TennCare Quarterly Report

Submitted to the Members of the General Assembly

July 2014

Status of TennCare Reforms and Improvements

Three proposed amendments to the TennCare Demonstration were in various stages of discussion during the quarter.

Demonstration Amendment 21: Possible Changes to TennCare Benefits. On January 27, 2014, the Bureau of TennCare submitted Demonstration Amendment 21 to the Centers for Medicare and Medicaid Services (CMS). Amendment 21 repeated 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 have been necessary if the fee had not been renewed in 2014 were:

- 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

With the passage of House Bill 1950 / Senate Bill 1908 (which ultimately became Public Chapter 877) on April 14, 2014, the General Assembly extended the hospital assessment fee through State Fiscal Year 2014-2015. Accordingly, on April 25, 2014, the Bureau submitted a letter to CMS withdrawing Amendment 21.

Demonstration Amendment 22: Proposal Concerning Copayments and Benefit Limits. On May 8, 2014, TennCare submitted Demonstration Amendment 22 to CMS. Amendment 22 proposed two modifications to the TennCare program:

- Implementation of the maximum copayment amounts allowable under federal regulations.
- Imposition of a limit of 200 diapers per month for adults age 21 and older when the diapers are furnished on an outpatient basis and for medical reasons.

With respect to the copayments portion of the proposal, the State requested relief from two specific regulations. First, the regulations require that the total amount of copayments charged to enrollees not

exceed 5 percent of household income, figured on a monthly or quarterly basis. The Bureau asked that the 5 percent aggregate limit be applied on an annual basis instead. Second, recognizing the difficulties in collecting real-time information across managed care entities about copays charged that could quickly and accurately identify when an enrollee had reached his aggregate cap, TennCare sought permission to assign the responsibility for tracking copayments to enrollees, who have a financial incentive to document the fulfillment of their cost-sharing obligations.

As of the end of the April-June 2014 quarter, CMS has not yet provided a response to TennCare's request for waivers associated with copays. As to coverage of adult diapers, the Bureau has requested the Managed Care Organizations (MCOs) to increase utilization review activities for requests for adult diapers that exceed 200 per enrollee per month.

Demonstration Amendment 23: Benefits for Pregnant Women During a Period of Presumptive Eligibility. On June 26, 2014, the Bureau notified the public of another proposal to be submitted to CMS. Demonstration Amendment 23 deals with the benefits a pregnant woman may receive from TennCare during a period of "presumptive eligibility," which is a period of temporary eligibility granted to certain groups of pregnant women who would likely qualify for TennCare coverage but who have not yet completed an application. Most members of this population are "presumptives" for only a few short weeks before becoming fully TennCare eligible. Traditionally, the Bureau has offered a complete package of benefits to a presumptively eligible pregnant woman to promote the health of her unborn child. CMS has advised the State to amend the TennCare Demonstration to allow coverage of non-ambulatory services (such as inpatient hospitalizations) for pregnant women during periods of presumptive eligibility to continue TennCare's longstanding practice. Additional information about the proposal is available in the State's public notice, which is located on the Bureau's website at http://www.tn.gov/tenncare/pol-notice3.shtml.

Concept Paper Regarding Long-Term Services and Supports (LTSS). Currently, TennCare and the Tennessee Department of Intellectual and Developmental Disabilities (DIDD) deliver Home and Community Based Services (HCBS) to individuals with intellectual disabilities through three Section 1915(c)[1] Waiver programs:

- The Statewide Waiver, which serves more than 6,500 people;
- The Arlington Waiver, which serves nearly 300 people; and
- The Self-Determination Waiver, which serves more than 1,100 people.

With the Statewide Waiver and the Arlington Waiver scheduled to expire on December 31, 2014, TennCare and DIDD initiated a fresh examination of the system of HCBS for TennCare members with intellectual and/or developmental disabilities to determine where meaningful improvements could be made. Meetings held in late 2013 and early 2014 with consumers and their family members, people

[1] Section 1915(c) of the Social Security Act is the provision of federal law that authorizes Medicaid programs to cover HCBS for individuals with intellectual disabilities.

who are not receiving services currently and their family members, HCBS providers, and advocacy groups yielded substantial feedback about the most effective ways to renew existing 1915(c) Waivers and to introduce new program designs. A summary report of stakeholder input was sent to Members of the General Assembly on March 27, 2014.

Drawing heavily on these suggestions, TennCare and DIDD published a joint proposal—entitled Renewal and Redesign of Tennessee's Long-Term Services and Supports Delivery System for Individuals with Intellectual Disabilities: A Concept Paper for Stakeholder Review and Input—on May 30, 2014. The document, which is available on TennCare's website at http://www.tn.gov/tenncare/forms/ConceptPaper.pdf and which was sent to Members on June 2, 2014, outlines a plan for renewing the Statewide Waiver and the Arlington Waiver with essential amendments,[2] and for launching a new program of managed long-term services and supports to be called *Employment and Community First CHOICES*. The stated goal of *Employment and Community First CHOICES* is "promoting and supporting integrated, competitive employment and independent living as the first and preferred option for all individuals with intellectual and developmental disabilities."[3]

In June 2014, representatives of TennCare and DIDD hosted a series of Community Meetings in all three regions of the state to share information and accept comments about the Concept Paper. Members of the public who could not attend one of the Community Meetings were invited to share their thoughts online by June 30, 2014. Feedback received will be incorporated into the formal proposals submitted to CMS later this year.

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 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 two plans per grand region.[4]

During the April-June 2014 quarter, TennCare continued its collaboration with the three contractors to ensure a seamless transition to the statewide service delivery model on January 1, 2015. The Bureau and the MCOs participated in a joint conference call on May 16, 2014, to discuss such issues as innovations that the MCOs will be required to implement, a list of key dates and milestones, and an upcoming desk review of the MCOs' policies and procedures. By the conclusion of the call, participants recognized the potential value of additional one-on-one sessions between TennCare and each contractor. Therefore, on June 13, 2014, the Bureau hosted meetings with the MCOs individually,

[2] The Concept Paper proposes corresponding amendments to the Self-Determination Waiver, even though it does not expire as soon as the Statewide and Arlington Waivers.
[3] Concept Paper, Page 2.
[4] 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.

focusing on overall readiness plans as well as the need to accommodate implementation plans developed by each TennCare Business Section.[5]

Another topic addressed during the April-June 2014 quarter was the transfer of portions of the enrollee population from one health plan to another on January 1, 2015, and on April 1, 2015. This reassignment will affect approximately one-third of TennCare's members, with certain segments of the population—such as residents of Intermediate Care Facilities for Individuals with Intellectual Disabilities and members of a household who are assigned to the same MCO—exempted from reassignment.[6] In addition, wherever possible, an individual dually eligible for Medicare and TennCare will be assigned to a single contractor that can serve simultaneously as a Medicare Dual Eligible Special Needs Plan (D-SNP) and TennCare MCO.

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[7] 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 (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 for a subsequent period of 90 consecutive days;
- Third-year payments to providers who continue to demonstrate meaningful use.

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

[5] TennCare's Information Systems division had already furnished its implementation plan to the MCOs and had been meeting with their Information Technology staff to address strategy and readiness.

[6] Enrollees exempted from the transfers occurring on January 1 and April 1, 2015, maintain the right to change health plans each year during the annual change period.

[7] 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).

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Apr-Jun 2014)	Cumulative Amount Paid to Date
First-year payments	274[8]	$6,390,184	$141,515,874
Second-year payments	347	$3,518,252	$39,526,706
Third-year payments	201	$3,403,436	$4,107,967

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;
- Telephone assistance throughout the quarter for eligible professionals attesting to Meaningful Use;
- Hosting webinars on April 22, May 22, May 29, and June 9;
- Involvement in the virtual eHealth Summit sponsored by CMS on May 19, 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.

A significant priority for TennCare staff in the coming months is scheduling 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 April-June 2014 quarter. EAH payments are made from a pool of $100 million ($34,500,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee. The $100 million pool is currently being supplemented with an additional $81.3 million made available through CMS's approval of Demonstration Amendment 20. (Amendment 20 had expanded the EAH pool to address the fact that Tennessee was the only state in the country without a Disproportionate Share Hospital allotment specified in federal statute.) Of the $81.3 million in new funds, the Bureau elected to distribute $46,860,000 in the April-June 2014 quarter, with the balance to be disbursed in the July-September 2014 quarter.

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

[8] Of the 274 providers receiving first-year payments in the April-June 2014 quarter, 13 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

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 fourth quarter of State Fiscal Year 2014 for dates of service during the third quarter are shown in the table below.

Essential Access Hospital Payments for the Quarter[9]

Hospital Name	County	EAH Fourth Quarter FY 2014
Vanderbilt University Hospital	Davidson County	$9,433,816
Regional Medical Center at Memphis	Shelby County	$8,847,384
Erlanger Medical Center	Hamilton County	$7,541,029
University of Tennessee Memorial Hospital	Knox County	$4,316,389
Johnson City Medical Center (with Woodridge)	Washington County	$3,628,152
Metro Nashville General Hospital	Davidson County	$2,233,230
LeBonheur Children's Medical Center	Shelby County	$2,061,438
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$1,898,096
East Tennessee Children's Hospital	Knox County	$1,538,562
Jackson – Madison County General Hospital	Madison County	$1,533,462
Methodist Healthcare – South	Shelby County	$1,287,800
Methodist Healthcare – Memphis Hospitals	Shelby County	$1,199,652
Saint Jude Children's Research Hospital	Shelby County	$1,184,467
University Medical Center (with McFarland)	Wilson County	$1,130,829
Saint Thomas Midtown Hospital	Davidson County	$1,106,733
Centennial Medical Center	Davidson County	$835,989
Physicians Regional Medical Center	Knox County	$825,290
Methodist Healthcare – North	Shelby County	$796,918
Skyline Medical Center (with Madison Campus)	Davidson County	$772,727
Saint Francis Hospital	Shelby County	$716,733
Saint Thomas Rutherford Hospital	Rutherford County	$709,450
Parkwest Medical Center (with Peninsula)	Knox County	$696,843
Wellmont Holston Valley Medical Center	Sullivan County	$682,294
Maury Regional Hospital	Maury County	$663,394
Fort Sanders Regional Medical Center	Knox County	$610,197

[9] All eligible EAH hospitals received two payments during the quarter, one on May 2 and one on June 20. Each dollar figure in the table represents the sum of those two payments.

Hospital Name	County	EAH Fourth Quarter FY 2014
Skyridge Medical Center	Bradley County	$551,720
Pathways of Tennessee	Madison County	$537,378
Gateway Medical Center	Montgomery County	$503,070
Cookeville Regional Medical Center	Putnam County	$499,498
Delta Medical Center	Shelby County	$487,061
Ridgeview Psychiatric Hospital and Center	Anderson County	$486,147
Parkridge East Hospital	Hamilton County	$472,817
Methodist Hospital – Germantown	Shelby County	$468,716
Blount Memorial Hospital	Blount County	$439,231
Wellmont Bristol Regional Medical Center	Sullivan County	$433,284
Baptist Memorial Hospital for Women	Shelby County	$417,049
Haywood Park Community Hospital	Haywood County	$406,032
NorthCrest Medical Center	Robertson County	$384,870
Southern Hills Medical Center	Davidson County	$338,828
LeConte Medical Center	Sevier County	$332,150
Horizon Medical Center	Dickson County	$329,876
Sumner Regional Medical Center	Sumner County	$322,424
Tennova Healthcare – Newport Medical Center	Cocke County	$311,493
Takoma Regional Hospital	Greene County	$295,676
Methodist Medical Center of Oak Ridge	Anderson County	$291,319
Heritage Medical Center	Bedford County	$290,567
Baptist Memorial Hospital – Tipton	Tipton County	$280,337
StoneCrest Medical Center	Rutherford County	$279,126
Rolling Hills Hospital	Williamson County	$276,475
Summit Medical Center	Davidson County	$276,169
Tennova Healthcare – LaFollette Medical Center	Campbell County	$275,743
Dyersburg Regional Medical Center	Dyer County	$265,099
Morristown – Hamblen Healthcare System	Hamblen County	$263,250
Henry County Medical Center	Henry County	$256,187
Sweetwater Hospital Association	Monroe County	$218,802
Sycamore Shoals Hospital	Carter County	$216,021
Harton Regional Medical Center	Coffee County	$210,388
Grandview Medical Center	Marion County	$204,292
Indian Path Medical Center	Sullivan County	$202,842
Regional Hospital of Jackson	Madison County	$195,600
Baptist Memorial Hospital – Union City	Obion County	$188,225
Lakeway Regional Hospital	Hamblen County	$184,534
Jellico Community Hospital	Campbell County	$183,024
Wellmont Hawkins County Memorial Hospital	Hawkins County	$181,866
Hardin Medical Center	Hardin County	$167,900
Crockett Hospital	Lawrence County	$167,543

Hospital Name	County	EAH Fourth Quarter FY 2014
Athens Regional Medical Center	McMinn County	$165,128
River Park Hospital	Warren County	$163,006
Southern Tennessee Medical Center	Franklin County	$159,179
Livingston Regional Hospital	Overton County	$157,836
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$152,598
Henderson County Community Hospital	Henderson County	$127,383
McNairy Regional Hospital	McNairy County	$122,662
Roane Medical Center	Roane County	$122,334
Skyridge Medical Center – Westside	Bradley County	$120,726
Bolivar General Hospital	Hardeman County	$106,939
McKenzie Regional Hospital	Carroll County	$106,394
Claiborne County Hospital	Claiborne County	$105,193
Hillside Hospital	Giles County	$103,719
Volunteer Community Hospital	Weakley County	$95,946
United Regional Medical Center	Coffee County	$93,005
Jamestown Regional Medical Center	Fentress County	$88,018
Wayne Medical Center	Wayne County	$82,162
Methodist Healthcare – Fayette	Fayette County	$81,747
Erlanger Health System – East Campus	Hamilton County	$79,469
DeKalb Community Hospital	DeKalb County	$74,778
Baptist Memorial Hospital – Huntingdon	Carroll County	$59,106
White County Community Hospital	White County	$48,758
Emerald – Hodgson Hospital	Franklin County	$44,490
Humboldt General Hospital	Gibson County	$38,223
Gibson General Hospital	Gibson County	$17,698
TOTAL		**$71,860,000**

Number of Recipients on TennCare and Costs to the State

During the month of June 2014, there were 1,247,780 Medicaid eligibles and 19,556 Demonstration eligibles enrolled in TennCare, for a total of 1,267,336 persons.

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

Spending Category	4th Quarter*
MCO services**	$1,406,123,300
Dental services	$38,966,700
Pharmacy services	$232,223,200
Medicare "clawback"***	$40,305,500

**These figures are cash basis as of June 30 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[10] 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[11] are processed and paid within 21 calendar days of receipt.	TennCare contract

[10] 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.

[11] Ibid.

Entity	Standard	Authority
DBM	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
PBM	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by TennCare Contract (i.e., East, Middle, or West Grand Region) and by subcontractor (e.g., claims processed by a vision benefits manager). Furthermore, the MCOs are required to identify separately non-emergency transportation (NEMT) claims in the data files. Finally, the MCOs are required to submit separate claims data files representing a subset of electronically submitted Nursing Facility and applicable Home and Community Based Services claims for CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by TennCare contract, and by total claims processed for the month.

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The TennCare Bureau can also assess liquidated damages pursuant to the terms of the Contractor Risk Agreement. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

Net worth requirement. By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) First Quarter 2014 Financial Statements. As of March 31, 2014, TennCare MCOs reported net worth as indicated in the table below.[12]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,550,992	$104,253,521	$86,702,529

[12] 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)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,885,278	$486,138,826	$421,253,548
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,942,038	$270,769,113	$235,827,075

All TennCare MCOs met their minimum net worth requirements as of March 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. The statistics for the fourth quarter of Fiscal Year 2014 are as follows:

TennCare Fraud & Abuse: Cases Received

	Quarter
TennCare Fraud Cases	1,674
TennCare Abuse Cases*	1,083

***** *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	$17,051
Court Costs & Taxes	$7,974
Court Ordered Restitution	$94,561 (a 38% increase from last quarter)[13]
Drug Funds/Forfeitures	$106

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), gaining TennCare eligibility by claiming a child who does not

[13] The increase in court ordered restitution that occurred during the April-June 2014 quarter corresponds with a rise in the number of cases involving substantial amounts of money (especially those in which an individual is found to be ineligible for TennCare coverage because of unreported income).

actually live in the home, reporting a false income, and ineligible individuals using a TennCare card. The 58 individuals arrested during the April-June 2014 quarter (a 16 percent increase from last quarter) were charged with a total of 263 criminal counts via Grand Jury indictments.

Arrest Totals

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Individuals Arrested	58	2,134
Criminal Counts / Charges	263	6,793[14]

OIG Case Recoupment & Civil Court Judgments

	Quarter
Consent Orders & Civil Judgments[15]	$131,613

Recommendations for Review

	Quarter
Recommended TennCare Terminations[16]	101
Potential Savings[17]	$369,295

[14] The total of 6,527 criminal counts/charges included in the previous Quarterly Report was subsequently revised to 6,530.

[15] 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.

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

[17] Savings are determined by multiplying the number of enrollees whose coverage would be terminated, 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).