TennCare Quarterly Report

Submitted to the Members of the General Assembly

July 15, 2013

Status of TennCare Reforms and Improvements

Start of New Demonstration Period. July 1, 2013, marked the beginning of the third extension of the TennCare Demonstration since TennCare II began on July 1, 2002. The most recently approved extension period ends on June 30, 2016.

John B. **Case.** The *John B.* lawsuit addressed the adequacy of services provided by TennCare to children under the age of 21. *John B*. was a consent decree filed in 1998 that had been the subject of ongoing litigation since 2000. In February 2012, District Judge Thomas A. Wiseman, Jr. ruled in favor of the State by dismissing the case on the grounds that TennCare had successfully established compliance with "all the binding provisions of the Consent Decree."[1] This decision was upheld unanimously by a three-judge panel of the United States Court of Appeals for the Sixth Circuit on March 14, 2013.

Although the Plaintiffs in the suit had the option of pursuing the matter to the United States Supreme Court, the June 12 deadline for filing an appeal of the Sixth Circuit's ruling passed without incident. The Plaintiffs' decision not to take further action leaves Judge Wiseman's order vacating the consent decree undisturbed. As a result, the litigation has concluded.

Demonstration Amendments. The Bureau worked with three amendments to the Demonstration during the April-June quarter.

- **Demonstration Amendment 17.** On February 4, 2013, TennCare submitted Demonstration Amendment 17 to the Centers for Medicare and Medicaid Services (CMS). Amendment 17 repeated several changes proposed in each of the last three years that were made unnecessary each time by the Tennessee General Assembly's renewal of a one-year Enhanced Coverage Fee. Specifically, the measure provided for the elimination of physical therapy, speech therapy, and occupational therapy for adults and the institution of benefit limits on certain hospital services, lab and X-ray services, and health practitioners' office visits for non-pregnant and non-

[1] John B. v. Emkes. U.S. District Court for the Middle District of Tennessee at Nashville. Order, pages 1-2. February 14, 2012.

institutionalized adults. In April 2013, the General Assembly passed the Annual Coverage Assessment Act of 2013 by an overwhelming majority, rendering the benefit modifications unnecessary.[2] As a result, TennCare notified CMS by letter dated April 26, 2013, of its decision to withdraw Amendment 17.

- **Demonstration Amendment 18.** On March 7, 2013, TennCare proposed to add Assisted Care Living Facility (ACLF) services for individuals in CHOICES 3 when certain criteria (including cost neutrality) were met. CHOICES 3 is the group of individuals who do not meet the Level of Care criteria for Nursing Facility (NF) services, but who have been found to be at risk for institutionalization. ACLF services are already available for persons in CHOICES 2, which consists of enrollees who meet the NF Level of Care criteria but who receive Home and Community Based Services as a safe and cost-effective alternative to institutional care. CMS wanted to require the State to abide by Home and Community Based Services regulations that have not yet been published in their final form. The State was reluctant to agree to something not yet seen and so requested that the amendment be held until the final regulations are published.

- **Demonstration Amendment 19.** On April 26, 2013, the Bureau submitted Demonstration Amendment 19 to CMS. Amendment 19 would allow a $1.50 co-payment for covered generic medications to be charged to those TennCare enrollees who now have a $3.00 co-pay on brand name drugs. The General Assembly approved this measure as part of the State Budget codified in Public Chapter Number 453.

Higher Reimbursement for Primary Care. One provision of the Affordable Care Act (ACA) with which all Medicaid programs—even those that do not expand eligibility—must comply is an enhanced reimbursement rate for primary care providers during Calendar Years 2013 and 2014. Section 1202 of ACA, entitled "Payments to Primary Care Physicians," requires Medicaid agencies to pay primary care physicians for identified primary care services at a rate no lower than the one at which primary care physicians are reimbursed under Medicare Part B, the "Medical Insurance" portion of Medicare that covers outpatient care. Medicaid providers eligible for the higher levels of reimbursement are those whose primary specialty falls within one of the following categories:

- Family medicine
- General internal medicine
- Pediatric medicine
- Related subspecialties

The Bureau of TennCare submitted a State Plan Amendment outlining its compliance with Section 1202 of ACA to CMS on March 27, 2013. Following a two-month period of negotiations, CMS approved the Amendment on May 29, 2013. While eligible claims could not be paid at the enhanced rate until CMS

[2] The Annual Coverage Assessment Act of 2013 (HB 0544 / SB 0441), which was passed by a vote of 89-5 in the House and a vote of 30-0 in the Senate, became Public Chapter Number 250 on April 29, 2013.

had issued its approval, retroactive reimbursement will occur automatically, requiring no further action by providers on claims that have already been submitted. TennCare Managed Care Organizations (MCOs), furthermore, will begin to pay primary care providers the higher rate for current dates of service beginning on August 1, 2013.

Update on Standard Spend Down Enrollment. Standard Spend Down (SSD) is an eligibility category available through an amendment to the TennCare Demonstration[3] and is designed to serve a limited number of Tennesseans who are not otherwise eligible for Medicaid but who are aged, blind, disabled, or the caretaker relative of a Medicaid-eligible child and who have enough unreimbursed medical bills to allow them to "spend down" their income to a low level known as the Medically Needy Income Standard (MNIS). The MNIS for a family of three in Tennessee is $317 per month.

As noted in TennCare's previous Quarterly Report to the General Assembly on April 15, 2013, SSD opened to new enrollment for the sixth time on March 21, 2013; given the proximity of that date to the end of the January-March quarter, however, statistics on the number of applications received and the number of individuals enrolled were unavailable for inclusion in the April 15 report. As of June 21, 2013, however, a total of 2,495 applications had been received, 506 of which had been approved, 1,271 of which had been denied, and 718 of which were still pending.

Awarding of Dental Benefits Management Contract. Following a competitive bidding process in which four companies submitted proposals, TennCare named DentaQuest USA Insurance Company as its new Dental Benefits Manager (DBM) on April 24, 2013. DentaQuest was awarded a three-year contract (containing options for two one-year extensions) that will begin—following a five-month period of "readiness review"—on October 1, 2013. While all previous contracts between TennCare and its DBMs were "Administrative Services Only" (or "ASO") contracts, the contract executed by the parties in May is a partial risk-bearing contract.

Although DentaQuest's responsibilities will include building an adequate network of dentists and administering dental benefits for more than 750,000 children enrolled in TennCare, the company's experience managing dental benefits for more than 16 million recipients in 26 states is a positive indication of the company's ability to succeed with projects of similar scope. Additional information is available on TennCare's website at http://news.tn.gov/node/10664.

Completion of Pharmacy Benefits Management Transition. On June 1, 2013, Magellan Health Services assumed full responsibilities as TennCare's Pharmacy Benefits Manager (PBM), a role previously held by Catamaran. To ensure a seamless transition, Magellan had engaged in six months of preparation before beginning to pay claims in June. This period of infrastructure development had included such tasks as establishing a pharmacy network, building a claims processing system, creating a call center and website to assist patients and providers, and contracting with drug manufacturers for supplemental rebates.

[3] See Expenditure Authority 7.b. and Special Term and Condition 21.a. of the TennCare Demonstration, a copy of which is available online at http://www.tn.gov/tenncare/forms/tenncarewaiver.pdf.

TennCare's contract with Magellan lasts through May 31, 2016, and contains options for two one-year extensions.

Before being named TennCare's PBM, Magellan had managed pharmacy benefits for more than eight million individuals. From June 1 through June 30, 2013 (the company's first full month of operations for the Bureau), Magellan paid 932,777 claims, a volume in line with typical TennCare pharmacy claims activity.

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 electronic systems that meet rigorous certification criteria and that can improve health care delivery and quality. The federal government provides 100 percent of the funding for the incentive payments and 90 percent of the administrative costs.

Currently, Medicaid providers may qualify for two types of payments:

- 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 calendar year 2011 and achieved meaningful use of EHR technology for any period of 90 consecutive days in Fiscal Year 2012 (for eligible hospitals) or Calendar Year 2012 (for eligible professionals).

During the April to June 2013 quarter, first-year and second-year payments made by TennCare were as follows:

Payment Category	Providers Paid During the Quarter	Quarterly Amount Paid	Cumulative Amount Paid
First-year payments	363 providers (165 physicians, 126 nurse practitioners, 58 dentists, 10 hospitals, 3 physician assistants, and 1 certified nurse midwife)	$14,639,292.00	$124,475,986.97

[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).

Payment Category	Providers Paid During the Quarter	Quarterly Amount Paid	Cumulative Amount Paid
Second-year payments	161 providers (105 physicians[5], 42 nurse practitioners, 10 hospitals, 2 physician assistants, and 2 certified nurse midwives)	$5,931,875.00	$21,102,908.00

Outreach activities conducted during the quarter included:

- Participation in the United Healthcare Provider Information Fair, an event held in Nashville on May 6, 2013, that attracted attendance of approximately 130 providers;
- Presentation to 30 staff members of tnREC (Tennessee's regional extension center for health information technology) on May 14, 2013;
- Coordination with managed care organizations and other insurance companies at the Tennessee Medical Association Workshop Planning Meeting held in Nashville on May 15, 2013;
- Attendance at the Fifth Annual CMS Multi-State Medicaid HITECH Conference held in Bethesda, Maryland, from May 21 through May 23, 2013;
- Presentation to 20 members of the Internal Health Council—a State planning group and "guide for the State's policies, priorities and programs related to HIE [Health Information Exchange] and health IT [Information Technology]"[6]—at a meeting held in Nashville on June 18, 2013;
- The deployment of two new tools through TennCare's online provider portal: 1) a confidential summary of each provider's history within the EHR program (including program year and payment year, date, and amount) and 2) meaningful use attestations that may be downloaded by providers or accessed through the aforementioned histories;
- Monthly newsletters distributed by the Bureau's EHR ListServ; and
- A quarterly reminder issued through the Provider Incentive Payment Program ("PIPP") system to Tennessee providers who had registered at the federal level but not at the state level.

Other projects in development include videos to assist providers with the EHR program,[7] and preparations for the third-year attestations that will begin for Eligible Hospitals in October 2013 and for Eligible Professionals in January 2014.

New General Counsel. On April 4, 2013, John G. (Gabe) Roberts joined TennCare and the Health Care Finance and Administration (HCFA) staff as General Counsel.

[5] This total includes a variety of physicians in categories that had not previously qualified for second-year payments, including ophthalmology, neurology, gastroenterology, and oncology.

[6] See Page 12 of the "State Medicaid Health IT Plan" document for Tennessee, which is available online at http://www.tn.gov/tenncare/forms/TNSMHP.pdf.

[7] Two such videos are already available: "Three Common Challenges to Achieving Stage 1 Meaningful Use" is located at http://www.tn.gov/tenncare/mu_prep.shtml, and "Timelines for the 2011 Cohort" is located at http://www.tn.gov/tenncare/mu_2011timeline.shtml.

Mr. Roberts, who is originally from Jackson, Mississippi, graduated from the University of Mississippi's E. H. Patterson School of Accountancy and Vanderbilt University Law School. He is a licensed Certified Public Accountant and, prior to attending law school, worked in the Memphis, Tennessee, office of Ernst & Young as an auditor of both publicly traded and privately held Tennessee companies.

Mr. Roberts comes to HCFA from the Nashville, Tennessee, law firm Sherrard & Roe, where his primary practice areas included general corporate law, mergers and acquisitions, and private equity investment transactions. While at Sherrard & Roe, his business law practice intersected regularly with the health care industry and regulatory environment. His unique perspective borne by the diversity of his professional experiences is one of the factors that make him ideally suited for this position.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the April-June 2013 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 Enhanced Coverage 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 four State mental health institutes.

The Essential Access Hospital payments made during the fourth quarter of State Fiscal Year 2013 for dates of service during the third quarter of State Fiscal Year 2013 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH Fourth Quarter FY 2013
Regional Medical Center at Memphis	Shelby County	$3,498,038
Vanderbilt University Hospital	Davidson County	$3,262,097
Erlanger Medical Center	Hamilton County	$2,653,725
University of Tennessee Memorial Hospital	Knox County	$1,444,289
Johnson City Medical Center (with Woodridge)	Washington County	$954,982
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$733,344

Hospital Name	County	EAH Fourth Quarter FY 2013
LeBonheur Children's Medical Center	Shelby County	$732,329
Metro Nashville General Hospital	Davidson County	$686,869
Jackson – Madison County General Hospital	Madison County	$590,596
East Tennessee Children's Hospital	Knox County	$517,671
Methodist Healthcare – South	Shelby County	$466,418
Methodist Healthcare – Memphis Hospitals	Shelby County	$425,649
Saint Jude Children's Research Hospital	Shelby County	$351,847
Baptist Hospital	Davidson County	$314,078
Parkwest Medical Center (with Peninsula)	Knox County	$312,139
Physicians Regional Medical Center	Knox County	$292,475
University Medical Center (with McFarland)	Wilson County	$280,181
Pathways of Tennessee	Madison County	$270,713
Wellmont Holston Valley Medical Center	Sullivan County	$254,870
Saint Francis Hospital	Shelby County	$249,314
Centennial Medical Center	Davidson County	$242,912
Skyline Medical Center (with Madison Campus)	Davidson County	$237,797
Maury Regional Hospital	Maury County	$234,478
Ridgeview Psychiatric Hospital and Center	Anderson County	$229,287
Methodist Healthcare – North	Shelby County	$222,671
Middle Tennessee Medical Center	Rutherford County	$222,517
Fort Sanders Regional Medical Center	Knox County	$219,407
Delta Medical Center	Shelby County	$217,238
Cookeville Regional Medical Center	Putnam County	$183,838
Skyridge Medical Center	Bradley County	$178,717
Gateway Medical Center	Montgomery County	$176,105
Parkridge East Hospital	Hamilton County	$173,932
Wellmont Bristol Regional Medical Center	Sullivan County	$163,268
Blount Memorial Hospital	Blount County	$160,229
Baptist Memorial Hospital for Women	Shelby County	$143,622
Morristown – Hamblen Healthcare System	Hamblen County	$136,301
Baptist Memorial Hospital – Tipton	Tipton County	$132,539
Sumner Regional Medical Center	Sumner County	$124,081
StoneCrest Medical Center	Rutherford County	$118,037
NorthCrest Medical Center	Robertson County	$114,729
Tennova Healthcare – Newport Medical Center	Cocke County	$110,710
Horizon Medical Center	Dickson County	$110,585
LeConte Medical Center	Sevier County	$109,840
Southern Hills Medical Center	Davidson County	$107,302
Summit Medical Center	Davidson County	$107,033
Tennova Healthcare – LaFollette Medical Center	Campbell County	$103,041

Hospital Name	County	EAH Fourth Quarter FY 2013
Methodist Medical Center of Oak Ridge	Anderson County	$100,604
Takoma Regional Hospital	Greene County	$92,046
Harton Regional Medical Center	Coffee County	$91,830
Sweetwater Hospital Association	Monroe County	$89,968
Henry County Medical Center	Henry County	$86,169
Baptist Memorial Hospital – Union City	Obion County	$85,339
Dyersburg Regional Medical Center	Dyer County	$83,857
Humboldt General Hospital	Gibson County	$77,962
Wellmont Hawkins County Memorial Hospital	Hawkins County	$77,377
United Regional Medical Center	Coffee County	$76,486
Lakeway Regional Hospital	Hamblen County	$75,474
Jellico Community Hospital	Campbell County	$74,678
Grandview Medical Center	Marion County	$73,041
Skyridge Medical Center – Westside	Bradley County	$72,495
Indian Path Medical Center	Sullivan County	$72,336
Athens Regional Medical Center	McMinn County	$71,119
Heritage Medical Center	Bedford County	$68,896
Regional Hospital of Jackson	Madison County	$65,759
Crockett Hospital	Lawrence County	$62,268
River Park Hospital	Warren County	$62,139
Lincoln Medical Center	Lincoln County	$60,038
Bolivar General Hospital	Hardeman County	$59,954
Southern Tennessee Medical Center	Franklin County	$59,095
Sycamore Shoals Hospital	Carter County	$58,928
Hardin Medical Center	Hardin County	$57,602
Livingston Regional Hospital	Overton County	$51,338
Wayne Medical Center	Wayne County	$50,466
Hillside Hospital	Giles County	$45,330
Roane Medical Center	Roane County	$43,291
Claiborne County Hospital	Claiborne County	$38,162
McKenzie Regional Hospital	Carroll County	$38,001
McNairy Regional Hospital	McNairy County	$34,412
Volunteer Community Hospital	Weakley County	$31,476
Jamestown Regional Medical Center	Fentress County	$30,885
Gibson General Hospital	Gibson County	$28,863
Haywood Park Community Hospital	Haywood County	$28,841
Baptist Memorial Hospital – Huntingdon	Carroll County	$27,915
Henderson County Community Hospital	Henderson County	$23,819
Methodist Healthcare – Fayette	Fayette County	$23,225
DeKalb Community Hospital	DeKalb County	$21,431
Decatur County General Hospital	Decatur County	$20,672
White County Community Hospital	White County	$19,787
Emerald – Hodgson Hospital	Franklin County	$14,786
TOTAL		**$25,000,000**

Number of Recipients on TennCare and Costs to the State

At the end of the period April 1, 2013, through June 30, 2013, there were 1,185,301 Medicaid eligibles and 20,299 Demonstration eligibles enrolled in TennCare, for a total of 1,205,600 persons.

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

Spending Category	4th Quarter*
MCO services**	$1,375,710,400
Dental services	$44,730,200
Pharmacy services	$197,801,600
Medicare "clawback"***	$43,266,600

**These figures are cash basis as of June 30 and are unaudited.*
***This figure includes Integrated Managed Care MCO expenditures.*
****The Medicare Part D clawback is money states are required to pay to the federal government to help offset costs the federal government incurs by covering the prescription benefit for enrollees who have both Medicare and Medicaid.*

Viability of MCCs in the TennCare Program

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

Entity	Standard	Authority
MCOs (non-CHOICES services)	90% of clean claims for payment for services delivered to TennCare enrollees are 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[8] 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[9] are processed and paid within 21 calendar days of receipt.	TennCare contract

[8] 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.
[9] Ibid.

Entity	Standard	Authority
DBM	90% of clean claims for payment for services delivered to TennCare enrollees are processed, and, if appropriate, paid within 30 calendar days of the receipt of such claims. 99.5% of all provider claims are processed, and, if appropriate, paid within 60 calendar days of receipt.	TennCare contract and in accordance with T.C.A. § 56-32-126(b)
PBM	100% of all clean claims submitted by pharmacy providers are paid within 10 calendar days of receipt.	TennCare contract

The MCOs, the DBM, and the PBM are required to submit monthly claims data files of all TennCare claims processed to the Tennessee Department of Commerce and Insurance (TDCI) for verification of statutory and contractual prompt pay compliance. The plans are required to separate their claims data by 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 Contractor Risk Agreement. If the DBM and PBM do not meet their contractual prompt pay requirements, only the TennCare Bureau can assess applicable liquidated damages against these entities.

Net worth requirement. 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 2013 Financial Statements. As of March 31, 2013, TennCare MCOs reported net worth as indicated in the table below.[10]

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,323,202	$112,170,452	$94,847,250

[10] 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, conducts only TennCare business.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$64,481,178	$477,995,733	$413,514,555
Volunteer State Health Plan (BlueCare & TennCare Select)	$35,639,453	$221,816,720	$186,177,267

All TennCare MCOs met their minimum net worth requirements as of March 31, 2013.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is: *To identify, investigate, and prosecute persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee.* The OIG staff receives case information from a variety of sources, including local law enforcement, the TennCare Bureau, Health Related Boards (HRB), the Department of Human Services (DHS), other state agencies, health care providers, Managed Care Contractors (MCCs), and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the fourth quarter of the 2012 - 2013 fiscal year are as follows:

Summary of Enrollee Cases

	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Cases Received	2,232	150,733
Abuse Cases Received*	1,606	73,438

***** *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	$5,550.00	$714,005.00
Court Costs & Taxes	$7,007.79	$231,935.00
Court Ordered Restitution	$37,053.55	$2,168,360.00
Drug Funds/Forfeitures	$387.44	$435,936.00

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), child not in the home, reporting a false income,

access to other insurance when one is enrolled in an "uninsured" category, and ineligible individuals using a TennCare card.

One relatively new development reflected in the "Arrest Categories" table below is OIG's participation in the Drug Enforcement Administration (DEA) Task Force. In June 2013, an OIG Special Agent assigned to the DEA Task Force made 25 felony drug arrests, served 8 search warrants, seized 10 vehicles, inventoried—and booked as evidence—$10,000 in cash, and took over 1,000 prescription pills (i.e., controlled substances) off the streets. These accomplishments contributed to a record number of arrests in the month of June (46) and in the fourth quarter of the Fiscal Year (81).

Arrest Categories

Category	Quarter	Grand Total to Date (since creation of OIG in July 2004)
Drug Diversion/Forgery RX	10	538
Drug Diversion/Sale RX	21	741
Doctor Shopping	9	281
Access to Insurance	0	55
Operation FALCON III[11]	0	32
Operation FALCON 2007[12]	0	16
False Income	2	80
Ineligible Person Using Card	0	20
Living Out Of State	6	29
Asset Diversion	0	7
ID Theft	2	65
Aiding & Abetting	0	7
Failure to Appear in Court	0	3
Child Not in the Home	6	19
DEA Task Force	25	38
GRAND TOTAL	**81**	**1,931**

[11] Operation FALCON ("Federal and Local Cops Organized Nationally") III—conducted October 22-28, 2006—was a joint mission among federal, state, city, and county law enforcement agencies to arrest fugitives, including individuals facing narcotics charges. Additional information about all of the Operation FALCON initiatives is available on the website of the United States Marshals Service at http://www.usmarshals.gov/falcon/index.html.

[12] Operation FALCON 2007, which took place from June through September of that year, was the follow-up initiative to Operation FALCON III (described in Footnote 11). Like its predecessor, Operation FALCON 2007 targeted fugitives with open warrants.

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[13]
Court Ordered Recoupment	$35,379.94	$4,570,259.00[14]
Recommended TennCare Terminations [15]	27	49,912
Potential Savings[16]	$98,722.53	$175,655,879.17

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

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

[15] 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.

[16] Savings are determined by multiplying the number of enrollees whose coverage would be terminated, assuming all of the State's criteria for termination are met, by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).