TennCare Quarterly Report

Submitted to the Members of the General Assembly

July 15, 2011

NOTE: Since October 15, 2002, the Bureau of TennCare has been preparing Quarterly and Annual Reports, using the format provided in T.C.A. § 3-15-510(g). In the most recent Legislative session, this statute was repealed. The format of this report and future reports will be that found in T.C.A. § 71-5-104(c).

Status of TennCare Reforms and Improvements

Amendment #12. As originally submitted to CMS on February 28, 2011, Amendment #12 had proposed an array of changes to the TennCare benefit package for adults, including the elimination of several types of therapy; annual limits on an array of medical services and visits to providers; and a $2 per trip copay on non-emergency transportation for non-institutionalized, non-pregnant adults. Following the Tennessee General Assembly's passage of a one-year extension of the hospital assessment fee, the Bureau of TennCare notified CMS by letter dated May 5, 2011, that most of the TennCare benefit eliminations and reductions proposed in Amendment #12 would not be needed in State Fiscal Year 2012.

The Bureau amended Waiver Amendment #12 to include only the proposed $2 copay on non-emergency transportation. However, the State has learned of the possibility of some one-time funding that may be available as the result of federal processing errors made over a period of many years under the "Special Disability Workload" (SDW) program. The impact of these errors is that state Medicaid funds were paid out for services to individuals who should have received Medicare benefits. If the federal government allows the TennCare program to recover the SDW funds, the State will withdraw the Amendment #12 request for a proposed $2 copay on non-emergency transportation.

EHR Provider Incentive Program. The Electronic Health Record (EHR) Incentive Program awards cash grants to Medicare and Medicaid providers[1] who demonstrate "meaningful use" (i.e., use that is measurable in both quantity and quality) of electronic health record technology. TennCare administers

[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 and children's hospitals).

Tennessee's Medicaid EHR program, the vast majority of funding for which is provided by the federal government.[2] During the April-June quarter, Tennessee's EHR Incentive Program achieved milestones in the categories of provider registration, attestation, and distribution of grant monies.

The registration of providers continues to exceed expectations. Although early estimates had placed the likely number of registrants for all of calendar year 2011 at 1,500, 1,399 providers[3] were registered by the conclusion of the first six months alone. In addition, as of the end of the quarter, Tennessee led the nation in the number of verified[4] registrants with 1,216, which was 340 greater than Texas, the state with the second highest total.[5]

Similarly positive progress was made in the field of attestation, the process by which providers affirm that they meet encounter and certification requirements. Attestation began on April 1, 2011, and, by the end of June, appropriate paperwork had been mailed to 974 providers with just over 400 completed forms returned. One key to the success of attestation has been the Bureau's ability to communicate instructions and updates to providers through a dedicated webpage (located at http://www.state.tn.us/tenncare/hitech.html) and through newsletters distributed by TennCare's EHR ListServ (subscriptions to which may be obtained at http://www.state.tn.us/tenncare/medicaidhitemail.html).

The quarter drew to a close with Tennessee's first distributions of grant funds. The Bureau approved or issued almost $2.5 million in payments to a total of forty-five providers (three hospitals and forty-two medical professionals).

Fluoride Varnish and Dental Screening Program. On April 1, 2011, TennCare launched a new initiative to improve the dental health of enrollees within the age range of three through five years. The program reimburses non-traditional providers who conduct dental screenings and apply fluoride varnish to the teeth of eligible TennCare recipients.[6] The category of non-traditional providers includes all of the following:

- Primary Care Physicians
- Pediatricians
- Physician Assistants
- Nurse Practitioners
- Public Health Nurses

[2] The federal government covers 90% of administrative costs and 100% of the incentive payments.
[3] The registration total consists of 759 physicians, 479 nurse practitioners, 69 acute care hospitals, 35 physician assistants, 28 certified nurse midwives, and 29 dentists.
[4] Verification consists of making sure that a provider has a valid Medicaid identification number and Tennessee Health Care license, and has no sanctions.
[5] See https://portal.cms.hhs.gov/.
[6] To qualify for reimbursement, the provider must deliver both services during the same visit.

Eligible TennCare enrollees are permitted two visits per year, translating to one application of fluoride varnish every six months. The program is expected to expand the number of children who receive preventive dental services and may increase referrals to dentists for dental care.

The fluoride and varnish dental screening program is administered by Delta Dental through its TennDent program. Providers interested in participating can begin the application process online at http://www.tenndent.com/Fluoride.aspx.

CMMI Grant. On April 5, 2011, the Center for Medicare and Medicaid Innovation (CMMI) awarded TennCare a planning grant worth up to $1 million to devise a system of integrated care for dual eligibles.

CMMI, a division of CMS, was established by the Affordable Care Act to "test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care furnished to individuals" who are dually eligible for Medicare and Medicaid (called "dual eligibles").[7] Recognizing that dual eligibles are likely to have significant health care needs, and recognizing that the current system of care available to this population is fragmented and costly, CMMI invited states to submit proposals to integrate care for dual eligibles. The Bureau advanced a proposal to develop a plan that would add Medicare Part A and Part B benefits to the TennCare program, thereby allowing dual eligibles to receive coordination of care through their TennCare Managed Care Organizations.

Tennessee is one of only fifteen states to receive the award. Development of an approvable plan is the necessary first step to additional funding for the implementation of TennCare's plan. Further details about the award are available from CMMI at http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/state-demonstrations-to-integrate-care-for-dual-eligible-individuals.

John B. The *John B.* lawsuit addresses the adequacy of services provided by TennCare to children under the age of 21. Shortly after assuming responsibility for the case, Judge Thomas A. Wiseman, Jr. issued a Case Management Order, which identified current substantial compliance with the requirements of the consent decree as the primary issue to be resolved at trial. The Order also provided a schedule for discovery, and set a trial date of October 31, 2011. During the April-June quarter, both parties met the discovery requirements of Judge Wiseman's Order by exchanging preliminary witness lists, preliminary exhibit lists, and proposed factual stipulations. The State, moreover, produced data from two databases: TennCare's claims database (known as "interChange") and the Department of Children's Services' Tennessee Family and Child Tracking System (referred to as "TFACTS"). The Plaintiffs, in turn, submitted their contentions regarding the State's claims of compliance with the *John B.* consent decree.

The deposition of witnesses began on June 9 but will not conclude until next quarter. All aspects of discovery related to expert testimony will be conducted next quarter as well.

[7] See Section 3021 of the Affordable Care Act.

Conclusion of Emergency Room Diversion Grant. From April 15, 2008, through April 14, 2011, TennCare was the recipient of the Tennessee Emergency Room Diversion Grant (ERDG) from CMS. The aim of the program was to encourage TennCare enrollees who needed medical care for non-emergency health problems to seek treatment from providers other than emergency rooms. Funds from the grant were used to open and operate medical clinics in all three Tennessee Grand Regions as an alternative to emergency rooms. Use of these facilities was not restricted to TennCare enrollees, and non-TennCare patients were responsible for reimbursing the clinics—through insurance or self-pay—as they would any other provider. On April 14, 2011, two initiatives funded by the grant, Brownsville's Haywood County Clinic and Chattanooga's VSHP Partnership Erlanger, concluded operations.[8]

Both clinics fulfilled the goals for which they were designed. Over the course of its existence, Haywood County Clinic treated a total of 2,329 patients, 1,211 (or 52 percent) of whom were TennCare recipients. Virtually all of these individuals would have sought treatment in an emergency room had the clinic not existed. VSHP Partnership Erlanger's pediatric clinic,[9] furthermore, provided care to 16,960 patients, 10,854 (or 64 percent) of whom were Medicaid[10] recipients. Patients of both clinics expressed high levels of customer satisfaction: 94 percent of Haywood County Clinic's patients and 98 percent of VSHP Partnership Erlanger's patients stated that they were either "satisfied" or "very satisfied" with the care they had received.

Provider Investigations Unit. Although the Provider Investigations Unit (PIU) began operations only in September 2010, its work has already become a critical component in maintaining the integrity of the TennCare program.

The mission of the PIU is to "monitor provider claims to ensure that they are reasonable, appropriate and comply with TennCare Rules and Policies." Using data about unusual provider claims furnished by managed care contractors, providers, and other internal and external sources, the unit conducts thorough investigations before presenting its findings on civil matters to TennCare leadership, which in turn refers certain matters to the Attorney General's Office and findings on criminal matters to the Tennessee Bureau of Investigation (TBI).[11]

The PIU staff consists of two investigators, one Certified Professional Coder, and an investigations manager, all of whom have achieved Certified Fraud Examiner status. This level of expertise is necessary in addressing the complexities of more than seventy cases referred to the unit so far. While the demands of such a caseload are imposing, the PIU has established even broader objectives, including

[8] A third initiative, Nashville Medical Home Connection, ceased work at the end of the April-June 2010 quarter as the result of exhaustion of its ERDG funds.

[9] VSHP Partnership Erlanger's planned adult clinic never became operational.

[10] A portion of these patients were enrolled in the Medicaid programs in Alabama and Georgia, states that border Chattanooga.

[11] Previously, the PIU referred cases to a committee staffed by members of TennCare, the Attorney General's Office, TBI, and others; the committee, in turn, determined whether further investigation was warranted. This intermediate step has now been removed in the interest of efficiency.

heightened supervision of pain medication clinics and physicians who prescribe the drug Suboxone®. Additional goals will be defined as the unit's investigations continue and as its staff expands.[12]

Quality Improvement Strategy. As required by federal law,[13] federal regulation,[14] and the State's Waiver agreement with CMS,[15] TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. The Bureau submitted its annual update of the strategy—entitled "2011 Quality Assessment and Performance Improvement Strategy"—to CMS on June 2, 2011. In addition to laying out the measures of quality assurance already in place, the report outlines TennCare's goals and objectives for the years ahead. CMS approved TennCare's strategy on June 10, 2011, and the Bureau posted the document online at http://www.tn.gov/tenncare/forms/qualitystrategy2011.pdf.

Recognition of Chief Information Officer. In June 2011, TennCare Chief Information Officer Brent Antony was named one of eleven top executives and thought leaders in the healthcare information technology industry. The honor was bestowed jointly by eMids Technologies, a healthcare IT and consultation company, and Healthcare Payer News, an online news source dedicated to IT, finance, and policy in the field of health. Antony, who joined TennCare in 2005 and holds dual masters degrees in health systems management, oversees all aspects of the Bureau's information technology systems management. The eleven recipients of the honor were cited for "leadership and innovation in their field."

Essential Access Hospital (EAH) 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 ($34,220,000 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 Essential Access Hospital payments for the fourth quarter of State Fiscal Year 2011 are shown in the table below.

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[12] A registered nurse and a second Certified Professional Coder are scheduled to begin work for the PIU on July 18, 2011.

[13] 42 U.S.C. § 1396u-2(c)(1)(A)

[14] 42 C.F.R. § 438.202

[15] Special Term and Condition #45(c) of the TennCare Waiver, which is located online at http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Fourth Quarter FY 2011
Regional Medical Center at Memphis	Shelby County	$4,009,617
Vanderbilt University Hospital	Davidson County	$3,067,589
Erlanger Medical Center	Hamilton County	$1,780,356
Johnson City Medical Center (with Woodridge)	Washington County	$1,384,124
University of Tennessee Memorial Hospital	Knox County	$1,296,650
Metro Nashville General Hospital	Davidson County	$961,664
Methodist Healthcare - LeBonheur	Shelby County	$820,482
Jackson - Madison County General Hospital	Madison County	$683,819
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$518,939
Parkwest Medical Center (with Peninsula)	Knox County	$451,752
East Tennessee Children's Hospital	Knox County	$429,518
Methodist Healthcare - South	Shelby County	$401,416
Methodist University Healthcare	Shelby County	$384,454
Saint Jude Children's Research Hospital	Shelby County	$350,321
Saint Francis Hospital	Shelby County	$325,971
Pathways of Tennessee	Madison County	$276,395
Centennial Medical Center	Davidson County	$272,322
Skyline Medical Center (with Madison Campus)	Davidson County	$268,215
Saint Mary's Medical Center	Knox County	$265,332
Wellmont Holston Valley Medical Center	Sullivan County	$260,937
Fort Sanders Regional Medical Center	Knox County	$236,951
Maury Regional Hospital	Maury County	$234,727
Delta Medical Center	Shelby County	$207,841
Methodist Healthcare - North	Shelby County	$205,311
University Medical Center	Wilson County	$187,484
Baptist Hospital	Davidson County	$186,988
Skyridge Medical Center	Bradley County	$184,617
Middle Tennessee Medical Center	Rutherford County	$182,399
Parkridge East Hospital	Hamilton County	$181,789
Wellmont Bristol Regional Medical Center	Sullivan County	$178,344
Gateway Medical Center	Montgomery County	$172,948
Ridgeview Psychiatric Hospital and Center	Anderson County	$167,170
Cookeville Regional Medical Center	Putnam County	$165,387

Hospital Name	County	EAH Fourth Quarter FY 2011
NorthCrest Medical Center	Robertson County	$142,941
Baptist Memorial Hospital for Women	Shelby County	$141,735
Morristown - Hamblen Healthcare System	Hamblen County	$138,953
Fort Sanders Sevier Medical Center	Sevier County	$135,878
Summit Medical Center	Davidson County	$130,181
Dyersburg Regional Medical Center	Dyer County	$122,834
Sumner Regional Medical Center	Sumner County	$118,904
Southern Hills Medical Center	Davidson County	$110,898
Jellico Community Hospital	Campbell County	$107,721
Methodist Medical Center of Oak Ridge	Anderson County	$106,284
Sweetwater Hospital Association	Monroe County	$106,089
Blount Memorial Hospital	Blount County	$99,879
Horizon Medical Center	Dickson County	$99,199
Saint Mary's Medical Center of Campbell County	Campbell County	$97,663
StoneCrest Medical Center	Rutherford County	$97,457
Baptist Hospital of Cocke County	Cocke County	$96,445
Baptist Memorial Hospital - Tipton	Tipton County	$88,580
Bolivar General Hospital	Hardeman County	$88,347
Hardin Medical Center	Hardin County	$87,442
Wellmont Hawkins County Memorial Hospital	Hawkins County	$83,487
Jamestown Regional Medical Center	Fentress County	$81,329
Humboldt General Hospital	Gibson County	$80,658
Sycamore Shoals Hospital	Carter County	$77,231
Henry County Medical Center	Henry County	$76,486
Regional Hospital of Jackson	Madison County	$75,813
Cumberland Medical Center	Cumberland County	$75,301
Harton Regional Medical Center	Coffee County	$73,442
North Side Hospital	Washington County	$72,190
Roane Medical Center	Roane County	$68,150
Grandview Medical Center	Marion County	$67,956
Lakeway Regional Hospital	Hamblen County	$66,798
United Regional Medical Center	Coffee County	$66,111
Southern Tennessee Medical Center	Franklin County	$65,439
Heritage Medical Center	Bedford County	$64,187
Erlanger North Hospital	Hamilton County	$61,362
Baptist Memorial Hospital - Union City	Obion County	$58,749
Saint Mary's Jefferson Memorial Hospital, Inc.	Jefferson County	$58,054
Athens Regional Medical Center	McMinn County	$57,074
Takoma Regional Hospital	Greene County	$56,793

Hospital Name	County	EAH Fourth Quarter FY 2011
River Park Hospital	Warren County	$56,771
Community Behavioral Health	Shelby County	$56,435
Lincoln Medical Center	Lincoln County	$55,462
Skyridge Medical Center - West	Bradley County	$54,220
McNairy Regional Hospital	McNairy County	$52,094
Haywood Park Community Hospital	Haywood County	$47,062
Crockett Hospital	Lawrence County	$46,400
Livingston Regional Hospital	Overton County	$45,367
Claiborne County Hospital	Claiborne County	$40,805
Volunteer Community Hospital	Weakley County	$40,227
Hillside Hospital	Giles County	$34,781
Riverview Regional Medical Center - North	Smith County	$34,019
Gibson General Hospital	Gibson County	$32,104
Wayne Medical Center	Wayne County	$30,442
Methodist Healthcare - Fayette	Fayette County	$30,043
McKenzie Regional Hospital	Carroll County	$24,007
White County Community Hospital	White County	$22,454
Baptist Memorial Hospital - Huntingdon	Carroll County	$21,689
Henderson County Community Hospital	Henderson County	$20,289
Portland Medical Center	Sumner County	$19,112
Emerald Hodgson Hospital	Franklin County	$15,254
Johnson City Specialty Hospital	Washington County	$15,094
TOTAL		$25,000,000

Number of Recipients on TennCare and Costs to the State

At the end of the period April 1, 2011, through June 30, 2011, there were 1,190,255 Medicaid eligibles and 29,743 Demonstration eligibles enrolled in TennCare, for a total of 1,219,998 persons.

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

	4th Quarter*
Spending on MCO services**	$1,860,223,000
Spending on dental services	$49,169,000
Spending on pharmacy services	$192,562,000
Medicare "clawback"***	$34,338,000

**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 pay to the federal government to help offset costs the federal government incurs by covering the prescription benefit for enrollees who have both Medicare and Medicaid.*

Viability of MCCs in the TennCare Program

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

Entity	Standard	Authority
MCOs (non-CHOICES services)	90% of clean claims for payment for services delivered to TennCare enrollees are paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	T.C.A . § 56-32-126(b)
MCOs (CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[16] are processed and paid with 14 calendar days of receipt. 99.5% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[17] are processed and paid within 21 calendar days of receipt.	TennCare contract
DBM	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid	TennCare contract and in accordance

[16] 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.

[17] Ibid.

Entity	Standard	Authority
	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.	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,[18] and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by TennCare Contract (i.e., East, Middle, or West Grand Region) and by subcontractor (i.e., 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 the CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES claim types, by subcontractor, by TennCare contract, and by total claims processed for the month.

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

Net worth requirement. By statute, the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue for the most recent calendar year.

TDCI's calculations for the net worth requirement reflect payments made for the calendar year ended December 31, 2010. The TennCare Contract further requires the TennCare MCOs to establish an enhanced net worth based on projected additional annual premiums for the CHOICES program. TDCI based the net worth requirement calculation on the greater of total projected premiums, reported premiums, or cash premiums for calendar year 2010. During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) First Quarter 2011 Financial Statement. As of March 31, 2011, TennCare MCOs reported net worth as indicated in the table below.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
AmeriGroup Tennessee	$17,616,712	$178,060,815	$160,444,103
UnitedHealthcare Plan of the River	$53,559,633	$416,911,342	$363,351,709

[18] Since Delta Dental did not begin operations until October 1, 2010, the previous DBM's compliance with prompt pay requirements continues to be analyzed during its claims run-out period.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Valley (UnitedHealthcare Community Plan)			
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,651,682	$129,086,781	$94,435,099

All TennCare MCOs met their minimum net worth requirements as of March 31, 2011.

Success of Fraud Detection and Prevention

The mission of the 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 web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the fourth quarter of the 2010 - 2011 fiscal year are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	1,566	133,996
Abuse Cases Received*	1,169	62,595

***** *Abuse cases may be referred to the appropriate Managed Care Organization (MCO), the TennCare Bureau, or DHS for further review/action.*

Court Fines & Costs Imposed

	Grand Total
Fines	$470,712.00
Court Costs & Taxes	$188,033.48
Court Ordered Restitution	$1,725,179.34
Drug Funds/Forfeitures	$416,852.90

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 ineligible individuals using a TennCare card.

Arrest Categories

Category	Number
Drug Diversion/Forgery RX	472
Drug Diversion/Sale RX	574
Doctor Shopping	163
Access to Insurance	55
Operation Falcon III	32
Operation Falcon IV	16
False Income	71
Ineligible Person Using Card	19
Living Out Of State	17
Asset Diversion	7
ID Theft	45
Aiding & Abetting	5
Failure to Appear in Court	2
GRAND TOTAL	**1,478**

OIG Case Recoupment & Recommendations

	Grand Total
Court Ordered Recoupment	$3,667,584.53[19]
Recommended TennCare Terminations [20]	$49,354
Potential Savings[21]	$173,615,613.45

[19] This total 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, 2011.

[20] 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.

[21] Savings are determined by multiplying the number of enrollees whose coverage has been terminated by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).