would be transitioned smoothly.
- The second notice was directed to all affected enrollees and provided instructions for remaining with their current MCO if preferred. In addition, individuals who had transferred to new health plans on January 1 retained the option of returning to their former MCOs as long as their requests had been received by February 14, 2015. Approximately 15 percent of members affected by the transfer decided to remain with—or return to—their original plans.

Preliminary reports indicate that the first quarter of the statewide service delivery model has been successful. TennCare monitored the rollout carefully and found that access to services had not been interrupted and, in particular, that critical care patients continued to receive needed care.

As of the end of the January-March 2015 quarter, both the Bureau and the MCOs were preparing for a second round of enrollee transfers on April 1, 2015. Approximately 6,900 enrollees (CHOICES members only) were scheduled to be transitioned to new plans during this second implementation phase, and TennCare mailed each affected individual the two notice letters well before the conclusion of the January-March 2015 quarter.

Demonstration Amendment 24: CHOICES Services. On March 4, 2015, TennCare submitted Demonstration Amendment 24 to the Centers for Medicare and Medicaid Services (CMS).[2] Amendment 24 would add two community-based residential alternative services to the menu of benefits covered by CHOICES. Both of the services in question—"community living supports" (CLS) and "community living supports-family model" (CLS-FM, an "adult foster care" arrangement)—are alternatives to Nursing Facility care: each provides access to services and supports in a small shared residential setting, allowing the individual to reside in the community. Delivery of CLS and CLS-FM would adhere to recently enacted federal regulations governing the provision of home and community-based services (HCBS) and HCBS settings. The proposal, which would take effect on July 1, 2015, is not projected to increase program expenditures: coverage is conditioned on a determination that provision of CLS or CLS-FM would not cost more than provision of other forms of CHOICES HCBS that the person would otherwise receive.

To date, discussions between CMS and TennCare on Amendment 24 have focused on points of clarification, such as the Bureau's plans for ensuring providers' compliance with relevant federal

[2] TennCare had previously notified the Tennessee General Assembly of Amendment 24 in a letter dated July 28, 2014.

regulations and the capability of existing provider networks to deliver such services throughout the state.

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 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 the following types of payments:

- First-year payments to providers (eligible hospitals or practitioners) who either—
  - Adopt, implement, or upgrade to certified EHR technology capable of meeting "meaningful use" in accordance with CMS standards, or
  - Achieve meaningful use of certified EHR technology for any period of 90 consecutive days;
- Second-year payments to providers who have received first-year payments and who achieved meaningful use for a subsequent period of 90 consecutive days;
- Third-year and fourth-year payments to providers who continue to demonstrate meaningful use.

EHR payments made by TennCare during the January-March 2015 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 2015)	Cumulative Amount Paid to Date
First-year payments	122[4]	$2,585,417	$150,636,919
Second-year payments	34	$1,952,672	$47,999,894
Third-year payments	69	$3,665,234	$8,808,717
Fourth-year payments	31	$263,500	$331,500

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

[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 122 providers receiving first-year payments in the January-March 2015 quarter, 7 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

- Expansion of the contract with Qsource (TennCare's External Quality Review Organization) to assist Tennessee providers with the attestation process;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use (with particular emphasis on the EHR final rule that took effect on October 1, 2014);
- 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.

TennCare continues to schedule EHR workshops with a variety of provider organizations to maintain the momentum of the program.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make EAH payments during the January-March 2015 quarter. EAH payments are made from a pool of $100 million ($34,935,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

The methodology for distributing these funds, as outlined in Special Term and Condition 55.e. of the TennCare Demonstration Agreement with CMS, specifically considers each hospital's relative contribution to providing services to TennCare members, while also acknowledging differences in payer mix and hospitals' relative ability to make up TennCare losses. Data from the Hospital Joint Annual Report is used to determine hospitals' eligibility for these payments. Eligibility is determined each quarter based on each hospital's participation in TennCare. In order to receive a payment for the quarter, a hospital must be a contracted provider with TennCare Select and at least one other Managed Care Organization (MCO), and it must have contracted with TennCare Select for the entire quarter that the payment represents. Excluded from the Essential Access Hospital payments are Critical Access Hospitals, which receive cost-based reimbursement from the TennCare program and, therefore, are not included, and the four State mental health institutes.

The Essential Access Hospital payments made during the third quarter of State Fiscal Year 2015 for dates of service during the first quarter are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Third Quarter FY 2015
Regional Medical Center at Memphis	Shelby County	$3,363,349
Vanderbilt University Hospital	Davidson County	$3,180,780
Erlanger Medical Center	Hamilton County	$2,696,914
University of Tennessee Memorial Hospital	Knox County	$1,447,794

Hospital Name	County	EAH Third Quarter FY 2015
Johnson City Medical Center (with Woodridge)	Washington County	$1,211,056
LeBonheur Children's Medical Center	Shelby County	$711,392
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$685,692
Metro Nashville General Hospital	Davidson County	$600,107
Jackson – Madison County General Hospital	Madison County	$544,865
East Tennessee Children's Hospital	Knox County	$538,608
Methodist Healthcare – Memphis Hospitals	Shelby County	$512,194
Methodist Healthcare – South	Shelby County	$491,779
Saint Jude Children's Research Hospital	Shelby County	$418,401
University Medical Center (with McFarland)	Wilson County	$386,219
Saint Thomas Midtown Hospital	Davidson County	$354,633
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$337,620
Wellmont – Holston Valley Medical Center	Sullivan County	$304,628
Fort Sanders Regional Medical Center	Knox County	$295,845
TriStar Centennial Medical Center	Davidson County	$271,774
Methodist Healthcare – North	Shelby County	$252,993
Saint Francis Hospital	Shelby County	$245,583
Parkridge East Hospital	Hamilton County	$229,905
Maury Regional Hospital	Maury County	$229,095
Parkwest Medical Center (with Peninsula)	Knox County	$223,563
Saint Thomas Rutherford Hospital	Rutherford County	$223,544
Pathways of Tennessee	Madison County	$216,560
Wellmont – Bristol Regional Medical Center	Sullivan County	$210,363
Cookeville Regional Medical Center	Putnam County	$193,927
Ridgeview Psychiatric Hospital and Center	Anderson County	$193,264
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$190,561
Methodist Hospital – Germantown	Shelby County	$173,815
Baptist Memorial Hospital for Women	Shelby County	$152,067
Skyridge Medical Center	Bradley County	$141,438
Blount Memorial Hospital	Blount County	$132,992
Gateway Medical Center	Montgomery County	$131,343
TriStar Horizon Medical Center	Dickson County	$129,330
TriStar StoneCrest Medical Center	Rutherford County	$121,218
TriStar Summit Medical Center	Davidson County	$119,956
NorthCrest Medical Center	Robertson County	$119,695
Delta Medical Center	Shelby County	$118,885
Dyersburg Regional Medical Center	Dyer County	$115,956
LeConte Medical Center	Sevier County	$114,173
Morristown – Hamblen Healthcare System	Hamblen County	$112,771

Hospital Name	County	EAH Third Quarter FY 2015
Southern Hills Medical Center	Davidson County	$111,391
Heritage Medical Center	Bedford County	$108,754
Sumner Regional Medical Center	Sumner County	$103,737
Takoma Regional Hospital	Greene County	$97,836
Tennova Healthcare – Newport Medical Center	Cocke County	$93,176
Sweetwater Hospital Association	Monroe County	$91,956
Laughlin Memorial Hospital	Greene County	$91,479
Rolling Hills Hospital	Williamson County	$90,176
Methodist Medical Center of Oak Ridge	Anderson County	$88,338
TriStar Hendersonville Medical Center	Sumner County	$83,295
Harton Regional Medical Center	Coffee County	$82,121
Henry County Medical Center	Henry County	$81,213
Tennova Healthcare – LaFollette Medical Center	Campbell County	$79,464
Grandview Medical Center	Marion County	$77,896
Sycamore Shoals Hospital	Carter County	$76,450
Skyridge Medical Center – Westside	Bradley County	$75,175
Regional Hospital of Jackson	Madison County	$73,517
Baptist Memorial Hospital – Union City	Obion County	$71,593
Lakeway Regional Hospital	Hamblen County	$71,137
Indian Path Medical Center	Sullivan County	$63,145
Wellmont Hawkins County Memorial Hospital	Hawkins County	$60,414
Jellico Community Hospital	Campbell County	$60,374
Hardin Medical Center	Hardin County	$59,218
McNairy Regional Hospital	McNairy County	$58,295
Starr Regional Medical Center – Athens	McMinn County	$57,601
River Park Hospital	Warren County	$54,627
Henderson County Community Hospital	Henderson County	$47,038
Roane Medical Center	Roane County	$43,761
United Regional Medical Center	Coffee County	$41,758
Hillside Hospital	Giles County	$40,078
Crockett Hospital	Lawrence County	$39,881
Livingston Regional Hospital	Overton County	$37,328
McKenzie Regional Hospital	Carroll County	$35,632
Volunteer Community Hospital	Weakley County	$33,418
Bolivar General Hospital	Hardeman County	$31,042
Wayne Medical Center	Wayne County	$30,080
Erlanger Health System – East Campus	Hamilton County	$27,308
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,164
DeKalb Community Hospital	DeKalb County	$24,236
Methodist Healthcare – Fayette	Fayette County	$22,142
Emerald Hodgson Hospital	Franklin County	$10,109
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of March 2015, there were 1,368,953 Medicaid eligibles and 19,176 Demonstration eligibles enrolled in TennCare, for a total of 1,388,129 persons.

Estimates of TennCare spending for the third quarter of State Fiscal Year 2015 are summarized in the table below.

Spending Category	3rd Quarter*
MCO services**	$1,493,823,900
Dental services	$43,467,500
Pharmacy services	$277,895,900
Medicare "clawback"***	$57,173,000

**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 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.	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[5] 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[6] are processed and paid within 21 calendar days of receipt.	TennCare contract

[5] 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.

[6] 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 Tennessee region (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 Tennessee region, 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. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the January-March 2015 quarter, the MCOs submitted their 2014 National Association of Insurance Commissioners (NAIC) Annual Financial Statements. As of December 31, 2014, TennCare MCOs reported net worth as indicated in the table below.[7]

[7] 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 and Volunteer State Health Plan, for instance, operate Medicare Advantage Plans, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$18,895,648	$156,552,359	$137,656,711
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$67,602,074	$600,328,649	$532,726,575
Volunteer State Health Plan (BlueCare & TennCare Select)	$37,185,058	$330,054,375	$292,869,317

For the January-March 2015 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

The following table compares the MCOs' net worth to the Company Action Level requirements as of December 31, 2014:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$61,407,788	$156,552,359	$95,144,571
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$244,098,654	$600,328,649	$356,229,995
Volunteer State Health Plan (BlueCare & TennCare Select)	$109,546,612	$330,054,375	$220,507,763

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of December 31, 2014.

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. Selected statistics for the third quarter of Fiscal Year 2015 are as follows:

TennCare Fraud & Abuse: Cases Received

	Quarter
TennCare Fraud Cases	2,047
TennCare Abuse Cases*	1,371

***** *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	$26,800
Court Costs & Taxes	$2,692
Court Ordered Restitution	$19,010
Court Ordered Restitution Received[8]	$18,014
Drug Funds/Forfeitures	$696

The OIG aggressively pursues enrollees who have committed fraud against the TennCare program. The primary criminal case types investigated are: (1) prescription medication cases (illegal sale of prescription medication, drug seekers, doctor shopping, and forging prescriptions), (2) gaining TennCare eligibility by claiming a child who does not actually live in the home, (3) receiving TennCare benefits while living outside Tennessee, (4) fraudulent reporting of income, (5) fraudulent reporting of resources, and (6) ineligible individuals using TennCare recipients' benefits.

Arrest Totals

	Quarter	FY 15 to Date
Individuals Arrested	67	184

OIG Case Recoupment & Civil Court Judgments

	Quarter
Consent Orders & Civil Judgments[9]	$18,371
Recoupments Received[10]	$14,722

[8] Restitution may have been ordered in a quarter earlier than the quarter in which payment was actually received.

[9] 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.

[10] A recoupment may be received in a quarter other than the one in which it is ordered.

Recommendations for Review

	Quarter
Recommended TennCare Terminations[11]	338
Potential Savings[12]	$1,235,860

During the January-March 2015 quarter, two OIG Special Agents partnered with the Social Security Administration's Cooperative Disability Investigations (CDI) Unit. This Unit'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 federal levels. The work of the CDI Unit supports the strategic goal of ensuring the integrity of Social Security programs with zero tolerance for fraud and abuse. This work ties in closely with OIG's mission of stopping TennCare fraud.

OIG/CDI Unit Statistics

	Quarter
Allegations Received	49
Cases Opened	34
Cases Closed	29
SSA Savings	$1,011,354
Medicaid/Medicare Savings	$1,568,718
Total Savings	$2,580,072

The January-March 2015 quarter furnished OIG other opportunities for statewide collaboration as well. Inspector General Manny Tyndall was appointed to Governor Haslam's Public Safety Subcabinet Working Group in January. In the same month, OIG began assisting the Tennessee Attorney General's Office with civil investigations related to medical providers alleged to have defrauded the TennCare program.

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

[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).