TennCare Quarterly Report

April – June 2019

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Amendments to the TennCare Demonstration. Five proposed amendments to the TennCare Demonstration were in various stages of development during the April-June 2019 quarter.

Demonstration Amendment 35: Substance Use Disorder Services. In May 2018, TennCare submitted Demonstration Amendment 35 to the Centers for Medicare and Medicaid Services (CMS). Amendment 35 would modify the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies such facilities as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities. Historically, TennCare's managed care organizations (MCOs) were permitted to cover residential treatment services in IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to other treatment options. However, CMS recently issued regulations restricting the ability of MCOs to pay for services in these facilities. Specifically, the new federal regulation limits this option to treatment stays of no more than 15 days per calendar month.[1] TennCare is seeking authority with Amendment 35 to allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

During the April-June 2019 quarter, TennCare and CMS continued their discussions concerning Amendment 35, including the possibility of using authority contained in federal opioid legislation (the SUPPORT Act) in lieu of modifications to the TennCare Demonstration. As of the end of the quarter, CMS's review of Amendment 35 was ongoing.

Demonstration Amendment 36: Providers of Family Planning Services. Amendment 36 was submitted to CMS in August 2018. Amendment 36 grew out of Tennessee's 2018 legislative session and, in particular, Public Chapter No. 682, which established that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of

[1] See 42 CFR § 438.6(e).

care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Amendment 36 requests authority for TennCare to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. As specified in Public Chapter No. 682, TennCare is proposing to exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity.

CMS held a 30-day federal public comment period on Amendment 36 during the third quarter of Calendar Year 2018. Close to 3,500 comments were received, and CMS subsequently began to review that feedback as well as the amendment itself. As of the end of the April-June 2019 quarter, CMS's review of Amendment 36 was ongoing.

Demonstration Amendment 37: Modifications to Employment and Community First CHOICES. On November 8, 2018, TennCare submitted Amendment 37 to CMS. Amendment 37 primarily concerns modifications to be made to Employment and Community First (ECF) CHOICES, TennCare's managed long-term services and supports program that is specifically geared toward promoting and supporting integrated, competitive employment and independent, integrated living as the first and preferred option for people with intellectual and developmental disabilities.

The primary modification to ECF CHOICES contained in Amendment 37 is the addition of two new sets of services and two new benefit groups in which the services would be available:

- ECF CHOICES Group 7 would serve a small group of children who live with their family and have intellectual and/or developmental disabilities (I/DD) and severe co-occurring behavioral health and/or psychiatric conditions. These children—who are at significant risk of placement outside the home (e.g., State custody, hospitalization, residential treatment, incarceration)—would receive family-centered behavioral health treatment services with family-centered home and community-based services (HCBS).
- ECF CHOICES Group 8 would serve adults with I/DD and severe behavioral and/or psychiatric conditions who are transitioning out of a highly structured and supervised environment to achieve and maintain stable, integrated lives in their communities. Individuals in Group 8 would receive short-term intensive community-based behavioral-focused transition and stabilization services and supports.

Other changes to ECF CHOICES contained in Amendment 37 include modifications to expenditure caps for existing benefit groups within the program, revised eligibility processes to facilitate transitions from institutional settings to community-based settings, and modifications and clarifications to certain ECF CHOICES service definitions.

Apart from the changes to ECF CHOICES, Amendment 37 would also revise the list of populations automatically assigned to the TennCare Select health plan by allowing children receiving Supplemental Security Income to have the same choice of managed care plans as virtually all other TennCare members.

During the April-June 2019 quarter, discussions between TennCare and CMS on Amendment 37 continued. By the conclusion of the quarter, discussions on the amendment were nearly complete, and CMS approval was expected to follow shortly thereafter.

Demonstration Amendment 38: Community Engagement. TennCare submitted Amendment 38 to CMS on December 28, 2018. Demonstration Amendment 38 implements a state law (Public Chapter No. 869) enacted by the Tennessee General Assembly in 2018. This law directed TennCare to seek federal authorization to establish reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. The legislation also required TennCare to seek approval from the U.S. Department of Health and Human Services (HHS) to use funds from the state's Temporary Assistance for Needy Families (TANF) program to support implementation of the community engagement program.

Preliminary discussions between TennCare and CMS on Amendment 38 have focused on certain operational details of the proposal, such as monitoring enrollee compliance with program requirements, as well as exempting economically distressed counties. As of the end of the April-June 2019 quarter, CMS' review of Amendment 38 was ongoing.

Demonstration Amendment 39: Program Modifications. On April 15, 2019, TennCare submitted Demonstration Amendment 39 to CMS. Amendment 39 outlined program changes that would be needed if the hospital assessment were not renewed during the 2019 Tennessee legislative session. Changes to the TennCare benefit package for non-exempt adults proposed in Amendment 39 were the following:

- 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.

As was the case in previous years, however, the General Assembly renewed the hospital assessment, thereby eliminating any funding gap in the TennCare program. Consequently, on May 29, 2019, TennCare withdrew Amendment 39 from consideration by CMS.

TennCare Connect Update. After a statewide launch in the previous quarter, TennCare's successful implementation of its new eligibility system and member portal—known as TennCare Connect—continued during the April-June 2019 quarter. During this quarter, TennCare completed the final conversions of member data into the new system. In addition, the final significant functionality related to the processing of SSI eligibility was also added to the system in late May to make the new system officially complete. TennCare Connect allows applicants and members to submit online applications and verification information to TennCare, as well as communicate with TennCare through a state-of-the art call center and mobile app. TennCare Connect is significantly improving the consumer experience for members and applicants and making the TennCare application and renewal process more user-friendly and easier to navigate.

Update on Episodes of Care. Episodes of care is a delivery system reform strategy that focuses on acute or specialist-driven health care delivered during a specified time period to treat physical or behavioral conditions such as an acute diabetes exacerbation or total joint replacement. Each episode has a principal accountable provider who is in the best position to influence the cost and quality of the episode.

Each year, TennCare hosts an annual feedback session in which stakeholders can provide in-person feedback on episode design at six locations across the state. The feedback session for this year was held on May 21, 2019, and was attended by over 100 providers. Attendees offered a number of suggestions for improving program design. Examples of this year's feedback include recommendations about how to identify the accountable provider more effectively and how to account for school-based services. Several speakers also expressed satisfaction with the program or appreciation for modifications previously made to the program by TennCare.

During the May 21 session, TennCare also showcased a new online document that answers frequently asked questions about episodes of care. The document, which is available on TennCare's website at https://www.tn.gov/content/dam/tn/tenncare/documents2/ForYourPatientsForYourPractice.pdf, was well received by stakeholders.

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[2] 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

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

the funding for administrative costs. Tennessee's EHR program[3] has issued payments for six years to eligible professionals and for three years to eligible hospitals.[4]

EHR payments made by TennCare during the April-June 2019 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 2019)	Cumulative Amount Paid to Date[5]
First-year payments	N/A	N/A	$179,892,011
Second-year payments	85	$682,834	$59,683,417
Third-year payments	90	$869,391	$37,444,185
Fourth-year payments	90	$750,834	$8,381,015
Fifth-year payments	117	$974,668	$5,352,171
Sixth-year payments	71	$592,157	$2,980,090

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 on a daily basis 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 2018 meaningful use attestations for returning eligible professionals;
- Partnering with the Tennessee Primary Care Association to provide clinical education and outreach to Federally Qualified Health Centers seeking to attest to meaningful use;
- Responding to provider questions at information expos hosted by Amerigroup Community Care and UnitedHealthcare in Chattanooga, Jackson, Johnson City, Knoxville, Memphis, and Nashville;
- Newsletters and alerts distributed by TennCare's EHR ListServ.

Although enrollment of new providers concluded on April 30, 2017, TennCare's EHR Incentive Program will continue through the 2021 program year as required by CMS rules. Tennessee's program team continues to work with a variety of provider organizations to maintain the momentum of the program, with particular emphasis on the benefits of electronic health records for patients. The focus of post-enrollment outreach efforts for 2019 is to encourage provider participants who remain eligible to continue attesting and complete the program, and to ensure that EHR technology is used by providers to improve clinical decision-making and health outcomes.

[3] In April 2018, CMS announced that its EHR programs would be renamed "Promoting Interoperability (PI) Programs." While Tennessee's EHR initiative falls within the scope of CMS's PI Programs, TennCare continues to refer to its initiative as "EHR Incentive Program" for purposes of clarity and consistency in communications with providers.

[4] At present, all but three participating hospitals have received three years of incentive payments.

[5] In certain cases, cumulative totals reflect adjustments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

Pharmacy Benefits Manager Readiness Activities. In January 2019, TennCare announced that OptumRx, Inc. had been selected through a competitive procurement process to replace Magellan Medicaid Administration as TennCare's Pharmacy Benefits Manager (PBM). Although Optum will not start processing pharmacy claims for TennCare until January 1, 2020, the company began readiness activities in March 2019. Priorities during this period of transition include the following:

- Establishing and managing a pharmacy network;
- Building a claims processing system and loading it with all information (enrollee data, edits specific to TennCare's outpatient formulary, clinical/quantity requirements, etc.) necessary for adjudication of claims;
- Creating a call center and website to assist patients and providers; and
- Helping TennCare negotiate and collect supplemental rebates from pharmaceutical manufacturers.

During the April-June 2019 quarter, preparations focused on the proper transfer to OptumRx of various types of pharmacy data, including those involving historical claims, prior authorization, TennCare's drug formulary, supplemental rebates, and drug pricing. Challenges involved in such a high volume of data conversion were anticipated and addressed early in the PBM transition period and are being addressed in a timely manner as they arise.

Supplemental Payments to Tennessee Hospitals. The Division of TennCare makes supplemental payments to qualifying Tennessee hospitals each quarter to help offset the costs these facilities incur in providing uncompensated care. The methodology for distributing these funds is outlined in Attachment H of the TennCare Demonstration Agreement with CMS. The supplemental payments made during the fourth quarter of State Fiscal Year 2019 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Fourth Quarter Payments – FY 2019
Methodist Medical Center of Oak Ridge	Anderson County	$100,919
Ridgeview Psychiatric Hospital and Center	Anderson County	$186,757
Tennova Healthcare – Shelbyville	Bedford County	$30,026
Blount Memorial Hospital	Blount County	$134,881
Tennova Healthcare – Cleveland	Bradley County	$124,487
Jellico Community Hospital	Campbell County	$103,274
Tennova Healthcare – LaFollette Medical Center	Campbell County	$62,845
Saint Thomas Stones River Hospital	Cannon County	$24,129
Sycamore Shoals Hospital	Carter County	$81,365
Claiborne Medical Center	Claiborne County	$24,519
Tennova Healthcare – Newport Medical Center	Cocke County	$67,074

Hospital Name	County	Fourth Quarter Payments – FY 2019
Tennova Healthcare – Harton	Coffee County	$65,280
Unity Medical Center	Coffee County	$46,607
TriStar Skyline Medical Center	Davidson County	$397,701
Nashville General Hospital	Davidson County	$427,043
Saint Thomas Midtown Hospital	Davidson County	$233,090
TriStar Centennial Medical Center	Davidson County	$572,453
TriStar Southern Hills Medical Center	Davidson County	$153,580
TriStar Summit Medical Center	Davidson County	$162,509
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$13
Vanderbilt University Medical Center	Davidson County	$3,955,316
Saint Thomas DeKalb Hospital	DeKalb County	$25,442
TriStar Horizon Medical Center	Dickson County	$185,760
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$157,709
Jamestown Regional Medical Center	Fentress County	$17,990
Southern Tennessee Regional Health System – Winchester	Franklin County	$60,325
Milan General Hospital	Gibson County	$21,195
Southern Tennessee Regional Health System – Pulaski	Giles County	$40,319
Laughlin Memorial Hospital	Greene County	$67,810
Morristown – Hamblen Healthcare System	Hamblen County	$115,838
Erlanger Medical Center	Hamilton County	$2,526,125
Parkridge Medical Center	Hamilton County	$1,205,930
HealthSouth Rehabilitation Hospital – Chattanooga	Hamilton County	$481
Kindred Hospital – Chattanooga	Hamilton County	$308
Siskin Hospital for Physical Rehabilitation	Hamilton County	$1,274
Hardin Medical Center	Hardin County	$65,881
Henderson County Community Hospital	Henderson County	$17,529
Henry County Medical Center	Henry County	$84,679
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$26,103
Parkwest Medical Center	Knox County	$344,435
Tennova Healthcare – North Knoxville Medical Center	Knox County	$105,637
East Tennessee Children's Hospital	Knox County	$2,379,697
Fort Sanders Regional Medical Center	Knox County	$221,187
University of Tennessee Medical Center	Knox County	$1,813,413
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$34,947
Lincoln Medical Center	Lincoln County	$169,663
Jackson – Madison County General Hospital	Madison County	$556,747
Pathways of Tennessee	Madison County	$162,763
Maury Regional Hospital	Maury County	$208,143
Starr Regional Medical Center – Athens	McMinn County	$60,027

Hospital Name	County	Fourth Quarter Payments – FY 2019
Sweetwater Hospital Association	Monroe County	$134,567
Tennova Healthcare – Clarksville	Montgomery County	$121,612
Baptist Memorial Hospital – Union City	Obion County	$65,405
Livingston Regional Hospital	Overton County	$33,470
Cookeville Regional Medical Center	Putnam County	$129,041
Roane Medical Center	Roane County	$46,903
NorthCrest Medical Center	Robertson County	$85,916
Saint Thomas Rutherford Hospital	Rutherford County	$239,011
TriStar StoneCrest Medical Center	Rutherford County	$143,476
TrustPoint Hospital	Rutherford County	$41,267
LeConte Medical Center	Sevier County	$130,833
Baptist Memorial Restorative Care Hospital	Shelby County	$1,280
Baptist Memorial Hospital – Memphis	Shelby County	$612,921
Methodist University Hospital	Shelby County	$1,079,627
Crestwyn Behavioral Health	Shelby County	$23,762
Delta Medical Center	Shelby County	$254,676
HealthSouth Rehabilitation Hospital – North Memphis	Shelby County	$396
HealthSouth Rehabilitation Hospital – Memphis	Shelby County	$453
LeBonheur Children's Hospital	Shelby County	$3,870,303
Regional One Health	Shelby County	$3,046,832
Regional One Health Extended Care Hospital	Shelby County	$103
Saint Francis Hospital	Shelby County	$278,239
Saint Jude Children's Research Hospital	Shelby County	$744,083
Bristol Regional Medical Center	Sullivan County	$117,065
HealthSouth Rehabilitation Hospital – Kingsport	Sullivan County	$985
Holston Valley Medical Center	Sullivan County	$217,669
Indian Path Community Hospital	Sullivan County	$102,080
TriStar Hendersonville Medical Center	Sumner County	$136,255
Sumner Regional Medical Center	Sumner County	$114,474
Baptist Memorial Hospital – Tipton	Tipton County	$81,376
Saint Thomas River Park Hospital	Warren County	$42,098
Johnson City Medical Center	Washington County	$1,606,271
Franklin Woods Community Hospital	Washington County	$76,767
Quillen Rehabilitation Hospital	Washington County	$552
Wayne Medical Center	Wayne County	$34,034
Spire Cane Creek Rehabilitation Hospital	Weakley County	$67
West Tennessee Healthcare Volunteer Hospital	Weakley County	$46,698
HealthSouth Rehabilitation Hospital – Franklin	Williamson County	$5
Rolling Hills Hospital	Williamson County	$1,718
Williamson Medical Center	Williamson County	$38,911
Tennova Healthcare – Lebanon	Wilson County	$292,574
TOTAL		**$31,625,000**

Number of Recipients on TennCare and Costs to the State

During the month of June 2019, there were 1,397,698 Medicaid eligibles and 18,642 Demonstration eligibles enrolled in TennCare, for a total of 1,416,340 persons.

Estimates of TennCare spending for the fourth quarter of State Fiscal Year 2019 are summarized in the table below.

Spending Category	Fourth Quarter FY 2019*
MCO services**	$1,748,835,900
Dental services	$44,910,600
Pharmacy services	$305,638,700
Medicare "clawback"***	$54,545,700

**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 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[6] are processed and paid within 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[7] are processed and paid within 21 calendar days of receipt.	TennCare contract

[6] Excludes Personal Emergency Response Systems (PERS), assistive technology, minor home modifications, and pest control claims. Claims for delivery of these services are handled like general MCO claims.

[7] Ibid.

Entity	Standard	Authority
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 April-June 2019 quarter, the MCOs submitted their NAIC First Quarter 2019 Financial Statements. As of March 31, 2019, TennCare MCOs reported net worth as indicated in the table below.[8]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$32,303,660	$191,925,756	$159,622,096

[8] The "Net Worth Requirement" and "Reported Net Worth" figures in the table are based on the MCOs' company-wide operations, not merely their TennCare operations.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$98,223,126	$410,667,649	$312,444,523
Volunteer State Health Plan (BlueCare & TennCare Select)	$53,841,080	$407,791,220	$353,950,140

During the April-June 2019 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.

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of March 31, 2019.

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 fourth quarter of Fiscal Year 2019 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	Fourth Quarter FY 2019
Fraud Allegations	1,335
Abuse Allegations*	865
Arrest/Conviction/Judicial Diversion Totals	**Fourth Quarter FY 2019**
Arrests	26
Convictions	17
Judicial Diversions	5

***** *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	Fourth Quarter FY 2019
Court Costs & Taxes	$1,012
Fines	$12,300
Drug Funds/Forfeitures	$2,027
Criminal Restitution Ordered	$86,769
Criminal Administrative Fee Received	$500
Criminal Restitution Received[9]	$81,437
Civil Restitution/Civil Court Judgments	**Fourth Quarter FY 2019**
Civil Restitution Ordered[10]	$0
Civil Restitution Received[11]	$9,936
Civil – Administrative Fee	$200

Recommendations for Review	Fourth Quarter FY 2019
Recommended TennCare Terminations[12]	84
Potential Savings[13]	$341,238

Program Totals

The following table identifies monies ordered by the courts as a direct result of TennCare fraud investigations conducted by the OIG since its inception in 2004. Some of these forms of restitution relate to types of fraud (e.g., food stamps) that do not relate directly to the TennCare program but that were discovered and prosecuted by OIG during the course of a TennCare fraud investigation.

Type of Court-Ordered Payment	Grand Total for Period of 2004-2019
Restitution to Division of TennCare	$5,268,028
Restitution to TennCare MCOs	$90,768
Restitution to Law Enforcement	$18,996
Food Stamps	$81,337
Fines	$1,373,306
Court Costs	$378,401
Drug Funds	$477,865

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

[10] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

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

[12] 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.

[13] 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 $4,062.36).