TennCare Quarterly Report

January – March 2018

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Amendments to the TennCare Demonstration. Three proposed amendments to the TennCare Demonstration were in various stages of development during the January-March 2018 quarter.

Demonstration Amendment 32: Medication Therapy Management. In September 2017, the Division of TennCare submitted a demonstration amendment to the Centers for Medicare and Medicaid Services (CMS) to establish a two-year pilot program in which certain TennCare enrollees will receive medication therapy management (MTM) services. MTM is a clinical service provided by licensed pharmacists, the aim of which is to optimize drug therapy and improve therapeutic outcomes for patients. Amendment 32 proposed to make MTM available to TennCare members enrolled in TennCare's health home program (Tennessee Health Link), and to members whose primary care providers participate in TennCare's patient-centered medical home (PCMH) program. The MTM pilot program would implement legislation enacted by the 110th General Assembly.

On February 1, 2018, TennCare received CMS approval of Amendment 32. (The approval letter and the revised Special Terms and Conditions (STCs) governing the TennCare Demonstration are available online at https://www.tn.gov/content/dam/tn/tenncare/documents/tenncarewaiver.pdf.) Based on CMS' approval of Amendment 32, TennCare has proceeded with implementing the MTM program and has been enrolling pharmacists to provide MTM services. These pharmacy providers will work as part of the extended care teams within the Tennessee Health Link and PCMH initiatives, engaging members to actively manage their drug therapy by identifying, preventing, and resolving medication-related problems. During the pilot, the pharmacists providing MTM services to TennCare enrollees will be particularly focused on providing their expertise to patients with the highest levels of clinical risk.

Demonstration Amendment 33: Supplemental Payment Pools for Tennessee Hospitals. On February 7, 2018, TennCare submitted Amendment 33 to CMS. Amendment 33 concerns the supplemental payments that TennCare makes to Tennessee hospitals to help offset the costs these facilities incur in providing uncompensated care. With Amendment 33, TennCare asked that CMS revisit changes

imposed on the supplemental payment structure during the most recent renewal of the TennCare Demonstration in 2016.

Amendment 33 consists of three components:

- Restoration of approximately $90 million to the maximum amount TennCare is authorized to pay to hospitals each year for uncompensated care costs;
- Continuation of a special funding pool—currently scheduled to end on June 30, 2018—that supports clinics operated by Meharry Medical College; and
- Extending the implementation period of a new hospital payment structure currently scheduled to take effect on July 1, 2018.

On February 16, 2018, CMS sent the State a letter acknowledging receipt of Amendment 33 and verifying that the State's submission contained all necessary components. As of the conclusion of the January-March 2018 quarter, CMS was continuing its review of the proposal.

Demonstration Amendment 34: Program Modifications. During the January-March 2018 quarter, TennCare issued public notice of another amendment to be submitted to CMS. Amendment 34 outlines program changes that would be needed if the hospital assessment is not renewed in 2018. These changes have also been proposed in previous years, but were made unnecessary each year by the General Assembly's passage or renewal of a one-year hospital assessment. Changes to the TennCare benefit package for non-exempt adults that would be necessary if the assessment were not renewed in 2018 are as follows:

- A combined annual limit of eight days per person for inpatient hospital and inpatient psychiatric hospital services;
- An annual limit on non-emergency outpatient hospital visits of eight occasions per person;
- A combined annual limit on health care practitioners' office visits of eight occasions per person;
- An annual limit on lab and X-ray services of eight occasions per person; and
- Elimination of coverage for occupational therapy, speech therapy, and physical therapy.

TennCare opened its public notice and comment period regarding Amendment 34 on March 6, 2018.

Amendment 34 was scheduled to be withdrawn from consideration upon renewal of the hospital assessment, which was still working its way through the legislative process as of the end of the January-March 2018 quarter.

Tennessee Eligibility Determination System. The Tennessee Eligibility Determination System (or "TEDS") is the name of the system (currently under development) that will be used by the State to process applications and identify persons who are eligible for TennCare and CoverKids. Preparations for implementation of the system progressed throughout the January-March 2018 quarter. The focal point

of these activities was systems integration testing, which is designed to ensure that various components (or sub-systems) of TEDS perform effectively and appropriately in conjunction with one another. Successful systems integration testing is a necessary precondition to the next stage of the project, user acceptance testing, which was expected to begin in April. Other tasks addressed during the January-March 2018 quarter included State review of system training materials and finalization of the TEDS pilot plan. Implementation of the TEDS system is planned for late 2018.

Implementing Strategies to Address Opioid Misuse and Dependence. On January 16, 2018, TennCare implemented a new limit on its coverage of opioids for first-time and non-chronic opioid users experiencing an acute health event that requires a prescription for opioid pain medications. This limit for new and non-chronic users is based on TennCare's review of current medical literature, which demonstrates that reducing prolonged exposure to opioids is effective in preventing chronic opioid dependence and opioid misuse from occurring. Under this new policy, first-time and non-chronic TennCare opioid users may receive opioid prescription coverage for 15 days' supply up to a maximum dosage of 40 morphine milligram equivalents (MME) per day every 6 months. A TennCare member's first opioid prescription is limited to a maximum of 5 days at a maximum dosage of 40 MME per day. Any subsequent prescription after the initial five-day prescription requires prior authorization. TennCare's limit allows targeted clinical exceptions for patients who may experience more frequent acute pain events, such as sickle cell disease, severe cancer pain undergoing active treatment, or hospice or end-of-life care. This limit is one part of TennCare's larger strategy to combat opioid misuse and dependence within the TennCare population. TennCare intends to monitor the implementation and impact of this policy on an ongoing basis to ensure that TennCare enrollees have access to medically necessary care while minimizing the risk of prolonged exposure to opioids that can lead to dependence and addiction. TennCare will also continue to review the new policy to determine whether updates are needed to improve alignment between TennCare's policy and any larger statewide initiatives addressing opioid prescriptions.

Reimbursement Methodology for Nursing Facilities. On February 23, 2018, TennCare held a rulemaking hearing for a rule that outlines a new reimbursement methodology for nursing facilities (NFs) participating in the TennCare program. The new payment approach is part of TennCare's larger payment reform efforts, and will take into consideration the acuity of residents served in facilities, as well as facilities' performance relative to specified quality measures. As part of TennCare's ongoing commitment to transparency, TennCare has sought broad stakeholder input throughout the development process for the new payment system, hearing directly from residents receiving NF services and their family members, as well as from staff of NFs participating in TennCare's Quality Improvement in Long-Term Services and Supports (QuILTSS) initiative. Each of the Medicaid NFs in the State and their Resident/Family Councils were invited to complete surveys to provide feedback regarding quality-related components of the new rule. Facility representatives also had the opportunity to discuss their experience with the QuILTSS initiative and ways in which the program could be improved, not only to aid the initiative's goal of improving quality of care and quality of life for NF residents, but also to minimize administrative burden on facilities. Implementation of the new reimbursement methodology will take place in State Fiscal Year 2019.

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 of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[1] to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous 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 funding for administrative costs. Tennessee's EHR program has issued payments for six program years to Medicaid providers meeting relevant eligibility requirements.

EHR payments made by TennCare during the January-March 2018 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 2018)	Cumulative Amount Paid to Date[2]
First-year payments	0	$0	$180,885,192
Second-year payments	30	$256,359	$57,773,759
Third-year payments	71	$1,102,482	$34,047,037
Fourth-year payments	15	$119,001	$5,527,845
Fifth-year payments	22	$184,167	$3,043,002
Sixth-year payments	19	$155,834	$999,334

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

- Communicating with and assisting providers via emails (including targeted emails to eligible professionals attesting to "meaningful use" of EHR technology), technical assistance calls, webinars, and onsite visits;
- Acceptance of Program Year 2017 meaningful use attestations for returning eligible professionals;
- Enhancements to TennCare's Provider Incentive Payment Program attestation software, including implementation of an update of federally mandated changes related to meaningful use, as well as improvements to the attestation review process;
- Submission of Tennessee's updated State Medicaid Health Information Technology Plan to CMS;

[1] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: medical professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and hospitals (acute care hospitals, critical access hospitals, and children's hospitals).

[2] Audits performed during the January-March 2018 quarter identified past payments to eligible hospitals to be recouped. The cumulative totals associated with first-year and second-year payments reflect these recoupments.

- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls; and
- Newsletters and alerts distributed by TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, TennCare's EHR Incentive Program team continues to work with a variety of provider organizations to maintain the momentum of the program. The focus of outreach efforts has shifted from new enrollments to providers who attested to EHR requirements only once or who have not attested in recent years. Plans were made during the quarter to continue this outreach by exhibiting at the upcoming Amerigroup Community Care and UnitedHealthcare Provider Information Expos in Chattanooga, Johnson City, Knoxville, Memphis, and Nashville.

Roan and Shackleford v. Long. This lawsuit was filed against TennCare in December 2017 by the Tennessee Justice Center and the Legal Aid Society of Middle Tennessee and the Cumberlands. The litigation, which was filed with the U.S. District Court for the Middle District of Tennessee, concerns limitations placed by TennCare on private duty nursing services for individuals aged 21 and older.

Federal Medicaid law requires states to provide an expansive benefits package to children (defined as persons younger than age 21) but allows states more discretion to manage the scope of benefits for adults age 21 and older. In 2008, TennCare (with CMS approval) implemented limitations on private duty nursing services for adults. At that time, expenditures for private duty nursing were growing at a dramatic and unsustainable rate, and TennCare determined that additional cost containment strategies were necessary. In some instances, children enrolled in TennCare may be receiving services in excess of these limits. In those cases, the enrollee's MCO works with them and their family prior to the enrollee's 21st birthday to help them transition to a different level of benefits that best meets their needs (and which can include long-term services and supports).

In *Roan and Shackleford v. Long*, two plaintiffs with disabilities who received private duty nursing services as children have challenged TennCare's ability to implement limits on the services they receive as adults. The plaintiffs allege that TennCare's limits violate the Americans with Disabilities Act (ADA) and are seeking an injunction prohibiting TennCare from reducing the services they receive.

The State has timely filed a response to the Motion for Preliminary Injunction, a Motion to Dismiss, and a Notice of Constitutional Question. The Notice contends that if the plaintiffs are entitled to the relief they seek under Title II of the ADA, then the federal statute is unconstitutional as applied to this case. Neither motion had been set for oral argument by the end of the January-March 2018 quarter.

Essential Access Hospital (EAH) Payments. The Division of TennCare continued to make EAH payments during the January-March 2018 quarter. EAH payments are made from a pool of $100 million ($34,395,000 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 53.a. 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 2018 (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 2018
Vanderbilt University Hospital	Davidson County	$3,652,292
Regional One Health	Shelby County	$3,216,140
Erlanger Medical Center	Hamilton County	$2,258,399
University of Tennessee Memorial Hospital	Knox County	$1,666,652
Johnson City Medical Center (with Woodridge)	Washington County	$1,151,981
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$864,997
LeBonheur Children's Medical Center	Shelby County	$770,710
Metro Nashville General Hospital	Davidson County	$554,536
Jackson – Madison County General Hospital	Madison County	$525,180
East Tennessee Children's Hospital	Knox County	$479,290
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$473,961
Saint Jude Children's Research Hospital	Shelby County	$409,472
Methodist Healthcare – Memphis Hospitals	Shelby County	$408,893
TriStar Centennial Medical Center	Davidson County	$367,639
Parkridge East Hospital	Hamilton County	$357,795
Methodist Healthcare – South	Shelby County	$345,033
Delta Medical Center	Shelby County	$306,238
Parkwest Medical Center (with Peninsula)	Knox County	$286,797
Baptist Memorial Hospital for Women	Shelby County	$266,102
Saint Thomas Midtown Hospital	Davidson County	$257,058
Methodist Healthcare – North	Shelby County	$251,979
Saint Francis Hospital	Shelby County	$231,026
University Medical Center (with McFarland)	Wilson County	$226,838
Saint Thomas Rutherford Hospital	Rutherford County	$210,289
Baptist Memorial Hospital – Memphis	Shelby County	$197,002

Hospital Name	County	EAH Third Quarter FY 2018
Fort Sanders Regional Medical Center	Knox County	$193,449
Wellmont – Holston Valley Medical Center	Sullivan County	$186,927
Erlanger North Hospital	Hamilton County	$185,902
Pathways of Tennessee	Madison County	$185,668
Ridgeview Psychiatric Hospital and Center	Anderson County	$180,838
Maury Regional Hospital	Maury County	$168,830
TriStar StoneCrest Medical Center	Rutherford County	$158,600
Methodist Le Bonheur Germantown Hospital	Shelby County	$157,629
TriStar Horizon Medical Center	Dickson County	$151,915
Tennova Healthcare	Knox County	$149,111
Wellmont – Bristol Regional Medical Center	Sullivan County	$140,210
TriStar Summit Medical Center	Davidson County	$138,487
Cookeville Regional Medical Center	Putnam County	$136,499
Rolling Hills Hospital	Williamson County	$133,494
Blount Memorial Hospital	Blount County	$130,221
Gateway Medical Center	Montgomery County	$125,027
TriStar Southern Hills Medical Center	Davidson County	$122,543
Dyersburg Regional Medical Center	Dyer County	$112,776
Lincoln Medical Center	Lincoln County	$110,047
Morristown – Hamblen Healthcare System	Hamblen County	$106,829
Skyridge Medical Center	Bradley County	$105,970
LeConte Medical Center	Sevier County	$96,650
Sumner Regional Medical Center	Sumner County	$95,962
Methodist Medical Center of Oak Ridge	Anderson County	$87,506
Takoma Regional Hospital	Greene County	$84,687
TriStar Hendersonville Medical Center	Sumner County	$82,775
Tennova Healthcare – Newport Medical Center	Cocke County	$78,212
Saint Francis Hospital – Bartlett	Shelby County	$75,410
Jellico Community Hospital	Campbell County	$70,720
Tennova Healthcare – Harton Regional Medical Center	Coffee County	$69,339
Indian Path Medical Center	Sullivan County	$68,505
Starr Regional Medical Center – Athens	McMinn County	$67,485
Tennova Healthcare – LaFollette Medical Center	Campbell County	$63,631
NorthCrest Medical Center	Robertson County	$61,899
Parkridge West Hospital	Marion County	$60,869
Henry County Medical Center	Henry County	$58,304
Southern Tennessee Regional Health System – Winchester	Franklin County	$53,465
Regional Hospital of Jackson	Madison County	$52,727
Wellmont Hawkins County Memorial Hospital	Hawkins County	$52,520
Roane Medical Center	Roane County	$46,046
Sycamore Shoals Hospital	Carter County	$45,530
Saint Thomas River Park Hospital	Warren County	$43,101

Hospital Name	County	EAH Third Quarter FY 2018
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$41,834
Heritage Medical Center	Bedford County	$40,545
Skyridge Medical Center – Westside	Bradley County	$39,467
Hardin Medical Center	Hardin County	$38,710
Bolivar General Hospital	Hardeman County	$37,424
Baptist Memorial Hospital – Union City	Obion County	$36,063
Erlanger Health System – East Campus	Hamilton County	$35,990
McKenzie Regional Hospital	Carroll County	$35,895
Lakeway Regional Hospital	Hamblen County	$35,793
Hillside Hospital	Giles County	$34,780
Starr Regional Medical Center – Etowah	McMinn County	$34,149
Livingston Regional Hospital	Overton County	$34,074
TrustPoint Hospital	Rutherford County	$30,931
United Regional Medical Center	Coffee County	$28,494
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$28,380
Volunteer Community Hospital	Weakley County	$28,026
Claiborne County Hospital	Claiborne County	$27,770
Saint Thomas DeKalb Hospital	DeKalb County	$23,856
Saint Thomas Stones River Hospital	Cannon County	$23,237
Henderson County Community Hospital	Henderson County	$23,155
Jamestown Regional Medical Center	Fentress County	$21,823
Milan General Hospital	Gibson County	$21,013
Wayne Medical Center	Wayne County	$17,854
Decatur County General Hospital	Decatur County	$13,709
Kindred Hospital – Chattanooga	Hamilton County	$12,854
Southern Tennessee Regional Health System – Sewanee	Franklin County	$11,391
Houston County Community Hospital	Houston County	$10,169
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of March 2018, there were 1,433,753 Medicaid eligibles and 13,376 Demonstration eligibles enrolled in TennCare, for a total of 1,447,129 persons.

Estimates of TennCare spending for the third quarter of State Fiscal Year 2018 are summarized in the table below.

Spending Category	Third Quarter FY 2018*
MCO services**	$1,996,952,800
Dental services	$44,076,400
Pharmacy services	$319,163,600
Medicare "clawback"***	$56,517,200

**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 that 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 Managed Care Contractors (MCCs) in the TennCare Program

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	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)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[3] 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[4] are processed and paid within 21 calendar days of receipt.	TennCare contract

[3] 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.

[4] Ibid.

Entity	Standard	Authority
Dental Benefits Manager (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)
Pharmacy Benefits Manager (PBM)	100% of all clean claims submitted by pharmacy providers are paid within 15 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 claims processor (e.g., MCO, vision benefits manager, etc.). 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 and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF CHOICES claim types, by claims processor, 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 Division of TennCare may 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 TennCare may assess applicable liquidated damages against these entities.

Net worth and company action level requirements. 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 reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement 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 2018 quarter, the MCOs submitted their 2017 NAIC Annual Financial Statements. As of December 31, 2017, TennCare MCOs reported net worth as indicated in the table below.[5]

[5] 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.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$30,058,528	$233,172,332	$203,113,804
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$65,141,772	$446,288,192	$381,146,420
Volunteer State Health Plan (BlueCare & TennCare Select)	$47,825,838	$479,849,260	$432,023,422

During the January-March 2018 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, 2017:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$110,985,558	$233,172,332	$122,186,774
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$221,464,280	$446,288,192	$224,823,912
Volunteer State Health Plan (BlueCare & TennCare Select)	$160,340,902	$479,849,260	$319,508,358

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of December 31, 2017.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee. The OIG receives case information from a variety of sources, including local law enforcement, the Division of TennCare, Health Related Boards, the Department of Human Services (DHS), other State agencies, health care providers, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the third quarter of Fiscal Year 2018 are as follows:

Fraud and Abuse Complaints	Third Quarter FY 2018
Fraud Allegations	1,064
Abuse Allegations*	835
Arrest/Conviction/Judicial Diversion Totals	**Third Quarter FY 2018**
Arrests	31
Convictions	23
Judicial Diversions	4

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

Criminal Court Fines and Costs Imposed	Third Quarter FY 2018
Court Costs & Taxes	$753
Fines	$2,020
Drug Funds/Forfeitures	$1,117
Criminal Restitution Ordered	$162,442
Criminal Restitution Received[6]	$34,187
Administrative Fees	$1,000
Civil Restitution/Civil Court Judgments	**Third Quarter FY 2018**
Civil Restitution Ordered[7]	$0
Civil Restitution Received[8]	$4,863
Administrative Fees Awarded	$35,057
Administrative Fees Received[9]	$674

Recommendations for Review	Third Quarter FY 2018
Recommended TennCare Terminations[10]	81
Potential Savings[11]	$296,168

[6] Restitution may have been ordered in a fiscal year other than the one in which payment was actually received.

[7] 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.

[8] Restitution may have been agreed to in a fiscal year other than the one in which payment was actually received.

[9] Administrative fees may have been awarded in a fiscal year other than the one in which payment was actually received.

[10] Recommendations that enrollees' TennCare coverage should be terminated are sent to the Division of TennCare for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. TennCare determines whether these referrals meet the criteria for termination. Reviews of these recommendations must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

[11] Potential 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 estimated by TennCare to be $3,656.39).

Statewide Communication

In an effort to stay connected with local law enforcement and achieve the OIG's mission, Special Agents continue to meet in person with sheriffs and police chiefs throughout the state. These meetings further collaborative relationships and aid the mutual goal of stopping TennCare fraud and prescription drug diversion.