TennCare Quarterly Report

October – December 2020

Submitted to the Members of the General Assembly

Status of TennCare Reforms and Improvements

Launch of Katie Beckett Program. On November 23, 2020, TennCare launched a new "Katie Beckett" program. The Katie Beckett program provides services and supports for children under age 18 with disabilities and/or complex medical needs who are not eligible for traditional Medicaid because of their parents' income or assets. The Katie Beckett program is an outgrowth of legislation (Public Chapter No. 494) passed by the Tennessee General Assembly in the 2019 legislative session. Following enactment of Public Chapter No. 494, TennCare submitted a waiver amendment ("Amendment 40") to CMS to establish the new program. CMS ultimately approved Amendment 40 on November 2, 2020.

The Katie Beckett program—developed by TennCare in close collaboration with the Tennessee Department of Intellectual and Developmental Disabilities and other stakeholders—contained two parts:

- **Part A** – Individuals in this group receive the full TennCare benefits package, as well as essential wraparound home and community based services. These individuals would be subject to monthly premiums to be determined on a sliding scale based on the member's household income.
- **Part B** – Individuals in this group would receive a specified package of essential wraparound services and supports, including premium assistance.

In addition to Parts A and B, the Katie Beckett program provides continued TennCare eligibility for children already enrolled in TennCare, who subsequently lose TennCare eligibility, and who would qualify for enrollment in Part A but for whom no Part A program slot is available.

Following CMS approval, the Katie Beckett program began accepting self-referral forms from interested families on November 23, 2020.

Response to COVID-19 Emergency. On March 12, 2020, Governor Bill Lee declared a state of emergency to help facilitate the state's response to the threat to public health and safety posed by coronavirus disease 2019 (or "COVID-19"). As the agency in Tennessee state government responsible for providing health insurance to more than 1.5 million individuals, the Division of TennCare has developed a

multilayered response to the COVID-19 emergency. Working in tandem with partners and stakeholders at the federal and state levels, TennCare designed and deployed a strategy consisting of such elements as—

- Coordinating with the provider community and TennCare's health plans to ensure access to care for TennCare members in need of testing or treatment for COVID-19;
- Assisting providers in offering covered services to TennCare members via telehealth when medically appropriate;
- Increasing care coordination services for members impacted by COVID-19 who are self-isolated so that they can receive additional supports as needed;
- Pausing nearly all terminations of eligibility for TennCare and CoverKids (the state's separate CHIP program) members during the COVID-19 emergency;
- Waiving copays on services related to the testing and treatment of COVID-19 for TennCare and CoverKids members;
- Working with TennCare's health plans to streamline or temporarily lift authorization requirements to ensure services are delivered promptly and claims paid quickly;
- Expediting access to home-based care for former nursing facility patients being discharged from hospitals and electing to transition home;
- Enhancing access to prescription drugs by allowing early refills of prescriptions and by allowing 90-day supplies to be prescribed for most medications;
- Obtaining a Section 1135 waiver from the Centers for Medicare and Medicaid Services (CMS) that provides flexibilities to help ensure that TennCare members receive necessary services;
- Submitting a Section 1115 waiver application seeking CMS authorization to reimburse hospitals, physicians, and medical labs for providing COVID-19 treatment to uninsured individuals;
- Obtaining federal approval to make supplemental retainer payments to providers of home- and community-based services for individuals with intellectual disabilities, as well as additional flexibilities to support these providers during the public health emergency;
- Assisting providers of long-term services and supports in reducing the spread of COVID-19 among individuals who are residents of nursing facilities; and
- Working with the federal government and healthcare providers in Tennessee to provide enhanced financial support for providers disproportionately affected by the COVID-19 emergency, including primary care providers, nursing facilities, dentists, and community mental health centers and other providers of behavioral health services.

Additional resources concerning TennCare's response to the COVID-19 pandemic are available on the agency's website at https://www.tn.gov/tenncare/information-statistics/tenncare-information-about-coronavirus.html.

Block Grant Demonstration Amendment and Approval of TennCare III Demonstration. On November 20, 2019, TennCare submitted a demonstration amendment ("Amendment 42") to CMS. The purpose of Amendment 42 was to convert the bulk of TennCare's federal funding to a block grant. Amendment 42 was developed and submitted in accordance with legislation passed by the General Assembly during the 2019 legislative session.

On January 8, 2021, CMS approved Amendment 42. CMS' approval takes the form of a new TennCare demonstration referred to as "TennCare III." Under the terms of this new demonstration, TennCare may access additional federal funds that would not have been available in the absence of the TennCare III waiver. TennCare's ability to access additional federal funding is contingent on spending less than the amount projected in the federal budget neutrality cap applied to the program, as well as maintaining or improving performance on key quality metrics. CMS approved the TennCare III waiver for a period of ten years. During this time, the program's budget neutrality cap will be increased annually based on the projected rate of growth in Medicaid spending in the President's budget. The budget neutrality cap will also be adjusted for any enrollment changes that are greater than one percentage point in magnitude. Under the terms of the TennCare III waiver, TennCare also received certain administrative flexibilities from CMS.

Additional information about Amendment 42 and the TennCare III waiver are available on the TennCare website at https://www.tn.gov/tenncare/policy-guidelines/tenncare-1115-demonstration.html.

Other Amendments to the TennCare Demonstration. Three proposed amendments to the TennCare Demonstration were in various stages of development during the October-December 2020 quarter.

Demonstration Amendment 35: Substance Use Disorder Services. In May 2018, TennCare submitted Demonstration Amendment 35 to CMS. Amendment 35 would modify the TennCare benefits package to cover residential substance use disorder (SUD) treatment services in facilities with more than 16 beds. The federal government classifies such facilities as "institutions for mental diseases" (IMDs), and federal law prohibits the expenditure of federal Medicaid dollars for services delivered to adults in these facilities. Historically, TennCare's managed care organizations (MCOs) were permitted to cover residential treatment services in IMDs, if the MCO determined that such care was medically appropriate and cost-effective as compared to other treatment options. However, CMS recently issued regulations restricting the ability of MCOs to pay for services in these facilities. Specifically, the new federal regulation limits this option to treatment stays of no more than 15 days per calendar month.[1] TennCare is seeking authority with Amendment 35 to allow enrollees to receive short-term services in IMDs beyond the 15-day limit in federal regulation, up to 30 days per admission.

As of the end of the October-December 2020 quarter, CMS's review of Amendment 35 was ongoing.

[1] See 42 CFR § 438.6(e).

Demonstration Amendment 36: Providers of Family Planning Services. Amendment 36 was submitted to CMS in August 2018. Amendment 36 grew out of Tennessee's 2018 legislative session and, in particular, Public Chapter No. 682, which established that it is the policy of the state of Tennessee to favor childbirth and family planning services that do not include elective abortions within the continuum of care or services, and to avoid the direct or indirect use of state funds to promote or support elective abortions.

Amendment 36 requests authority for TennCare to establish state-specific criteria for providers of family planning services, and to exclude any providers that do not meet these criteria from participation in the TennCare program. As specified in Public Chapter No. 682, TennCare is proposing to exclude any entity that performed, or operated or maintained a facility that performed, more than 50 abortions in the previous year, including any affiliate of such an entity.

CMS held a 30-day federal public comment period on Amendment 36 during the third quarter of Calendar Year 2018. Close to 3,500 comments were received, and CMS subsequently began to review that feedback as well as the amendment itself. As of the end of the October-December 2020 quarter, CMS's review of Amendment 36 was ongoing.

Demonstration Amendment 38: Community Engagement. TennCare submitted Amendment 38 to CMS on December 28, 2018. Demonstration Amendment 38 implements a state law (Public Chapter No. 869) enacted by the Tennessee General Assembly in 2018. This law directed TennCare to seek federal authorization to establish reasonable work and community engagement requirements for non-pregnant, non-elderly, non-disabled adults enrolled in the TennCare program who do not have dependent children under the age of six. The legislation also required TennCare to seek approval from the U.S. Department of Health and Human Services (HHS) to use funds from the state's Temporary Assistance for Needy Families (TANF) program to support implementation of the community engagement program.

As of the end of the October-December 2020 quarter, discussions between TennCare and CMS on Amendment 38, as well as conversations between TennCare and federal TANF officials, were ongoing.

Update on Episodes of Care. TennCare's episodes of care program aims to transform the way specialty and acute healthcare services are delivered by incentivizing high-quality, cost-effective care, promoting evidence-based clinical pathways, encouraging care coordination, and reducing ineffective or inappropriate treatments. Episodes of care is part of TennCare's delivery system transformation initiative, which is changing healthcare delivery in Tennessee by moving from paying for volume to paying for value.

In October 2020, all providers participating in the episodes of care program were invited to a collaborative conference on delivery system transformation hosted jointly by TennCare and TennCare's managed care organizations (MCOs). A key learning collaborative session during the conference—titled "Risk Coding and Episodes of Care"—included a productive discussion on the relationship between accuracy in coding and positive outcomes in the episodes program. The conference was hosted virtually, and providers from across the state attended. TennCare leadership anticipates that 2021 will be a particularly strong year for provider engagement opportunities related to episodes of care.

Incentives for Providers to Use Electronic Health Records. The Electronic Health Records (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 of 2009. The purpose of the program is to provide financial incentives to Medicaid providers[2] to replace outdated, often paper-based approaches to medical record-keeping with Certified Electronic Health Record Technology (as defined by CMS) that meets rigorous 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 funding for administrative costs. Tennessee's EHR program[3] has issued payments for six years to eligible professionals and for three years to eligible hospitals.

EHR payments made by TennCare during the October-December 2020 quarter as compared with payments made throughout the life of the program appear in the table below:

Payment Type	Number of Providers Paid During the Quarter	Quarterly Amount Paid (Oct-Dec 2020)	Cumulative Amount Paid to Date[4]
First-year payments	N/A	N/A	$180,176,644
Second-year payments	3	$25,500	$59,990,155
Third-year payments	2	$17,000	$37,948,519
Fourth-year payments	5	$42,500	$8,998,682
Fifth-year payments	8	$68,000	$6,142,672
Sixth-year payments	5	$42,500	$3,725,248

Technical assistance activities, outreach efforts, and other EHR-related projects conducted by TennCare staff during the quarter included the following:

- Launching TennCare's attestation software for Program Year 2020 on November 1, 2020 (as permitted by CMS);
- Ongoing communications with providers on attestation timelines for Program Years 2020 and 2021;
- Providing daily technical assistance to providers via email and telephone calls;
- Participation in CMS-led calls regarding the EHR Incentive Program; and
- Newsletters and alerts distributed by TennCare's EHR ListServ.

[2] CMS allows two types of providers to participate in the Medicaid EHR Incentive Program: eligible professionals (medical and osteopathic physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants who meet certain criteria) and eligible hospitals (acute care hospitals, critical access hospitals, and children's hospitals). All hospitals participating in the program have received all payments available to them.

[3] In April 2018, CMS announced that its EHR programs would be renamed "Promoting Interoperability (PI) Programs." While Tennessee's EHR initiative falls within the scope of CMS's PI Programs, TennCare continues to refer to its initiative as "EHR Incentive Program" for purposes of clarity and consistency in communications with providers.

[4] In certain cases, cumulative totals reflect adjustments of payments from previous quarters. The need for these recoupments was identified through standard auditing processes.

Although enrollment of new providers concluded on April 30, 2017, TennCare's EHR Incentive Program will continue through the 2021 program year as required by CMS rules. Tennessee's program team continues to work with a variety of provider organizations to maintain the momentum of the program. The focus of post-enrollment outreach efforts for the remainder of the program is to encourage all providers who remain eligible to continue attesting and receive all six payments available.

Dyersburg Family Walk-In Clinic, Inc. v. Tennessee Department of Finance and Administration, et al. **Lawsuit.** On December 22, 2020, Dyersburg Family Walk-In Clinic, Inc., which does business under the registered assumed name Reelfoot Family Walk-In Clinic, filed a federal lawsuit against TennCare in the District Court for the Western District of Tennessee. Reelfoot operates three Rural Health Clinics that receive supplemental payments from TennCare. The lawsuit challenges TennCare requirements related to these supplemental payments and seeks injunctive and declaratory relief. As of the end of the October-December 2020 quarter, TennCare was preparing a motion to dismiss, which was expected to be filed in January 2021.

Supplemental Payments to Tennessee Hospitals. The Division of TennCare makes supplemental payments to qualifying Tennessee hospitals each quarter to help offset the costs these facilities incur in providing uncompensated care. The methodology for distributing these funds is outlined in Attachment H of the TennCare Demonstration Agreement with CMS that was in effect during the October-December 2020 quarter. The supplemental payments made during the second quarter of State Fiscal Year 2021 are shown in the table below.

Supplemental Hospital Payments for the Quarter

Hospital Name	County	Second Quarter Payments – FY 2021
Methodist Medical Center of Oak Ridge	Anderson County	$124,695
Ridgeview Psychiatric Hospital and Center	Anderson County	$162,945
Tennova Healthcare – Shelbyville	Bedford County	$37,024
Blount Memorial Hospital	Blount County	$173,726
Tennova Healthcare – Cleveland	Bradley County	$145,058
Jellico Medical Center	Campbell County	$107,212
Tennova Healthcare – LaFollette Medical Center	Campbell County	$66,115
Saint Thomas Stones River Hospital	Cannon County	$34,880
Sycamore Shoals Hospital	Carter County	$95,122
Claiborne Medical Center	Claiborne County	$58,708
Tennova Healthcare – Newport Medical Center	Cocke County	$71,662
Tennova Healthcare – Harton	Coffee County	$71,755
Unity Medical Center	Coffee County	$65,245
Ascension Saint Thomas Hospital	Davidson County	$427,132
TriStar Skyline Medical Center	Davidson County	$569,441
Nashville General Hospital	Davidson County	$290,479
Select Specialty Hospital – Nashville	Davidson County	$203

Hospital Name	County	Second Quarter Payments – FY 2021
TriStar Centennial Medical Center	Davidson County	$943,495
TriStar Southern Hills Medical Center	Davidson County	$182,500
TriStar Summit Medical Center	Davidson County	$184,835
Vanderbilt Stallworth Rehabilitation Hospital	Davidson County	$124
Vanderbilt University Medical Center	Davidson County	$5,504,621
Saint Thomas DeKalb Hospital	DeKalb County	$37,889
TriStar Horizon Medical Center	Dickson County	$298,788
West Tennessee Healthcare Dyersburg Hospital	Dyer County	$107,258
Southern Tennessee Regional Health System – Winchester	Franklin County	$94,476
West Tennessee Healthcare Milan Hospital	Gibson County	$28,810
Southern Tennessee Regional Health System – Pulaski	Giles County	$83,067
Greeneville Community Hospital	Greene County	$152,727
Morristown – Hamblen Healthcare System	Hamblen County	$215,543
Erlanger Behavioral Health Hospital	Hamilton County	$14,292
Erlanger Health System	Hamilton County	$2,919,854
Parkridge Medical Center	Hamilton County	$1,532,049
Encompass Health Rehabilitation Hospital of Chattanooga	Hamilton County	$321
Siskin Hospital for Physical Rehabilitation	Hamilton County	$422
Hardin Medical Center	Hardin County	$114,581
Henderson County Community Hospital	Henderson County	$29,570
Henry County Medical Center	Henry County	$146,637
Tennova Healthcare – Jefferson Memorial Hospital	Jefferson County	$40,778
Parkwest Medical Center	Knox County	$449,774
Tennova Healthcare – North Knoxville Medical Center	Knox County	$143,458
East Tennessee Children's Hospital	Knox County	$2,422,790
Fort Sanders Regional Medical Center	Knox County	$350,909
University of Tennessee Medical Center	Knox County	$1,751,974
Southern Tennessee Regional Health System – Lawrenceburg	Lawrence County	$53,284
Lincoln Medical Center	Lincoln County	$309,719
Jackson – Madison County General Hospital	Madison County	$709,352
Pathways of Tennessee	Madison County	$148,276
Perimeter Behavioral of Jackson	Madison County	$46,459
West Tennessee Healthcare Rehabilitation Hospital Jackson	Madison County	$414
Maury Regional Medical Center	Maury County	$237,371
Sweetwater Hospital Association	Monroe County	$147,818
Tennova Healthcare – Clarksville	Montgomery County	$149,354
Baptist Memorial Hospital – Union City	Obion County	$99,264

Hospital Name	County	Second Quarter Payments – FY 2021
Livingston Regional Hospital	Overton County	$44,808
Cookeville Regional Medical Center	Putnam County	$249,328
Roane Medical Center	Roane County	$82,987
NorthCrest Medical Center	Robertson County	$119,586
Saint Thomas Rutherford Hospital	Rutherford County	$295,922
TriStar StoneCrest Medical Center	Rutherford County	$240,270
LeConte Medical Center	Sevier County	$248,205
Baptist Memorial Restorative Care Hospital	Shelby County	$1,397
Baptist Memorial Hospital – Memphis	Shelby County	$992,986
Methodist University Hospital	Shelby County	$1,432,029
Crestwyn Behavioral Health	Shelby County	$165,522
Delta Specialty Hospital	Shelby County	$318,544
Encompass Health Rehabilitation Hospital of North Memphis	Shelby County	$579
Encompass Health Rehabilitation Hospital of Memphis	Shelby County	$522
Le Bonheur Children's Hospital	Shelby County	$4,727,210
Regional One Health	Shelby County	$2,789,667
Regional One Health Extended Care Hospital	Shelby County	$55
Saint Francis Hospital	Shelby County	$319,610
Saint Francis Hospital – Bartlett	Shelby County	$109,718
Saint Jude Children's Research Hospital	Shelby County	$744,864
Bristol Regional Medical Center	Sullivan County	$176,052
Creekside Behavioral Health	Sullivan County	$5,792
Encompass Health Rehabilitation Hospital of Kingsport	Sullivan County	$685
Holston Valley Medical Center	Sullivan County	$303,154
Indian Path Community Hospital	Sullivan County	$124,824
TriStar Hendersonville Medical Center	Sumner County	$200,616
Sumner Regional Medical Center	Sumner County	$137,298
Baptist Memorial Hospital – Tipton	Tipton County	$144,650
Unicoi County Hospital	Unicoi County	$21,992
Saint Thomas River Park Hospital	Warren County	$130,329
Johnson City Medical Center	Washington County	$1,568,405
Franklin Woods Community Hospital	Washington County	$115,768
Quillen Rehabilitation Hospital	Washington County	$329
Wayne Medical Center	Wayne County	$22,688
West Tennessee Healthcare Rehabilitation Hospital Cane Creek	Weakley County	$68
West Tennessee Healthcare Volunteer Hospital	Weakley County	$35,471
Saint Thomas Highlands Hospital	White County	$75,979
Encompass Health Rehabilitation Hospital of Franklin	Williamson County	$17

Hospital Name	County	Second Quarter Payments – FY 2021
Williamson Medical Center	Williamson County	$67,141
Vanderbilt Wilson County Hospital	Wilson County	$273,964
TOTAL		**$38,443,286**

Number of Recipients on TennCare and Costs to the State

During the month of December 2020, there were 1,506,436 Medicaid eligibles and 20,163 Demonstration eligibles enrolled in TennCare, for a total of 1,526,599 persons.

Estimates of TennCare spending for the second quarter of State Fiscal Year 2021 are summarized in the table below.

Spending Category	Second Quarter FY 2021*
MCO services**	$2,044,008,300
Dental services	$42,035,900
Pharmacy services	$328,906,000
Medicare "clawback"***	$51,185,400

**These figures are cash basis as of December 31 and are unaudited.*

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

****The Medicare Part D clawback is money that 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 Managed Care Contractors (MCCs) in the TennCare Program

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

Entity	Standard	Authority
MCOs (services other than CHOICES and ECF CHOICES)	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)
MCOs (CHOICES and ECF CHOICES services)	90% of clean electronically submitted Nursing Facility and applicable Home and Community Based Services claims[5] 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[6] are processed and paid within 21 calendar days of receipt.	TennCare contract

[5] 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.

[6] Ibid.

Entity	Standard	Authority
Dental Benefits Manager (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)
Pharmacy Benefits Manager (PBM)	100% of all clean claims submitted by pharmacy providers are paid within 15 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 claims processor (e.g., MCO, vision benefits manager, etc.). 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 and ECF CHOICES enrollees. TDCI then performs an analysis and reports the results of the prompt pay analyses by NEMT and CHOICES and ECF CHOICES claim types, by claims processor, 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 Division of TennCare may 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 TennCare may assess applicable liquidated damages against these entities.

Net worth and company action level requirements. According to Tennessee's "Health Maintenance Organization Act of 1986" statute (T.C.A. § 56-32-101 *et seq.*), the minimum net worth requirement for each TennCare MCO is calculated based on premium revenue reported on the National Association of Insurance Commissioners (NAIC) Annual Financial Statement for the most recent calendar year, as well as any TennCare payments made to the MCO that are not reported as premium revenue.

During the October-December 2020 quarter, the MCOs submitted their NAIC Third Quarter 2020 Financial Statements. As of September 30, 2020, TennCare MCOs reported net worth as indicated in the table below.[7]

[7] 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.

MCO	Net Worth Requirement	Reported Net Worth	Excess/ (Deficiency)
Amerigroup Tennessee	$33,562,799	$254,083,584	$220,520,785
UnitedHealthcare Plan of the River Valley (UnitedHealthcare Community Plan)	$77,500,193	$660,005,694	$582,505,501
Volunteer State Health Plan (BlueCare & TennCare Select)	$56,256,150	$528,957,353	$472,701,203

During the October-December 2020 quarter, the MCOs were also required to comply with Tennessee's "Risk-Based Capital for Health Organizations" statute (T.C.A. § 56-46-201 *et seq.*). Risk-based capital (RBC) involves a method of calculating the minimum amount of capital necessary for a health entity to support its overall business operations depending on its size and risk profile. A health entity with a higher amount of risk is required to hold a higher amount of capital. The RBC statute gives TDCI the authority and mandate to use preventive and corrective measures that vary depending on the amount of capital deficiency indicated by the RBC calculations. A "Company Action Level" deficiency (defined at T.C.A. § 56-46-203(a)) would require the submission of a plan to correct the entity's capital deficiency.

All TennCare MCOs met their minimum net worth requirements and Company Action Level requirements as of September 30, 2020.

Success of Fraud Detection and Prevention

The mission of the Tennessee Office of Inspector General (OIG) is to identify, investigate, prosecute, and arrest persons who commit fraud or abuse against the TennCare program and to recoup money owed to the State of Tennessee. The OIG receives case information from a variety of sources, including local law enforcement, the Division of TennCare, Health Related Boards, the Department of Human Services (DHS), other State agencies, health care providers, MCCs, and the general public via the OIG website, fax, written correspondence, and phone calls to the OIG hotline. Cases adjudicated during a particular fiscal year may have no relationship to dates of arrest during the same year. Selected statistics for the second quarter of Fiscal Year 2021 furnished for this report by the OIG are as follows:

Fraud and Abuse Allegations	Second Quarter FY 2021
Fraud Allegations	332
Abuse Allegations*	180
Arrest/Conviction/Judicial Diversion Totals	**Second Quarter FY 2021**
Arrests	8
Convictions	3
Judicial Diversions	6

***** *Abuse cases may be referred to the appropriate Managed Care Contractor (MCC), the Division of TennCare, or DHS for further review/action.*

Criminal Court Fines and Costs Imposed	Second Quarter FY 2021
Criminal Restitution Ordered	$297,351
Criminal Restitution Received[8]	$149,222
Civil Restitution/Civil Court Judgments	**Second Quarter FY 2021**
Civil Restitution Ordered[9]	$0
Civil Restitution Received[10]	$1,516

Recommendations for Review	Second Quarter FY 2021
Recommended TennCare Terminations[11]	180
Potential Savings[12]	$802,397

Program Totals

The following table identifies monies ordered by the courts as a direct result of TennCare fraud investigations conducted by the OIG since its inception in 2004. Although food stamps are not part of the TennCare program, OIG occasionally discovers evidence of fraud in this area during the course of a TennCare fraud investigation.

Type of Court-Ordered Payment	Grand Total for Period of 2004-2020
Restitution to Division of TennCare	$5,820,863
Restitution to TennCare MCOs	$90,768
Food Stamps	$81,337
Civil Restitution	$3,129,725

[8] Restitution may have been ordered in a fiscal year other than the one in which payment was actually received.

[9] This total reflects dollars identified for recoupment by the OIG in such non-criminal contexts as civil cases, administrative hearings, and voluntary reimbursements to TennCare.

[10] Restitution may have been agreed to in a fiscal year other than the one in which payment was actually received.

[11] Recommendations that enrollees' TennCare coverage should be terminated are sent to the Division of TennCare for review and determination of appropriate action. These recommendations are based on information received and reviewed by the OIG. TennCare determines whether these referrals meet the criteria for termination. Reviews of these recommendations must factor in some limitations, such as the inability to disenroll individuals in certain federally protected categories.

[12] Potential 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 estimated by TennCare to be $4,457.76).