TennCare Quarterly and Annual Report

Submitted to the TennCare Oversight Committee and the Fiscal Review Committee

July 15, 2008

Status of TennCare Reforms and Improvements

For the quarter and for the year:

Waiver extension. The five-year waiver under which TennCare had operated since July 1, 2002, was scheduled to expire on June 30, 2007. The state had requested a three-year extension to the waiver on June 15, 2006, and negotiated with CMS for this extension through the winter of 2006 and the spring of 2007.

On June 29, 2007, CMS sent the state a letter extending the existing waiver until July 13, 2007. Five subsequent extensions were granted, with respective end dates of August 15, August 31, September 14, September 30, and October 15.

The approval letter finally came from CMS on October 5, 2007. Key changes in the demonstration included the following:

- There is a new cap on supplemental payments to hospitals. The annual limit on all supplemental payments to hospitals is $540 million.
- Amendments to the demonstration must be submitted no later than 120 days prior to implementation.
- TennCare Standard children with incomes below 200% of poverty are now considered "SCHIP children," although they continue to be eligible for all TennCare benefits.
- TennCare is required to revise its cost-sharing policies so that no cost-sharing amounts exceed those charged by CoverKids, the state's SCHIP program.
- There are significant new reporting requirements with respect to reporting member months and linking expenditures and member months to eligibility groups.

Long-term care transformation. On March 6, 2008, Governor Bredesen announced details of the "Long-Term Care Community Choices Act of 2008." This Act fundamentally restructures the Medicaid Long-Term Care (LTC) service delivery system for persons in Tennessee who are elderly and adults who have physical disabilities.

The Special Joint Legislative Committee to Study the Development and Implementation of a LTC Plan worked closely with the Administration and aging and disability consumer

groups including AARP, nursing facility industry representatives, and other long term care providers, to craft the legislation.

Some of the key components of the Act are as follows:

- It provides for the expansion of home and community based services—the ability to offer more kinds of home care options and to serve more people using existing LTC funds.

- A single entity will help TennCare members access all of the different kinds of Medicaid benefits they need, including medical, behavioral, nursing facility, and home care services.

- This will be accomplished by integrating LTC within the existing managed care system, building in strong consumer protections and aligning financial incentives in order help ensure that the right care is provided in the right place at the right time.

- Over time, these changes will help to rebalance LTC spending between institutional and home and community based care.

- The bill includes certain cost controls to help ensure that the state doesn't make obligations or promises beyond our ability to pay for them.

- It provides for a "Single Point of Entry" to help people who need LTC and their families find out about the options that are available and how to access them.

- It includes requirements to streamline eligibility—to make changes in the system to help make it easier and faster to access LTC services.

- It provides for the expansion of more kinds of cost-effective community-based residential alternatives to nursing home care, including models like Adult Care Homes in Oregon which serve people in small, family-type settings.

- It provides for the development and implementation of an acuity-based reimbursement methodology for nursing facility services—we will pay nursing homes based on the level of need of the persons they serve.

- It also provides assistance to nursing homes (which are a critical part of the LTC continuum) in diversifying their businesses—so they can begin to offer the same kinds of services they offer in their facilities today in people's homes as well.

- It provides for more options and choices for persons receiving HCBS, which may include the ability to select, direct, and even employ, staff who will deliver care, with careful controls in place to ensure accountability for taxpayer funds.

- It provides for some additional funding for things like meals on wheels, homemaker services, and personal care to be provided through the State-funded Options program for people who are not eligible for Medicaid and are currently on a waiting list for those services.

- It changes the licensure requirements for Assisted-Care Living Facility Services to allow the benefit to be more flexible so that people will not be forced to leave their "home" in an Assisted Living Facility in order to receive certain kinds of medical services that could safely be provided there, just as they could be in the person's private residence.

- It establishes a LTC Oversight Committee to continue to oversee the development and implementation of the managed LTC system created by this Act to ensure that the new system needs the needs of Tennesseans who need long term care services.

The bill was passed by unanimous votes in both the House and Senate and has the added distinction of having passed through every assigned committee of both houses without a single "no" vote. The bill was signed into law this summer.

Already, the state has begun implementation of those components that do not require federal approval. These include changes to help streamline eligibility determination processes, as well as provider enrollment and payment processes, and to establish a Single Point of Entry for persons seeking long-term care services.

Even with these small changes, enrollment in the state's existing HCBS waiver program has nearly tripled over the last year to more than 3,700 persons served. Funding by the General Assembly will permit continued access to HCBS for an additional 2,300 persons while the state seeks an amendment to the TennCare 1115 waiver in order to put broader long-term care reforms in place. The target date to begin implementation of broader changes is July 1, 2009.

Standard Spend Down (SSD) program. Once the extension to the waiver had been approved on October 5, 2007, the state was ready to move forward with enrolling persons in the SSD program. The SSD program is intended to serve non-pregnant adults who meet criteria patterned after those of the Medicaid Medically Needy program.

The first group to be tested for eligibility for the new program included persons whose eligibility in the Medicaid Medically Needy category for non-pregnant adults had been held open since April 29, 2005, when the state officially closed that category to new enrollment. Once all of the persons in that group have been tested for eligibility, the state's intent is to open the program to new applicants.

In November 2007 the state conducted an ex parte review of persons in the first group. An ex parte review occurs when the state matches data on enrollees with data from other programs, such as the Social Security Administration, to determine if our enrollees would qualify for another Medicaid category and could thus be moved into that category so that they can remain eligible for TennCare.

After the ex parte review process had been completed, the state began sending out Requests for Information (RFIs) to persons who had not been determined eligible through the ex parte review process. These mailings occurred in batches so that the Department of Human Services would be able to complete eligibility determinations in a timely fashion. Approximately 35,000 RFIs were sent out between February and the end of the state's fiscal year.

As of the end of the state fiscal year, approximately 500 people who received RFIs have been found eligible for Standard Spend Down. An additional 1500 have been found to be eligible for Medicaid categories.

NASMD Executive Committee. This year TennCare Director Darin Gordon was named to the 12-member Executive Committee of the National Association of State Medicaid Directors. NASMD is a bipartisan, professional, nonprofit organization of representatives from state Medicaid agencies and has been affiliated since 1979 with the American Public Human Services Association (APHSA). It plays an active role in discussing issues with CMS and in fostering communication among states about matters of concern. As a member of this committee, Director Gordon will be able to ensure that Tennessee has a voice in policy development at the federal level.

New contractors. There were several contract procurement processes that occurred during the year, with new contractors joining the program.

- In September, Keystone Peer Review Organization, or KePro, began work on TennCare medical appeals. KePro replaced Schaller-Anderson of Tennessee in this role.
- In September, the Bureau issued a Request for Proposal (RFP) for reprocurement of a facilities manager for the TennCare Management Information System (TCMIS). The winning bid came from ACS State Healthcare, Inc., replacing EDS. The new contract was to start in February, but the start date was delayed because of a protest from another bidder on the project.
- In January the Bureau released an RFP for health care plans to offer integrated medical and behavioral services in East and West Tennessee. (A similar process was completed during the 2006-2007 year in Middle Tennessee.) Bid winners announced in April were AmeriChoice and BlueCross BlueShield of Tennessee. These new plans will be operational in West Tennessee on November 1 of the coming year and East Tennessee on January 1.
- In February the Bureau released an RFP for a Pharmacy Benefits Manager (PBM). The purpose of the RFP was to secure a contract for a state-of-the-art online Point of Sale (POS) pharmacy claims processing system with a prospective drug utilization review (Pro-DUR) and retrospective DUR (retro-DUR) capability, as well as other reporting and adjudication capabilities. The successful bidder, announced in April, was SXC. SXC will be replacing First Health when the new contract begins on October 1.

Home health and private duty nursing services. In late 2006 and early 2007, Tennessee made rule clarifications in the home health and private duty nursing benefit to assist TennCare's managed care health plans in being able to better manage the benefit and address the growth being experienced.

Tennessee's home health and private duty nursing coverage, utilization and expenditures are outliers when compared to other state Medicaid programs. Tennessee has no coverage limitations on these benefits, while most other states have limits on the home health benefit and many do not offer private duty nursing services to people over age 21 at all. Adult private duty nursing is an optional Medicaid benefit.

In December 2007, TennCare discussed during a public budget hearing the unsustainable growth the program was experiencing with respect to these two services -

home health and private duty nursing. The fact that home health and private duty nursing costs were growing at an unsustainable rate prompted TennCare to propose a restructuring of the benefit. More detailed information about the expenditures and utilization of home health and private duty nursing in the TennCare program can be found in the state's most recent independent actuarial report.

In February 2008 Tennessee requested that CMS allow TennCare to place reasonable limits on the home health and private duty nursing benefits. TennCare's original proposal involved a cost ceiling for adults using home heath and private duty nursing that would not exceed the cost of nursing facility care. After working with CMS, TennCare modified its request to more closely resemble the benefit structure used by other states and Medicare, establishing weekly limitations on home health services and limiting the private duty nursing benefit to technology dependent adults. These limits do not affect children under age 21.

As of the end of State Fiscal Year 08, TennCare was still awaiting approval from CMS. The request is in the final approval stages.

While awaiting federal approval of benefit limits, TennCare trained its health plans on use of the "least costly alternative" component of the state's statutory definition of medical necessity to address some of the growth of home health and private duty nursing. The "least costly alternative" is a factor plans may use in determining the medical necessity of a requested service. If the proposed course of diagnosis or treatment is not the least costly alternative that is available to the enrollee and that will adequately meet the enrollee's needs, then that course of diagnosis or treatment would not meet the definition of medical necessity.

The rate of growth experienced in home health and private duty nursing has been most pronounced in the middle region of the state. TennCare has been in discussions with both of the plans in the middle region for the last months of SFY 08 as part of the normal annual process the state uses to update rates for the upcoming contract period and to make additional programmatic modifications. Typically the state amends the health plans' contracts at least twice a year for such reasons, but at a minimum once a year.

TennCare's discussions with both of the at-risk plans in the middle region, Amerigroup and AmeriChoice, as well as the state's actuaries, have included the experience with home health and private duty nursing services in their first year of operation in the middle region, as well as the annual rate renewal for the coming contract period. The state's independent actuary considered the plans' actual experience when calculating the rate renewal. The actuaries determined that rate adjustments were required for the April 1, 2007 – March 31, 2008 period, the April 1, 2008 – June 30, 2008 period, and the July 1, 2008 – June 30, 2009 period. The July 2008 rates were based on health plan experience, taking into consideration any changes to TennCare's benefit structure.

It is important to note that home health and private duty nursing services are different than what is typically referred to as home and community based services (HCBS). The first are more medical and "hands on" in nature, while the latter offer a broader range of assistance with activities of daily living. Currently, and in the history of the program, the managed care organizations are not responsible for HCBS and nursing home services but are responsible for home health and private duty nursing services.

***Daniels* Motion.** On February 1, 2008, the state entered a motion asking permission of the federal court to implement a process for redetermining the eligibility of *Daniels* class members and disenrolling those who are found to be ineligible for TennCare. The *Daniels* class is composed of persons who at one time received SSI cash benefits from the federal government but have since been determined ineligible for those benefits. SSI eligibles are automatically TennCare eligible. However, in the absence of the lawsuit, persons who no longer qualify for SSI eligibility would not be able to remain on TennCare unless they were determined eligible in another category.

There are about 154,000 persons in the *Daniels* class, many of whom may be ineligible for TennCare once their eligibility is redetermined. These individuals would, therefore, be subject to disenrollment. Some class members are incarcerated, and as such, would not be eligible for TennCare. An Agreed Order was entered by the Court at the end of February 2008 allowing the state to begin terminating the eligibility of *Daniels* class members who are, or who become, either incarcerated in a state penitentiary or incarcerated as a state prisoner in a county jail. On June 11, 2008, TennCare sent termination notices to 1,737 *Daniels* class members identified as incarcerated individuals. Eligibility for these individuals was terminated on July 1, 2008.

The format of the reverification process for the remaining members of the *Daniels* class remains an undecided issue. As of July 2008, formal discovery was reopened for the production of both electronic and hardcopy records.

John B. During the second quarter of SFY 07-08, continued progress was made on discovery in the *John B.* case. *John B. v. Menke* is a case brought on behalf of all TennCare beneficiaries under age 21 that challenged the adequacy of the provision of EPSDT services. A Consent Decree was entered in this case in 1998, and TennCare continues to be involved in litigation concerning its compliance with the terms of the Decree.

Preservation of electronic documents was the focus of attention in this quarter. The plaintiffs allege that the state has not preserved its electronic documents appropriately and that the voluminous paper documents provided to them over the years are therefore insufficient. On November 15 and 19, 2007, the District Court issued a series of Orders requiring, among other things, that computers of state workers, including those of the Governor, be forensically imaged by the plaintiff's computer expert. The forensic imaging process was to extend to the privately owned home computers of any state workers who had used their home computers for state business. Federal marshals were to oversee the process.

The state appealed this Order to the Sixth Circuit Court of Appeals in Cincinnati. An *amicus* brief supporting the state's position was filed jointly by the states of Ohio, Kentucky, and Michigan, which are the other states included in the Sixth Circuit. On November 26, 2007, the Sixth Circuit issued a stay of the Order, pending further review. On December 7, 2007, a more lengthy Order was issued by the Sixth Circuit. This Order extended the stay, observing that the orders in the case "are extremely broad" and "raise issues of federalism and comity not presented in the typical civil discovery dispute." During the months of January and February, briefs were to be prepared for the Sixth Circuit by the state and by the plaintiffs. Oral arguments were heard by the Sixth Circuit in March 2008.

On June 26, 2008, the Sixth Circuit, finding there was no purposeful or intentional destruction of relevant electronically stored information, granted the state's petition for mandamus and set aside those provisions of the District Court's Orders that required the forensic imaging of state-owned and privately-owned computers, including the provisions that would have required that U.S. Marshals oversee the imaging process.

Discovery continued on the case in areas that were not stayed, namely electronic document discovery of vast numbers of state e-mails and other electronically stored documents. The state has also been required to produce numerous databases containing transactional data related to the Medicaid program. Each of the Managed Care Contractors has also been required to produce similar materials.

Removal of premiums. In accordance with Section VI of the STCs, effective December 1, 2007, the state ceased collecting new premium payments from any TennCare enrollees. Notices were mailed to all enrollees with premium obligations informing them that premiums were no longer required, although enrollees would continue to remain responsible for any past-due premiums.

Reduction in audit findings. On February 28, 2008, the Comptroller's office released its annual audit of TennCare. The audit showed a significant decrease in the number and severity of findings, down to only three for the year, as compared to 39 just six years ago. One of the three findings dealt with the *Daniels* case, which has been a repeat finding for several years. As noted above, the state is taking steps to address this issue.

Medicaid Transformation Grant. On January 17, 2009, TennCare was notified that we had been awarded an additional $223,254 for our Medicaid Transformation grant for an Electronic Prescription Pilot Project. These funds are for Federal Fiscal Year 2008 and are in addition to $450,950 awarded for Federal Fiscal Year 2007. The project was designed to assist physicians who practice in rural areas and who lack access to e-prescription technology. Fifty rural physician practices in 13 counties are participating in the e-prescribing initiative.

Medicaid Emergency Room Diversion grant. The Deficit Reduction Act of 2005 provided $50 million in Federal grant funds for State Medicaid agencies to develop alternative non-emergency service providers, primarily in rural or underserved areas and, as a result, reduce the use of hospital emergency rooms for the treatment of non-emergent medical conditions. CMS made use of a competitive application process to distribute the funds, and on April 15, 2008, CMS announced that the grant funds would be distributed to 20 state Medicaid programs over a two-year period. Based on the merit of the Bureau of TennCare's application, Tennessee received a total of $4,472,240 for the implementation of one Medicaid Emergency Room Diversion initiative in each Grand Region of the State. TennCare will forward the entire award directly to communities so that local hospitals and clinics can provide TennCare enrollees with the opportunity to access healthcare services from the most appropriate service provider, resulting in improved health for TennCare enrollees and overall cost savings.

Through partnerships with TennCare managed care contractors, Federally Qualified Health Centers, and healthcare service providers, this grant award will be used to implement unique initiatives in Haywood, Hamilton, and Davidson Counties that collectively include establishing new health clinics; extending the hours of operation for existing clinics; coordinating care through effective referral and health information

exchange processes; and educating TennCare enrollees about establishing or revitalizing a healthcare home, effectively accessing routine medical services, and utilizing available TennCare-related information and resources to facilitate access to care. Beginning July 1, 2008, the Haywood County Clinic, Nashville Medical Home Connection, and the Volunteer State Health Plan Partnership initiatives will lay the groundwork for expanded access to routine healthcare services for TennCare enrollees at times when traditional provider offices are not available for care; within 18 months, the alternative non-emergency service providers settings will be fully operational.

Autism detection grant. On November 8, 2007, the Bureau of TennCare announced a grant to the Tennessee chapter of the American Academy of Pediatrics (TNAAP) to help community-based pediatricians evaluate young children for autism, a highly prevalent developmental condition. The grant enabled the Vanderbilt Kennedy Center's Treatment and Research Institute for Autism Spectrum Disorders (TRIAD) to train community pediatricians to assess children suspected of having autism so that they can receive specialized intervention as soon as possible. The new program is called START ED (Screening Tools and Referral Training - Evaluation and Diagnosis).

Five Middle Tennessee pediatricians participated in the six-month pilot, which began with a two-day training workshop. Pediatricians learned how to assess the children and interview their parents to make a diagnostic determination. They also videotaped autism assessments from their own practices to gather feedback.

Annual beneficiary survey. Each year the Bureau of TennCare conducts a survey of Tennesseans to gather information TennCare enrollees' satisfaction with their health care. This survey has been conducted every year since 1993 by the Center for Business and Economic Research (CBER) at the University of Tennessee.

The 2007 survey was published in August. CBER reported that the uninsured rate for all Tennesseans declined to 10 percent in 2007, after a significant increase the previous year. The uninsurance rate for children was measured at 4.8 percent.

CBER reported that respondents who were TennCare eligibles continued to express satisfaction with their care. Ninety percent of TennCare enrollees said that they were either somewhat satisfied or very satisfied with their health care, an increase from 87 percent in 2006.

The survey found that the efforts to educate TennCare enrollees about the most cost-effective ways to get medical care appear to be paying off in fewer emergency room visits and more visits to doctors' offices. The number of TennCare enrollees seeking care at hospital emergency rooms in 2007 was the lowest level of any year since the survey started. Only 4 percent reported going to the hospital first, down from 7 percent in 2006 and 14 percent in 1993.

Recognition for healthcare technology innovation. In a report released on August 21, 2007, the U. S. Office of Inspector General for the Department of Health and Human Services found that the Bureau of TennCare is among the few state Medicaid agencies implementing electronic health initiatives. Of the 52 agencies surveyed, TennCare was one of only 12 found to be using innovative health information technology in its day-to-day operations. TennCare also was one of only five such state agencies that have developed e-prescribing initiatives for their providers.

TennCare, in partnership with Shared Health, has implemented a claims-based electronic health record (EHR) that contains diagnoses, procedure or visit information, and prescription histories. It contains non-claims information from other sources, such as lab results from participating labs and immunization records provided by the Department of Health. The TennCare EHR also allows providers to maintain other pertinent information such as vital signs, allergies, and documentation of early periodic screening, diagnosis, and treatment (EPSDT) screenings.

TennCare also offers e-prescribing to its providers through the secure TennCare EHR web portal. The e-prescribing application includes information about TennCare's drug formulary, dosing instructions, and side effects, and it offers a tool to alert providers about potential drug interactions based on a patient's prescription history or allergies. Such health information technology and health information exchange initiatives have been identified by the Governor and federal officials as having the potential to reduce health care costs that arise from inefficiency, medical errors, inappropriate care, and incomplete information.

Essential Access Hospital payments. The TennCare Bureau continued to make Essential Access Hospital payments during this period. Essential Access Hospital payments are payments from a pool of $100 million ($36,265,000 in state dollars) appropriated by the General Assembly.

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 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 do not have unreimbursed TennCare costs, and the five state mental health institutes.

The projected Essential Access Hospital payments for the fourth quarter of State Fiscal Year 2008 are shown in the following table. The total payments for the year are also included in the table.

	FY 2008	
Name of Hospital	**4th Qtr EAH**	**Total FY 2008**
Regional Medical Center (The Med)	$ 4,900,894	$ 19,603,576
Vanderbilt University Hospital	$ 2,743,042	$ 10,972,168
Erlanger Medical Center	$ 1,594,760	$ 6,379,040
University of Tennessee Memorial Hospital	$ 1,562,381	$ 6,249,524
Metro Nashville General Hospital	$ 993,725	$ 3,974,900
Methodist Healthcare Lebonheur	$ 881,319	$ 3,525,276
Johnson City Medical Center Hospital	$ 705,198	$ 2,820,792
Jackson Madison County General Hospital	$ 544,636	$ 2,180,036

Name of Hospital	FY 2008 4th Qtr EAH	Total FY 2008
East Tennessee Childrens Hospital	$ 368,681	$ 1,474,724
Methodist University Healthcare	$ 346,679	$ 1,387,666
Saint Francis Hospital	$ 340,576	$ 1,363,238
Tennessee Christian Medical Center	$ 338,466	$ 1,354,792
University Medical Center	$ 310,310	$ 1,242,090
Saint Jude Childrens Research	$ 296,377	$ 1,186,320
Wellmont Bristol Regional Medical Center	$ 268,828	$ 1,076,048
Middle Tennessee Medical Center	$ 268,614	$ 1,075,192
Methodist Healthcare South	$ 257,904	$ 1,032,322
Fort Sanders Regional Medical Center	$ 255,673	$ 1,023,392
Wellmont Holston Valley Medical Center	$ 229,249	$ 917,624
Delta Medical Center	$ 226,406	$ 906,244
Centennial Medical Center	$ 220,576	$ 882,908
Baptist Hospital	$ 212,613	$ 851,036
Saint Mary's Health System	$ 197,189	$ 789,296
Northcrest Medical Center	$ 195,354	$ 781,952
Gateway Medical Center	$ 187,416	$ 750,178
Maury Regional Hospital	$ 185,200	$ 711,852
Baptist Hospital of Cocke County	$ 175,938	$ 704,234
Methodist Healthcare North	$ 174,107	$ 696,906
Parkridge Valley Hospital	$ 172,403	$ 689,612
Sumner Regional Medical Center**	$ 155,416	$ 622,090
Methodist Medical Center of Oak Ridge	$ 141,261	$ 565,432
Bradley Memorial Hospital	$ 139,491	$ 558,346
Sweetwater Hospital Association	$ 138,703	$ 555,192
Morristown Hamblen Healthcare System	$ 137,538	$ 550,530
Wellmont Hawkins County Memorial Hospital	$ 134,178	$ 537,080
Fort Sanders Sevier Medical Center	$ 133,917	$ 536,036
Blount Memorial Hospital	$ 127,979	$ 512,266
Cookeville Regional Medical Center	$ 126,572	$ 506,634
Lakeway Regional Hospital	$ 115,516	$ 462,380
Parkridge East Hospital	$ 115,340	$ 461,676
Jellico Community Hospital	$ 113,747	$ 455,298
Cleveland Community Hospital	$ 113,475	$ 454,210
Dyersburg Regional Medical Center	$ 112,479	$ 450,224
Cumberland Medical Center	$ 110,139	$ 440,858
Summit Medical Center	$ 108,776	$ 435,402
Hardin County General Hospital	$ 105,156	$ 420,912
Regional Hospital of Jackson	$ 105,122	$ 420,776
Bedford County Medical Center	$ 104,877	$ 419,796
Claiborne County Hospital	$ 103,876	$ 415,788
Pathways of Tennessee	$ 103,684	$ 414,736
Baptist Hospital of East Tennessee	$ 102,834	$ 411,618
Baptist Memorial Hospital Tipton	$ 102,184	$ 409,016
St. Marys Medical Center of Campbell County	$ 101,828	$ 407,592
Jamestown Regional Medical Center	$ 97,997	$ 392,258

Name of Hospital	FY 2008 4th Qtr EAH	Total FY 2008
Sycamore Shoals Hospital	$ 90,704	$ 363,064
Laughlin Memorial Hospital	$ 88,615	$ 354,702
Humboldt General Hospital	$ 88,160	$ 352,880
Henry County Medical Center	$ 87,953	$ 352,052
Skyline Medical Center	$ 85,977	$ 344,144
Baptist Memorial Hospital for Women	$ 84,268	$ 337,304
Indian Path Medical Center	$ 82,606	$ 330,650
Stonecrest Medical Center	$ 79,782	$ 319,346
Hillside Hospital	$ 77,451	$ 310,016
Harton Regional Medical Center	$ 76,609	$ 306,646
Southern Hills Medical Center	$ 75,803	$ 303,418
Horizon Medical Center	$ 73,418	$ 293,874
Community Behavioral Health	$ 72,519	$ 290,076
Parkridge Medical Center	$ 72,382	$ 289,726
Grandview Medical Center	$ 70,129	$ 280,708
North Side Hospital	$ 66,039	$ 264,336
Southern Tennessee Medical Center	$ 59,171	$ 236,846
Scott County Hospital	$ 58,477	$ 234,068
Takoma Adventist Hospital	$ 58,201	$ 232,964
Ridgeview Psychiatric Hospital and Center	$ 57,540	$ 230,160
Roane Medical Center	$ 56,633	$ 226,688
Jefferson Memorial Hospital	$ 56,543	$ 226,326
Athens Regional Medical Center	$ 55,008	$ 220,182
Baptist Memorial Hospital Union City	$ 54,364	$ 217,606
Bolivar General Hospital	$ 54,076	$ 216,454
Crockett Hospital	$ 52,703	$ 210,958
Woodridge Psychiatric Hospital	$ 51,055	$ 204,220
Methodist Healthcare Fayette	$ 50,031	$ 200,262
Hendersonville Medical Center	$ 49,230	$ 197,054
River Park Hospital	$ 49,106	$ 196,560
Fort Sanders Loudon Medical Center	$ 45,382	$ 181,652
United Regional Medical Center	$ 45,354	$ 181,540
Lincoln Medical Center	$ 44,954	$ 179,938
Woods Memorial Hospital	$ 44,408	$ 177,754
Livingston Regional Hospital	$ 44,020	$ 176,200
McNairy Regional Hospital	$ 43,929	$ 175,836
Indian Path Pavilion	$ 42,799	$ 171,196
McKenzie Regional Hospital	$ 42,016	$ 168,180
Gibson General Hospital	$ 40,828	$ 163,424
Volunteer Community Hospital	$ 34,941	$ 139,860
Wayne Medical Center	$ 33,115	$ 132,550
Tennessee Christian Medical Center Portland	$ 32,748	$ 131,082
Stones River Hospital	$ 31,449	$ 125,882
White County Community Hospital	$ 30,675	$ 122,784
Haywood Park Community Hospital	$ 30,401	$ 121,688
Unicoi County Memorial Hospital	$ 29,766	$ 119,146

Name of Hospital	FY 2008 4th Qtr EAH	Total FY 2008
Baptist Memorial Hospital Huntingdon	$ 28,163	$ 112,728
Baptist Dekalb Hospital	$ 27,109	$ 108,510
Decatur County General Hospital	$ 25,411	$ 101,714
Henderson County Community Hospital	$ 25,177	$ 100,778
Milan General Hospital	$ 23,825	$ 95,366
Erlanger North Hospital	$ 23,678	$ 94,776
Smith County Memorial Hospital	$ 23,363	$ 93,516
Emerald Hodgson Hospital	$ 21,325	$ 85,358
Cumberland River Hospital	$ 13,987	$ 55,986
Johnson City Specialty Hospital	$ 12,822	$ 51,322
Women's East Pavilion	$ 12,366	$ 49,498
Baptist Womens Treatment Center	$ 2,585	$ 10,348
Baptist Treatment Center of Murfreesboro	$ 2,252	$ 9,014
	$ 25,000,000	$100,000,000

- Projected 4th Qtr. EAH payments

Reverification Status

We have completed a good deal of work on reverifying the eligibility of those non-pregnant Medically Needy adults who have been on TennCare since that category was closed to new enrollment in 2005. These persons were held on TennCare pending approval of the waiver extension, which occurred in October of 2007. The reverification process has been approved by CMS and the Sixth Circuit Court of Appeals.

On January 24, 2008, TennCare mailed approximately 7,000 notices to the first group of enrollees scheduled for reverification. These enrollees received a notice and a Request for Information (RFI). They had until February 29, 2008, to complete the RFI and return it to the Department of Human Services to be reviewed for any open category of Medicaid or for eligibility in the new Standard Spend-Down (SSD) program.

Our second set of RFIs, going to approximately 7,200 people, was mailed on February 28, 2008. Responses were due back on March 31, 2008.

The third set of RFIs, going to approximately 6,747 people, was mailed at the end of March, and the fourth set, going to approximately 6,800 people, was mailed at the end of April. The fifth set, going to approximately 6,900 people, was mailed at the end of May.

Once the reverification process for the non-pregnant adult Medically Needy population is complete, our goal is to open the SSD program to new enrollment.

Status of Filling Top Leadership Positions in the Bureau

Two key appointments were made this year in the Information Systems area.

Roger Oren was appointed June 1, 2007, as Information Systems Director, Division of Information Systems, responsible for managing the application development component of the Bureau's facilities management contract. In addition he is responsible for management of applications that support over 2,000 users across several state agencies, including TennCare, the Department of Human Services, the Department of Children's Services, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, the Department of Health, the Office of the Inspector General and others. Mr. Oren has over 16 years management experience and possesses an MBA with a focus on Finance and International Business from Mercer University, an MS in Computer Science from University of New Haven, and is a certified Project Management Professional (PMP).

Tammy Gennari was appointed October 1, 2007, as Information Systems Director, Division of Information Systems. Ms. Gennari will serve as Director of Claims and Encounters, directing activities for both internal and external staff relating to the processing and storage of claims and encounter data through the TennCare Management Information System (TCMIS). TennCare claims and encounter data represent the administrative record of care for over 1 million Tennesseans and provide supporting detail for a majority of the approximate $8 billion in annual program expenses. Ms. Gennari brings to TennCare over 15 years of experience in Medicaid operations with particular expertise in system operations and business process management. She possesses a BS in Interpersonal Communication from Ohio University, and is a certified Project Management Professional (PMP).

Number of Recipients on TennCare and Costs to the State

At the end of the quarter and the end of the year, there were 1,187,742 Medicaid eligibles and 33,541 uninsured/uninsurable persons enrolled in TennCare, for a total of 1,221,283 persons.

Projections of TennCare spending for the fourth quarter and the year are summarized in the table below. These are not final numbers, since the fiscal year will not close for accounting purposes until late fall 2008.

	4th Quarter*	Total*
Spending on MCO services**	$946,883,300	$3,185,562,300
Spending on BHO services	$86,954,600	$306,994,700
Spending on dental services	$36,642,700	$144,546,500
Spending on pharmacy services	$175,605,500	$695,688,200
Medicare "clawback"	$76,623,300	$230,597,400

**These figures are cash basis as of June 30 and are unaudited.*
***This figure includes Integrated Managed Care MCO expenditures.*

Claims payment analysis

The prompt pay requirements of T.C.A. § 56-32-226(b) mandate that each managed care organization ("MCO") and behavioral health organization ("BHO") ensure that 90% of clean claims for payment for services delivered to a TennCare enrollee are paid within 30 calendar days of the receipt of such claims and 99.5% of all provider claims are processed within 60 calendar days of receipt. TennCare's contract with its Dental Benefit Manager requires that the DBM also process claims in accordance with this statutory standard.

TennCare's contract with its Pharmacy Benefits Manager requires that the PBM must pay 95% of all clean claims within 20 calendar days of receipt and the remaining 5% of clean claims within the following 10 calendar days.

To monitor prompt pay compliance, TDCI requests the MCOs, BHOs, DBM and PBM to submit claims data by month on a quarterly basis. If the contractor has not processed claims timely in accordance with statutory and/or contractual requirements, the contractor is required to submit claims data on a monthly basis until it processes claims timely for three consecutive months. If an MCO or BHO does not comply with the prompt pay requirements, 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 determined, and the TennCare Bureau can also assess liquidated damages pursuant to the terms of the TennCare Contract. If the DBM or PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

During fiscal year 2008, TDCI requested data files of all processed TennCare claims from all TennCare contractors from May 2007 through April 2008. (Some contractors also had to submit claims data for May 2008 if they were on monthly reporting as described above.) TDCI also requested data files of pended TennCare claims and paid claims triangle lags to ensure that the claims data submitted was complete and accurate.

The analyses of the claims data during fiscal year 2007-2008 found the following contractors were out of compliance for at least one month:

- Windsor Health Plan – June 2007, July 2007, September 2007, October 2007, November 2007 and December 20071
- Volunteer State Health Plan (TennCare Select) – June 20072

1 Effective April 1, 2007, WHP no longer contracted with the TennCare Program to provide medical services to TennCare enrollees. The claims processed after the contract termination were claims with dates of service prior to April 1, 2007. The volume of "run out" claims being processed significantly decreased each month and most of the processed claims were adjustments. As a result, TDCI did not assess an administrative penalty for failure to comply with the prompt pay statute since the TennCare operations were in wind down during FY 2008. Furthermore, TDCI ceased testing WHP's compliance with the prompt pay statute after the MCO completed nine months of claims runout in December 2007.

2 VSHP has two (2) separate contracts with TennCare: Bluecare and TennCare Select. VSHP processed all BlueCare claims in accordance with the statutory prompt pay requirements and met

- Memphis Managed Care Corporation – June 2007 and August 20073
- Unison Health Plans – June 2007, July 2007, August 2007, September 2007 and October 20074
- Premier Behavioral Sytems of Tennessee – February 2008

Net worth requirement

By statute, the minimum net worth requirement for each TennCare MCO and BHO is established based on calendar year premium revenue. The TennCare MCOs and BHOs reported TennCare premiums for Calendar Year 2007 on their NAIC annual financial statements submitted to TDCI on March 1, 2008. As December 31, 2007, TennCare MCOs/BHOs reported net worth as indicated in the table below. TDCI's calculations for the net worth requirement reflect payments made for the calendar year ending December 31, 2007, including payments made under the "stabilization plan."

Reported Net Worth of MCOs/BHOs as of December 31, 2007

	Net Worth Require-ment	Reported Net Worth	Excess/ (Deficiency)
AMERIGROUP Tennessee [(A)]	15,656,844	24,061,114	8,404,270
UnitedHealthcare Plan of the River Valley (AmeriChoice)	24,300,637	168,499,155	144,198,518
Memphis Managed Care [(B)]	1,500,000	8,932,450	7,432,450
Preferred Health Partnership	6,837,598	39,149,233	32,311,635
UAHC Health Plan	7,226,227	14,616,274	7,390,047
Unison Health Plan	4,950,860	6,828,499	1,877,639
Volunteer (BlueCare & Select)	21,024,621	31,363,217	10,338,596
Windsor Health Plan	6,111,473	8,284,598	2,173,125
Premier Behavioral Systems	4,978,291	14,461,144	9,482,853
Tennessee Behavioral Health	6,638,818	14,822,842	8,814,024

[(A)] AMERIGROUP did not begin its TennCare operations until April 1, 2007. Per its contract with TennCare, it must maintain an enhanced net worth requirement based on projected annualized premiums until it has been in operation for one full calendar year. Also, effective November 1, 2007, AMERIGROUP purchased substantially all of Memphis Managed Care Corporation's operations, including its TennCare contract. As a result, AMERIGROUP's enhanced net worth requirement was increased to reflect this enrollment expansion.

[(B)] Because MMCC sold substantially all of its operations to AMERIGROUP effective November 1, 2007 and no longer had any enrollment as of that date, its net worth requirement was reduced to the statutory minimum of $1,500,000.

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the prompt pay requirements when the results for all claims VSHP processed in June 2007 were combined.

3 TDCI and MMCC entered into a consent order in which MMCC paid a $10,000 administrative penalty for its failure to comply with the statutory prompt pay requirements.

4 TDCI and Unison entered into a consent order in which UHP paid a $30,000 administrative penalty for its failure to meet the prompt pay requirements.

All TennCare MCOs and BHOs met their minimum net worth requirements for the calendar year ended December 31, 2007.

Each TennCare MCO and BHO is required to submit quarterly NAIC financial statements which are analyzed to ensure it is maintaining the minimum statutory and contractual net worth requirement determined from the NAIC annual financial statement. The MCOs and BHOs submitted their quarterly financial statements reporting results of operations for the quarter January 1, 2008 through March 31, 2008 to TDCI on June 1, 2008.

As of March 31, 2008, TennCare MCOs/BHOs reported net worth as indicated in the table below.

Reported Net Worth of MCOs/BHOs as of March 31, 2009

	Net Worth Require-ment	Reported Net Worth	Excess/ (Deficiency)
AMERIGROUP Tennessee	15,656,844	19,913,932	4,257,088
UnitedHealthcare Plan of the River Valley (d/b/a AmeriChoice)	24,300,637	167,418,880	143,118,243
Memphis Managed Care	1,500,000	9,538,019	8,038,019
Preferred Health Partnership	6,837,598	38,464,663	31,627,065
UAHC Health Plan	7,226,227	14,759,470	7,533,243
Unison Health Plan	4,950,860	7,630,814	2,679,954
Volunteer (BlueCare & Select)	21,024,621	29,131,570	8,106,949
Premier Behavioral Systems	4,978,291	16,635,298	11,657,007
Tennessee Behavioral Health	6,638,818	16,221,967	9,583,149

All TennCare MCOs and BHOs met their minimum net worth requirements as of March 31, 2008.

Financial issues

Xantus Healthplan of Tennessee, Inc. (Xantus). On June 30, 2008, the Xantus Liquidation made its final distribution of $10.3 million to providers for claims with dates of service prior to April 1, 1999, the date Xantus was placed in rehabilitation. Previous distributions made in 1999 and 2000 totaled approximately $50 million. As a result, the Xantus Liquidation made total distributions of $60.3 million against a total debt of $87.7 million. Because some providers did not elect to receive an interim distribution, the payout percentage varied among between providers, but the average payout was 69 cents of every dollar owed.

It should be noted that providers were paid 100% of the computed payable for claims for services provided to TennCare enrollees from April 1, 1999 through July 31, 2003.

Tennessee Coordinated Care Network d/b/a Access MedPlus (TCCN). On August 24, 2007, the TCCN Liquidation made the final distribution of $11.9 million to providers.

This final distribution, added to previous distributions totaling $39.5 million, resulted in medical providers receiving $51.4 million against a total provider debt of $76.1 million, or 68 cents of every dollar owed for claims with dates of service through October 20, 2001.

Universal Care of Tennessee (Universal). On May 6, 2008, the Universal Liquidation made its final distribution of $32.1 million to providers against a total debt of $50.6 million, or 63 cents of every dollar owed for claims for dates of service prior to April 12, 2002. Providers were paid 100% of the computed payable for claims for services provided to TennCare enrollees from April 12, 2002 to May 31, 2003.

Success of Fraud Detection and Prevention

The Office of Inspector General (OIG) was established four years ago (July 1, 2004). The mission of the OIG is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program.* 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 (MCC), OIG data mining, and the general public via the OIG web site, faxes, letters, and phone calls to the OIG hotline. The statistics for the fourth quarter of the 2007 - 2008 fiscal year are as follows:

***NOTE**: Included are the fiscal year totals (FYT) and the grand totals to date -- since the OIG was created (July 2004)*

Summary of Enrollee Cases

	Quarter	FYT	Grand Total
Cases Received	**7,792**	**24,099**	**100,318**
Cases Closed*	**7,399**	**21,891**	**98,456**

***Cases are closed when there is inadequate information provided to investigate the complaint, the information has been researched and determined to be unfounded, the case was referred to another agency (as per appropriate jurisdiction), or prosecuted by the OIG and closed. This number also includes reports the OIG runs for the TennCare Bureau regarding potential fraud or abuse.*

Summary of Enrollee Abuse Cases

	Quarter	T[2]
Abuse Cases Received	**3,773**	**33,466**
Abuse Cases Closed	**1,962**	**10,201**
Abuse Cases Referred [1]	**1,811**	**24,112**

[1] Abuse cases may be referred to the appropriate Managed Care Organization (MCO), the TennCare Bureau, or DHS for further review.

[2] Totals are for the last 24 months (eight quarterly reports)

Summary of Provider Cases

	Quarter	FYT	Grand Total
Cases opened	**127**	**283**	**1,219**
Cases closed	**105**	**246**	**1,012**
Cases referred to TBI*	**13**	**80**	**154**
Cases referred to HRBs**	**2**	**16**	**89**

***The OIG refers **provider cases** to the TBI Medicaid Fraud Unit (as per state and federal law) and assists with these investigations as requested.*

***Health Related Boards*

Summary of Arrests & Convictions

	Quarter	FYT	Grand Total
Arrests	**69**	**259**	**715**
Convictions	**38**	**117**	**293**
Diversions*	**11**	**52**	**117**

Note: *Special Agents were in the field making arrests effective February 2005.*

***Judicial Diversion**: A guilty plea or verdict subject to expungement following successful completion of probation. Tennessee Code Annotated § 40-35-313*

***Pre-trial Diversion**: Prosecution was suspended and if probation is successfully completed, the charge will be dismissed. Tennessee Code Annotated § 40-15-105*

Court Fines & Costs Imposed

	QUARTER	FYT	GRAND TOTAL
Fines	**$23,620.00**	**$61,270.00**	**$139,961.50**
Court Costs & Taxes	**$3,847.00**	**$21,051.50**	**$56,768.11**
Restitution (ordered)	**$64,363.07**	**$334,812.17**	**$1,108,974.97**
Drug Funds	**$2,079.50**	**$15,156.00**	**$19,108.50**

The OIG aggressively pursues enrollees who have apparently committed fraud or abuse against the TennCare program. The primary criminal case types are: drug cases (drug diversion, drug seekers, doctor shopping, and forging prescriptions), reporting a false income, access to other insurance, and living outside of the State of Tennessee.

Arrest Categories

Drug Diversion/Forged Prescription	498
Access to Insurance	55
Doctor Shopping	26
Operation Falcon III	32
Operation Falcon IV	16
False Income	30
Ineligible Person Using Card	15
Living Out Of State	10
Asset Diversion	7
Theft of Services	10
ID Theft	13
Aiding & Abetting	3
GRAND TOTAL	**715**

TennCare Referrals & Recoupments

	Quarter	FYT	Grand Total
Recoupment **1**	$48,342.99	$356,617.32	$1,340,640.42
Recommended TennCare Terminations **2**	3,492	13,179	34,297
Potential Savings**3**	$11,705,044	$43,675,144	$122,577,221

Footnotes for the *TennCare Referral and Recoupments* table

1 The total in the last column reflects dollars collected by the OIG and sent to the TennCare Bureau from February 15, 2005, (when a Fiscal Manager and an attorney joined the OIG staff to facilitate and document this process) through June 30, 2008.

2 Enrollee recommendations sent to the TennCare Bureau for consideration based on reports run from *file net* (i.e. Prisoner Report, State Wage Report, the Deceased Report, the Department of Human Resources Report, and the PARIS Report).

3 There were 3,492 enrollee terminations *recommended* by the OIG to the TennCare Bureau for their review during the fourth quarter. The TennCare Bureau uses $3,351.96 as the average annual cost per enrollee for MCO, Pharmacy, BHO, and Dental services (effective FY 08).

Investigative Sources

	Quarter	FYT	Grand Total
OIG Hot Line	1,071	4,413	17,410
OIG Mail Tips	50	335	3,050
OIG Web Site	349	1,530	5,950
OIG Email Tips	105	630	2,462

Other Investigative Sources for this Quarter:

Data Mining	6,110
Fax	85
Cash for Tips	42
Other	20

Case Type for this Quarter (*sample*)

Drug Diversion	400
Drug Seeker	927
Other Insurance	328
Income/Other Assets	1,331
Using Another Person's Card	54
Out of State	3,289
Transfer of Assets	13
Abusing ER	54
Dr. Shopping	268

The Office of Inspector General participated in the following activities during the fourth quarter:

Meetings with Law Enforcement Officials and other State Agencies:

Each of the Judicial Task Forces, District Attorneys, Sheriffs and Chiefs of Police, TBI Drug Diversion Task Force, Middle Tennessee Law Enforcement Committee (in Brentwood), the East Tennessee Medicaid Fraud Investigation Group, the District Attorney's Conference, the FBI National Academy Graduates Retraining Session, ROCIC Regional Meeting, Commission on Law Enforcement Accreditation, Law Enforcement Accreditation Coalition of Tennessee, FBI National Academy Associates bi-monthly meeting, the MCC Roundtable, Health Care Task Force, TennCare Bureau MIP, Judicial Drug Task Force Website Meeting, and the Southeast Regional Investigator's Meeting.

Presentations:
*Walgreens Pharmacy Managers – Middle Tennessee
*Walgreens Pharmacy Managers – East Tennessee
*National Association of Medicare Program Integrity Group
*U T Family Practice Group, East Tennessee
*Roane County Anti Drug Coalition
*MedStat National Meeting

Media:
*Channel 4 – Davidson County Drug Roundup
*WPLN – OIG arrests
*WLAC – OIG arrests

Training:
*FBI National Academy Retraining Session
*Grants Management Training
*TGMI
*TLEEDS
*Legal Division CEU classes
*Accounting CEU classes
*TLETA Instructor School

Other OIG Activities:

The OIG conducted a drug sting operation in conjunction with the Metropolitan Nashville Police Department in the Madison area of Davidson County. Fourteen people were indicted and arrested for selling their TennCare drugs and other related charges.

The OIG staff continues to work with the state's contractor, Medstat, to develop the fraud and abuse detection reports. The OIG is working with this vendor to initiate proactive reports for identifying TennCare fraud. Targeted queries are generated on a routine basis. The goal behind these reports and queries is to assist with a successful OIG investigation and prosecution of individuals who have violated the law as it pertains to TennCare fraud.

Two employee vacancies occurred during this quarter due to both taking jobs in the private sector.

Training continued for OIG personnel during this quarter. The Special Agents continued their annual In-Service training that includes POST required courses,

instruction regarding new policies and procedures, all qualifications with approved weapons, a legal update, accreditation updates, etc.

All CEU training continued for OIG "professional" staff members, i.e. attorneys, an accountant, registered nurses, and information technology personnel.

The Assistant Inspector General/Fiscal Manager, Georganne Martin, began participating in the 2008 TGMI class.

Deputy Inspector General Rob White participated in the 2008 TLEEDS class (Tennessee Law Enforcement Executive Development Association).

The OIG held a Lance Armstrong *Live Strong Day* during the lunch period to honor a colleague who is fighting cancer. National Live Strong Day is held each year throughout the United States on May 13.

The OIG hosted the spring 2008 LEACT meeting and training session for agencies from Tennessee involved in law enforcement accreditation.

The OIG Legal Division continues to assist OIG staff members by providing legal advice on issues including how to meet the requirements of various statutes and drafting and reviewing documents that have legal implications. The Legal Division facilitates the case preparation process and works closely with various District Attorneys toward a successful prosecution of OIG cases. They review all legal matters of the OIG and advise on pending legislative issues.

The Inspector General and the Deputy Inspector General over Criminal Investigations have continued visits to various Tennessee counties. In each jurisdiction visited, there is a courtesy call to the Sheriff and Chief of Police. The goal is to continue to solidify the collaboration between local law enforcement and the OIG. More visits are planned for the next quarter.

The OIG continues to maintain accredited status by complying with the standards of the Commission on Accreditation for Law Enforcement Agencies (CALEA). The OIG was accredited in November 2006. **The State of Tennessee OIG is the only Office of Inspector General agency to achieve law enforcement accreditation both nationally and internationally**. A re-accreditation on-site assessment and hearing will occur during the 2009 - 2010 fiscal year.

The Doctor Shopping legislation (approved by the General Assembly June 2007) has generated a number of criminal investigations. There have been 26 arrests as of this writing for Doctor Shopping. The OIG continues to mail letters and posters and provide presentations to notify licensed medical providers and law enforcement agencies in the state about this new law. As a result, positive feedback has been received.

Plans for next quarter:

a. Continue to exchange information with local, state, and federal government agencies.
b. Continue to work with Medstat to improve reports that would assist with the data mining function of the OIG.

c. Provide presentations and training for interested parties regarding TennCare fraud and the role of the OIG.
d. Continue staff training and develop best practices.
e. Continue to track the *Tips for Cash* pay incentive program for information that leads to a successful conviction for TennCare fraud. This program is a result of legislation from the 104th General Assembly.
f. Continue the process for re-accreditation (a three year process). The OIG was accredited in November 2006.
g. Continue using the newly created Doctor Shopping Law on investigations regarding suspected chronic abusers of the TennCare program.