

**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 DIAGNOSIS AND TREATMENT
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Diagnosis and treatment are arguably the most critical aspects of EPSDT. In reality, all other EPSDT mandates exist only to ensure that children are properly diagnosed and treated.

Screening, in and of itself, does not provide any protection to the health and safety of children. It is only when that screening leads to appropriate diagnosis and treatment that the screening itself can be considered effective. At the core, then, the questions to be

answered are whether children who are screened are properly diagnosed and, having been diagnosed, whether they are receiving medically necessary and appropriate treatment.

Notwithstanding its importance in the hierarchy of health care provision, diagnosis and treatment have received the least amount of attention in this lawsuit. Unlike the provisions in the Consent Decree relating to screening, those relating to diagnosis and treatment provide no easily defined statistical or empirical measures of success.

Under TennCare, physical health care is provided through eight managed care organizations (MCOs): BlueCare; John Deere Health Plan, Inc. (John Deere); Preferred Health Partnership of Tennessee, Inc. (PHP); TennCareSelect (TSC); TLC Family Care Healthplan (TLC); UAHC Health Plan, Inc. (UAHC); Unison Health Plan of Tennessee, Inc. (Unison); and VHP Community Care (VHP). Each of these MCOs then contracts with primary care physicians (PCPs) and specialists who provide diagnosis and medically necessary care to the enrollees of the MCO.

TennCare was initially established as a capitated program. Under the capitated system, each MCO received a certain amount for each enrollee (the capitated payment). Regardless of the amount of health care actually needed and utilized by the enrollee, the MCO only received the capitated payment. The policy underlying a capitated system is to encourage preventative medicine by creating financial incentives for the MCO to avoid expensive medical treatments which could have been avoided through prevention and early detection.

Because of problems in the system, the TennCare Bureau switched the EPSDT

component of TennCare to a fee-for-service rather than capitated program.¹ Under the fee-for-service program, the MCOs are still responsible for each of their enrollees and still contract with providers to supply medical care. The difference is in the mechanism of payment. Under the fee-for-service system, the MCO submits claims to the TennCare Bureau for all services provided by the health care providers. Because the MCO in a capitated system receives a per-person payment regardless of the amount of health care services utilized by that person, the MCO bears the financial risk for the provision of health care. In a capitated system, if an enrollee utilizes a large measure of health services, the MCO pays for those services even though they may far exceed the amount of capitated payment. Under the fee-for-service system, the state bears the financial risk for the provision of health care. In a fee-for-service program, if an enrollee utilizes a large measure of health services, the state pays all the costs associated with that care. Interestingly, the state has just entered into a contract for a capitated system (on an experimental basis) in Middle Tennessee. The remainder of the state's EPSDT is being provided by the MCOs on a fee-for service basis. Regardless whether the court finds that the defendants are currently in compliance with the Consent Decree provisions relative to health care, the question remains whether compliance can be maintained under a capitated program.

The defendants claim that they have established compliance with the diagnosis and treatment provisions of the Consent Decree. The defendants explain that they are providing diagnosis and treatment by pointing to the many programs that they have

¹ TennCare EPSDT is not a completely fee-for-service program as there are financial incentives for the MCOs contingent on their compliance with certain standards. It does, however, much more closely approximate a fee-for-service program.

implemented – many very ambitious and creative programs – but provide little data as to the efficacy of these programs.² Likewise, they point to the policies and procedures mandated by their contracts with the BHOs and MCOs as well as their Standard Operating Procedures, all of which are consistent with the Consent Decree.

Conversely, plaintiffs rely on horror stories of children with severe diagnosis or multiple diagnoses and point to the inadequacy of the system to effectively treat these children. Unfortunately, there will always be children who are difficult and expensive to treat, and it is hardly productive to attempt to create a system that allows none of these cases to be less than optimally treated.

Unquestionably, the Consent Decree mandates many “process” based measures for determining the adequacy of diagnosis and treatment. And, indeed, one cannot provide care without having in place necessary process to effectuate that care within the system. And, equally clearly, the state cannot ensure that each individual child receives every possible available treatment. The state’s responsibility is to provide a system that creates a strong probability that children will receive medically necessary care. Provision of adequate diagnosis and treatment can only exist where there are effective processes in place. The harder question is how one measures the efficacy of those processes and procedures.

In response to this Court’s order that it provide an explanation of its manners of measuring compliance with the Consent Decree, on January 31, 2006, the defendants filed a two paragraph declaration of Dr. Thomas Catron, director of the Governor’s Office of Children’s Care Coordination (GOCCC). According to Dr. Catron, the

² See, e.g., Semi-Annual Progress Report (Doc. No. 675) at 59-71.

responsibilities of the GOCCC include the coordination of the state's response to John B. and compilation of the Semi-Annual Reports.³ In this declaration, Dr. Catron describes the Programmatic Process Response (PPR) which the state is now using to ensure compliance with the John B. Consent Decree and with federal Medicaid law.⁴ The declaration also references the Semi-Annual Reports which "document in detail the steps the State has taken to improve its EPSDT program and to improve overall healthcare for the children of Tennessee."⁵

The PPR is a "process used by the State to guide, monitor, document and evaluate action to create and sustain an infrastructure that promotes compliance and improves outcomes for children."⁶

The PPR has seven components: (1) coordination and oversight by the GOCCC; (2) the Consent Decree grid which details the requirements of the Consent Decree; (3) community workgroups; (4) children's care coordination steering panel; (5) semi-annual reports; (6) infrastructure improvements; and (7) the PPR Matrix.⁷

Specifically, the Consent Decree grid "serves as the foundation upon which the GOCCC has built the current PPR process."⁸ As of the January 31, 2006, filing, the

³ Attachment to Decl. of Thomas Catron, Ph.D. (Jan. 31, 2006), entitled *State of Tennessee Programmatic Process Response [t]o the John B. Consent Decree* (Doc. No. 581) at 5 [hereinafter PPR].

⁴ Decl. of Thomas Catron, Ph.D. (Jan. 31, 2006) (Doc. No. 581) at ¶¶ 1-2.

⁵ *Id.* at ¶ 2.

⁶ PPR, *supra* note 3, at 1.

⁷ *Id.* at 4.

⁸ *Id.* at 5.

Consent Decree grid was “a work in progress and needs further updating.”⁹ The Consent Decree grid was the “springboard” for establishing the PPR Matrix. Again, of as January 31, 2006, the PPR Matrix did not yet exist but, according to Dr. Catron, when it exists it “will summarize all compliance activities in a single document ... [and] will focus on the use of data in the evaluation and reporting components.”¹⁰

On March 13, 2006, the State filed a response to this Court’s order directing it to file any documents it contends represent the State’s “remedial plan of compliance.”¹¹ This response incorporated Dr. Catron’s declaration of January 31, 2006, and the PPR. The state also appended an “updated and improved upon the Consent Decree Grid.”¹² To date, the state has not filed a PPR Matrix with the Court nor has it provided one to the plaintiffs or to the Monitors.¹³

Based upon the state’s response to this Court’s order, the Monitors look to the Consent Decree grid and to the Semi-Annual Reports to determine how the state is measuring compliance with the Consent Decree. Thus, the essential questions that must be asked are: (1) What is required by each provision of the Consent Decree relating to diagnosis and treatment? (2) How does the state measure compliance with that provision? (3) Is the state’s measurement an effective determinant of compliance?

⁹ *Id.*

¹⁰ *Id.* at 12.

¹¹ Defs.’ Resp. to the Feb. 14, 2006 Order (Doc. No. 624).

¹² Consent Decree Grid, Attachment to Defs.’ Resp. to the Feb. 14, 2006 Order (Doc. No. 624) [hereinafter Consent Decree Grid].

¹³ The Semi-Annual Report of July 31, 2006, indicates that the state is still in the process of developing the PPR Matrix. July 2006 Semi-Annual Progress Report (Doc. No. 675) at 3.

Diagnosis and treatment generally are covered in paragraphs 55-59, 61-65 and 71-72 of the Consent Decree. In reviewing Judge Nixon's order of 2001, one notes that there are no findings relative to many of these provisions. The Court found generally that:

Children frequently do not receive appropriate diagnoses through the TennCare managed care system. Defendants admit that "sometimes the system breaks down," and the Court finds that in this case, the State Government's healthcare system has indeed broken down. However, the system itself is to blame for TennCare's failures. A depleted provider network and lack of proper oversight by MCO's and BHO's is directly attributable to the TennCare managed care system, which has proven to be unable to fully comply with both the EPSDT and the Consent Decree's requirements for proper diagnosis of children under 21.¹⁴

Likewise, the Court found fault with the state contracts with the MCOs and BHOs:

[T]he contracts, the documents that enable TennCare to actually implement its mandates, contain only general aspirational language regarding the contractors' duties under EPSDT, rather than clear, unambiguous language requiring absolute compliance with EPSDT. The contracts require a "trickle down" approach to EPSDT, whereby hortatory language by the State will result in similar language by the contractors, which ultimately will lead to the providers following the EPSDT mandates. However, EPSDT does not trickle down; it requires hard work and mandatory language.¹⁵

According to Judge Nixon, there are several questions to be answered: (1) whether, in its contracts with MCOs and BHOs, the state has moved from "hortatory" language to mandates; (2) whether there is proper oversight of the MCOs and BHOs; and (3) whether the provider network is adequate to ensure appropriate diagnosis and treatment?

¹⁴ *John B. v. Menke*, 176 F. Supp. 2d 786, 798 (M.D. Tenn. 2001).

¹⁵ 176 F.Supp.2d at 801 (footnote omitted).

In its simplest terms, the Consent Decree requires that children receive all “medically necessary” care. In order to provide this care, the state must first provide for proper diagnosis, then must ensure that there are neither barriers between diagnosis and treatment nor impediments to the provision of treatment and then, finally, must assure provision of treatment.

The first relevant provision in the Consent Decree focuses on how a child goes from diagnosis to treatment. According to the Consent Decree, defendants were required to “establish and maintain a process for reviewing the practices and procedures of the MCOs and DCS ... to ensure that children can be appropriately referred from one level of screening or diagnosis to another”¹⁶

Defendants document compliance with this provision through the adoption of Section 2-3.u in the MCO contract, through the report of the External Quality Review Organization [EQRO] and NCQA accreditation results and through review of appeals reports. The state monitors compliance with this provision through its EQRO process, MCO UM policies and procedures and review of appeals information.¹⁷ Clearly, the state’s contracts with providers are consistent with the Consent Decree provision.¹⁸

¹⁶ Consent Decree for Medicaid-Based Early and Periodic Screening, Diagnosis and Treatment Services (Doc. No. 12) at 30, ¶ 53 [hereinafter Consent Decree].

¹⁷ Consent Decree Grid, *supra* note 12, at 20.

¹⁸ Section 2-3.u.5 of the Standard Provider Contract provides that:

The CONTRACTOR shall have policies and procedures in place, approved by TENNCARE, to require providers to refer enrollees for other necessary health care, diagnostic services, treatment and other measures to correct, ameliorate or prevent from worsening defects, and mental illnesses and conditions discovered by the screening service, regardless of whether the required services is (sic) covered by the enrollee’s BHO or MHO and to document said referrals in the enrollee’s medical record.

Section 2-3.u.6 provides that:

In the EQRO report, the question that is asked is whether the contractor “shows evidence that it ensures provider compliance with appropriate referral from one level of screening or diagnosis to another, more sophisticated level of diagnosis as needed to determine the child’s physical health, behavioral health, and developmental needs, as to medically necessary services. This is done regardless of whether the required services are covered by the MCO.”¹⁹ As to each contractor, the EQRO simply reports that the contractor is in compliance with this provision, but notes as support only Section 2-3.u.5 of the standard contract.²⁰ The other question asked by the EQRO is whether the MCO has a process in place “for directing providers to notify the MCO in the event a screening reveals a need for other health care and the provider is unable to make an appropriate referral” and whether the “MCO has policy and procedure for securing an appropriate referral and contacting the enrollee to offer scheduling assistance and transportation.”²¹

In reviewing the EQRO for the year 2005, which was released in August 2006, one is struck that the review included a review of records from the BHOs but did not

The CONTRACTOR shall direct its network providers to notify the MCO in the event a screening reveals the need for other health care and the provider is unable to make an appropriate referral for those services. Upon notification of the failed referral, the CONTRACTOR shall secure an appropriate referral and contact the enrollee to offer scheduling assistance and transportation for enrollees lacking access to transportation. If the needed health care is a BHO benefit, the CONTRACTOR shall contact the enrollee’s BHO and inform them of the need to contact the enrollee to secure an appropriate referral and offer scheduling assistance and transportation. The CONTRACTOR shall maintain documentation of said contacts. In the event of a dispute regarding the organization responsible for the provision of services, the CONTRACTOR shall adhere to the requirements specified in Section 2-3.c.2.

¹⁹ State of Tennessee Department of Finance and Administration, Bureau of TennCare, 2006 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Report, August 2006 Final Report (EQRO) at 91, 99, 109, 120, 130, 139, 149, 158 [hereinafter EQRO, August 2006].

²⁰ *Id.*

²¹ *Id.* at 92, 99, 110, 121, 131, 140, 150, 159. Again, the EQRO simply reported that each MCO was in compliance and cited § 2-3.u.6 of the uniform contract.

include a review of any medical records of any MCO, other than review of ten records from each MCO to ensure appropriate tracking.²² In all the materials reviewed by the Monitors, there are none that include a review of medical records of enrollees for any purpose other than to determine screening percentages. Since no medical records were reviewed, the EQRO could only report on the existence of policies, not outcomes.

According to the Consent Decree grid and the EQRO, compliance with the mandates of Paragraph 53 is achieved through the existence of the contractual and policy provisions. But the language of the Consent Decree itself suggests that something more than adoption of policies is necessary. Paragraph 53 mandates that the state require the *modification of policies and practices* as are necessary to ensure that children are appropriately referred from one level to another. The requirement of modification of policies and practices implies that the state must monitor the policies and practices to ensure that they are having the desired result. The Consent Decree also states that the policies are in place to “ensure” that children receive medical care, again suggesting that the policies’ effectiveness must be measured.

If, therefore, compliance is determined not just by the existence of these policies, but by their efficacy, one would need to review the records of children enrolled in TennCare to determine whether they did, indeed, receive appropriate diagnoses and appropriate referral for necessary services under EPSDT.

Clearly, the state is not expected to review the records of over 600,000 children enrolled in TennCare. But, are there any measures that might reflect whether the state is in compliance with this provision of the Consent Decree? With the encounter data that

²² EQRO, August 2006, *supra* note 19, at 6.

that state captures, the state could determine the number of children diagnosed with certain conditions, such as asthma or diabetes. The Centers for Disease Control maintains statistical information on the percentage of children diagnosed nation-wide with certain conditions, such as asthma and diabetes.²³ Obviously, the CDC data cannot be used to determine the exact number of children expected to be diagnosed, but it could certainly be used to see whether the rate of diagnosis is significantly out of the range of what might be expected. The encounter data might also indicate whether there are certain MCOs or providers who are significantly above or below the expected numbers of these diagnoses. The mere fact that a provider or MCO is either above or below these indicia would not in any way indicate that the diagnoses were inaccurate, it would simply suggest the need for more careful and detailed review of individual files of the children.

In addition, as the state does with screening, the state might review the medical records of a statistically significant number of children. The review could determine whether diagnoses were appropriate in relation to the medical information in the file. Likewise, the state could determine whether there are children who are diagnosed with a particular condition, but who were screened at an earlier date. They might then review the earlier screen and/or examinations of that child to determine whether the diagnosis should have been made earlier.

One might ask whether there is any indication in the record that this further investigation is necessary. Interesting statistics appear in the description that the state provides of its Head Start/Early Head Start EPSDT/TENNderCare Diagnosis and

²³ www.cdc.gov

Treatment for Children.²⁴ This is a program that identifies children in Head Start Programs and utilizes those programs to increase participation in EPSDT. In the January 31, 2006, Semi-Annual Report, the state reported that the number of children who were in the program and who were up-to-date on a schedule of age appropriate preventative and primary health care, including all appropriate tests and physical examinations increased from 17,832 in 2003-04 to 18,469 in 2004-05 (an increase of 637 children). At the same time, of those children, the number diagnosed as needing medical treatment declined from 5,099 to 3,472 (a decrease of 1,627).²⁵ Without further explanation, this is a strange phenomenon. One would expect that the number diagnosed as needing medical treatment would be a fairly constant percentage of the number who are up-to-date on medical treatment. Instead, the percentage diagnosed as needing medical treatment decreased from 28% in 2003-04 to 18.8% in 2004-05. During that same period, and having screened 637 more children, the number of children being treated for anemia decreased by 199, the number being treated for asthma decreased by 56, the number being treated for hearing difficulties decreased by 159, the number being treated for being overweight decreased by 334 and the number being treated for vision problems decreased by 320.²⁶ There may be some reason for these apparently aberrational statistics, but it appears nowhere in the record of this case. These statistics alone do not indicate that the state is not in compliance, but they certainly suggest that more statistical information is needed.

²⁴ This information appears in the Semi-Annual Report dated January 31, 2006.

²⁵ January 2006 Semi-Annual Progress Report (Doc. No. 579) at 54.

²⁶ *Id.* at 55.

Paragraph 54 of the Consent Decree provides that the state must ensure that the MCOs, BHOs, DCS and TennCare, within their respective fields of responsibility, provide all “medically necessary” EPSDT care to children as required by Medicaid law and regulations. This provision contains mandatory language – the state must ensure the provision of treatment.

The parties have spent much time and discussion regarding the definition of “medical necessity.” Tennessee has statutorily changed its definition of this term. The state has indicated that it has not yet implemented this definition for children covered by EPSDT. The question for the court is, if utilized, whether the new definition is consistent with the provisions of EPSDT law. It is beyond the purview of the Monitors to suggest an answer to that fundamental legal question. And, obviously the choice of definition will have effects on individual children and their healthcare. The issue of importance to the system, however, is the effect that the change in definition will have on the systemic delivery of health care and on the locus of decision-making in the system. By requiring that medical necessity be determined by evidence-based medical standards, or, at the very least by the standards in the industry, the new definition of medical necessity moves much of the decision-making from the individual provider to the MCO. Providers may become more conservative in their approach to treatment, and certainly a common law will arise as to the validity of treatment options. But the provision of health care will become more layered and attenuated as the decisions flow away from the individual provider.

Regardless of the definition, Paragraph 54 of the Consent Decree requires that medically necessary care actually be provided to children. The state documents

compliance with this provision through TennCare Rules 1200-13-13-.04(1)(b) and 1200-13-14-(1)(b)²⁷ and MCC contract sections 2-3.a.1 and 2-3.h.²⁸ Compliance is monitored through the EQRO and NCQA reviews and through review of appeals information.

When reviewing compliance with this provision, the EQRO looks only to the policies of the various MCOs to determine whether the policies require provision of medically necessary services. The question asked in the EQRO is whether “[t]he health plan has a policy and procedure to provide all medically necessary health care.”²⁹ The state also relies on appeals information. While data about appeals is helpful, it does not provide valid data about the provision of health care. Not every parent whose child is denied care has the wherewithal or resources to appeal. The Monitors believe that appeals data captures only those cases where parents have the fortitude and foresight to continue to assert their child’s right to healthcare.

Without review of medical records, without empirical information about the MCOs’ actual practice, one cannot decide whether medically necessary services are actually being provided.

Again, one may review other indicia to determine whether more empirical information would be useful. The state has compiled the HEDIS Childhood Combo 2 Immunization Rates for 2005.³⁰ The childhood rate for the various MCOs is between

²⁷ These regulations list the panoply of services available under TennCare.

²⁸ Section 2-3.a.1 lists the services available under TennCare and EPSDT. Section 2-3.h allows the MCOs to use alternative services “whether listed as covered or non-covered or omitted in Section 2-3.a of this Agreement when the use of such alternative services is medically appropriate and cost effective.”

²⁹ EQRO, August 2006, *supra* note 19, at 92, 100, 110, 121, 131, 140, 150, 159. The EQRO answered this question “yes” as to all eight MCOs.

³⁰ JB006349.

79.1 and 45.6%, with a weighted average of 73%. This rate is at about the 90th percentile for HEDIS 2004 Medicaid Percentile.³¹ HEDIS also reviews the Adolescent Combo 2 Immunization Rates. In 2005, the MCO rates were between 7.5 and 29.2%, with a weighted average of 19.6%. This percentage is at approximately the Medicaid HEDIS 2004 25th percentile, and well below the Medicaid HEDIS 2004 50th percentile of 33.2%. This statistic certainly suggests some concerns about the provision of healthcare to adolescents.

In the Provider Network Adequacy Report for 2004, one of the HEDIS-like measures reported was Children's Access to Primary Care Practitioners. The report states that the HEDIS national Medicaid average is provided for informational purposes only and cannot be utilized for comparisons because of modifications in the technical specifications. Nonetheless, the report as to each MCO demonstrates that the percentage of children in various age groups who had at least one appointment with a primary care physician during 2004 was below the national average. Again, this does not necessarily demonstrate a lack of compliance, but it certainly suggests the need for such indicia.³²

In July, 2004, several researchers reported on "Family Reports of Care Denials for Children Enrolled in TennCare."³³ The researchers interviewed 399 families of children enrolled in TennCare. Study participants were the families of patients at twenty one pediatric and family practice centers throughout the state.

Their findings were:

³¹ Childhood immunizations are required for enrollment in public school.

³² JB001853 – Table 7.4 in the report of each MCO.

³³ Valet et al., *Family Reports of Care Denials for Children Enrolled in TennCare*, 114 PEDIATRICS 37 (July 2004).

Among the respondent caregivers, 146 (36.6%) reported experiencing 1 or more denials of care for their children in the previous 12 months. Denials were experienced at physician's offices (n=50; 12.5% of respondents), dentist's office (n=55; 13.8%), emergency departments (n=8; 2.0%), and pharmacies (n=80; 20%; Table 2). Several families (n=45; 11.3%) experienced denials at > 1 provider site. Reported denials of care differed among children by sociodemographic characteristics (Table 2). Denials were reported more commonly for the white children and children with chronic health conditions. Denials were reported less commonly for black children and by caregivers with lower levels of education.³⁴

The researchers also stated that:

Although it is expected that managed Medicaid will inevitably lead to some care denials, unanticipated consequences may occur. Reimbursement procedures implemented by health plans might affect provider behavior, as was suggested by families who reported their belief that payment to providers drove some denial decisions. Previous work has demonstrated the role of provider reimbursement on providers' care behavior and that the behavioral changes may not be perceived by providers who are affected by reimbursement. Both physician and non-physician providers (e.g., pharmacists, hospitals) may be affected by the administrative barriers imposed when care is restricted. For example, some providers may believe that it is easier to collect payment in full from a family rather than process necessary appeals. Indeed, families in this study reported that they were told that they would have to pay for the care themselves because of law reimbursement by health plans. Families may seek care less often in anticipation of denials or to avoid arduous appeals processes, as was seen in the Rand Health Experiment studies in the 1980s.³⁵

The conclusion of the researchers was that more study was needed. Limitations of their study included the fact that their group was limited to those who were already at a health care provider, which might result in an underrepresentation of care denial. In addition, the researchers recognize that their study was based on interviews, without accessing the relevant medical records. As such, they did not review the accuracy of the

³⁴ *Id.* at 5.

³⁵ *Id.* at 7.

reporting nor did they know whether the denied medical care would have been determined to be medically necessary.³⁶

Again, this study, in and of itself, does not establish that medically necessary care is being denied by providers. But it does certainly suggest the need for additional empirical study to determine whether care is being provided.

In order to ensure the provision of medically necessary treatment, the Consent Decree also contains several process-based mandates, which are found at Paragraphs 55-59 of the Consent Decree. At Paragraph 55, the Consent Decree requires that the state review MCO “practices” with regard to making decisions about medical necessity to ensure that they are consistent with federal law and that the state “identify” any practices inconsistent with federal law.³⁷ Similarly, Paragraph 56 of the Consent Decree requires that the MCOs and DCS use only the definition of medical necessity in the TennCare MCO contracts when making determinations of medical necessity. In the Consent Decree grid, defendants state that they monitor compliance of each of these provisions through “the EQRO review of MCO UM policies and procedures” and defendants document compliance with these provisions through TennCare rules, Standard Operating

³⁶ *Id.*

³⁷ The Consent Decree also mandates that the state uphold the following clarifications: (1) that prior authorizations and medical determinations shall be made on a case-by-case basis for each service sought; (2) that services be provided if necessary “to correct or ameliorate defects and physical and mental illnesses and conditions, pursuant to U.S.C. § 1396d(r)(5); (3) that “medical necessity” be applied to any services that “correct, compensate for, improve, or prevent a condition from worsening, even if the condition cannot be prevented or cured;” (4) that medically necessary services be provided “whether or not the condition existed prior to any screening and whether or not the screener is under contract with the particular managed care entity;” and (5) that the state and its contractors be in compliance with HCFA Office of Managed Care Operational Policy Letter No. 96.045 (December 3, 1996) and “do not have financial or contractual arrangements which undermine class members’ access to covered services.” Consent Decree, *supra* note 16, at 32-33, ¶ 55.

Procedures³⁸ and the contract with MCOs.³⁹ The EQRO evaluations asks (1) whether the

³⁸ TSOP 036 reiterates that services much correct, compensate for improve or correct a condition from worsening.

42 U.S.C. §§ 1396a(43), 1396d(a)(4)(B), and 1396d(r) set forth the basic requirements for the EPSDT program. Under the EPSDT benefit, TennCare, through its contractors, must provide for well-child screenings, vision, hearing, and dental screenings at the intervals recommended by the American Academy of Pediatrics (AAP). Interperiodic screenings are required outside the AAP periodicity schedule whenever health problems are suspected. Additionally, it is required that any service which the Bureau is permitted to cover under the federal Medicaid program that is necessary to treat or ameliorate a defect, physical or mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in Tennessee's Medicaid plan.

³⁹ The applicable portions of the MCO contract are 2-3.a.2, 2-3.d, 2-17 and 2-18. Section 2-3.a.2 states that:

The CONTRACTOR shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the CONTRACTOR's ability to establish for the determination of medical necessity or to use medically appropriate, cost-effective alternative services in accordance with Section 2-3.h which have been approved by the Centers for Medicare and Medicaid Services. The determination of medical necessity shall be made on a case by case method. Except for benefit limits as may be described in Section 2-3.a the CONTRACTOR shall not employ, and shall not permit others acting on their behalf of employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. The CONTRACTOR shall have the ability to place tentative limits on a service; however, such tentative limits placed by the CONTRACTOR shall be exceeded when medically necessary based on a patient's individual characteristics. The CONTRACTOR shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. The CONTRACTOR may deny services that are non-covered except as otherwise required by EPSDT or unless otherwise directed to provide by TENNCARE and/or an administrative law judge. Any procedures used to determine medical necessity shall be consistent with the definition of medical necessity as described in this Agreement.

All medically necessary services shall be covered for enrollees under 21 years of age in accordance with EPSDT requirements, including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989. Effective upon receipt of written notification from TENNCARE, the CONTRACTOR is not required to provide the services in accordance with EPSDT requirements to TennCare Standard enrollees under the age of 21.

Section 2-3.d.1 provides that:

The CONTRACTOR and/or its subcontractors shall have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services and have in effect mechanisms to ensure consistent application of review criteria for authorization decisions; and consult with the requesting provider when appropriate Prior authorization requests shall be reviewed subject to the guidelines described in TennCare Rules 1200-13-13 and 1200-13-14 which include, but are not limited to, provisions regarding decisions, notices, medical contraindication, and the failure of an MCO to act timely upon a request. The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less

plan “has a policy and procedure that ensures consistent decisions are rendered concerning issues of medical necessity, which are compliant with federal and state laws;” (2) whether “the Health Plan showed evidence of methods being used to ensure consistent UM decisions are made by UM employees (i.e., inter-rater reliability [IRR]);” (3) whether “the health plan conducted appropriate follow-up to IRR or other method of assurance, as indicated;” (4) whether “only the definition of ‘medical necessity in the TennCare MCO/BHO Contract is used when making utilization decisions;” and (5) whether the health plan demonstrated that it does not impose duration/scope, benefit limitations or monetary limitations and whether “services are provided based upon each child’s individual needs and utilization controls do not unreasonably delay the initial or continued receipt of services.”

Since the EQRO did not review medical records, one can assume that these questions are being answered by reviewing the policies of the MCOs. Indeed, when one of the MCOs, JDH, was found not to have satisfied these provisions in the previous, 2005 survey,⁴⁰ the recommendations that were made were that JDH establish policies relative to these requirements.⁴¹

than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.

⁴⁰ EQRO, August 2006, *supra* note 19, at 101. The 2006 EQRO provides background information on the performance levels of the contractors in previous years. Although JDH was compliant with this question in 2006, JDH was not in compliance according to the 2005 EQRO.

⁴¹ *Id.* The answer in the 2005 EQRO to the question of whether JDH showed evidence of methods being used to ensure consistency of decisions was “No.” The recommendation was that JDH “establish a written process for ensuring consistent decisions, including frequency of testing, thresholds, and methods of follow-up.” Likewise, when the answer to whether there was appropriate follow-up was “no,” the recommendation was the JDH “conduct appropriate follow-up to IRR/other method of assurance, as indicated.” Finally, although the answer to the question about utilization of the appropriate definition of medical necessity was “yes,” the 2005 recommendation was that JDH “consider establishing a specific policy regarding definition of medical necessity.”

Paragraph 57 of the Consent Decree prohibits both the state defendants and their contractors from imposing absolute amount limitations, duration and scope limitations or monetary caps on EPSDT services.⁴² According to the Consent Decree grid, documentation for this provision is found in the MCO contract §§ 2-3.1.2, 2-3.d⁴³ and 2-3.s,⁴⁴ in the EQRO annual surveys and NCQA accreditation results, and by appeals reports. Compliance is monitored through EQRO and NCQAS review of MCO UM policies and procedures, and by review of appeals information.

And finally, as regards utilization review and prior authorization decisions, the Consent Decree requires that all such decisions be made “only by qualified personnel with education, training or experience on child and adolescent health.” The defendants were required to establish standards and procedures to monitor compliance with this

⁴² The Consent Decree does provide that this provision is not intended to limit an MCO’s ability to place “tentative” limits on a service. “However, any such limits must be consistent with the ‘preventative thrust’ of EPSDT. Utilization controls cannot unreasonably delay the initial or continued receipt of services, nor can they cause recipients to go without needed care. There must be an expeditious process in place to ensure that children receive without interruption any medically necessary services which exceed tentative limits.” Consent Decree, *supra* note 16, at 33-34, ¶ 57.

⁴³ See *supra* note 38.

⁴⁴ The relevant portion of 2-3.s states:

The CONTRACTOR shall develop and maintain a Utilization Management Program Description defining the structures and processes within the CONTRACTOR’s utilization management program. The program description shall assign responsibility to appropriate individuals including a designated senior physician. The Utilization Management Program shall be supported by an associated work plan. The program shall be evaluated annually The CONTRACTOR shall not place arbitrary maximum limits on the length of stay for enrollees requiring hospitalization and/or surgery. The CONTRACTOR shall not employ, and shall not permit others acting on their behalf to employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his/her medical history. Individual patient characteristics must be considered in the determination of readiness for discharge. This requirement is not intended to limit the ability of the CONTRACTOR to place “tentative” limits on the length of a prior authorization or pre-certification.

provision.⁴⁵ According to the Consent Decree grid, documentation for compliance with this provision is found in the MCO contract at Section 2-3.d⁴⁶ and through EQRO annual surveys and NCQA accreditation results. Compliance is monitored through EQRO and NCQA review of MCO UM policies and procedures.

The question asked by the EQRO is whether “only qualified medical professionals are employed to make case-by-case decisions regarding prior authorization and concurrent review.” Several health plans fell short of this measure. JDH was found to be in only partial compliance. The recommendation was that JDH “develop a specific policy that states only qualified personnel with education, training or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for enrollees 20 and under.”⁴⁷ The same finding – of partial compliance – was made as to PHP with the recommendation that it “assure that all personnel making utilization review and prior authorization decisions for enrollees 20 and under are qualified with education, training, or experience in child and adolescent health.”⁴⁸ The EQRO found that VHP currently had qualified staff, but “should have a policy and procedure in place that guarantees that only qualified personnel with the education,

⁴⁵ Consent Decree, *supra* note 16, at 34, ¶ 58.

⁴⁶ The relevant portion of 2-3.d.1 states:

The CONTRACTOR must use appropriately licensed professionals to supervise all medical necessity decisions and specify the type of personnel responsible for each level of utilization management (UM) decision making. The CONTRACTOR must have written procedures documenting access to Board Certified Consultants to assist in making medical necessity determinations. Any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the enrollee’s condition or disease.

⁴⁷ EQRO, August 2006, *supra* note 19, at 102.

⁴⁸ *Id.* at 113.

training, or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for enrollees 20 years of age and younger.⁴⁹

MCOs are required to provide all medically necessary, covered services regardless whether the need for services “was identified by a provider whose services had received prior authorization from the MCO or an in-network provider.”⁵⁰ Compliance is monitored by EQRO review of MCO UM policies and procedures and review of appeals information. Documentation is provided by the EQRO surveys, TennCare Rules 1200-13-13-.04(a)(i)(l)⁵¹ and 1200-13-14-.04(a)(i)(l)⁵² and appeals reports.

The question asked by the EQRO is whether “the Health Plan has a policy and process in place assuring that all medical necessity, covered services are provided, regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the plan or by an in-network

⁴⁹ *Id.* at 162. Interestingly, VHP was only in partial compliance with this provision both in 2004 and 2003. In 2003, it was recommended that VHP ensure that only qualified professionals make these decisions and in 2004, it was recommended that VHP have a policy and procedure in place to guarantee that only qualified professionals make these decisions.

⁵⁰ Consent Decree, *supra* note 16, at 34, ¶ 59.

⁵¹ TennCare Rule 1200-13-13.04(a)(i)(l) states:

There are two instances in which an MCC may not refuse to pay for a service solely because of a lack of prior authorization. These instances are as follows: (l) EPSDT services. In the event a service requiring prior authorization is delivered without prior authorization and is proven to be a medically necessary covered service, the MCC cannot deny payment for the service solely because the provider did not obtain prior authorization or approval from the enrollee’s MCC.

⁵² TennCare Rule 1200-13-14-.04(a)(i)(l) states:

There are two instances in which an MCC may not refuse to pay for a service solely because of a lack of prior authorization. These instances are as follows: (l) Preventive, diagnostic, and treatment services for persons under age 21. In the event a service requiring prior authorization is delivered without prior authorization and is proven to be a medically necessary covered service, the MCC cannot deny payment for the service solely because the provider did not obtain prior authorization or approval from the enrollee’s MCC.

provider.” As to all the eight MCOs, the EQRO answered this question in the affirmative.⁵³

In order to provide medically necessary care, the MCOs must have established adequate provider networks.

Paragraph 61 of the Consent Decree provides that each MCO establish standards for creating sufficient provider networks, and that each MCO “have enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” The state documents compliance through the network adequacy reports, appeals reports and the EQRO annual network analysis. Compliance is monitored through geo-access mapping and phone surveys, review of appeals and review of the annual network analysis.⁵⁴

The most recent EQRO report finds problems with the provider network utilized by the majority of MCOs.⁵⁵ The question asked by the EQRO is whether “the MCO has demonstrated that they comply with reasonable promptness standards when establishing provider networks and that they have ‘enough providers so that care and services are available to the general population in the area.’” TennCare Select was determined to only partially comply with this provision of the Consent Decree. The Recommendation made by the EQRO was that “TCS should continue to pursue contracts with providers to correct any contract deficiencies. The EQRO supports the continued use of out-of-

⁵³ EQRO, August 2006, *supra* note 19, at 94, 103, 112, 124, 134, 143, 153, 162.

⁵⁴ Consent Decree Grid, *supra* note 12, at 28-29.

⁵⁵ The EQRO did first ask whether each Health Plan had “established standards for development of provider networks that are compliant with the provisions of the TennCare MCO/BHO Contract.” The answer as to each MCO was “yes.” EQRO, August 2006, *supra* note 19, at 94, 103, 114, 124, 134, 143, 153, 163.

network referrals to contracted providers in neighboring communities (and the provision of transportation services if needed) for enrollees requiring identified specialty care until agreements are reached with an in-county provider.”⁵⁶ The exact same finding and recommendation were made regarding Preferred Health Partnership,⁵⁷ John Deere Health Plan,⁵⁸ TLC Family Care Health Plan,⁵⁹ UAHC Health Plan, Inc.,⁶⁰ and Unison Health Plan of Tennessee, Inc.⁶¹ According to the EQRO, the only health plans that satisfied this provision of the Consent Decree were BlueCare⁶² and VHP.⁶³

Looking behind the generalities of the EQRO, one can review the methodology of the Report of the Review of Provider Networks produced in conjunction with the EQRO. The Provider Network Report that was provided in conjunction with discovery was dated May, 2004. In reviewing that report, one is struck not only by the questions that were asked, but by questions that were not asked. The reviewers report on various measures of adequacy, generally referring to the number of providers who have contracted with each MCO or BHO. There is determination of geo-mapping to ensure that providers are within specified distances from each county.

One of the features that the report assessed was waiting time for an appointment.

⁵⁶ *Id.* at 125.

⁵⁷ *Id.* at 115.

⁵⁸ *Id.* at 104.

⁵⁹ *Id.* at 135.

⁶⁰ *Id.* at 144.

⁶¹ *Id.* at 154.

⁶² *Id.* at 95.

⁶³ *Id.* at 163.

It was initially recognized that timely access to health care providers is essential.

MCOs much strive to contract with qualified providers and health care institutions that have adequate resources and available appointments to guarantee that enrollees may easily access their providers and early medical care before their conditions become more serious or complicated. Wait times to obtain an appointment or to be seen for a scheduled appointment should not discourage the enrollee from seeking early medical care. The MCO must determine the necessary number of providers and their specialty distribution based on the demographics of their enrollees to further ensure Appointment Availability. Additionally, the provider needs sufficient time with the enrollee to explain any medical conditions and answer questions that will facilitate the improvement of the enrollee's health.⁶⁴

Notwithstanding this language, in determining the availability of appointments, HSAG reviewed the policies and procedures of each MCO to find language regarding wait time requirements. The EQRO then examined provider contracts for five specific statements encouraging the availability of appointments. Finally, the EQRO reviewed any enrollee complaints related to Appointment Availability. There was, however, a complete lack of any data as to appointment availability. There was no evidence as to how long enrollees actually waited for appointments with specialty or primary care providers.

The Consent Decree requires that each primary care physician is provided with a list of specialists to whom the PCP may refer patients.⁶⁵

And, finally, as relates to physical health, the Consent Decree requires that two services be covered within the ambit of EPSDT. Paragraph 63 requires that rehabilitation include "any medical or remedial services recommended by a physician or other licensed

⁶⁴ JB001853. BlueCare 2004 Provider Network Adequacy and Benefit Delivery Review Report, HSAG at 7-6. The questions asked were the same as to each MCO.

⁶⁵ Consent Decree, *supra* note 16, at 37, ¶ 62. All MCOs appear to be in compliance with this provision. EQRO, August 2006, *supra* note 19, at 95, 105, 116, 126, 136, 145, 155, 163.

practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level.” Second, the Consent Decree requires that maintenance services which prevent or mitigate the worsening of conditions or prevent the development of additional health problems be covered by TennCare.⁶⁶ The state monitors compliance of both of these provisions through “EQRO review of UM policies and procedures” and review of appeals information.⁶⁷ The state documents compliance with both of these provisions through Sections 2-3.a.1 and 2-3.u.8 of the MCO contract,⁶⁸ through EQROs, and through appeals reports. According to the EQRO, all MCOs include this appropriate definition of rehabilitation in their policies.⁶⁹ Likewise, all MCOs include maintenance services within their ambit of covered services.⁷⁰ Again, there is no review of whether these services are actually being provided. Rather, the review is of the existence of appropriate contractual and policy provisions.

The state’s monitoring of the diagnosis and treatment provisions of the Consent Decree in the area of medical care indicates that the state has appropriately issued

⁶⁶ Consent Decree, *supra* note 16, at 64.

⁶⁷ Consent Decree Grid, *supra* note 12, at 30.

⁶⁸ The relevant portion of 2-3.a.1 states:

All medically necessary (rehabilitation) services shall be provided to enrollees under 21 years of age in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

Section 2-3.u.8 lays out responsibilities among the BHO, MCO and TennCare for various services available under TennCare.

⁶⁹ EQRO, August 2006, *supra* note 19, at 96, 105, 116, 126, 136, 145, 155, 164.

⁷⁰ *Id.* at 96, 106, 117, 127, 137, 146, 156, 164.

contractual provisions, standard operating procedures and TennCare Rules. It is also apparent that the EQRO adequately reviews the policies and procedures of the MCOs to determine whether their policies are consistent with the Consent Decree. It is also clear that all but two of the MCOs do not have adequate provider networks to fulfill their obligations under TennCare.

There is, however, virtually no empirical information about the efficacy of these procedures. The consent decree itself mandates that “medically necessary” care be provided. Yet there is no proof in the record whether the care is actually being received by the covered children. The state indicates that one could look to appeals within the system to determine whether care is being provided. Relying solely on appeals data gives access only to those cases where the parents or guardian have the wherewithal to appeal. The most recent data provided by the state in its July 31, 2006, Semi-Annual Report indicates that there were:

2, 329 EPSDT appeals received from January 1, 2006, through June 30, 2006 (Figure 4) and 3,223 EPSDT appeals received during the previous reporting period, July 1, 2005, through December 31, 2005, representing a 26.85 percent reduction in EPSDT appeals. The reduction in EPSDT appeals is primarily related to a decrease in Pharmacy and Dental appeals (Figure 5).

The top three reasons for appeals were Reimbursement and Billing (22% or 507 appeals), Dental (21% or 495 appeals) and DCS (17% or 407 appeals). Together, the above listed top three accounted for 60% of the EPSDT appeals received during the reporting period (Figure 6).⁷¹

According to these figures, 38% of all appeals during the period related to Dental or DCS cases. This would leave approximately 1500 appeals that were based on denial of physical or behavioral health care. According to the study of care denials under

⁷¹ July 2006 Semi-Annual Progress Report (Doc. No. 675) at 116.

TennCare, approximately 36% of parents or guardians at medical offices reported at least one denial of care for their child during the previous year.⁷² Approximately the same number reported denials of dental care as of medical care. The figures reported in the study suggest that the level of denial of care is much higher than that seen in the appeals reports. While this does not, in and of itself, suggest that the state is not in compliance, it certainly suggests that more empirical data must be developed if the state is to show that it is in compliance. The state agrees with the need for more data. In describing the value of the PPR, the state indicates that the PPR Matrix will increase the utilization of data, lead to enhanced data collection and increase process evaluation, which, in turn should lead to better demonstrated outcomes as well as stronger evaluation of reporting components.⁷³

Basically, in order to determine that there is an adequate and appropriate array of treatment services, it is first necessary to know the needs of the population being served. If children have been screened and/or assessed and a treatment recommended, then we should be able to expect that they will receive the recommended treatment. So, very simply, in order to assess diagnosis and treatment, the state needs to be able to provide information about who has been screened, what diagnoses have been made, and what services/treatment have been recommended for those children. Only at that point can one determine whether appropriate treatment has been afforded.

One may reasonably ask whether a study could be devised to determine the level of care provided under TennCare. Two researchers have written an article describing

⁷² See notes 32 and 33 and accompanying text.

⁷³ July 2006 Semi-Annual Progress Report (Doc. No. 675) at 3.

how to evaluate Medicaid Managed Care Programs for Children.⁷⁴ According to this article, one should begin by looking at the contracts, operating rules, and waiver applications to determine program requirements. The authors then suggest that providers and others who have contact with families be interviewed as this “may yield information about pertinent barriers to health care.” The authors then suggest that one look at encounter data, including enrollment files, information on providers, data on prescriptions that individuals fill and information about health encounters at long-term care, in-patient, outpatient and dental settings. Because of the possible incomplete nature of administrative encounter data, the authors finally suggest that one review electronic medical records.⁷⁵

At this point, the record does not establish whether the state is in compliance with the Diagnosis and Treatment Provisions of the Consent Decree. While the state has adequately established contractual provisions, policies, TSOPs and has adequately ensured policy compliance by the MCOs, there is not sufficient proof in the record to determine whether all “medically necessary” care is being provided. Moreover, there is proof in the record to establish that the provider networks are not sufficient to adequately provide treatment under EPSDT.

In addition to medical care, EPSDT requires that the state provide both dental and behavioral care to children.

Doral Dental is the sole provider of dental services under the state’s EPSDT

⁷⁴ William Cooper & Karen Kuhlthau, *Evaluating Medicaid Managed Care Programs for Children*, 1 AMBULATORY PEDIATRICS 112 (2001).

⁷⁵ *Id.* at 112-13.

program. Essentially, the EQRO asked the same questions about Doral as it did about the MCOs. This included: establishing that there was a policy for appropriate referral from one level of care to another;⁷⁶ establishing that there was a policy and procedure requiring the provisions of all medically necessary care;⁷⁷ establishing that there was a policy and procedure ensuring that consistent decisions are made regarding medical necessity and that these decisions are consistent with federal law;⁷⁸ demonstrating appropriate utilization management decisions;⁷⁹ and establishing policies to assure that all medically necessary care is provided regardless whether the need for such services was identified by a provider who had received prior authorization or by an in-network provider.⁸⁰ The answer to all of these questions was “yes.” Interestingly, the EQRO asked whether Doral had established “standards for development of provider networks that are compliant with the provisions of the TennCare Dental Contract,”⁸¹ but did not ask whether Doral had demonstrated that it could “comply with reasonable promptness standards when establishing provider networks” and whether it had “enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” In other words, there is nothing in the EQRO to establish whether Doral, as the single provider of dental services, has sufficient providers to properly care for children under TennCare. In

⁷⁶ EQRO, August 2006, *supra* note 19, at 196.

⁷⁷ *Id.*

⁷⁸ *Id.* at 197.

⁷⁹ *Id.* at 198-99.

⁸⁰ *Id.* at 200.

⁸¹ *Id.* at 200, to which the answer was also “yes.”

reviewing the Semi-Annual Report, one is struck that 21% of the appeals were based on dental care issues.⁸² Likewise, in the report on denials of care under TennCare, denials of dental care were reported by more parents than the denials of any other services.⁸³

The record simply does not establish whether the state is in compliance with provisions of the Consent Decree regarding dental care.

Behavioral health care is provided by two BHOs – Premier and Tennessee Behavioral Health (TBH). The EQRO asks the same policy and procedure questions about BHOs as it did about the MCOs, with generally similar answers.

In reviewing the EQRO, it appears that neither organization has established a sufficient provider network. Two questions ask about the sufficiency of the networks. First, the EQRO asks whether “the Health Plan has established standards for development of provider networks that are compliant with the provisions of the TennCare MCO/BHO Contract.” As to both BHOs, the answer was “partially.” The recommendation for each was identical: the BHO “should continue to pursue contracts with providers to correct any contract deficiencies. The EQRO supports the continued 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 services providers.”⁸⁴ Likewise, the EQRO asked whether “the BHO provides a comprehensive and appropriate scope of geographically accessible child and adolescent behavioral health services and in a range

⁸² July 2006 Semi-Annual Progress Report (Doc. No. 675) at 116.

⁸³ See *supra* notes 32 and 33 and accompanying text.

⁸⁴ EQRO, August 2006, *supra* note 19, at 171, 186. As to each of these providers, the same finding was made in 2005, with the same recommendation.

of treatment settings.” As to both BHOs, the answer was “partially.” Also, as to both BHOs, the recommendation was that the BHO “continue to pursue contracts with providers of correct any contract deficiencies. The EQRO supports the continued 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.”⁸⁵

As late as the fall of 2006, the State continued to work with the BHOs in an attempt to improve their provider networks. Clearly, access to behavioral health has suffered as a result of insufficient provider networks. This is evident in the reviews of both care coordination and the needs of the population which is at risk of entering DCS custody due to serious emotional and behavioral problems. Many of these children are entering custody solely because of a lack of resources in the community.

A lingering issue in regard to access to behavioral health care is the skewed incentives for providing behavioral health care to children. While physical health care is no longer capitated, the BHOs continue to be reimbursed on a capitated system. Thus, if a child is at risk of entering DCS because the child has severe emotional or behavioral problems, the incentives would push the BHO to deny care. If the child’s problems become severe enough and are untreated, the child will eventually go into the custody of DCS. At that time, the cost of providing services to the child will fall to DCS, rather than the BHO.

Based on this record, one can not find that the state is in compliance as to the

⁸⁵ EQRO, August 2006, *supra* note 19, at 178, 192. As to each of these providers, the deficiencies were also reported in 2005 with the same recommendation.

provision of behavioral health care. There is no data, nor is there empirical or statistical proof that behavioral health care is actually being provided. Moreover, there are consistent and specific findings in the record that the provider networks are insufficient.