TennCare Quarterly Report

Submitted to the Members of the General Assembly

July 13, 2012

Status of TennCare Reforms and Improvements

Approval of Waiver Amendments 14 and 16. On June 15, 2012, TennCare received notification that the Centers for Medicare and Medicaid Services (CMS) had approved Amendments 14 and 16 to the TennCare demonstration. (Amendment 15, which dealt with program reductions that would be required if the Hospital Assessment Fee were not renewed by the General Assembly, was withdrawn on April 3 after the fee had passed.)

Amendment 14 proposed changes to TennCare's CHOICES program, which delivers Long-Term Services and Supports (LTSS) to persons who qualify for TennCare-reimbursed Nursing Facility care. CHOICES currently has two groups:

- CHOICES Group 1, for persons receiving LTSS in a Nursing Facility; and
- CHOICES Group 2, for persons receiving Home and Community Based Services (HCBS) as an alternative to Nursing Facility care.

The waiver includes a third group, CHOICES Group 3, for persons who have been found to be "at risk" for Nursing Facility care, but this group has been closed since CHOICES began in 2010.

Under Amendment 14, an "interim" CHOICES Group 3 was to be added effective July 1, which will remain open for enrollment through December 31, 2013. Having this group open, with no enrollment target, means that the State can amend its "Level of Care" (LOC) criteria for Nursing Facility admission and ensure that Nursing Facility services are reserved for those with the highest acuity of need. The availability of Interim CHOICES 3 allows the State to make appropriate changes to the program while remaining in compliance with the "Maintenance of Effort" requirements of the Affordable Care Act.

Amendment 16 removed Disproportionate Share Hospital (DSH) funds from the list of supplemental pool payments subject to an annual cap in the current TennCare demonstration. TennCare made this request to be able to distribute to eligible hospitals the full Congressional allotment of DSH funds to which Tennessee is entitled in State Fiscal Year 2012 and in future years.

"TennCare PLUS" Proposal to Integrate Care. On May 17, 2012, TennCare submitted a proposal to the Medicare-Medicaid Coordination Office (MMCO) within CMS. The program outlined within the proposal is called "TennCare PLUS", and the population the program is designed to serve is Full Benefit Dual Eligibles (FBDEs), meaning individuals enrolled in both Medicare and Medicaid.[1] FBDEs represent more than 11 per cent of the total TennCare population and approximately 90 per cent of TennCare members receiving Long-Term Services and Supports through the Bureau's CHOICES program.

One of the principal health care problems that FBDEs face—the problem that TennCare PLUS is intended to address—is the fragmented nature of their coverage. Members of this population have one set of providers and benefits through Medicare and a different set through Medicaid. Medicare and Medicaid are not at all coordinated. The Medicare program does not even provide basic data to states to help them coordinate Medicaid services with Medicare benefits.

The Bureau's TennCare PLUS proposal seeks to eliminate this lack of coordination by assigning responsibility for each FBDE's Medicare and Medicaid benefits to a single entity: the individual's TennCare managed care organization (MCO). The MCO will deliver a comprehensive package of benefits—including primary care, acute care, prescription drug coverage, and long-term services and supports—which will be facilitated by care coordination. Savings achieved by Medicaid through this model of integration will be reinvested into the program and, if adequate, would be used to provide a supplemental set of dental, vision, and hearing benefits.

The TennCare PLUS proposal, available online at http://www.tn.gov/tenncare/forms/pluspropposal.pdf, reflects not just the vision of the Bureau, but also the feedback provided by a variety of stakeholders in meetings dating back to February 2011 and in public hearings held on May 3 and 8, 2012. If MMCO approves the proposal as submitted, implementation of TennCare PLUS would occur on January 1, 2014.

Application to Renew the TennCare Waiver. Unlike traditional fee-for-service Medicaid programs, TennCare is a demonstration project. In exchange for a waiver of certain federal statutes and regulations governing Medicaid, TennCare "demonstrates" the principle that a managed care approach to health care can extend coverage to people who would not otherwise be eligible for Medicaid, and can do so without increasing expenditures or diminishing the quality of care. One limitation imposed on demonstration projects, however, is that they may operate only for finite periods of time (referred to as "approval periods") before having to be renewed.

Although the TennCare demonstration does not expire until July 1, 2013, federal regulations require Medicaid programs to submit applications for renewal a full year in advance.[2] Furthermore, such applications must be preceded by a 30-day public notice and comment period, during which time the

[1] The only FBDEs who would be ineligible to participate in TennCare PLUS are those individuals enrolled in TennCare's Program of All-Inclusive Care for the Elderly (PACE), which already offers a fully integrated set of Medicare and Medicaid benefits to eligible individuals in Hamilton County.
[2] See 42 C.F.R. § 431.412(c).

details of the request for renewal must be made available for review, and the public must be provided multiple opportunities to provide feedback.[3] Therefore, in addition to publishing an abbreviated notice in several Tennessee newspapers and in the "Announcements" section of the *Tennessee Administrative Register*, TennCare created a dedicated page on its website. This webpage offered not only an overview of the TennCare demonstration, but also a copy of the draft renewal application, an email address and telephone number for submitting comments, a link to CMS's own online resources regarding TennCare, and information about two public hearings hosted by the Bureau on May 15 and 22 to solicit public comments.

The State's application to renew the TennCare demonstration was submitted to CMS on June 29, 2012.

New Pharmacy Leadership. On May 14, 2012, Bryan Leibowitz and Michael Polson joined the team responsible for managing TennCare's Pharmacy Division.

Bryan, who succeeds Nicole Woods as the Bureau's Director of Pharmacy, earned a Doctorate of Pharmacy degree from the Ernest Mario School of Pharmacy at Rutgers University. The range of Bryan's experience as a pharmacist—more than a decade spent in such varied disciplines as home infusion/specialty, hospital, retail, and pharmacy benefit management—uniquely qualifies him to oversee the complexities of a program that accounted for more than $826 million of TennCare's budget in State Fiscal Year 2012.

Michael joins the Pharmacy Division as its Clinical Director. The chief function of this role is to ensure that TennCare's pharmacy benefit is clinically appropriate based on the latest guidelines and medical research. Michael's educational achievements—a bachelor's degree in mathematical sciences, a master's degree in statistics, and a Doctorate of Pharmacy—in conjunction with his previous work experience at TennCare (within the Health Care Informatics Division) make him ideally suited for the position.

Providing optimal pharmaceutical care to TennCare enrollees within a fiscally responsible framework is the priority that Bryan and Michael have established in their tenure with the Bureau thus far.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Record (EHR) Incentive Program is a partnership between federal and state governments that grew out of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The purpose of the program, as its name suggests, is to provide financial incentives to Medicaid providers[4] to replace outdated, often paper-based approaches to medical record-keeping with an electronic system that meets rigorous certification criteria and that can improve health care delivery and quality. Currently, Medicaid providers may qualify for two types of payments:

[3] The details of the "State public notice process" are located at 42 C.F.R. § 431.408.

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

- First-year payments to providers who adopted, implemented, or upgraded to certified EHR technology capable of meeting "meaningful use" (i.e., use that is measurable in both quantity and quality) standards; and
- Second-year payments to providers who earned first-year payments in 2011 and achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2012 (for eligible hospitals) and calendar year 2012 (for eligible professionals).

TennCare administers Tennessee's Medicaid EHR program, the funding for which is provided by the federal government.[5] During the April-June 2012 quarter, TennCare not only continued to distribute first-year incentives, but also opened the attestation process for—and began the distribution of—second-year incentives.

Building on the momentum that had been established during calendar year 2011 and that accelerated considerably during the January-March 2012 quarter, the Bureau exceeded even its own expectations from April through June 2012. In those three months alone, TennCare issued over $34 million of first-year payments to a total of 676 providers, including 399 physicians, 198 nurse practitioners, 36 hospitals, 34 dentists, 5 certified nurse midwives, and 4 physician assistants. This achievement is largely attributable to TennCare's evolving communications network related to the EHR program, some facets of which are a dedicated webpage (the introductory segment of which is located at http://www.tn.gov/tenncare/ehr_intro.shtml), newsletters distributed by the Bureau's EHR ListServ, and the TennCare Provider Incentive Payment Program ("PIPP") portal that became operational in November 2011.

Those tools played a significant role in TennCare's activation of the next phase of the program: second-year payments. The web portal, for instance, was the mechanism through which providers submitted documentation—or "attested"—that they met the meaningful use criteria for such payments. (Tennessee was one of only sixteen states to take this step in early April 2012.) In addition, because the standards for determining whether meaningful use has been achieved are highly technical, TennCare staff posted an overview of the subject on the Bureau's website at http://www.tn.gov/tenncare/mu.shtml; addressed the topic in ListServ newsletters on May 8 and June 5; hosted a webinar for providers on May 23; and made an in-person presentation at a meeting of Medical Directors hosted by the Tennessee Primary Care Association on May 18. Given this active outreach effort, 22 providers—11 physicians, 10 nurse practitioners, and 1 hospital—had successfully applied for and received second-year payments totaling $546,698 by the conclusion of the April-June quarter.

Enhanced Coordination of Pharmacy Benefits and SXC Client Innovation Award. Pharmacy Benefits Manager SXC Health Solutions presented its 2012 Client Innovation Award to TennCare on April 25. The honor was bestowed on the Bureau in recognition of its successful implementation of SXC's Enhanced

[5] The federal government covers 90% of administrative costs and 100% of the incentive payments.

Coordination of Benefits (Enhanced COB) program in July 2011. Accepting the award on behalf of TennCare were Director Darin Gordon and Chief Medical Officer Wendy Long.

Enhanced COB enables TennCare to detect other forms of pharmacy insurance that an enrollee may have before a claim is processed. Instead of paying for a medication initially and then pursuing reimbursement from another insurer at a later point (a cycle frequently referred to as "pay and chase"), TennCare may now identify other forms of coverage before payment is rendered and require the pharmacist who filled the prescription to seek compensation from those sources first. Information provided to the pharmacist in response to a submitted claim is much more detailed than in the past and is designed to make redirection easier. Conservative estimates indicate that savings generated by the Enhanced COB program are twice as much as those produced prior to its implementation. As a result, "enhanced third party pharmacy collection" was included in TennCare's budget for State Fiscal Year 2013 as a method of reducing the Bureau's expenditures by $9,634,600 ($7,200,000 of federal funds and $2,434,600 of state funds).

The benefits of Enhanced COB are not limited to cost avoidance alone. When multiple insurers pay for an individual's medications, there is less coordination of care and, consequently, a greater likelihood that hazardous drug interactions or excessive drug quantities may result. By continually directing pharmacists to their patients' primary source of prescription drug coverage, conversely, more effective monitoring of medication regimens may be achieved. Although the impact of Enhanced COB on patient safety is difficult to quantify, the principle of improved coordination among insurers and providers is a central tenet of TennCare's vision of health care.

Quality Oversight Awards. As part of its quarterly meeting with the Bureau's External Quality Review Organization and Managed Care Contractors (MCCs) on June 12, TennCare's Division of Quality Oversight presented its second annual awards to the MCCs that demonstrated "excellence in improving healthcare for members as well as innovative and emerging best practices."

Nominations and awards were based on recommendations from TennCare's Quality Oversight staff, TennCare's Medical Director, and the MCCs themselves. While some honors (such as "2012 Highest Annual Quality Survey Score Award" and "2011 Highest NCQA-Ranked TennCare Health Plan Award") recognized MCCs, others (like "Disease Management Collaboration Award" and "CHOICES Care Coordinator of the Year Award") were bestowed on individual MCC staff members. The "Best All Around Award", which acknowledges exceptional performance across a broad spectrum of disciplines, was presented to Amerigroup.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the April-June 2012 quarter. Essential Access Hospital payments are payments from a pool of $100 million ($34,220,000 in State dollars) appropriated by the General Assembly and funded by the hospital assessment fee.

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 2012 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Fourth Quarter FY 2012
Regional Medical Center at Memphis	Shelby County	$3,918,611
Erlanger Medical Center	Hamilton County	$2,815,559
Vanderbilt University Hospital	Davidson County	$2,471,141
University of Tennessee Memorial Hospital	Knox County	$1,369,701
Johnson City Medical Center (with Woodridge)	Washington County	$1,173,395
LeBonheur Children's Medical Center	Shelby County	$768,520
Metro Nashville General Hospital	Davidson County	$751,593
Jackson - Madison County General Hospital	Madison County	$630,757
Methodist Healthcare - South	Shelby County	$567,179
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$497,192
East Tennessee Children's Hospital	Knox County	$481,480
Parkwest Medical Center (with Peninsula)	Knox County	$442,401
Methodist University Healthcare	Shelby County	$408,488
Saint Jude Children's Research Hospital	Shelby County	$345,034
Centennial Medical Center	Davidson County	$304,488
Saint Francis Hospital	Shelby County	$298,022
Delta Medical Center	Shelby County	$273,699
University Medical Center	Wilson County	$249,878
Skyline Medical Center (with Madison Campus)	Davidson County	$249,155
Wellmont Holston Valley Medical Center	Sullivan County	$244,410
Maury Regional Hospital	Maury County	$242,257
Mercy Medical Center	Knox County	$238,950
Pathways of Tennessee	Madison County	$222,372
Fort Sanders Regional Medical Center	Knox County	$213,117

Hospital Name	County	EAH Fourth Quarter FY 2012
Ridgeview Psychiatric Hospital and Center	Anderson County	$199,927
Middle Tennessee Medical Center	Rutherford County	$177,312
Methodist Healthcare - North	Shelby County	$174,868
Gateway Medical Center	Montgomery County	$173,520
Cookeville Regional Medical Center	Putnam County	$171,153
Baptist Hospital	Davidson County	$171,065
Wellmont Bristol Regional Medical Center	Sullivan County	$169,781
Skyridge Medical Center	Bradley County	$161,171
Baptist Memorial Hospital for Women	Shelby County	$144,904
Parkridge East Hospital	Hamilton County	$144,815
Morristown - Hamblen Healthcare System	Hamblen County	$139,812
NorthCrest Medical Center	Robertson County	$139,054
Summit Medical Center	Davidson County	$126,383
Regional Hospital of Jackson	Madison County	$115,342
LeConte Medical Center	Sevier County	$113,715
Sweetwater Hospital Association	Monroe County	$113,290
Sumner Regional Medical Center	Sumner County	$112,687
StoneCrest Medical Center	Rutherford County	$110,156
Baptist Hospital of Cocke County	Cocke County	$110,053
Dyersburg Regional Medical Center	Dyer County	$109,390
Methodist Medical Center of Oak Ridge	Anderson County	$106,850
Southern Hills Medical Center	Davidson County	$106,607
Baptist Memorial Hospital - Tipton	Tipton County	$106,255
Horizon Medical Center	Dickson County	$103,811
Blount Memorial Hospital	Blount County	$103,801
United Regional Medical Center	Coffee County	$98,623
Saint Mary's Medical Center of Campbell County	Campbell County	$98,351
Takoma Regional Hospital	Greene County	$84,088
Harton Regional Medical Center	Coffee County	$84,015
Jellico Community Hospital	Campbell County	$83,928
Hendersonville Medical Center	Sumner County	$83,885
Sycamore Shoals Hospital	Carter County	$81,178
Community Behavioral Health	Shelby County	$77,701
Athens Regional Medical Center	McMinn County	$72,868
Lakeway Regional Hospital	Hamblen County	$71,774
Hardin Medical Center	Hardin County	$71,737
Heritage Medical Center	Bedford County	$70,122
Henry County Medical Center	Henry County	$69,531
Indian Path Medical Center	Sullivan County	$68,522
Crockett Hospital	Lawrence County	$64,484
Saint Mary's Jefferson Memorial Hospital	Jefferson County	$61,910
River Park Hospital	Warren County	$61,016

Hospital Name	County	EAH Fourth Quarter FY 2012
Humboldt General Hospital	Gibson County	$60,755
Southern Tennessee Medical Center	Franklin County	$59,347
Grandview Medical Center	Marion County	$58,710
Bolivar General Hospital	Hardeman County	$58,263
Claiborne County Hospital	Claiborne County	$58,010
Lincoln Medical Center	Lincoln County	$56,893
Wellmont Hawkins County Memorial Hospital	Hawkins County	$53,605
Baptist Memorial Hospital - Union City	Obion County	$52,893
Jamestown Regional Medical Center	Fentress County	$50,293
Roane Medical Center	Roane County	$48,738
Hillside Hospital	Giles County	$47,564
Skyridge Medical Center - West	Bradley County	$46,619
Riverview Regional Medical Center - North	Smith County	$41,536
Livingston Regional Hospital	Overton County	$41,506
Volunteer Community Hospital	Weakley County	$38,195
Methodist Healthcare - Fayette	Fayette County	$35,737
McKenzie Regional Hospital	Carroll County	$34,407
Wayne Medical Center	Wayne County	$32,724
McNairy Regional Hospital	McNairy County	$29,037
Henderson County Community Hospital	Henderson County	$28,381
Haywood Park Community Hospital	Haywood County	$26,979
Baptist Memorial Hospital - Huntingdon	Carroll County	$26,526
Erlanger East Hospital	Hamilton County	$24,153
Gibson General Hospital	Gibson County	$23,949
Johnson City Specialty Hospital	Washington County	$21,465
White County Community Hospital	White County	$20,329
Decatur County General Hospital	Decatur County	$20,029
Emerald Hodgson Hospital	Franklin County	$16,503
TOTAL		$25,000,000

Number of Recipients on TennCare and Costs to the State

At the end of the period April 1, 2012, through June 30, 2012, there were 1,199,740 Medicaid eligibles and 18,855 Demonstration eligibles enrolled in TennCare, for a total of 1,218,595 persons.

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

	4th Quarter*
Spending on MCO services**	$1,387,248,200
Spending on dental services	$48,435,500
Spending on pharmacy services	$229,602,500
Medicare "clawback"***	$69,700,500

**These figures are cash basis as of June 30 and are unaudited.*

***This figure includes Integrated Managed Care MCO expenditures.*

****The Medicare Part D clawback is money states 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[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
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.	TennCare contract and in accordance with T.C.A. § 56-32-

[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
	99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	126(b)
PBM	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

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

If an MCO does not comply with the prompt pay requirements based on the total claims processed in a month, TDCI has the statutory authority to levy an administrative penalty of $10,000 for each month of non-compliance after the first instance of non-compliance was reported to the plan. The TennCare Bureau can also assess liquidated damages pursuant to the terms of the 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, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During this quarter, the MCOs submitted their National Association of Insurance Commissioners (NAIC) First Quarter 2012 Financial Statement. As of March 31, 2012, TennCare MCOs reported net worth as indicated in the table below.[8]

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,551,988	$87,755,165[9]	$70,203,177
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community	$62,651,284	$501,198,539	$438,547,255

[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. Amerigroup, for instance, operates a Medicare Advantage Plan in Middle Tennessee, while UnitedHealthcare has several lines of business in Illinois, Iowa, Virginia, and Tennessee. Volunteer State Health Plan, by contrast, operates solely on TennCare's behalf.

[9] The decrease in Amerigroup's net worth this quarter is a direct result of the company's decision to make a $65 million dividend distribution in March 2012.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Plan)			
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,832,427	$179,596,924	$144,764,497

All TennCare MCOs met their minimum net worth requirements as of March 31, 2012.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee.* The OIG staff receives case information from a variety of sources including: local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCCs), and the general public via the OIG web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the fourth quarter of the 2011 - 2012 fiscal year are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	1,701	140,336
Abuse Cases Received*	960	68,067

***** *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

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Fines	$31,725.00	$570,067.00
Court Costs & Taxes	$2,283.50	$201,489.99
Court Ordered Restitution	$35,955.96	$1,940,064.70
Drug Funds/Forfeitures	$53.00	$419,160.40

The OIG aggressively pursues enrollees who have apparently committed fraud or abuse against the TennCare program. The primary criminal case types are: prescription drug cases (drug diversion, drug seekers, doctor shopping, and forging prescriptions), reporting a false income, access to other insurance when one is enrolled in an "uninsured" category, and ineligible individuals using a TennCare card.

Arrest Categories

Category	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	13	514
Drug Diversion/Sale RX	31	653
Doctor Shopping	20	232
Access to Insurance	0	55
Operation Falcon III	0	32
Operation Falcon IV	0	16
False Income	0	76
Ineligible Person Using Card	0	20
Living Out Of State	0	19
Asset Diversion	0	7
ID Theft	5	55
Aiding & Abetting	0	5
Failure to Appear in Court	1	3
Child Not in the Home[10]	2	2
GRAND TOTAL	**72**	**1,689**

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[11]
Court Ordered Recoupment	$127,707.77	$3,993,432.19[12]
Recommended TennCare Terminations [13]	27	49,514
Potential Savings[14]	$98,722.53	$174,200,635.95

[10] This category was not added until the April-June 2012 quarter.

[11] On February 15, 2005, a Fiscal Manager and an attorney joined the OIG staff to facilitate and document recoupment and recommended terminations.

[12] This total reflects dollars collected by the OIG and sent to the TennCare Bureau.

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

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