

**IN THE UNITED STATES DISTRICT COURT  
FOR THE MIDDLE DISTRICT OF TENNESSEE  
NASHVILLE DIVISION**

**JOHN B., CARRIE G., JOSHUA M., MEAGAN A., )  
and ERICA A. by their next friend, L.A.; DUSTIN P. )  
by his next friend, Linda C.; BAYLI S. by her next )  
friend, C.W.; JAMES D. by his next friend, )  
Susan H.; ELSIE H. by her next friend, )  
Stacy Miller; JULIAN C. by his next friend, )  
Shawn C.; TROY D. by his next friend, T.W.; )  
RAY M. by his next friend, P.D.; ROSCOE W. by )  
his next friend, B.W.; WILLIAM B. by his next )  
friend, K.B.; JACOB R. by his next friend, Kim R.; )  
JUSTIN S. by his next friend, Diane P.; ESTEL W. )  
by his next friend, E.D.; individually and on behalf )  
of all others similarly situated, )**

**Plaintiffs,**

**v.**

**NANCY MENKE, Commissioner, Tennessee )  
Department of Health; THERESA CLARKE, )  
Assistant Commissioner, Bureau of TennCare; )  
GEORGE HATTAWAY, Commissioner, Tennessee )  
Department of Children’s Services, )**

**Defendants.**

**No. 3:98-0168  
Judge Haynes**

**MONITORS’ REPORT ON  
COORDINATION OF SERVICES IN THE  
TENNCARE EPSDT PROGRAM**

**I. Introduction**

This part of the monitors’ report addresses the Consent Decree’s provisions related to Coordination of Services. It identifies the requirements of the Consent Decree and relevant provisions of the Social Security Act establishing the EPSDT program. It discusses the meaning of the concept of coordination of services and the related concept

of case management. It reviews provisions of the documents that implement the EPSDT program in Tennessee, including State rules and regulations and contracts with public and private agencies. Finally, it makes observations about the operation of the TennCare EPSDT program. The observations in the report should not be considered findings of fact or conclusions of law. They are based on an independent review of evidence made freely available by both parties. It is hoped that the observations contained in this report will help to clarify the issues in this case and lead to a resolution of the dispute.

## **II. Consent Decree and Federal Statutory Requirements**

The Consent Decree requires the Commissioners of the Tennessee Department of Finance and Administration and the Department of Children’s Services and the Deputy Commissioner of the Bureau of TennCare to develop policies and regulations to ensure coordination of the state agencies that deliver EPSDT services, the private contractors who manage and deliver health services to children, and other state programs that service children and their families.<sup>1</sup> The adequacy of such coordination is to be measured by the language of 42 C.F.R. § 441.61 that urges agencies such as the TennCare Bureau to “make use of other public health, mental health, and education programs and related programs, . . . to ensure an effective child health program.”<sup>2</sup>

The Consent Decree also requires the defendants and their contractors to “provide case management services consistent with federal law.”<sup>3</sup> Case management is a form of

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<sup>1</sup> See Consent Decree for Medicaid-Based Early and Periodic Screening, Diagnosis and Treatment Services (Doc. No. 12) at 43, ¶ 82 [hereinafter Consent Decree]. This report uses the terms “children” and “children and adolescents” interchangeably to refer to individuals under the age of 21 who are eligible for EPSDT services.

<sup>2</sup> See *id.* at 42-43, ¶ 81.

<sup>3</sup> See *id.* at 38-39, ¶ 66.

coordination of services that focuses on the needs of the individual recipient. The State Medicaid Manual issued by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services describes case management as “an activity under which responsibilities for locating, coordinating and, monitoring necessary and appropriate services for a recipient rest with a specific individual or organization.”<sup>4</sup> The State Medicaid Manual describes the process of case management as it applies to

EPSDT:

In EPSDT, it centers on the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history, and activating the examination/diagnosis/treatment “loop.” Case management provides the difference between a fragmented program in which examinations, diagnosis, treatment, and other functions are performed in isolation from each other, and a comprehensive program based on the concept of getting children into the existing “mainstream” system of health care delivery. Notifying recipients of the time they are due to receive a screening service is an integral part of your responsibility and an essential part of case management.”<sup>5</sup>

The Social Security Act requires the State to inform all eligible persons of the availability of early and periodic screening, diagnostic, and treatment services “and the need for age-appropriate immunizations against vaccine-preventable diseases.”<sup>6</sup> Early and periodic screening, diagnostic, and treatment services include screening services, vision services, dental services, hearing services, and “[s]uch other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the

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<sup>4</sup> State Medicaid Manual § 5310 (2006); *see also* Consent Decree, *supra* note 1, Attachment 1 (reproducing State Medicaid Manual §§ 5010-5360)).

<sup>5</sup> State Medicaid Manual § 5310 (2006); *see also* Consent Decree, *supra* note 1, at 38-39, ¶ 66 and Attachment 1.

<sup>6</sup> 42 U.S.C. § 1396a(a)(43)(A).

State plan.”<sup>7</sup> Appropriate immunizations are included in the definition of screening services.<sup>8</sup>

The State must provide or arrange for the provision of screening services in all cases where they are requested.<sup>9</sup> The State must arrange for “(directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services.”<sup>10</sup> The State’s plan must establish methods and procedures for the utilization of care and services “as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care...”<sup>11</sup>

The State of Tennessee delivers EPSDT services through a managed care system. The managed care system sacrifices the freedom to choose healthcare providers guaranteed to each enrollee by the Medicaid laws, and in return promises comprehensive management of the enrollee’s healthcare needs by a managed care organization.<sup>12</sup> The Social Security Act requires States with managed care systems to be more proactive in the delivery of healthcare than States without managed care.<sup>13</sup> As a State with a managed care system, Tennessee is required to develop and implement a strategy that

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<sup>7</sup> 42 U.S.C. § 1396d(r)(5).

<sup>8</sup> 42 U.S.C. § 1396d(r)(1)(B)(iii).

<sup>9</sup> 42 U.S.C. § 1396a(a)(43)(B).

<sup>10</sup> 42 U.S.C. § 1396a(a)(43)(C).

<sup>11</sup> 42 U.S.C. § 1396a(a)(30).

<sup>12</sup> In 2005 the State asked the Centers for Medicare and Medicaid Services of the U. S. Department of Health and Human Services for permission to restrict further the freedom of choice guaranteed in Section 1902(a)(23) of the Social Security Act by amending the TennCare Section 1115 Demonstration Project to add the language in bold type: “To enable the state (a) to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans that would not be consistent with the requirements of 1932 **and to permit the state to contract with only one MCO to service non-rural areas for interim periods of time . . .**” *Supplement to September 24, 2004 Proposed Amendment to the TennCare Demonstration Project, Office of the Governor, State of Tennessee, January 19, 2005.*

<sup>13</sup> See 42 U.S.C. § 1396u-2.

includes “[s]tandards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.”<sup>14</sup> The State must also develop “[p]rocedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State.”<sup>15</sup>

The Social Security Act defines case management services as “services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.”<sup>16</sup> Such services include assessments to determine the need for medical, social, educational, or other services.<sup>17</sup> They also include:

Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual’s authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.”<sup>18</sup>

Case management services also include making referrals to medical, social, and educational providers for needed services and scheduling appointments for the individual. They include monitoring and followup activities conducted as frequently as necessary to ensure that the care plan is effectively implemented.<sup>19</sup> The Social Security Act also

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<sup>14</sup> 42 U.S.C. § 1396u-2(c)(1)(A)(i).

<sup>15</sup> 42 U.S.C. § 1396u-2(c)(1)(A)(iii).

<sup>16</sup> 42 U.S.C. § 1396n(g)(2)(A)(i).

<sup>17</sup> 42 U.S.C. § 1396n(g)(2)(A)(ii)(I).

<sup>18</sup> 42 U.S.C. § 1396n(g)(2)(A)(ii)(II).

<sup>19</sup> 42 U.S.C. § 1396n(g)(2)(A)(ii)(III).

permits “targeted case management services” which are case management services as described above made available to specific classes of individuals.<sup>20</sup>

### **III. The Meaning of Coordination of Services**

Coordination of healthcare services is a dual responsibility of (1) marshalling resources for a diverse population and (2) delivering appropriate resources to individual recipients. The State Medicaid Manual describes the EPSDT program in terms of this dual responsibility:

“The EPSDT program consists of two, mutually supportive, operational components:

- assuring the availability and accessibility of required health care resources and
- helping Medicaid recipients and their parents or guardians effectively use them.”<sup>21</sup>

To achieve these dual goals, a healthcare delivery system must provide both clinical processes and administrative processes. The clinical processes are prescriptive. They must meet the unique needs of an individual, and they are ordered or prescribed by a person with specialized knowledge and training relevant to the individual’s needs. The administrative processes are programmatic. Their goal is to deliver a range of services to a targeted population or individual.

A large healthcare organization will have multiple layers of administrative processes with varying degrees of generality. The most general level of the administrative process provides for coordination of efforts at the top level of management. The most specific level of the administrative process provides for

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<sup>20</sup> 42 U.S.C. § 1396n(g)(2)(B).

<sup>21</sup> State Medicaid Manual § 5010.B. (2006); *see also* Consent Decree, *supra* note 1, Attachment 1 (reproducing State Medicaid Manual §§ 5010-5360)).

coordination of services to an individual. In between these two levels of generality are administrative processes at all levels of management as required to put programs into place to serve targeted populations. At the level of minimum generality, the administrative process coincides with the clinical process.

The TennCare system relies on multiple layers of administrative processes to deliver healthcare to children in Tennessee.<sup>22</sup> The entire State TennCare program represents the maximum level of generality. Several State departments administer processes aimed at delivering services to targeted portions of the total population of children eligible for TennCare. Private contractors, such as the Managed Care Organizations (MCOs) and Behavioral Health Organizations (BHOs), administer processes targeted at more limited populations. Private providers, such as physicians' offices, pharmacies, dentists' offices and community mental health centers, implement administrative processes that target only the consumers of their services. At the level of minimum generality, the health care provider anticipates and meets the needs of an individual child by securing personnel time, knowledge, and supplies that meet the unique needs of that child.

Case management is a strategy for delivering service to an individual at the level where the administrative process and the clinical process coincide. Case management can be a programmatic task and part of the administrative process or it can be a prescriptive task and part of the clinical process.<sup>23</sup> The skill required to do case management depends on the needs of the child. The case management of a well child

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<sup>22</sup> See Decl. of Thomas Catron, Ph.D. (Doc. No. 581) and the attached *State of Tennessee Programmatic Process Response [t]o the John B. Consent Decree* (describing the administrative processes used by the State to coordinate EPSDT services).

<sup>23</sup> See State Medicaid Manual, § 4302.G. (2006) (explaining that case management can be billed as either a medical service or an administrative service).

who needs only screening and immunizations can be handled by an unlicensed staff person with administrative skills. The case management of a child with a serious illness requires both clinical skills and administrative skills. Case management can be carried out by an individual or by a team that brings together persons with administrative skills, persons with relevant clinical skills who can prescribe treatment and make appropriate referrals, and members of the family or community who are familiar with the child.

It is appropriate to tailor the resources allocated for case management to the needs of the individual child. The intensity of case management needed depends on the medical, behavioral, and social needs of the child. Healthcare experts have various approaches to tiering children according to the level of coordination of service that they are likely to require. The following approach using four tiers is an example:

Tier 1: Healthy children with no suspected or identified physical or mental conditions that could delay healthy development (i.e., children with the normal range of preventive, primary, and acute care needs).

Tier 2: Children who face significant social risks, such as homelessness, extreme poverty, or the presence of physical or mental abuse in a home, and who, even if not exhibiting any signs and symptoms of physical or mental health conditions, need to be watched for possible health problems.

Tier 3: Children who are suspected of, or identified as, having symptoms suggesting the presence of one or more physical or mental health conditions that have the potential to delay or impair healthy development. Conditions may be mild, moderate, or severe as they present themselves, but it is evident that they need a combination of clinical interventions at the assessment, diagnosis,

treatment, and management stages, along with watchful coordination by an individual skilled in the management of children with special needs.

Tier 4: Children who exhibit both health conditions and social risks, mild, moderate, and severe. These are children who are in the highest tier, who may already have been removed from their homes, or who are living in seriously unstable family environments.

The number of children that can be served by one case manager or case management team decreases as the complexity of the children's cases increases. One person or team might be able to assume responsibility for the case management of numerous children in the first tier. However, a reasonable caseload of children in the highest tier for a single case manager might be 10, 20 or 30 children.

A State's case management strategy must also be able to adapt to children's changing conditions through the transmission of timely and appropriate information across the care system. Children's developmental needs are dynamic, and the case management system must be able to alter the level of response over time as children grow and develop. Children who face serious social risks can easily and rapidly move from healthy to high risk individuals who exhibit symptoms of serious physical or mental conditions. For example, a pediatrician managing a child's health care will need a way to deploy a skilled medical case manager rapidly if the child develops a serious illness. Where family crisis leads to removal of a sibling group, the care system needs to notify the pediatrician rapidly of the social development that may lead the pediatric provider to contact the removing agency immediately for followup care. Where basic services are covered through one form of insurance (e.g., the MCO agreement) and specialized

services are covered through another insurance system (e.g., the BHO agreement), the pediatrician needs to be able to reach into both financing systems to command services and to secure specialty case management as part of ongoing patient care.

To be effective, a delivery system should allocate responsibility clearly, delegate the authority necessary to carry out assigned responsibilities, and provide procedural safeguards for participants and beneficiaries.<sup>24</sup> The allocation of responsibility, delegation of authority, and procedural safeguards can be evaluated in part by reviewing the legal framework and the documents that establish the systems. However, it is also necessary to examine how the systems work in practice. Obtaining feedback on how a system works in practice is an accepted function of any service endeavor. Evaluation of the TennCare system requires a method of tracking that allows the evaluator to know whether a child received services, what services were delivered, and what the outcomes were.<sup>25</sup> Furthermore, service systems, such as the delivery of health care, must change constantly to meet the changing needs of the populations they serve. Making appropriate changes depends on having accurate knowledge of what the system is doing and what the results are.

Coordination of agencies that are subject to control by the State is a complex endeavor. State law and Constitutional principles disperse power throughout state government, and coordination and control can require a variety of mechanisms. In some

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<sup>24</sup> See, e.g., Consent Decree, *supra* note 1, at 15-18, ¶ 39 (requiring the State to allocate responsibility for outreach activities); 19-22, ¶ 41 (requiring the State to allocate responsibility for screening activities); 38, ¶ 65 (requiring the State to develop policies clarifying the duty to provide EPSDT diagnosis and treatment services).

<sup>25</sup> The Consent Decree recognized this need in Paragraph 94, which states: “The defendants shall require their contractors to achieve and maintain the capability of tracking each child in the plaintiff class, for purposes of monitoring that child’s receipt of the required screening, diagnosis and treatment. The tracking system shall have the capacity of generating an immediate report on the child’s EPSDT status, reflecting all encounters reported to the contractor more than 60 days prior to the report.” *Id.* at 47, ¶ 94.

cases, the Governor can exercise control through the power of appointment and removal. In other cases, one department of government must obtain the services of another department of government through the execution of interagency agreements and contracts, and by resorting to legal means to enforce unfulfilled promises.

When a State contracts with private service delivery systems to carry out its responsibilities, coordination and control is achieved through contracts with the private entities and individuals. In general, private entities have no enforceable obligation to provide services and supplies beyond that which they have promised in a contract. If a government agency chooses to rely on private contractors to carry out an obligation that the State has undertaken, the agency must negotiate contracts with comprehensive and unambiguous requirements.

#### **IV. Administrative Processes in the TennCare Program**

Numerous State agencies and private contractors share in the administration of the TennCare program in Tennessee. The TennCare Bureau, which has primary responsibility for administering TennCare, is an agency of the Department of Finance and Administration. Contracts between the TennCare Bureau and private contractors are reviewed, approved, and monitored by the Department of Commerce and Insurance. The Department of Children's Services (DCS), the Department of Health (DOH), the Department of Mental Health and Developmental Disabilities (DMHDD), and the Division of Mental Retardation Services of the Department of Finance and Administration all administer aspects of the TennCare program. The Department of Human Services screens applicants for eligibility. The TennCare Bureau also coordinates its activities with the Department of Education and local education agencies.

## **A. Coordination of Services by State Departments, Contractors, and Providers**

The Governor established the Governor's Office of Children's Care Coordination (GOCCC) to foster communication and cooperation among the multiple state agencies involved in the administration of TennCare. The GOCCC serves an essential function of facilitating the administrative process at the level of maximum generality. The GOCCC is able to convene meetings of the Commissioners of affected Departments to address problems in the delivery of services to children. It coordinates work groups that bring together representatives of the public and private agencies needed to solve administrative problems. The GOCCC also has a role in administering services at the level of minimum generality through the Crisis Management Team (CMT), a high level team that provides case management for individuals with complex behavioral problems who are at risk of entering state custody.<sup>26</sup>

The TennCare Bureau administers the TennCare program through contracts with privately-owned Managed Care Organizations, Pharmacy Benefits Managers (PBMs), and Dental Benefits Managers (DBMs) and through agreements with other state agencies.

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<sup>26</sup> See July 2006 Semi-Annual Progress Report (Doc. No. 675-2) at 79-80. The Crisis Management Team served as the case manager for seventy-seven children in the six months preceding the latest report. *Id.* at 79.

The *Contract between the State of Tennessee Department of Finance and Administration Bureau of TennCare, Department of Health Bureau of Health Services Administration, and Department of Children's Services (ID-04-07954-00)*, dated March 26, 2004 [hereinafter *TennCare/DOH/DCS Contract*], TCJB0406-B 10303 to TCJB0406-B 10353, § A.1.1, and *Amendment Number 2 to ID-04-07954-00 between the State of Tennessee Department of Finance and Administration Bureau of TennCare and Department of Health and Department of Children's Services (ID 04-07954-02)* [hereinafter *TennCare/DOH/DCS Contract Amendment 2*], TCJB0406-B 10285 to TCJB0406-B 10294, § A.1.m, refer to the CMT as the Implementation Team. The amended contract provides: "The purpose of the Implementation Team of the Children's Care Coordination Office is to prevent children from entering state custody when there are services available that would benefit the child and prevent state custody. The Implementation Team prevents custody by helping find the appropriate services for the child and advocating on their behalf with the provider, court system, parents, advocacy groups, and the BHO, as needed. The Implementation Team is part of the Governor's Office of Children's care [sic] Coordination." *TennCare/DOH/DCS Contract Amendment 2*, § A.1.m.

TennCare contracts with The Department of Mental Health and Developmental Disabilities (DMHDD) to oversee the delivery of behavioral health services. DMHDD contracts with Behavioral Health Organizations (BHOs) to administer the delivery of behavioral health services to eligible children who are not in state custody.<sup>27</sup> TennCare contracts with the Department of Health Bureau of Health Services Administration and the Department of Children's Services to administer the delivery of behavioral health services to eligible children who are in state custody or at risk of entering state custody.<sup>28</sup> DCS also contracts with MCOs and BHOs to administer the delivery of behavioral health services to children who are in state custody or at risk of entering state custody. The TennCare Bureau contracts directly with the MCOs for delivery of health services to enrollees.<sup>29</sup>

The MCOs and BHOs subcontract with providers who deliver clinical services. The MCOs and BHOs have responsibility for developing and maintaining a network of

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<sup>27</sup> See *Reissue of Contract between the State of Tennessee Department of Mental Health and Developmental Disabilities and Premier Behavioral Health, L.L.C, Working Document January, 2006 – Includes Amendments #1 - #14*, JB 007398-007751 [hereinafter *BHO Contract*]; and *Reissue of Contract between the State of Tennessee Department of Mental Health and Developmental Disabilities and Tennessee Behavioral Health, Inc. Middle/West Section, Working Document January, 2006 – Includes Amendments #1 - #14*, JB 007752- JB 008081 [hereinafter *BHO Contract with TBH-M/W*]. All citations below are to the contract with Premier Behavioral Health, L.L.C. The *BHO Contract with TBH-M/W* appears to be identical to the contract with Tennessee Behavioral Health, L.L.C. A separate contract titled, *TennCare Partners, Behavioral Health Contractor Agreement between the State of Tennessee Department of Mental Health and Developmental Disabilities and Tennessee Behavioral Health, Inc. in the Tennessee East Grand Region, July 1, 2004, Working Document – TBH East – Jan. 2006 Includes amendments #1 - #4*, JB 007039- JB 007397 [hereinafter *BHO Contract with TBH-E*], numbers its sections differently, but appears to have the same requirements as the other two contracts.

<sup>28</sup> See *TennCare/DOH/DCS Contract; Amendment Number 1 to ID-04-07954-00 between the State of Tennessee Department of Finance and Administration Bureau of TennCare and Department of Health and Department of Children's Services (ID 04-07954-01)* [hereinafter *TennCare/DOH/DCS Contract Amendment 1*]; and *TennCare/DOH/DCS Contract Amendment 2*.

<sup>29</sup> See *Amended and Restated Contractor Risk Agreement between the State of Tennessee, d.b.a. TennCare and (Name of Contractor) (d.b.a. Trade-name), July 1, 2001, Blended Document –Includes Amendments 1 through 8* [hereinafter *MCO Contract*]. The *MCO Contract*, the *BHO Contract*, the *BHO Contract with TBH-M/W*, and the *BHO Contract with TBH-E* provided to the monitors by the defendants were not copies of executed agreements, but there appears to be no dispute that they accurately represent the content of the contracts between the State and the MCOs and BHOs.

providers adequate to meet the needs of the enrollees whose care they manage.

Monitoring has consistently shown that provider networks have been inadequate to meet the needs of eligible children, particularly in the area of behavioral health services. The August 2006 Final Report of the External Quality Review Organization (EQRO) retained by the TennCare Bureau to evaluate the EPSDT program found that in 2003, 2004, and 2005 the two BHOs relied on by the State to deliver behavioral health services had only partially satisfied the requirement of having “established standards for development of provider networks that are compliant with the provisions of the TennCare MCO/BHO Contract.”<sup>30</sup> The 2004 Survey Report recommended that the BHO’s consider contracting with more providers to be in compliance with the BHO Contract.<sup>31</sup> The 2005 Survey Report made the same recommendation.<sup>32</sup> The 2006 Survey Report recommended that the BHOs:

should continue to pursue contracts with providers to correct any contract deficiencies. The EQRO supports the use of out-of-network referrals or referrals to contracted providers in neighboring communities (and the provision of transportation services if needed) for enrollees requiring identified services until agreements are reached with identified service providers.<sup>33</sup>

The *BHO Contract* limits the ability of the BHOs to request help from the State to correct network deficiencies. The Contract provides:

It is the responsibility of the Contractor to recruit providers with the appropriate expertise to address the network deficiency. The Contractor agrees by execution of this CONTRACT that no additional funding is necessary in order to satisfy this requirement, and under no circumstances shall additional funding be sought.<sup>34</sup>

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<sup>30</sup> *QSource, 2006 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Report, August 2006 Final Report* [hereinafter *2006 EQRO Report*].

<sup>31</sup> *2006 EQRO Report* at 171 and 192.

<sup>32</sup> *2006 EQRO Report* at 171 and 192.

<sup>33</sup> *2006 EQRO Report* at 171 and 192.

<sup>34</sup> *BHO Contract* § 2.5.2.2.2.3 (JB 007415).

The 2006 EQRO Report found that 6 of the 8 MCOs surveyed were not in compliance with their contractual obligation to have an adequate network of providers. The 2006 Survey Report recommended making referrals to out-of-network, out-of-county providers until in-county providers are found.<sup>35</sup> In January, 2005, the state requested permission from the federal Center for Medicare and Medicaid Services to operate only one MCO in certain rural and non-rural areas of the state, reporting that “there may not be a sufficient number of MCOs in all regions of the state capable of meeting the standards, therefore resulting in the possible reduction in the number of MCOs statewide.”<sup>36</sup>

If a child fails to obtain a needed medical service through a provider or a Managed Care Organization, the TennCare Bureau does not ordinarily fill in the gap by providing direct services outside of its network of MCOs, BHOs, and their providers.<sup>37</sup> The TennCare Bureau defines its responsibility as overseeing the activities of its contractors, not as a service provider. Regulations of the TennCare Bureau list the responsibilities of the Bureau and of its Contractors with regard to EPSDT services.<sup>38</sup>

The Bureau undertakes to:

- (i) Keep Contractors informed as to changes to the requirements for the operation of the EPSDT program;
- (ii) Make changes to TennCare policy when necessary to keep the EPSDT program in compliance with federal and state requirements;
- (iii) Provide policy clarifications when needed; and
- (iv) Oversee the activities of the Contractors to assure compliance with all aspects of the EPSDT program.<sup>39</sup>

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<sup>35</sup> 2006 EQRO Report at 104, 115, 125, 135, 144, and 154. Two MCOs were in compliance. 2006 EQRO Report, at 95 and 163.

<sup>36</sup> Supplement to September 24, 2004 Proposed Amendment to the TennCare Demonstration Project, Office of the Governor, State of Tennessee, January 19, 2005, at 8.

<sup>37</sup> The TennCare Bureau has some staff with direct involvement in outreach efforts.

<sup>38</sup> Rules of the Tenn. Dept. of Finance and Administration, Bureau of TennCare, Rule 1200-13-13-.04 (13).

<sup>39</sup> Rules of the Tenn. Dept. of Finance and Administration, Bureau of TennCare, Rule 1200-13-13-.04 (13) (a).

The provision in the *MCO Contract* for coordination between MCOs and the State Department of Education and local school districts refers to a State program to provide federal reimbursement to some school districts for medical services in a school setting.<sup>40</sup>

The Contract explains:

These services must be medically necessary and included in the student's Individualized Education Plan (IEP). ... This program does not replace the MCOs obligation to pay for medical services for these enrollees, but allows the school districts the option to receive fee-for-service Medicaid payment directly from TennCare where providers are direct employees of the school district or are community providers. ... MCOs should continue to reimburse qualified providers for services provided in the school setting, such as services coordinated through Department of Health's Project Teach.<sup>41</sup>

This provision of the *MCO Contract* conflicts with a later section of the *MCO Contract* listing services which an MCO is responsible for providing. A note after the list of approved services explains:

Certain services are not coverable even under a Home and Community Based Waiver and are not EPSDT services. These services include room and board, and special education and related services which are otherwise available through a Local Education Agency.<sup>42</sup>

Related services available to children with disabilities in Tennessee schools under the Individuals with Disabilities Education Act include medical services by a school nurse, physical therapy, occupational therapy, speech therapy, language therapy, and other healthcare services that might also be covered by TennCare's EPSDT program.<sup>43</sup>

The *MCO Contract* appears to eliminate the responsibility of MCOs to provide a broad

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<sup>40</sup> See *MCO Contract* § 2-3.c.5.

<sup>41</sup> *MCO Contract* § 2-3.c.5.

<sup>42</sup> *MCO Contract* § 2-3.u.8, Note 5.

<sup>43</sup> See Individuals with Disabilities Education Act, 20 U.S.C. § 1401 et seq., especially, § 1401(26) (defining related services); § 1412(a)(1-5) (requiring that eligible children with disabilities receive services pursuant to an individualized education program); and § 1414 (d)(1)(A)(i)(IV) (requiring that an individualized education program include related services to be provided to a child).

range of health care services to children with disabilities who qualify for special education.<sup>44</sup> On the other hand, when the Regulations of the TennCare Bureau list services that are not covered by TennCare, they include, “Services that are free to the public, with the exception of services delivered in schools pursuant to the Individuals with Disabilities Education Act (IDEA).”<sup>45</sup>

## **B. Coordination of Services to Individuals**

The TennCare program uses the terms coordination of care and case management to refer to the function of delivering appropriate services to individual children. The TennCare program does not provide a consistent definition or a standard for measuring the adequacy of coordination of care or case management. In general, the system applies the concept of coordination of care to children in the lower tiers of need. It uses the term case management when significant medical and behavioral needs have already been identified.

### **Coordination of Care**

The TennCare program implements coordination of care for individual children through the TennCare Bureau’s contracts with private MCOs and various public and private agencies and through the contracts of DMHDD with private BHOs and various public and private agencies. In general, the TennCare program assigns responsibility for coordinating the care of healthy children, including and children who face significant social risks, and children with undiscovered medical or psychological conditions to an

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<sup>44</sup> See *MCO Contract* § 2-3.u.8, Note 5.

<sup>45</sup> *Rules of the Tenn. Dept. of Finance and Administration, Bureau of TennCare*, Rule 1200-13-13-.10(j).

MCO.<sup>46</sup> Ordinarily, the MCO assigns responsibility for case management to a primary care provider (PCP).

The definition of a primary care physician in the Rules of the TennCare Bureau describe the physician's responsibility for coordinating care: "Primary Care Physician shall mean a physician responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals for specialist care; and for maintaining the continuity of patient care."<sup>47</sup> The TennCare Bureau's definition of a "Primary Care Provider" (PCP) includes a range of practitioners:

Primary Care Provider shall mean health care professional capable of providing a wide variety of basic health services. Primary care providers include practitioners of family, general, or internal medicine; pediatricians and obstetricians; nurse practitioners; midwives; and physician's assistant in general or family practice.<sup>48</sup> The *MCO Contract* has specific provisions for children who are at risk of entering DCS custody.<sup>49</sup> In such cases, the MCO has the option of assigning itself as the primary care provider or case manager in lieu of a specific primary care provider. However, not all children who face significant social risks are also at risk of entering DCS custody. The *TennCare/DOH/DCS Contract* defines children at risk of state custody as children who meet the criteria for imminent risk of placement. The contract specifies:

Imminent risk is a status which, absent intervention, will likely result in a child being placed in or returned to state custody. A child will be considered at imminent risk as long as there is one (1) or more factor(s) which would likely result in the state serving as custodian for the child. Imminent risk can occur prior to state custody for children who have encounters with the judicial system for acts of delinquency or other acts that are illegal according to law solely because they are performed by minors (i.e., unruliness, truancy, runaway, etc.) or because of

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<sup>46</sup> See *MCO Contract* § 2-3.j ("The CONTRACTOR shall provide primary care case management services to TennCare eligible enrollees. The CONTRACTOR shall be responsible for the management of medical care and continuity of care for all its TennCare enrollees. Primary care case management services include the management of medical care and continuity of care for TennCare enrollees.")

<sup>47</sup> *Rules of the Tenn. Dept. of Finance and Administration, Bureau of TennCare*, Rule 1200-13-13-.01(76).

<sup>48</sup> *Rules of the Tenn. Dept. of Finance and Administration, Bureau of TennCare*, Rule 1200-13-13-.01(77).

<sup>49</sup> See *MCO Contract* § 2-3.c.1.

allegations the child has been neglected or abused. Imminent risk can occur after state custody when the child is being returned to the family unit on a trial basis after a period of state custody. Imminent risk will be deemed to not exist in the absence of a strong suspicion the child will soon be in state custody. TCA 37-5-103(10) and TCA 37-3-602(2) define imminent risk and imminent risk of placement as “circumstances or behavior likely to produce, within a relatively short period of time, a reasonably strong probability that the child will be placed in state custody as a result of being adjudicated dependent and neglected, delinquent, unruly or in need of mental health services under 37-1-175.”<sup>50</sup>

Although the generic concept of case management can apply to all efforts to coordinate care for individual children, the TennCare program uses the term “case management” to refer only to services that are prescribed as a medical necessity. However, all children require individualized coordination of care to some degree, including healthy children with a normal range of preventive, primary, and acute care needs, and especially children who face significant social risks, whether or not they are exhibiting signs and symptoms of physical or mental health conditions. All eligible children require periodic screenings and immunizations. Some require referrals for other services, such as dental treatment, behavior management, and hearing and vision services. However, TennCare’s *MCO Contract* and *BHO Contract* do not explain unambiguously what is required by the responsibility to coordinate services for an individual child. The language of the contracts serves as a roadmap for services that providers are required to deliver, but it also serves as a limit on services that MCOs, BHOs, and their providers can be required to deliver.

The ability of healthcare providers to seek payment for services necessary to coordinate care for an individual is limited by the terms of the *MCO Contract*. The *MCO Contract* lists the services authorized by the Social Security Act, Section 1905(a), for TennCare reimbursement and explains, “All services, other than EPSDT screens and

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<sup>50</sup> *TennCare/DOH/DCS Contract* § A.1.c.(1).

interperiodic screens, must be medically necessary in order to qualify for TennCare coverage.”<sup>51</sup> The contract specifically authorizes case management services, but only if they are medically necessary.<sup>52</sup>

Children who do not meet the State’s criteria for receiving case management as a medical necessity may receive only those specific coordination of care services mandated in the *MCO Contract*. The specific care coordination services required by the *MCO Contract* are components of case management, but they do not constitute a full program of case management designed to meet the needs of individual enrollees.

The *MCO Contract* specifically requires MCOs to have a mechanism for notifying families when EPSDT screens are due; to include an offer of transportation and scheduling assistance; to attempt to contact a child who does not obtain timely screenings; and to make referrals for children who are screened and found in need of further services.<sup>53</sup>

When children do not get timely screenings, the MCO is required to make one “outreach contact” each quarter for a year.<sup>54</sup> Each of the outreach contacts must use a “different written or oral strategy.”<sup>55</sup> When an eligible child has used no services within a year, in addition to the four outreach contacts, the MCO must make “two reasonable attempts to re-notify such members about EPSDT. One of these attempts can be a referral to the health department.”<sup>56</sup> Furthermore, “The MCO must make and document

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<sup>51</sup> *MCO Contract* § 2-3.u.8.

<sup>52</sup> *MCO Contract* § 2-3.u.8 (19).

<sup>53</sup> *MCO Contract* § 2-3.u.7.

<sup>54</sup> *MCO Contract* § 2-3.u.7(b).

<sup>55</sup> *MCO Contract* § 2-3.u.7(b).

<sup>56</sup> *MCO Contract* § 2-3.u.7(c). The *MCO Contract* also specifies: “All MCOs participating in TennCare shall be required to contract with each Local Health Department for the provision of EPSDT services in the community service area(s) in which it is authorized to serve, until such time as the MCO achieves an adjusted periodic screening percentage of eighty percent (80%) or greater.” *MCO Contract* § 2-3.n.2.

a minimum of two (2) reasonable attempts to find a family when mail is returned as undeliverable. At least one of these attempts must be oral.”<sup>57</sup>

The actions described above designed to contact an enrolled child and to secure the child’s participation in the healthcare system are significant elements of coordination of care for a child. However, they are not reasonable as limits on the obligation to ensure continuity of services to a child. A strategy to contact children and engage them in the healthcare system should be reasonably calculated to work.<sup>58</sup> Children who face significant social risks might require more complex strategies to bring them into the system than the limited number of notices required by the *MCO Contract*. Children who are homeless, migrant children, children neglected by their parents, or children from families that do not speak English might require efforts by persons with social work skills and other specific training to be brought into the system.<sup>59</sup> Some children might be contacted most effectively by the Department of Human Services, which certifies and recertifies families for TennCare eligibility. Some children might be contacted most effectively by the public schools, which children are required by law to attend. However, neither TennCare regulations nor the *MCO Contract* require cooperation with these state agencies to reach individual children. Because TennCare relies on private contractors, it cannot expect to deliver services not required by its contracts.

Although radio announcements, posters, and brochures have an important role in promoting EPSDT services, they are not sufficient to ensure continuity of care to

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<sup>57</sup> *MCO Contract* § 2-3.u.7(e).

<sup>58</sup> See Consent Decree, *supra* note 1, at 29, ¶ 51 (“The Defendants shall be presumed to be in compliance with their screening obligation under the law and the terms of this order in any year in which: (1) the above applicable standard has been met, or (2) all children who have not received complete screenings, consistent with this Order, *have been the subject of outreach efforts reasonably calculated to ensure their participation.*” (italics added)).

<sup>59</sup> The *BHO Contract* requires steps to make services accessible and available to special groups such as these. *BHO Contract* § 2.5.2.4 (JB 007415-007416).

individual enrollees. It is feasible to gather data necessary to determine which children need a special approach to involve them in the system. Every enrolled child has requested TennCare benefits through an application filed by his or her parent or guardian with the Tennessee Department of Human Services. Many enrollees receive other benefits, such as Food Stamps or Families First services, which require periodic contacts with state agencies. The Department of Human Services is capable of requesting and maintaining relevant information about the eligible child and his or her family. Such information might include the primary language spoken in the home, literacy of family members, whether key family members have disabilities, the employment status of family members, and the methods of transportation available to family members. Currently, information maintained by the Department of Human Services is not readily available to the TennCare system.<sup>60</sup>

In the school year 2004-2005 the TennCare Bureau received permission from the State Department of Education to disseminate TENNderCare brochures to every student in schools across the state, and principals were required to certify that students received the brochures. In the school year 2005-2006, principals were required to certify that each child received a TENNderCare flyer to take home and brochures were made available upon request. In 2006-2007 the TennCare Bureau sent each school four posters that were health specific to a yearly checkup, including dental, depression/suicide, and drugs and alcohol. Although these are valuable outreach efforts, they do not involve the State Department of Education or the local school systems in efforts to locate and reach individual children who have failed to appear for screenings or treatment.

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<sup>60</sup> See Minutes of Outreach Workgroup on 4-5-05 (JB 000054-55) (discussing the difficulty of transferring information from DHS to the TennCare system to notify TennCare when eligible children have parents with disabilities).

A reasonably calculated effort to ensure the participation of each child in EPSDT would require a strategy to locate each child who fails to receive services; to assess the physical, social, and cultural barriers that might prevent the child from receiving services; to determine whether the failure to accept services is voluntary; to take steps to make the services accessible; and to take steps to persuade the child (or the child's caretaker) to participate in screenings or treatment. The TennCare program should also be able to evaluate whether services are delivered in a manner that is reasonably acceptable to intended recipients. Making services acceptable might require explaining procedures to unsophisticated recipients, providing services in languages understandable to recipients, or communicating with children and teenagers in age-appropriate ways.<sup>61</sup>

Once children have received screenings, primary care providers are required "to refer enrollees for other necessary health care, diagnostic services, treatment and other measures to correct, ameliorate, or prevent from worsening defects, mental illnesses and conditions discovered by the screening service, regardless of whether the required services is [sic] covered by the enrollee's BHO or MCO, and to document said referrals in the enrollee's medical record."<sup>62</sup> The *MCO Contract* does not specify other duties that the MCOs could perform or require of primary care providers, such as monitoring to ascertain whether the enrollee made it to a referral appointment, received services, or required additional services as a result of the appointment.<sup>63</sup>

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<sup>61</sup> See, e.g., *Outreach Workgroup Meeting, October 4, 2005, Meeting Notes* (JB 000037- JB 000039) at 1 (pointing out "that the TENNderCare name is not appealing to teens"); *Outreach Workgroup Meeting, November 1, 2005, Meeting Notes* (JB 000035- JB 000036) (reporting that in one region the doctors' offices that had the best results getting teens to come in for screenings "were those that had someone in their office call the teens directly to ask them to come in")

<sup>62</sup> *MCO Contract* § 2-3.u.5.

<sup>63</sup> The *MCO Contract* section 2-3.j.2 requires MCOs to monitor enrollees with ongoing medical conditions.

The *MCO Contract* specifies that responsibility reverts to the MCO if a provider is unable to make a referral for needed services identified through screening. When the provider notifies the MCO of a failed referral, the MCO “shall secure an appropriate referral and contact the enrollee to offer scheduling assistance and transportation for enrollees lacking access to transportation.”<sup>64</sup>

The specific care coordination services required by the *MCO Contract*, such as those listed above, do not require a medical necessity determination, because they have been mandated through contract requirements. Case management services beyond those mandated by the *MCO Contract* require a determination of medical necessity before they can be provided.

MCOs are required to “encourage PCPs, at their discretion,” to contact BHOs for consultation on behavioral health issues, and to refer to the BHO for coordination of treatment of any mental health covered condition.<sup>65</sup> The *MCO Contract* further provides that:

The carve out of all other mental health and substance abuse services shall not relieve the contractor from the responsibility to assist in the coordination of mental health and medical care of enrollees. The MCO and BHO shall assure active coordination between primary health care and mental health/substance abuse care, including case management and continuity of care services.<sup>66</sup>

The *MCO Contract* specifies minimum requirements for coordination of physical health care and mental health care. Such coordination must include means for referral which assures immediate access for emergency care and provision of urgent and routine care according to TennCare guidelines; means for the transfer of information;

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<sup>64</sup> *MCO Contract* § 2-3.u.6.

<sup>65</sup> See *MCO Contract* § 2-3.c.1.

<sup>66</sup> *MCO Contract* § 2-3.c.1.

maintenance of confidentiality; and cooperation with the BHOs regarding training activities provided by the BHOs.<sup>67</sup> The *MCO Contract* contains extensive provisions for resolving disputes between the BHO care coordinator and the PCP or the MCO care coordinator when there are disputes about who has primary responsibility and who is responsible for specific duties.<sup>68</sup> It requires that disputes be resolved within 90 days.<sup>69</sup> The *MCO Contract* also requires MCOs to coordinate dental benefits and pharmacy benefits with medical benefits.<sup>70</sup>

### **Case Management**

The Social Security Act defines case management as requiring the State to assist eligible individuals “in gaining access to needed medical, social, educational, and other services.”<sup>71</sup> Under the federal statute, case management includes assessments to determine medical, social and educational needs; development of a specific care plan; making referrals and scheduling appointments for needed medical, social and educational services; monitoring and following up to ensure that the individual’s care plan is effectively implemented.<sup>72</sup>

The *MCO Contract* provides that the MCO is responsible for management of medical care and continuity of care for all its TennCare enrollees.<sup>73</sup> However, the *MCO Contract* lists case management as a service that is available only if it is medically

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<sup>67</sup> *MCO Contract* § 2-3.c.2.(a).

<sup>68</sup> See *MCO Contract* § 2-3.c.2(b).

<sup>69</sup> *MCO Contract* § 2-3.c.2(b).

<sup>70</sup> See *MCO Contract* §§ 2-3.c.3(a), 2-3.c.4.

<sup>71</sup> 42 U.S.C. § 1396n(g)(2)(A)(i).

<sup>72</sup> 42 U.S.C. § 1396n(g)(2)(A)(ii).

<sup>73</sup> *MCO Contract* § 2-3.j.

necessary.<sup>74</sup> The *MCO Contract* identifies some categories of eligible children for whom case management is recommended or required, but it does not give guidelines for when case management is medically necessary. Children who face significant social risks but have not been diagnosed with physical or mental health conditions appear not to qualify for case management under the *MCO Contract*.

The utilization management provisions of the *MCO Contract* require MCOs to maintain a voluntary case management program for enrollees with high risk, unique, chronic, or complex cases that might benefit from intensive medical case management.<sup>75</sup> The *MCO Contract* also makes a provision for case management for persons with special needs. It explains that, “other vulnerable populations (e.g., persons with special needs such as multiple handicaps, or acute chronic conditions, etc.) may be assigned to a case manager at the MCO level or, at the MCO’s discretion, to their attending specialist as their primary care provider.”<sup>76</sup>

The utilization management provisions of the *MCO Contract* require each MCO to offer “case management/care coordination services” to enrollees identified as needing intensive medical case management.<sup>77</sup> The MCO must have a process to identify enrollees who might benefit from intensive medical case management, to inform them about the availability of case management programs, and to inform an enrollee’s PCP

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<sup>74</sup> *MCO Contract* § 2-3.u.8 (19).

<sup>75</sup> *MCO Contract* § 2-3.s.2 (“Case Management. The CONTRACTOR shall maintain a case management program for enrollees. Enrollee participation is voluntary. The CONTRACTOR must document and utilize a systematic approach to identify high risk, unique, chronic, or complex cases that may benefit from intensive medical case management. Enrollees identified through this process must be offered case management/care coordination services. The CONTRACTOR shall develop a process to inform enrollees and providers about the availability of case management programs and to inform the enrollees PCP when a patient has been assigned to a case management program.”).

<sup>76</sup> *MCO Contract* § 2-3.j.1(f).

<sup>77</sup> *MCO Contract* § 2-3.s.2.

when a patient has been assigned to a case management program.<sup>78</sup> However, enrollee participation is voluntary, and the enrollee, or in the case of a child, the child's caretaker, may refuse to accept case management.<sup>79</sup> The *MCO Contract* does not specify the responsibilities of the MCO or the PCP for managing the care of an individual with a high risk, unique, chronic, or complex case if the individual or the individual's family refuses case management.

The *MCO Contract* requires MCOs to initiate case management services in two special circumstances. MCOs must offer "Disease Management" to enrollees who are pregnant, have diabetes, have congestive heart failure, or have asthma.<sup>80</sup> Disease Management services are provided to eligible enrollees unless they specifically opt out of the services.<sup>81</sup> The *MCO Contract* also requires MCOs to place enrollees in active case management if they are found to make excessive use of Emergency Departments.<sup>82</sup> The MCOs reported to the TennCare Bureau that 17,415 EPSDT enrollees received care coordination, case management, or disease management services from the MCOs during the second quarter of 2006.

The TennCare system uses the terms case management and primary care case management interchangeably. The *MCO Contract's* list of authorized services explains, "Primary care case management services include the management of medical care and continuity of care for TennCare enrollees."<sup>83</sup> It gives the MCO responsibility for primary

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<sup>78</sup> *MCO Contract* § 2-3.s.2.

<sup>79</sup> *MCO Contract* § 2-3.s.2.

<sup>80</sup> *MCO Contract* § 2-3.s.6.

<sup>81</sup> *MCO Contract* § 2-3.s.6.

<sup>82</sup> *MCO Contract* § 2-3.s.5.

<sup>83</sup> *MCO Contract* § 2-3.j.

care case management.<sup>84</sup> Under the heading, “Contractor Qualifications,” the *MCO Contract* requires that the MCO:

Clearly demonstrate the capability and intent to provide or arrange for primary care case management services to TennCare eligible enrollees either by the organizational structure of the MCO using case managers or by primary care providers (PCPs), at the MCO’s discretion, for all health care services provided to enrollees.<sup>85</sup>

The *MCO Contract’s* list of minimum functions of primary care case management includes:

Performance of reasonable preventive health case management services, as well as mechanisms to assess the quality and appropriateness of care furnished, appropriate referral and scheduling assistance of enrollees with special health care needs, including those identified through the provision of preventive services.<sup>86</sup>

The list includes monitoring of enrollees with ongoing medical conditions.<sup>87</sup> It requires documentation of authorized referral services.<sup>88</sup> It includes tracking of preventive screening status and preventive screening due dates for each enrollee.<sup>89</sup> It requires MCOs to identify enrollees utilizing Emergency Department Services inappropriately.<sup>90</sup> It also includes assistance in coordination of mental health and medical care.<sup>91</sup>

The Disease Management provisions of the *MCO Contract* illustrate one possible approach to case management. However, Disease Management services are available only to enrollees with designated diagnoses. The *MCO Contract* provides:

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<sup>84</sup> *MCO Contract* § 2-3.j.

<sup>85</sup> *MCO Contract* § 2-2.c

<sup>86</sup> *MCO Contract* § 2-3.j.2(a).

<sup>87</sup> *MCO Contract* § 2-3.j.2(c).

<sup>88</sup> *MCO Contract* § 2-3.j.2(b).

<sup>89</sup> *MCO Contract* § 2-3.j.2(f).

<sup>90</sup> *MCO Contract* § 2-3.j.2(d).

<sup>91</sup> *MCO Contract* § 2-3.j.2(h).

Disease Management. Each MCO is required to establish and operate (either directly or via a subcontract with an accredited disease management vendor) a minimum of four disease management (DM) programs designed to address maternity care management, comprehensive diabetes management, management of congestive heart failure and management of asthma.

Each DM program must utilize evidence-based best practice guidelines and patient empowerment strategies to support the practitioner-patient relationship and the plan of care. The programs must emphasize prevention of exacerbation and complications as evidenced by decreases in emergency room utilization and inpatient hospitalization and/or improvements in condition-specific health status indicators.

(a) Identifying Eligible Members

The MCO must have a systematic method of identifying and enrolling eligible members in each DM program. Annually, on July 1st, the MCO must report to the Bureau the active participation rate for each of the four DM programs. This report must also include a narrative description of the eligibility criteria and the method used to identify and enroll eligible enrollees. The active participation rate, as defined by NCQA, is the percentage of identified eligible members who have received an intervention divided by the total population who meet the criteria for eligibility in the DM program. The MCO must also identify and report the total number of active enrollees having one or more of the diagnosis codes (ICD-9 Codes) relating to each of the required disease management programs. The MCO must operate each program using an “opt out” methodology, meaning that services will be provided to eligible members unless they specifically ask to be excluded. The Bureau may elect to mandate the eligibility criteria the MCO must use if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the criteria in use are overly restrictive.

(b) Interventions Based on Stratification

The MCO must classify eligible members according to disease severity or other clinical or member-provided information and provide disease management interventions of differing intensity based on such stratification. The MCO must maintain a written description of the stratification levels for each of the four DM programs including member criteria and associated interventions and make such description available to the Bureau upon request.

(c) Program Content

The MCO must adopt clinical practice guidelines that serve as the basis for each DM program. The guidelines must be evidence-based and formally adopted by the QI or other clinical committee. The guidelines must be distributed to practitioners who are likely to use them and must be made available to the Bureau upon

request. Upon enrollment in the DM program, the MCO must provide information to the member and practitioner regarding how to use the services and specific information to the practitioner concerning how the program works with the practitioner's patients. MCOs must provide primary care providers with a list of their patients enrolled in each program upon initial enrollment and at least annually thereafter.

Each DM program must be based on a treatment plan that serves as the outline for all of the activities/interventions in the program. At a minimum the activities/interventions associated with the treatment plan must address condition monitoring, patient adherence to the treatment plan, consideration of other comorbidities, and condition-related lifestyle issues. The Bureau may elect to mandate an intervention strategy the MCO must employ if the program evaluation does not demonstrate the desired effect and/or if the Bureau determines that the interventions are suboptimal.<sup>92</sup>

The *MCO Contract* also requires MCOs to manage the care of enrollees who are determined to have excessive or inappropriate use of Emergency Departments.<sup>93</sup> The MCOs must make a periodic review of data on Emergency Department use by enrollees, and they must place enrollees in active case management if they exceed a specified number of visits in the previous six months.<sup>94</sup> The MCO must assess the cause of the problem and develop a case management plan based on the results of the assessment.<sup>95</sup> In addition to the foregoing models of case management available to some enrollees under the *MCO Contract*, the TennCare program administers a detailed model of case management for some children with behavioral health needs through its *BHO Contract*.

### **Case Management for Children Who Require Behavioral Health Services**

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<sup>92</sup> *MCO Contract* § 2-3.s.6(a-c).

<sup>93</sup> See *MCO Contract* § 2-3.s.5.

<sup>94</sup> *MCO Contract* § 2-3.s.5.(a-b).

<sup>95</sup> *MCO Contract* § 2-3.s.5.(a-b).

The *MCO Contract* requires MCOs to encourage PCPs to refer children to their BHOs for coordination of mental health treatment.<sup>96</sup> The *MCO Contract* requires the MCOs to cooperate with the BHOs that are responsible for children's behavioral health needs and provides a dispute resolution process to decide disputes over responsibility and payments. The *MCO Contract* provides:

Coordinating the delivery of behavioral health services to TennCare members is the primary responsibility of the BHO. To ensure coordination, the BHO shall identify a staff member to serve as lead for coordination of services with each MCO and shall notify the respective MCOs, TDMHDD, and the Bureau of TennCare of the name, title, telephone number and other means of communicating with the care coordinator. ... With respect to specific member services, including transfer of responsibility for services from the PCP to the BHO, resolution of problems shall be carried out between the PCP (or MCO representative) and the BHO coordinator. Should systemic issues arise, the MCO and the BHO agree to meet and resolve these issues. In the event that such issues cannot be resolved, the MCO and the BHO shall meet with TDMHDD and TennCare to reach final resolution of matters involved. Final resolution of system issues shall occur within 90 days from referral to TDMHDD or TennCare.<sup>97</sup>

The *BHO Contract* is more specific than the *MCO Contract* in its requirements for coordination of care and case management. TennCare eligible children who require behavioral health services can receive case management if it is a medical necessity. The *BHO Contract* provides for two levels of case management:

Level 1 mental health case management is the most intensive level of service. Frequent and comprehensive support is to be provided and available 24 hours per day, 7 days per week. Children may be at imminent risk of out-of-home placement, including psychiatric hospitalization, and/or exhibiting multiple needs requiring services from multiple agencies. Intensive case management may include such models as CTT, CFT, etc.

Level 2 mental health case management is a less intensive level for children with multiple needs requiring services from more than one or more agencies.

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<sup>96</sup> *MCO Contract* § 2-3.c.1.

<sup>97</sup> *MCO Contract* § 2-3.c.2.(b).

Mental health case management to both parent(s) and child in the same family, should include skills and experience needed for both ages.<sup>98</sup>

The case manager assists the child or adolescent through regular face-to-face meetings and by contacting schools, therapists, probation officers, and other support systems.<sup>99</sup> The *BHO Contract* specifies that the average caseload of a case manager should be 18 cases “with no case manager having a case load of over 30.”<sup>100</sup> The case manager acts pursuant to a service plan. The *BHO Contract* defines the service plan as:

An individualized, comprehensive plan which is developed negotiated and agreed upon by the consumer and mental health case manager and/or essential others. Mental health case managers coordinate the development of the service plan.<sup>101</sup>

In addition to case management services available to children for whom it is determined to be a medical necessity, the TennCare program provides targeted case management for children who are in DCS custody and children who are at risk of entering DCS custody. However, the line between children who qualify for targeted case management because they are at risk of entering state custody and children who have serious mental health conditions but are not at risk of entering state custody is difficult to interpret.

## **V. Monitors' Observations**

The TennCare program does not have a systematic approach to the administrative requirements of coordinating care for children. The TennCare system has not yet achieved compliance with Paragraphs 78, 81 and 82 of the Consent Decree which require

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<sup>98</sup> *BHO Contract*, Attachment B. Part 3 (JB 007653-5).

<sup>99</sup> *BHO Contract*, Attachment B. Part 3 (JB 007655).

<sup>100</sup> *BHO Contract*, Attachment B. Part 3 (JB 007655).

<sup>101</sup> *BHO Contract*, Attachment B. Part 3 (JB 007653).

the State to develop policies and regulations to ensure coordination of the state agencies that deliver EPSDT services and to ensure an effective child health program. In spite of considerable efforts by many leaders in State government, there remain aspects of the TennCare program for which administrative efforts have not been effective. The development and maintenance of provider networks, especially for behavioral health services, is an example. The State's surveying process points to repeated deficiencies. However, the responsibility for correcting the deficiencies has been left to private managed care contractors when coordination of efforts by the State officials with ultimate responsibility for the TennCare program might be more effective.

Coordination of services administered by the various state agencies and private contractors at the level of the individual child remains fragmented and inconsistent. For many eligible children, the responsibility for coordinating care and ensuring continuity of care is divided between different contractors and agencies, with responsibility and authority not clearly allocated. In many aspects of the TennCare program, the individuals or organizations with responsibility for a service do not have the authority to deliver it or the duty to pay for it. The division of responsibility for medical services and behavioral health services between the MCOs and the BHOs requires each type of organization to identify the need for services that it does not have the authority or duty to deliver. The GOCCC has generated valuable ideas about ways to improve the TennCare system, but the GOCCC does not have the authority to make the changes that are necessary.<sup>102</sup>

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<sup>102</sup> See, e.g., *Email from Kacie Fitzpatrick, Governor's Office of Children's Care Coordination, to Dusti Williams, Aug. 25, 2005 (GCJB0406-00073)* ("PCP's don't have time to coordinate with schools, attend IEPs in person/or phone, to follow up with MCOs, etc. This will fall through the crack if it is not done through a central nonpartisan entity.")

The TennCare system's contracts do not do a sufficient job of translating the State's EPSDT responsibilities toward individual children into clear obligations that can be monitored and measured through process and outcome data and monitoring and measurement techniques. The provisions of the TennCare regulations and contracts dealing with case management services for children with serious physical and behavioral conditions are too fragmented and ambiguous to be enforceable. It is appropriate for the TennCare program to adjust the level of coordination of care to the needs of children and to develop a system of tiering in order to allocate intensive services to children with the greatest need and to allocate basic administrative services to children with routine needs. However, the programs that TennCare has in place to manage the care of children in need of intensive medical case management, children with designated diseases, and children who make too frequent use of Emergency Departments target an unduly limited class of children and exclude an unknown number of children with less serious medical and emotional problems who need the collaboration, planning and advocacy that a case manager can provide.

Effective coordination requires early identification of children who are at risk of incurring physical or mental health conditions in order to take steps to prevent or ameliorate the conditions. The focus of EPSDT on "early" diagnosis and treatment to "ameliorate" or correct physical and mental health conditions lies at the heart of the legal entitlement in terms of measuring the sufficiency of a system. Proper recognition of these requirements would give rise to a tiered system of intervention tied to early evidence of risk.

The use of the medical necessity standard to determine eligibility for case management prevents the TennCare system from coordinating the full range of services called for by EPSDT. The TennCare system does not provide the administrative processes necessary to ensure coordination of care and continuity of care for individual children because it treats coordination of care as a clinical function that is only available to meet diagnosed medical needs. Although the TennCare system requires its MCOs and BHOs to offer all eligible children some services that are components of case management, it limits these services to the specific requirements of the *MCO Contract* and the *BHO Contract*, and, therefore, the vast majority of EPSDT-eligible children do not have access to a range of case management services tailored to their individual needs. Furthermore, case management services available as a medical necessity are subject to end when a child's medical or mental health condition improves.<sup>103</sup>

The medical necessity standard also leaves the availability of medical or mental health case management dependent on the judgment of a provider and the provider's ability to communicate the need for case management to the parent, guardian or child who must accept it. With the exception of the ED Utilization case management program and some aspects of the Disease Management program, case management must be accepted voluntarily by the enrollee.

Finally, the TennCare program should be able to alter its level of response over time as children grow and develop. The State's management scheme, whether directly or

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<sup>103</sup> See, e.g., *Email from Kacie Fitzpatrick, Governor's Office of Children's Care Coordination, to Dusti Williams and Tom Catron*, Aug. 22, 2005 (GCJB0406-C 00076) (“[I]n reference to coordination between MCO and BHO it appears that to be successful there needs to be an entity doing this job that is nonpartisan who can coordinate all sides including education. The MCO and BHO typically case manage until a child receives a service and then they are discharged from cm services. If a person is not spelled out this coordination will not occur in most circumstances.”).

contractually furnished, needs to be able to adapt to children's changing conditions through transmission of timely and appropriate information within and across the care system. The provisions of the TennCare program's managed care documents concerning coordination of care and case management are so ambiguous that they create almost no enforceable duties with respect to managing pediatric care. It would be possible for the State, through appropriate amendments to its contracts and agreements, to provide a framework for ensuring contractor performance that complies with EPSDT requirements and gives the court a basis for measuring performance. However, the current system of regulations and contracts is not sufficient to assure the provision of appropriate services to each eligible child.