TennCare Quarterly Report

Submitted to the Members of the General Assembly

October 15, 2012

Status of TennCare Reforms and Improvements

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 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 June 30, 2013, the Bureau filed its renewal application with the Centers for Medicare and Medicaid Services (CMS) on June 29, 2012, to comply with provisions in federal regulation and the Waiver requiring submission a year in advance.[1] The Bureau requested a three-year extension, through June 30, 2016. CMS is currently reviewing the extension request in light of federal changes that are scheduled to take place under the Affordable Care Act on January 1, 2014.

Annual Beneficiary Survey. On September 14, 2012, TennCare submitted the results of the annual Beneficiary Survey to CMS.

The Beneficiary Survey (entitled *The Impact of TennCare: A Survey of Recipients, 2012*, but occasionally referred to as the "Patient Satisfaction Survey") records the impressions of Tennessee citizens—TennCare enrollees, individuals with private insurance, and uninsured individuals alike—on the quality of the health care they receive. The survey of 5,000 households has been conducted by the University of Tennessee's Center for Business and Economic Research (CBER) since 1993 and, as a result, provides a valuable perspective on how Tennesseans have viewed health care issues and the TennCare program over time.

[1] See 42 C.F.R. § 431.412(c) and Special Term and Condition #8 of the TennCare Waiver.

Although the findings of a single survey must be viewed in context of long-term trends, several results from 2012 are noteworthy:

- The estimated number of "uninsured" Tennesseans (577,813) is at its lowest point since 2008.
- The percentage of respondents classifying themselves as "uninsured" (9.2 percent) is at its lowest point since 2005.
- 93 percent of respondents covered by TennCare expressed satisfaction with the quality of care they had received. This level of satisfaction is one of the highest in the program's history.
- The vast majority of respondents covered by TennCare report that they seek initial medical care for themselves (89 percent) and for their children (97 percent) at a doctor's office or clinic instead of at the hospital. These figures are significant because seeking initial medical care at the emergency room (in the absence of an emergency) is clearly less cost-effective than seeking this care at a doctor's office or clinic.

Such statistics illustrate the report's concluding observation that "TennCare continues to receive positive feedback from its recipients, indicating the program is providing medical care in a satisfactory manner and up to the expectations of those it serves."

CBER published the Beneficiary Survey report in September 2012. It may be viewed online at http://cber.bus.utk.edu/tncare/tncare12.pdf.

Standard Spend Down. The TennCare Standard Spend Down (SSD) eligibility category opened to new enrollment for the fifth time on September 13, 2012 (following previous periods of open enrollment on October 4, 2010, February 22, 2011, September 12, 2011, and February 21, 2012). SSD is available through an amendment to the TennCare Waiver[2] and is designed to serve a limited number of persons 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.

During the open enrollment period, the Department of Human Services (DHS) received 2,731 calls in less than one hour. As a result, 2,626 callers not already covered by TennCare were invited to apply for SSD. As of the end of the quarter, the announced deadline for submitting an application was October 31, 2012.

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

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

its name suggests, is to provide financial incentives to Medicaid providers[3] 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. 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 July to September 2012 quarter, first year and second year payments made by TennCare were as follows:

	Number of Providers	**Quarterly Amount Paid**	**Cumulative Amount Paid**
First year payments	246 providers (155 physicians, 56 nurse practitioners, 20 dentists, 7 certified nurse midwives, 6 hospitals, and 2 physician assistants)	$11,516,941.00	$94,140,059.97
Second year payments	80 providers (44 physicians, 32 nurse practitioners, and 4 hospitals	$1,558,165.00	$2,104,863.00

Outreach efforts conducted during the quarter included the mailing of individualized inquiries to nearly 400 providers in two categories: those who had completed TennCare's EHR registration process but had not attested to meeting applicable criteria, and those who had completed CMS's EHR registration process but had not logged into TennCare's Provider Incentive Payment Program (PIPP) web portal for more than 90 days. That these providers had demonstrated interest in the program without actually earning payments made them ideal targets for renewed contact.

Other outreach activities included:

[3] 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).

- Co-hosting an attestation webinar with Qualifacts Systems, Inc. on July 16;
- Making a presentation at the TennCare Dental Advisory Committee Meeting on August 31;
- Participating in Tennessee Medical Association workshops in six different cities during September; and
- Addressing payment and meaningful use issues at the September 11 meeting between TennCare and the Tennessee Chapter of the American Academy of Pediatrics.

Such activities complement TennCare's considerable online resources devoted to these subjects, some facets of which are a dedicated webpage (located at http://www.tn.gov/tenncare/ehr_intro.shtml) and newsletters distributed by the Bureau's EHR ListServ.

Request for Proposals for Pharmacy Benefits Management. With less than a year remaining until the contract between TennCare and pharmacy benefits manager (PBM) SXC Health Solutions[4] expires on May 31, 2013, the State issued a request for proposals (RFP) for a new pharmacy benefits manager on August 3, 2012.

According to the "Scope of Services" portion of the RFP document (available online at http://tn.gov/generalserv/purchasing/ocr/documents/31865-00346_001.pdf), actual delivery of services would begin on June 1, 2013, but would be preceded by a six-month period of "readiness review" to ensure proper benefits implementation, so that no disruptions of service occur. Responsibilities of the PBM include:

- Design, implementation, and operation of an online system of claims management, adjudication, and payment;
- Management of TennCare's Preferred Drug List;
- Reviewing enrollees' patterns of prescription drug use and providers' prescribing habits for possible fraud, abuse, and/or waste;
- Operation of a Prior Authorization Review Unit to review and adjudicate requests for non-preferred drugs and requests for preferred drugs that do not conform to established guidelines;
- Operation of a Pharmacy Help Desk that responds to pharmacies' questions concerning systems and claims issues; and
- Furnishing an adequate network of retail, specialty, and long-term care pharmacies throughout the state.

Comments and questions from potential bidders occupy 26 pages of the RFP document, suggesting that interest in the contract with TennCare is substantial. The deadline for submission of a proposal is October 15, 2012.

[4] SXC recently changed its name to "Catamaran." Additional information about this development appears later in the report.

Recognition of TennCare. In August 2012, Mercy Children's Clinic, a non-profit provider of medical care to disadvantaged children in Williamson County, honored TennCare with a Certificate of Recognition. The award commends the Bureau's "outstanding dedication in collaborative partnership to provide health care services to the underserved in Tennessee." TennCare Medical Director Jeanne James accepted the certificate on behalf of the Bureau.

The stated mission of Mercy Children's Clinic, which has treated patients since 1999, is to "reflect the love and compassion of Jesus Christ by providing healthcare services to all children and support to their families."[5]

Quality Improvement Strategy. As required by federal law,[6] federal regulation,[7] and the State's Waiver agreement with CMS,[8] TennCare has developed a strategy for evaluating and improving the quality and accessibility of care offered to enrollees through the managed care network. The Bureau submitted its annual update of the strategy—entitled "2012 Quality Assessment and Performance Improvement Strategy"—to CMS on August 1, 2012. In addition to laying out the measures of quality assurance already in place, the report outlines TennCare's goals and objectives for the year ahead. Although CMS has not completed its review of the report, last year's approved strategy remains available online at http://www.tn.gov/tenncare/forms/qualitystrategy2011.pdf.

Name Change for Pharmacy Benefits Manager. Following the completion of its merger with Catalyst Health Solutions on July 2, 2012, TennCare Pharmacy Benefits Manager (PBM) SXC Health Solutions announced on July 10 that the company's name had changed to Catamaran. Although SXC's acquisition of Catalyst made Catamaran the nation's fourth largest PBM by prescription volume, the effect of the merger on TennCare enrollees is expected to be minimal: neither the Bureau's coverage of prescription drugs nor the network of pharmacies serving the TennCare population has been affected. While the "TennCare Pharmacy Program" website (located at https://tnm.rxportal.sxc.com/rxclaim/portal/preLogin) now displays the Catamaran insignia and includes provider notices reflecting the name change, member materials will not bear the company's new name until January 2013. A notice mailed to all enrollees on September 28, 2012, summarizes this development and informs recipients that they will receive a new pharmacy card.

Essential Access Hospital (EAH) Payments. The TennCare Bureau continued to make Essential Access Hospital payments during the July-September 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.

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[5] See the organization's "Mission/History" page, which is located online at http://mercytn.org/about-us-our-missionhistory/.
[6] 42 U.S.C. § 1396u-2(c)(1)(A)
[7] 42 C.F.R. § 438.202
[8] Special Term and Condition #45(c) of the TennCare Waiver, a link to which appears in Footnote 2.

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 first quarter of State Fiscal Year 2013 are shown in the table below.

Essential Access Hospital Payments for the Quarter

Hospital Name	County	EAH First Quarter FY 2013
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 First Quarter FY 2013
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 First Quarter FY 2013
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 July 1, 2012, through September 30, 2012, there were 1,181,449 Medicaid eligibles and 18,516 Demonstration eligibles enrolled in TennCare, for a total of 1,199,965 persons.

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

	1st Quarter*
Spending on MCO services**	$960,739,800
Spending on dental services	$40,206,300
Spending on pharmacy services	$170,781,700
Medicare "clawback"***	$41,984,300

**These figures are cash basis as of September 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[9] 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[10] are processed and paid within 21 calendar days of receipt.	TennCare contract

[9] 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.

[10] 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 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) Second Quarter 2012 Financial Statement. As of June 30, 2012, TennCare MCOs reported net worth as indicated in the table below.[11]

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$17,551,988	$94,570,941	$77,018,953

[11] 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.

	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$62,651,284	$481,256,798	$418,605,514
Volunteer State Health Plan (BlueCare & TennCare Select)	$34,832,427	$196,627,600	$161,795,173

All TennCare MCOs met their minimum net worth requirements as of June 30, 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 website, fax, written correspondence, and phone calls to the OIG hotline. The statistics for the first 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	1,896	142,232
Abuse Cases Received*	1,268	69,335

***** *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	$102,443.00	$672,510.00
Court Costs & Taxes	$9,808.62	$211,298.61
Court Ordered Restitution	$107,644.86	$2,047,709.56
Drug Funds/Forfeitures	$15,203.82	$434,364.22

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	7	521
Drug Diversion/Sale RX	22	675
Doctor Shopping	18	250
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	2	21
Asset Diversion	0	7
ID Theft	5	60
Aiding & Abetting	0	5
Failure to Appear in Court	0	3
Child Not in the Home[12]	3	5
GRAND TOTAL	**57**	**1,746**

OIG Case Recoupment & Recommendations

	Quarter	Grand Total to Date (since February 2005)[13]
Court Ordered Recoupment	$54,562.13	$4,047,994.32[14]
Recommended TennCare Terminations [15]	129	49,643
Potential Savings[16]	$471,674.31	$174,672,310.26

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

[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 by the average annual cost per enrollee for MCO, pharmacy, and dental services (currently, $3,656.39).