TennCare Quarterly Report

Submitted to the Members of the General Assembly

July 2015

Status of TennCare Reforms and Improvements

Four proposed amendments to the TennCare Demonstration were in various stages of negotiation during the quarter. Three of the four amendments pertain to CHOICES, TennCare's program of long-term services and supports (LTSS).

Demonstration Amendment 18: Assisted Care Living Facility (ACLF) Services. The Bureau of TennCare originally submitted Amendment 18 to the Centers for Medicare and Medicaid Services (CMS) on March 7, 2013. Amendment 18 proposed to add ACLF services—excluding room and board, as required pursuant to federal law—for individuals in CHOICES Group 3 when certain criteria were met, including that such services would not cost more than other CHOICES Home and Community Based Services (HCBS) that the person would otherwise receive. CHOICES Group 3 is the population of individuals who do not meet the Level of Care criteria for Nursing Facility (NF) services, but who have been found to be "at risk" of institutionalization. ACLF services had already been available for persons in CHOICES Group 2, which consists of enrollees who meet the NF Level of Care criteria but who receive HCBS as a safe and cost-effective alternative to institutional care.

Amendment 18 was put on hold in 2013 until new federal regulations pertaining to HCBS and HCBS settings had been published in their final form. Following extensive review of those regulations, TennCare notified CMS on March 5, 2015, of its intent to proceed with Amendment 18. Discussions between the two parties took place throughout the April-June 2015 quarter, and, on June 24, 2015, CMS issued written approval of Amendment 18, as well as updated versions of the Special Terms and Conditions (STCs), Waivers, and Expenditure Authorities associated with the TennCare Demonstration. On June 30, 2015, TennCare notified CMS of its acceptance of the materials but noted several technical corrections to be made prior to finalizing the approval documents.

Demonstration Amendment 24: Community Living Supports Services. Amendment 24, which TennCare submitted to CMS on March 4, 2015, proposed to add two new community-based residential alternative services to the menu of benefits covered by CHOICES: "community living supports" (CLS) and "community living supports-family model" (CLS-FM, an "adult foster care" arrangement). The two sets of services represent additional 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 the aforementioned federal HCBS regulations and, like Assisted Living services for members in CHOICES Group 3, would not cost more than other CHOICES HCBS that the person would otherwise receive. Implementation of these benefits would occur on July 1, 2015.

CMS issued written approval of Amendment 24 in conjunction with Amendment 18 on June 24, 2015. As with Amendment 18, TennCare accepted the approval on June 30 but identified technical corrections that would be needed within the accompanying approval materials.

Demonstration Amendment 26: Expenditures for Hospital Pool Payments. Under the terms of the TennCare Demonstration, the Bureau of TennCare has the "expenditure authority" (specifically, "Expenditure Authority #4") to make certain payments to providers through "pools" that exist outside the managed care program. The names of the pools are as follows:

- Graduate Medical Education Pool
- Essential Access Hospital Pool
- Critical Access Hospital Pool
- Meharry Medical College Pool
- Unreimbursed Public Hospital Costs Pool for Certified Public Expenditures
- Unreimbursed Hospital Cost Pool
- Public Hospital Supplemental Payment Pool

The recipients of funds from most of the pools are identified groups of Tennessee hospitals. The primary purpose of pool funds is to offset the costs of delivering uncompensated care, but they have some other purposes as well, such as providing support for graduate medical education programs.

Currently, Expenditure Authority #4 is scheduled to expire on December 31, 2015, which is six months prior to the end date of TennCare's current approval period on June 30, 2016. In Special Term and Condition #69 of TennCare's Demonstration Agreement with CMS, the Bureau is directed to conduct a study of uncompensated care costs for the uninsured, which will focus on payments being made under the pools. Since one purpose of the study is to evaluate the continuing need for the pools, it does not make sense to make changes to the pools while the study is still being conducted. Therefore, Amendment 26 requests that Expenditure Authority #4 continue through June 30, 2016.

Amendment 27: Employment and Community First CHOICES. On June 23, 2015, the Bureau submitted Amendment 27 to CMS. Amendment 27 envisions a new program—named *Employment and Community First CHOICES*—within the arena of LTSS, a description of which appears at the opening of the proposal:

> With Amendment 27 to the TennCare demonstration, Tennessee proposes to implement within its existing managed care demonstration an integrated managed long-term services and supports (MLTSS) program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated community living as the first and preferred option for individuals with intellectual and developmental disabilities (I/DD).

The amendment would apply to individuals with intellectual disabilities and individuals with developmental disabilities who are newly enrolling into HCBS programs. *Employment and Community First CHOICES* would not, however, alter the manner in which services in an Intermediate Care Facility for Individuals with Intellectual Disabilities are delivered and would not make any changes for individuals served in the three HCBS waiver programs that currently exist (the Comprehensive Aggregate Cap Waiver, the Statewide Waiver, and the Self-Determination Waiver).

A principal aim of Amendment 27 is to provide services more cost-effectively in order to be able to serve more of the 6,000 individuals with intellectual disabilities who are currently on a waiting list for the aforementioned HCBS waiver programs, and an undetermined number of individuals with developmental disabilities who do not qualify for services in the existing HCBS waivers. In laying the groundwork to realize this goal, the proposal identifies four target populations to be served, as well as three benefit packages designed to address the diverse needs of individuals within those populations. To ensure that *Employment and Community First CHOICES* operates within available state resources, however, each benefit package contains an individual cost limit, and TennCare retains the right to establish enrollment caps as well.

A copy of Amendment 27 is currently available on TennCare's website at http://www.tn.gov/assets/entities/tenncare/attachments/Amendment27ECFCHOICES.pdf. TennCare's June 22 notification letter to members of the General Assembly contained additional details about the proposal.

Tennessee Eligibility Determination System. As reported last quarter, TennCare announced plans to move in a new direction with regard to the continued development of the Tennessee Eligibility Determination System (TEDS). The purpose of TEDS is to review applications and identify which persons are eligible for state-sponsored health care assistance, meaning TennCare and CoverKids.

After agreements between Northrop Grumman, the company originally hired to develop TEDS, and TennCare ended, the Bureau adopted a new approach to the undertaking: rather than consolidating all aspects of the project under one vendor, TennCare opted to procure three separate contracts. The contracts in question address the following functions:

- Technical Advisory Services;
- Strategic Program Management Office; and

- Systems Integrator.

This approach was recommended to TennCare by KPMG, the international consulting firm with which the State contracted to review the TEDS project in late 2014. By the conclusion of the April-June 2015 quarter, the State had moved forward with procurement on the "Technical Advisory Services" element, bidders had submitted proposals, and TennCare had begun scoring the proposals. Furthermore, procurement documents for the "Strategic Program Management Office" element had been developed and were being reviewed for release in the near future. The "Systems Integrator" component will be addressed once the other two contracts have been awarded and are in place.

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[1] 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 April-June 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 (Apr-Jun 2015)	Cumulative Amount Paid to Date
First-year payments	189[2]	$3,439,815	$154,076,734
Second-year payments	110	$710,101	$48,709,995

[1] 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).

[2] Of the 189 providers receiving first-year payments in the April-June 2015 quarter, 7 earned their incentives by successfully attesting to meaningful use of EHR technology in their first year of participation in the program.

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Apr-Jun 2015)	Cumulative Amount Paid to Date
Third-year payments	178	$3,795,732	$12,604,449
Fourth-year payments	96	$773,505	$1,105,005

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

- Expansion of the contract with Qsource (TennCare's External Quality Review Organization) to assist Tennessee providers with the attestation process, including the "Security Risk Agreement" portion of the Meaningful Use attestation;
- Participation throughout the quarter in several Southeast Regional Collaboration for HIT/HIE (SERCH) calls;
- Operation of a booth at the Tennessee Medical Group Management Association Conference in April 2015;
- Attendance at the UnitedHealthcare Provider Expos in Chattanooga, Kingsport, Knoxville, Memphis, and Nashville in May 2015;
- Hosting 12 technical assistance calls during the quarter to help providers with return issues and with planning for the next year's attestations;
- Responding to more than 500 inquiries submitted to the EHR Meaningful Use email box;
- Email notices to providers in April and June 2015 reminding them to complete any remaining Meaningful Use attestations for payment year 2014;
- 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 April-June 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 fourth quarter of State Fiscal Year 2015 for dates of service during the third quarter are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Fourth 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
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	$685,737
Metro Nashville General Hospital	Davidson County	$600,107
Jackson – Madison County General Hospital	Madison County	$544,902
East Tennessee Children's Hospital	Knox County	$538,608
Methodist Healthcare – Memphis Hospitals	Shelby County	$512,229
Methodist Healthcare – South	Shelby County	$491,813
Saint Jude Children's Research Hospital	Shelby County	$418,430
University Medical Center (with McFarland)	Wilson County	$386,246
Saint Thomas Midtown Hospital	Davidson County	$354,658
TriStar Skyline Medical Center (with Madison Campus)	Davidson County	$337,644
Wellmont – Holston Valley Medical Center	Sullivan County	$304,649
Fort Sanders Regional Medical Center	Knox County	$295,865
TriStar Centennial Medical Center	Davidson County	$271,792
Methodist Healthcare – North	Shelby County	$253,011
Saint Francis Hospital	Shelby County	$245,600
Parkridge East Hospital	Hamilton County	$229,921
Maury Regional Hospital	Maury County	$229,110
Parkwest Medical Center (with Peninsula)	Knox County	$223,578
Saint Thomas Rutherford Hospital	Rutherford County	$223,559
Pathways of Tennessee	Madison County	$216,560
Wellmont – Bristol Regional Medical Center	Sullivan County	$210,377
Cookeville Regional Medical Center	Putnam County	$193,940
Ridgeview Psychiatric Hospital and Center	Anderson County	$193,264
Tennova Healthcare – Physicians Regional Medical Center	Knox County	$190,574
Methodist Hospital – Germantown	Shelby County	$173,827

Hospital Name	County	EAH Fourth Quarter FY 2015
Baptist Memorial Hospital for Women	Shelby County	$152,077
Skyridge Medical Center	Bradley County	$141,448
Blount Memorial Hospital	Blount County	$133,001
Gateway Medical Center	Montgomery County	$131,352
TriStar Horizon Medical Center	Dickson County	$129,339
TriStar StoneCrest Medical Center	Rutherford County	$121,227
TriStar Summit Medical Center	Davidson County	$119,964
NorthCrest Medical Center	Robertson County	$119,703
Delta Medical Center	Shelby County	$118,893
Dyersburg Regional Medical Center	Dyer County	$115,964
LeConte Medical Center	Sevier County	$114,181
Morristown – Hamblen Healthcare System	Hamblen County	$112,779
Southern Hills Medical Center	Davidson County	$111,399
Heritage Medical Center	Bedford County	$108,761
Sumner Regional Medical Center	Sumner County	$103,745
Takoma Regional Hospital	Greene County	$97,842
Tennova Healthcare – Newport Medical Center	Cocke County	$93,182
Sweetwater Hospital Association	Monroe County	$91,962
Laughlin Memorial Hospital	Greene County	$91,486
Rolling Hills Hospital	Williamson County	$90,176
Methodist Medical Center of Oak Ridge	Anderson County	$88,344
TriStar Hendersonville Medical Center	Sumner County	$83,301
Harton Regional Medical Center	Coffee County	$82,127
Henry County Medical Center	Henry County	$81,219
Tennova Healthcare – LaFollette Medical Center	Campbell County	$79,470
Grandview Medical Center	Marion County	$77,902
Sycamore Shoals Hospital	Carter County	$76,455
Skyridge Medical Center – Westside	Bradley County	$75,180
Regional Hospital of Jackson	Madison County	$73,522
Baptist Memorial Hospital – Union City	Obion County	$71,598
Lakeway Regional Hospital	Hamblen County	$71,142
Indian Path Medical Center	Sullivan County	$63,150
Wellmont Hawkins County Memorial Hospital	Hawkins County	$60,419
Jellico Community Hospital	Campbell County	$60,378
Hardin Medical Center	Hardin County	$59,222
McNairy Regional Hospital	McNairy County	$58,299
Starr Regional Medical Center – Athens	McMinn County	$57,605
River Park Hospital	Warren County	$54,631
Henderson County Community Hospital	Henderson County	$47,041
Roane Medical Center	Roane County	$43,764
United Regional Medical Center	Coffee County	$41,761

Hospital Name	County	EAH Fourth Quarter FY 2015
Hillside Hospital	Giles County	$40,081
Crockett Hospital	Lawrence County	$39,884
Livingston Regional Hospital	Overton County	$37,331
McKenzie Regional Hospital	Carroll County	$35,634
Volunteer Community Hospital	Weakley County	$33,420
Bolivar General Hospital	Hardeman County	$31,044
Wayne Medical Center	Wayne County	$30,082
Erlanger Health System – East Campus	Hamilton County	$27,310
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,166
DeKalb Community Hospital	DeKalb County	$24,238
Methodist Healthcare – Fayette	Fayette County	$21,405
Emerald Hodgson Hospital	Franklin County	$10,108
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

During the month of June 2015, there were 1,403,069 Medicaid eligibles and 19,040 Demonstration eligibles enrolled in TennCare, for a total of 1,422,109 persons.

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

Spending Category	4th Quarter*
MCO services**	$1,481,685,400
Dental services	$38,989,100
Pharmacy services	$269,749,000
Medicare "clawback"***	$43,511,600

**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 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[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
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 April-June 2015 quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) First Quarter 2015 Financial Statements. As of March 31, 2015, 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. 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	$144,423,927	$125,528,279
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$67,602,074	$545,821,081	$478,219,007
Volunteer State Health Plan (BlueCare & TennCare Select)	$37,185,058	$336,223,639	$299,038,581

During the April-June 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 March 31, 2015:

MCO	Company Action Level	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$61,407,788	$144,423,927	$83,016,139
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$244,098,654	$545,821,081	$301,722,427
Volunteer State Health Plan (BlueCare & TennCare Select)	$109,546,612	$336,223,639	$226,677,027

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of March 31, 2015.

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 fourth quarter of Fiscal Year 2015 are as follows:

TennCare Fraud & Abuse: Cases Received

	Quarter
TennCare Fraud Cases	1,879
TennCare Abuse Cases*	1,410

***** *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	$17,425
Court Costs & Taxes	$3,078
Court Ordered Restitution	$44,550
Court Ordered Restitution Received[6]	$23,098
Drug Funds/Forfeitures	$2,060

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	65	249

OIG Civil Restitution & Civil Court Judgments

	Quarter
Consent Orders & Civil Judgments Ordered[7]	$18,371
Recoupments Received[8]	$14,604

[6] Restitution may have been ordered in a quarter earlier than the quarter 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] A recoupment may be received in a quarter other than the one in which it is ordered.

Recommendations for Review

	Quarter
Recommended TennCare Terminations[9]	278
Potential Savings[10]	$1,016,476

During the April-June 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	61
Cases Opened	40
Cases Closed	31
SSA Savings	$1,512,390
Medicaid/Medicare Savings	$2,345,718
Total Savings	$3,858,108

The April-June 2015 quarter furnished OIG other opportunities for statewide collaboration as well. Inspector General Manny Tyndall continued to participate in Governor Haslam's Public Safety Subcabinet Working Group, and he was also invited to join the Opioid Abuse Reduction Act Working Group chaired by the Commissioner of the Tennessee Department of Mental Health and Substance Abuse Services.

[9] 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.

[10] 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).