TennCare Quarterly Report

Submitted to the TennCare Oversight Committee, The Fiscal Review Committee, and Members of the General Assembly

October 15, 2010

Status of TennCare Reforms and Improvements

Waiver extension. A new three-year extension of the TennCare Demonstration Waiver began on July 1, 2010. The extension was approved by the federal Centers for Medicare and Medicaid Services under the authority of Section 1115(e) of the Social Security Act.

As reported in the July 15, 2010, Quarterly Report, the new extension does not include the benefit reductions and limitations that the State had planned for July 1. The General Assembly's action in passing Public Chapter 909, the "Annual Coverage Assessment Act of 2010," played a role in averting the need to make these reductions during the current year.

The Special Terms and Conditions (STCs) of the extension include a new Unreimbursed Hospital Cost (UHC) Pool, which allows the State to make payments to certain hospitals in accordance with Public Chapter 909. The STCs also include a new Public Hospital Supplemental Payment (PHSP) pool, which allows the State to use a $10 million intergovernmental transfer from Shelby County government to generate a supplemental payment to the Regional Medical Center in Memphis to address critical health care needs.

Amendment #11. On July 21, 2010, the Bureau of TennCare submitted Waiver Amendment #11 to CMS, after providing advance notification to the Members of the General Assembly in accordance with Public Chapter 1079. Amendment #11 will permit the State to expand the PHSP pool mentioned above by accepting a $5 million intergovernmental transfer (IGT) from the Metropolitan Government of Nashville and Davidson County to generate a supplemental payment to Nashville General Hospital. As of the end of the quarter, CMS had not yet approved Amendment #11.

CHOICES program. The CHOICES program, which implemented the Long-term Care Community Choices Act of 2008 and which was approved by CMS in the late summer of 2009, was formally implemented in Middle Tennessee on March 1, 2010. On August 1, 2010, the program began in East and West Tennessee, completing the statewide restructuring of long-term care service delivery within TennCare.

One of the goals of CHOICES is to rebalance the long-term care system by increasing the proportion of long-term care spending that goes to community programs. The CHOICES program offers more home

and community based options for meeting the long-term care needs of adults who are elderly or who have physical disabilities, thereby reducing their reliance on more costly Nursing Facility care. Progress is already being seen in meeting this goal, with the State being authorized to provide home and community based care to up to 9,500 persons in the current year whose needs are such that they would otherwise require Nursing Facility care.

A second goal of CHOICES is to integrate long-term care for persons who are elderly and disabled into the managed care program. Tennessee is one of the few states to attempt such integration and one of the even fewer states that allow enrollees in Medicaid managed care to receive long-term care services without changing their Managed Care Organizations (MCOs).

The Statewide Home and Community Based Waiver for the Elderly and Disabled, which has been in existence in various iterations for over 20 years, was terminated in August. It is no longer needed due to the full implementation of CHOICES.

PAE improvements. All persons applying for Nursing Facility care, or Home and Community Based Services (HCBS) as an alternative to Nursing Facility care, must file documents called Pre-Admission Evaluations (PAEs) that report the specifics of their medical condition and need for assistance. An important administrative step was taken during the quarter to make the processing of PAEs more efficient.

For the first time in Tennessee's Medicaid history, TennCare has moved from a medical eligibility application process based entirely on paper to one that is electronic. PAEs are now submitted electronically through a web-based portal and processed by registered nurses through an electronic workflow application. In addition, medical eligibility records are now stored electronically rather than on some 250,000 paper cards, which have taken up a huge amount of physical storage space. The paper cards are being converted to electronic data so that all information can soon be stored electronically. These improvements have resulted in significant efficiencies in the operations of the Division of Long-Term Care and are the culmination of five years' work.

Annual HEDIS/CAHPS report. In August 2010, TennCare published the annual report of HEDIS/CAHPS data. HEDIS stands for Healthcare Effectiveness Data and Information Set and CAHPS stands for Consumer Assessment of Healthcare Providers and Systems.

In 2006 Tennessee became the first state in the nation to require that all of its Managed Care Organizations (MCOs) be accredited by NCQA (the National Committee for Quality Assurance). As part of accreditation, the MCOs are required to report a full HEDIS and CAHPS data set annually. The HEDIS/CAHPS report provides data that enables the State to compare the performance of its MCOs against national norms and benchmarks and to compare performance among MCOs. This report is shared with CMS each year and posted on the TennCare website at http://www.tn.gov/tenncare/pro-hedis.html.

This year, improved statewide performance was noted in child health measures such as:

- Childhood Immunization Status
- Lead Screening in Children
- Appropriate Testing for Children with Pharyngitis
- Appropriate Treatment for Children with Upper Respiratory Infection

- Well-Child Visits in the First 15 months of Life (6 or more visits)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits

Chronic Disease Management continues to improve statewide in the following areas:

- Cholesterol Management for Patients with Cardiovascular Conditions
- Controlling High Blood Pressure
- Comprehensive Diabetes Care
- Annual Monitoring for Patients on Persistent Medications
- Medical Assistance with Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit and Discussing Cessation Medications)

"Comprehensive Diabetes Care" has improved since 2008; however, rates were lower than the HEDIS 2009 Medicaid National Average. This area continues to be a high priority for quality improvement efforts.

Targeted preventive care continues to present mixed results. "Breast Cancer Screening" rates declined somewhat. However, improvement was seen in the rates of "Cervical Cancer Screening and Chlamydia Screening in Women," both of which were above the 2009 Medicaid National Average.

HEDIS 2010 marks the first year of statewide reporting of "Behavioral Health" measures following integration of medical-behavioral health services among TennCare's MCOs. "Antidepressant Medication Management" was higher than the 2009 Medicaid National Average, while "Follow-up after Hospitalization for Mental Illness" was slightly below the National Average.

Beneficiary survey. Every year since 1993, the Center for Business and Economic Research (CBER) at the University of Tennessee in Knoxville has conducted a survey of TennCare enrollees to assess opinions about their health care. Non-TennCare enrollees are included in the survey as well, in order to provide a point of comparison with TennCare enrollees.

The 2010 survey was released in August. It revealed the highest satisfaction score to date among TennCare enrollees (94 percent, compared with 61 percent in 1994). The following findings were noted from interviews with heads of TennCare households:

- 65 percent rated the quality of health care they received as good or excellent
- 88 percent rated the quality of health care their children received as good or excellent
- 92 percent said that they initially sought health care for themselves at a doctor's office or clinic, rather than the emergency room
- 97 percent said that they initially sought health care for their children at a doctor's office or clinic, rather than the emergency room

The survey also collects information about lack of insurance. This year the uninsured rate for children under 18 was determined to be 3.9 percent, while the uninsured rate for adults aged 18 and older was determined to be 12 percent.

The report is available on-line at http://cber.bus.utk.edu/tncare/tncare10.pdf.

Health Information Technology. The HITECH Act, the Health Information Technology for Economic and Clinical Health Act, was passed as a part of the American Recovery and Reimbursement Act (ARRA) to

encourage the adoption of electronic health records (EHR) by the medical community. The distribution of monetary incentives was part of the HITECH Act.

This quarter, TennCare submitted its Health Information Technology (HIT) Implementation Advance Planning Document (IAPD) to CMS. The IAPD is a formal request for federal dollars to plan activities and services or acquire equipment for required HIT activities included in the HITECH Act.

TennCare also sent information to the MCOs about the EHR Provider Incentive Program. The plans will be reaching out to providers to inform them about the program and encourage them to fill out the Provider Survey posted on TennCare's website. TennCare also submitted Tennessee's State Medicaid Health Information Technology (HIT) Plan (SMHP) to CMS. The SMHP is related to the upcoming EHR Provider Incentive Program in that it provides CMS with the following:

- A current HIT landscape assessment
- A vision of the State's HIT future
- Specific actions necessary to implement the incentive payments program
- A HIT road map.

Award. On August 13, Tennessee Voices for Children presented Dr. Jeanne James, TennCare's Medical Director, with the Innovations for Children and Families Award. The award recognizes Dr. James for her leadership and support for family driven services in the children's mental health system.

Budget issues. The first quarter of the fiscal year continued to be challenging. A declining economy results in increases in the number of individuals eligible for and enrolling in TennCare, while medical costs continue to rise. Through a combination of the American Recovery and Reinvestment Act (ARRA) matching funds, the Centers for Medicare and Medicaid Services' (CMS's) approval of Amendment #10 permitting the use of the annual hospital assessment fee to offset costs in the current year, and the funds the State will not have to expend due to CMS's decision relating to how the Medicare Part D clawback[1] is calculated, TennCare has been able to postpone any reductions in benefits or provider payment rates in the current year. The fact that some of these offsetting funds will no longer be available in the future creates a difficult scenario for the Fiscal Year 2012 budget.

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

[1] The 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. The states and CMS originally disagreed on how ARRA affected the Part D clawback calculation, but in February 2009, CMS revised the calculation which reduced TennCare's clawback payments by approximately $120 million.

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 first quarter of State Fiscal Year 2011 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2011
Regional Medical Center at Memphis	Shelby County	$ 4,328,739
Vanderbilt University Hospital	Davidson County	$ 3,178,412
Erlanger Medical Center	Hamilton County	$ 1,830,214
University of Tennessee Memorial Hospital	Knox County	$1,256,490
Johnson City Medical Center (with Woodridge)	Washington County	$ 984,588
Metro Nashville General Hospital	Davidson County	$ 921,557
Methodist Healthcare - LeBonheur	Shelby County	$ 829,099
Jackson - Madison County General Hospital	Madison County	$ 623,574
Parkwest Medical Center (with Penninsula)	Hamilton County	$ 525,587
Saint Francis Hospital	Shelby County	$ 472,022
Parkridge Medical Center (with Parkridge Valley)	Hamilton County	$ 452,996
East Tennessee Children's Hospital	Knox County	$ 420,901
Methodist University Healthcare	Shelby County	$ 359,929
Saint Jude Children's Research Hospital	Shelby County	$ 339,550
Wellmont Holston Valley Medical Center	Sullivan County	$ 329,305
Fort Sanders Regional Medical Center	Knox County	$ 280,866
Methodist Healthcare - South	Shelby County	$ 259,782
Centennial Medical Center	Davidson County	$ 248,972
Skyline Medical Center (with Madison Campus)	Davidson County	$ 245,821
Pathways of Tennessee	Madison County	$ 224,231
Middle Tennessee Medical Center	Rutherford County	$ 221,327
Wellmont Bristol Regional Medical Center	Sullivan County	$ 219,763
Parkridge East Hospital	Hamilton County	$ 204,239
Delta Medical Center	Shelby County	$ 189,306
Saint Mary's Medical Center	Knox County	$ 171,309
Baptist Hospital	Davidson County	$ 168,075
Gateway Medical Center	Montgomery County	$ 164,615
University Medical Center	Wilson County	$ 163,510
Methodist Healthcare - North	Shelby County	$ 161,366

Hospital Name	County	EAH First Quarter FY 2011
Cookeville Regional Medical Center	Putnam County	$ 159,867
Regional Hospital of Jackson	Madison County	$ 158,787
Maury Regional Hospital	Maury County	$ 157,516
NorthCrest Medical Center	Robertson County	$ 156,319
Ridgeview Psychiatric Hospital and Center	Anderson County	$ 146,311
Skyridge Medical Center	Bradley County	$ 145,984
Methodist Medical Center of Oak Ridge	Anderson County	$138,186
Baptist Memorial Hospital for Women	Shelby County	$137,788
Sweetwater Hospital Association	Monroe County	$ 136,219
Morristown - Hamblen Healthcare System	Hamblen County	$135,539
Community Behavioral Health	Shelby County	$129,458
Claiborne County Hospital	Claiborne County	$124,980
Indian Path medical center (with Indian Path Pavillion)	Sullivan County	$124,239
Blount Memorial Hospital	Blount County	$122,767
Fort Sanders Sevier Medical Center	Sevier County	$121,824
Summit Medical Center	Davidson County	$120,791
Skyridge Medical Center - West	Bradley County	$116,564
Dyersburg Regional Medical Center	Dyer County	$115,361
Hardin Medical Center	Hardin County	$111,731
Sumner Regional Medical Center	Sumner County	$109,993
Lakeway Regional Hospital	Hamblen County	$108,417
Baptist Hospital of Cocke County	Cocke County	$101,752
Baptist Memorial Hospital - Tipton	Tipton County	$ 97,750
Southern Hills Medical Center	Davidson County	$ 97,041
Humboldt General Hospital	Gibson County	$95,478
Saint Mary's Medical Center of Campbell County	Campbell County	$85,897
Horizon Medical Center	Dickson County	$84,103
Cumberland Medical Center	Cumberland County	$81,986
Jellico Community Hospital	Campbell County	$80,435
Sycamore Shoals Hospital	Carter County	$78,775
StoneCrest Medical Center	Rutherford County	$76,939
Bolivar General Hospital	Hardeman County	$74,739
Henry County Medical Center	Henry County	$72,686
Athens Regional Medical Center	McMinn County	$69,133
Takoma Regional Hospital	Greene County	$68,879
Harton Regional Medical Center	Coffee County	$63,869
Grandview Medical Center	Marion County	$61,266
Baptist Memorial Hospital - Union City	Obion County	$59,867
Jefferson Memorial Hospital	Jefferson County	$59,526
Roane Medical Center	Roane County	$59,323

Hospital Name	County	EAH First Quarter FY 2011
Bedford County Medical Center	Bedford County	$57,963
Livingston Regional Hospital	Overton County	$57,534
Crockett Hospital	Lawrence County	$57,010
River Park Hospital	Warren County	$54,129
United Regional Medical Center	Coffee County	$53,762
Southern Tennessee Medical Center	Franklin County	$52,760
Volunteer Community Hospital	Weakley County	$50,287
Lincoln Medical Center	Lincoln County	$42,946
McKenzie Regional Hospital	Carroll County	$42,275
Hillside Hospital	Giles County	$41,708
Wellmont Hawkins County Memorial Hospital	Hawkins County	$41,260
Baptist Memorial Hospital - Huntingdon	Carroll County	$41,046
McNairy Regional Hospital	McNairy County	$40,624
Woods Memorial Hospital	McMinn County	$40,539
Jamestown Regional Medical Center	Fentress County	$34,459
Gibson General Hospital	Gibson County	$33,389
Haywood Park Community Hospital	Haywood County	$31,877
Decatur County General Hospital	Decatur County	$25,705
Wayne Medical Center	Wayne County	$25,695
Henderson County Community Hospital	Henderson County	$24,250
Methodist Healthcare - Fayette	Fayette County	$24,234
White County Community Hospital	White County	$22,418
Riverview Regional Medical Center - North	Smith County	$21,364
Emerald Hodgson Hospital	Franklin County	$16,472
Portland Medical Center	Sumner County	$15,550
Johnson City Specialty Hospital	Washington County	$14,551
Erlanger East	Hamilton County	$11,963
TOTAL		$25,000,000

Reverification Status

The eligibility of TennCare enrollees continues to be redetermined in accordance with TennCare's rules and policies.

Status of Filling Top Leadership Positions in the Bureau

The following top leadership positions have been filled during the past year:

Eugene A. Grasser was appointed July 25, 2010, to serve as TennCare Director of Audit and Program Integrity. Mr. Grasser is responsible for directing and overseeing operations in TennCare's newly created Audit and Program Integrity Division. The division consists of two primary areas: the Office of Audit and Investigation, charged with performing internal audits and reviews, internal investigations and Medicaid investigations; and the Office of Program Integrity, charged with the responsibility of monitoring the utilization habits and patterns of both members and providers of the Medicaid community. The new Office of Audit and Program Integrity provides an independent examination and evaluation of programs, activities, and resources by conducting internal investigations of alleged violations of TennCare policies, procedures, rules or laws, as well as investigating TennCare providers suspected of fraud or abuse in the program. Mr. Grasser has been with the Bureau of TennCare since February 2003, serving in the role of TennCare's Chief of Operations.

Michael Cole assumed the duties of TennCare Director of Operations responsible for the direct oversight and management of the Division of Administrative Services, which includes the Human Resources Office, Purchasing/Procurement Unit, Property/Facility Management Office, and the Project Management Office (PMO). In addition, he also retained his responsibility for the direction and oversight of the Office of Legislative Affairs which encompasses legislative casework referred to the Bureau; legislative correspondence and policy clarification activities; facilitating the development of proposed legislation and tracking all legislation that affects the TennCare Program. Mr. Cole possesses over 29 years of state service and has served as Director of Internal Audit and Deputy Commissioner with the Department of Revenue.

Jarrett J. Hallcox was appointed September 19, 2010, to serve as Deputy of Long-Term Care Strategic Planning and Program Implementation. Mr. Hallcox will work with the Chief of Long-Term Care in analyzing the Division's program goals, including strengths, weaknesses, and factors that will contribute to or impede the Division's ability to attain those goals, identifying areas for improvement and setting the agenda for long-term care programs and services. Mr. Hallcox will identify resources, assign responsibilities, and coordinate with team members and third-party contractors and consultants in order to implement strategic initiatives. In addition, he will also continue to manage the day-to-day operational aspects of long-term care projects from beginning to end. Mr. Hallcox previously served as Director of Long-Term Care Project Management. He possesses a Master's Degree in Public Administration and a Bachelor of Arts Degree with a double major in Political Science and History from the University of Tennessee, Knoxville.

Julie Johnson was appointed September 19, 2010, to serve as Director of Long-Term Care Enrollment and Appeals responsible for the ongoing management and direction of comprehensive enrollment and appeals processes pertaining to the TennCare CHOICES in Long-Term Care Program, the Governor's initiative based on the Long-Term Care Community Choices Act of 2008. These enrollment activities are designed to ensure that enrollment into the CHOICES program is carried out in accordance with federal and State law and regulations, the State's approved Section 1115 Waiver, and contract requirements. Ms. Johnson has over ten years of experience in the TennCare Program and previously worked in the Division of Member Services and the Division of Appeals.

Sarah L. Moore was appointed September 20, 2010, to serve as the Assistant Director of Policy. In this role, Ms. Moore is responsible for overseeing the administrative functions of the Policy Office to ensure that TennCare's policies and rules accurately reflect the mission and operational mandates of the Bureau of TennCare. Ms. Moore is responsible for supervising senior level professional staff as they develop, document, and maintain TennCare policy and rules. She also assists the Director of Policy by conducting research and by serving as a liaison with CMS regarding the TennCare Demonstration Waiver and the Medicaid State Plan. Ms. Moore has been with the Bureau of TennCare since 1999, previously serving as a Legal Assistant, an Administrative Hearing Officer, and, most recently, a Senior Policy Analyst.

Number of Recipients on TennCare and Costs to the State

At the end of the period July 1, 2010, through September 30, 2010, there were 1,157,195 Medicaid eligibles and 29,434 Demonstration eligibles enrolled in TennCare, for a total of 1,186,629 persons.

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

	1st Quarter*
Spending on MCO services**	$1,467,554,700
Spending on dental services	$43,487,000
Spending on pharmacy services	$181,513,000
Medicare "clawback"	$0

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

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

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	90 percent of clean claims for payment for services delivered to TennCare enrollees are paid within 30 calendar days of the receipt of such claims.	T.C.A .§ 56-32-126(b)
MCOs	99.5 percent of all provider claims are processed, and if appropriate paid, within 60 calendar days of receipt.	T.C.A .§ 56-32-126(b)

Entity	Standard	Authority
MCOs (CHOICES services)	90 percent of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[2] are processed and paid with 14 calendar days of receipt. 99.5 percent of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[3] are processed and paid within 21 calendar days of receipt.	TennCare contract
DBM	90 percent 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 .§ 56-32-126(b)
DBM	99.5 percent 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 percent 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 (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 NF and applicable HCBS 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, 2009. The TennCare Contract further requires the TennCare MCOs to establish an enhanced net worth based on projected additional annual premiums for the CHOICES program. During

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

[3] Ibid.

this quarter, the MCOs submitted their NAIC Second Quarter 2010 Financial Statement. As of June 30, 2010, TennCare MCOs reported net worth as indicated in the table below.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
AMERIGROUP Tennessee	$16,133,399	$112,487,475	$96,354,076
UnitedHealthcare Plan of the River Valley (AmeriChoice)	$43,370,119	$317,304,223	$273,934,104
Volunteer (BlueCare & Select)	$28,764,984	$85,888,103	$57,123,119

All TennCare MCOs met their minimum net worth requirements as of June 30, 2010.

Success of Fraud Detection and Prevention

The Office of Inspector General (OIG) was established six 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 (MCCs), and the general public via the OIG web site, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the first quarter of the 2010 - 2011 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	1,688	1,688	129,955
Cases Closed*	1,357	1,357	125,502

**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.*

Summary of Enrollee Abuse Cases*

	Quarter	Grand Total
Abuse Cases Received	1,184	59,130
Abuse Cases Closed	856	19,657
Abuse Cases Referred **	328	40,111

**Totals are for the last 51 months (17th quarterly report)*

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

Summary of Provider Cases

	Quarter	FYT	Grand Total
Cases Received	40	40	1,622
Cases referred to TBI* as part of the Provider Fraud Task Force	5	5	233
Cases referred to HRBs**	21	21	15

***The OIG refers **provider cases** to the TBI Medicaid Fraud Unit (as per state and federal law) and assists with these investigations as requested. **Provider Fraud Task Force** – this group is made up of representatives of the Attorney General's Office, the TennCare Bureau, the Tennessee Bureau of Investigation, and the OIG; OIG's participation began during the 4th quarter of FY 2008-2009.*

***Health Related Boards*

Summary of Arrests & Convictions

	Quarter	FYT	Grand Total
Arrests	44	44	1,281
Convictions	36	36	667
Diversions*	13	13	251

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	$30,620.00	$30,620.00	$391,652.00
Court Costs & Taxes	$9,486.42	$9,486.42	$146,900.23
Restitution (ordered)	$7,825.38	$7,825.38	$1,650,803.21
Drug Funds/Forfeitures	$9,803.00	$9,803.00	$404,903.90

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	430
Drug Diversion/Sale RX	493
Doctor Shopping	110
Access to Insurance	55
Operation Falcon III	32
Operation Falcon IV	16
False Income	63
Ineligible Person Using Card	19
Living Out Of State	13
Asset Diversion	7
ID Theft	38
Aiding & Abetting	3
Failure to Appear in Court	2
GRAND TOTAL	**1,281**

TennCare Case Referral & Recoupment

	Quarter	FYT	Grand Total
Recoupment	$41,181.78	$41,181.78	$1,950,581.05[4]
Civil Case Recoupment	$35,756.84	$35,756.84	$1,351,320.20[5]
Recommended TennCare Terminations	41	41	49,199[6]
Potential Savings	$149,911.99	$149,911.99	$173,198,784.99[7]

Investigative Sources

	Quarter	FYT	Grand Total
OIG Hot Line	946	946	25,338
OIG Mail Tips	49	49	3,745
OIG Web Site	216	216	8,225
OIG Email Tips	229	229	4,266

[4] 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 September 30, 2010.

[5] The Grand Total for this column is based on recoupment tracked by the OIG Legal Division since FY 2006. ***These numbers reflect consent orders enforceable in court***.

[6] Enrollee recommendations sent to the TennCare Bureau for consideration based on information received and reviewed by the OIG.

[7] There were 41 *recommended* enrollee terminations by the OIG to the TennCare Bureau for their review during the first quarter. The TennCare Bureau uses $3,656.39 as the average annual cost per enrollee for MCO, pharmacy, behavioral health, and dental services (***effective FY 08-09***). [**NOTE**: Prior reports reflect $3,351.96 as the average annual cost per enrollee.]

Other Investigative Sources for this Quarter

Fax……	31
Cash for Tips (pending).....	7

Case Types for this Quarter (*sample*)

Drug Diversion……	279
Drug Seeker ……	88
Living Out of State……	118
Transfer of Assets……	10
Abusing ER……	45
Doctor Shopping……	309
Other insurance……	192

The Office of Inspector General participated in the following activities during the First Quarter:

Meetings with Law Enforcement Officials and other State Agencies

- Various Judicial Task Forces, District Attorneys, Sheriffs, and Chiefs of Police
- Provider Fraud Task Force meeting at the TennCare Bureau
- TBI Drug Diversion Task Force
- Middle Tennessee Law Enforcement Committee (in Brentwood)
- FBI National Academy Graduates
- MCC Roundtable
- East Tennessee Drug Diversion Task Force Meeting – Chattanooga

Media

- Electronic and print media throughout the State of Tennessee reported the arrests and convictions of the OIG

Training

- Leadership Nashville Co-Chair for Criminal Justice Day
- Leadership Franklin Co-Chair for Criminal Justice Day
- Leadership Marshall County -- Participation
- Presentation given to the staff of the Jackson-Madison County General Hospital
- Presentation given to the staff of Northcrest Hospital in Springfield
- ROCIC Training
- Tennessee Government Executive Institute Alumni Meetings
- Tennessee Government Management Institute Alumni Meetings
- FBI National Academy Alumni Meetings

- OIG In-Service Training for all commissioned personnel
- OIG Attorneys, RNs, and CPA attending training sessions for their CEU's

Other OIG Updates & Activities

- Current OIG staffing has 29 fewer positions from the original staffing level. This represents a 41 percent reduction in staffing.
    - 3 employees took the Voluntary Buyout in 2008
    - 8 positions were eliminated in 2009
    - 6 positions were eliminated in the 2011 budget
    - 3 IS employees were transferred to the TennCare Bureau
    - 1 Paralegal transferred to the Department of Health
    - 1 Special Agent transferred to the State Law Enforcement Training Academy
    - 1 Attorney resigned
    - 2 Special Agents resigned
    - 1 ASA 4 retired
    - 2 additional positions are vacant: ASA 4 and a PHNC 1
    - 1 PHNC 1 retired

- The Inspector General, the Deputy Inspector General over Criminal Investigations, and all of the Special Agents have continued to make visits to various Tennessee counties. In each jurisdiction visited, there is a planned meeting with the Sheriff, Chief of Police, and members of the Drug Task Force. 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 *Doctor Shopping* legislation (approved by the General Assembly, June 2007) has generated **110 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.

OIG Plans for next quarter:

- Continue to exchange information with local, state, and federal government agencies.
- Provide presentations and training for State and local law enforcement, health care providers, and other interested parties regarding TennCare fraud and the role of the OIG.
- Continue staff training and develop best practices.
- Continue to track the *Tips for Cash* incentive program regarding information that leads to a successful arrest and conviction for TennCare fraud. This program is a result of legislation from the 104th General Assembly.
- Continue using the Doctor Shopping Law on investigations regarding suspected chronic abusers of the TennCare program.

- The OIG will continue to participate as an active member of the *TennCare Provider Fraud Task Force* with other members including the Attorney General's Office, the TennCare Bureau, and the Tennessee Bureau of Investigation Medicaid Fraud Control Unit.
- Ensure all policies and procedures are reviewed, revised as needed, and distributed to the OIG staff. The OIG will continue to strive towards best practices.