

**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 EARLY AND PERIODIC SCREENING¹

The Consent Decree requires defendants (i) to establish rules and guidelines that clearly describe, allocate responsibility for, and require compliance with each specific screening requirement under federal law; (ii) to ensure that contractor networks are sufficient in terms of qualifications, training, and in numbers in conformity with state and federal guidelines; and (iii)

¹ This report does not address issues related to early and periodic screening of children in the Department of Children Services (“DCS”) custody.

to take certain steps to ensure that each periodic screen accurately identifies enrollees who should be referred for further assessment for behavioral/developmental problems and/or possible hearing or vision impairment.² In addition, the Consent Decree requires defendants to either (i) achieve certain screening performance minimums; (ii) establish that all children who did not receive complete screenings have been subject to outreach efforts reasonably calculated to ensure their participation; or (iii) establish that their failure to meet the minimum screening requirements is due to factors beyond their control or that of their agents.³ Defendants contend that they are in compliance with the screening requirements of the Consent Decree.⁴

Incorporated throughout the Consent Decree is the over-arching goal of assuring an effective child health program. Such a goal will not be achieved simply through the existence of policies and procedures and prescriptive activities alone. The goal will be achieved when defendants undertake to implement a comprehensive plan of action to achieve the objectives of the Consent Decree, monitor that plan, and continuously assess the effectiveness of their activities.

I. Screening Requirements

Issue: Whether TennCare rules and guidelines clearly describe and allocate responsibility for compliance with federal laws related to screening

TennCare rules and guidelines describe and incorporate by reference the federal EPSDT requirements. In order to fulfill the federal mandates, TennCare entered into contracts (“CRAs”)

² See Consent Decree for Medicaid-Based Early and Periodic Screening, Diagnosis and Treatment Services (Doc. No. 12) at 19-25, ¶¶ 41-44 [hereinafter Consent Decree].

³ *Id.* at 25-29, ¶¶ 45 - 51.

⁴ See Transcript of February 10, 2006 (Doc. No. 596) at 47.

with seven managed care organizations (“MCOs”)⁵, two behavioral health organizations (BHOs)⁶, and one dental benefits manager (“DBM”)⁷ (collectively referred to as managed care contractors (“MCCs”)). The terms of those contracts require the MCCs and its providers to comply with the specific screening mandates set forth in the Consent Decree.⁸

Notwithstanding the contractual obligations of the MMCs, TennCare agrees that ultimately it has the final responsibility for compliance with the Consent Decree; the responsibility for EPSDT compliance is actually set by federal law, which makes clear that the responsibility for EPSDT compliance lies solely with the single state Medicaid agency. Defendant state that the only exception to TennCare’s ultimate authority and responsibility relates to those sections of the Consent Decree that include requirements above and beyond what is required by federal EPSDT law (i.e. requirements of the Adoption Assistance and Child Welfare Act). For those DCS specific requirements, the State allocates responsibility to DCS.

Defendants produced much information about the EPSDT activities of the various departments and committees within the State, including information about the interactions between those departments and committees.⁹ Given the large number inter-departmental

⁵ John Deere Health Plan, Inc., Preferred Health Partnership of Tennessee, Inc., TLC Family Care Health Plan, UAHC Health Plan of Tennessee, Unison Health Plan of Tennessee, and BHP Community Care operate under the Amended and Restated Contractor Risk Agreement dated July 1, 2001, and Volunteer State Health Plan, Inc., d.b.a. BlueCare operates under the Amended and Restated Contractor Risk Agreement dated July 1, 2001, as amended.

⁶ Premier Behavior Systems of Tennessee, L.L.C. and Tennessee Behavioral Health, Inc. provide services under the Re-Issue of the Managed Care Contract Provider Risk Contract dated February 29, 1996, as amended.

⁷ Doral Dental of Tennessee, L.L.C. provides dental coverage under a contract with the State.

⁸ See Amended and Restated Contractor Risk Agreements between the State and the MCOs, BHOs, and DBM, at § 2-3.u and § 4-1.

⁹ For example, see the Semiannual Reports filed by TennCare and the most updated Consent Decree Grid describing various departmental and agency activities related to compliance with the screening requirements of the Consent Decree.

activities, the Governor's Office of Children's Care Coordination ("GOCCC") was created to coordinate the activities of those departments in attempt to maximize effectiveness.¹⁰

Issue: Whether TennCare rules and guidelines require the MCCs to comply with federal laws related to screening

Interestingly, defendants argue that paragraphs 41 and 42 the Consent Decree do not require TennCare to monitor and enforce its rules and guidelines. Defendants argue that TennCare is only required to the "establish" rules and guidelines. They assert that the fact that TennCare monitors the MCCs for compliance with the rules and guidelines created by paragraphs 41 and 42 of the Consent Decree is evidence that TennCare actually requires standards greater than those set forth in the strict language of the Consent Decree.

Contrary to the position of defendants, the Monitors believe that the spirit of the Consent Decree, through its express language and the incorporation of federal EPSDT regulations and guidelines, requires TennCare to proactively enforce, assess, and improve (as needed) all established rules and guidelines implemented under the Consent.¹¹ Accordingly, the Monitors do not find the defendants' argument convincing. Given the numerous activities undertaken by the TennCare to improve its effectiveness in providing EPSDT services (as discussed further below and in other Monitor reports), one could suspect that the defendants do not seriously believe their own argument and that their "stated" position is simply that of litigation strategy. Notwithstanding, the ongoing addition of new programs demonstrate TennCare's desire to improve its outcomes related to effective EPSDT services.

¹⁰ In addition, the GOCCC oversees the State's response to the Consent Decree by organizing and compiling the required Semiannual Reports and tracking activities related to compliance with the Consent Decree.

¹¹ See Consent Decree, *supra* note 2, at 13, ¶ 35 (identification and make recommendations regarding problems); 29, ¶ 51 (demonstrate compliance by showing failure was due to factors beyond the control of defendants or their agents); 42 U.S.C. § 1396u-2 (proactive delivery of healthcare); State Medicaid Manual § 5010.B. (*assure* availability and accessibility).

The Consent Decree requires the State to contract with an external quality review organization (“EQRO”) to review the MMC contracts and to determine whether any provisions within those contracts encourage violations of the EPSDT mandate, including those related to screening.¹² Federal regulations mandate how quality measurement and performance improvement methods should be applied to Medicaid managed care programs through two specific approaches:

- State agencies must develop and implement a quality assessment and improvement strategy that includes (i) standards for access to care, (ii) examination of other aspects of care and services related to improving quality, and (iii) monitoring procedures for regular and periodic review of strategy, and
- State agencies, through contracts with MCOs, must provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO.

TennCare contracts with QSource¹³ to serve as the EQRO that conducts the review activities required by the Consent Decree. QSource conducts on-site quality audits and surveys of each MCC and assesses that organization’s compliance with the elements of the Consent Decree, the 2001 Judge Nixon ruling, as well as certain CRA contract provisions.¹⁴ The surveys are conducted by use of interviews, document reviews, and direct observations.¹⁵ In addition to

¹² Consent Decree at 49-50, ¶102. The Balanced Budget Act of 1997 (“BBA”) requires a state Medicaid agency the contracts with Medicaid MCOs to develop a state quality assessment and improvement strategy that is consistent with regulations established by the Department of Health and Human Services (“DHHS”).

¹³ QSource is an independent, not-for-profit, federally approved healthcare quality improvement organization. QSource works with consumers, physicians, hospitals, nursing homes, home health agencies and other caregivers, providing services to assist organizations and providers of healthcare improve the quality of healthcare delivery (<http://qsource.org/about1.htm>). Since 1973, QSource has been under contract with CMS to determine whether Medicare patients in Tennessee receive quality healthcare. QSource provides technical support, data analysis, and outcomes reporting as part of the external quality review (“EQR”) contract (<http://qsource.org/eqro/index.htm>).

¹⁴ QSource 2006 Early and Periodic Screening, Diagnosis and Treatment Report, August 2006 Final Report at 4 [hereinafter EQRO August 2006 Report].

¹⁵ Prior to implementation of the survey tools, the final tools are approved by the TennCare Director of Quality Oversight, the TennCare Dental Director, and representatives from the TDMHDD. *Id.*

complying with the requirement of the Consent Decree, TennCare uses QSource as its primary monitor of the MCCs, and to a lesser extent, as a consulting/analysis agent.

There are mandatory and optional activities that QSource must perform as a part of its review activities, including specific federal protocols. The following is a summary of the activities that QSource performs, some of which exceed the requirements under the Consent Decree and federal regulations:

Annual Quality Survey

- Evaluate MCC compliance with CRA terms and conditions, federal regulations, and quality standards established by the State
- The evaluation includes:
 - Pre-assessment of health plan documents (performed at QSource)
 - On-site document/file review (2-3 days)
 - Interview with key MCC personnel (e.g., Quality Director, Medical Director, CEO)
 - Assessment of adequacy of MMC information systems
- Surveys relevant providers (scheduled from early April to mid –June)
- Report relevant information for each MCC:
 - Strengths and opportunities for improvement
 - Recommendations for improving quality
 - Assessment of MCCs attention to prior recommendations

EPSDT

- Evaluate MCC compliance with EPSDT requirements, including:
 - Pre-assessment of health plan documents
 - On-site document/file review
 - Interviews with key MCC personnel (e.g., Quality Director, EPSDT Coordinator)

Annual Network Adequacy and Benefit Delivery Review

- Evaluate MCC compliance with:
 - delivery of Amended and Restated Contractor Risk Agreement (“CRA”) contractually required benefits with specified timeframes
 - adequacy of provider networks
 - Evaluation to include:
 - Pre-assessment of health plan documents
 - On-site document/file review
 - Interviews with key MCC personnel (e.g., Quality Director, Credentialing Coordinator, Contract Manager)

- Reports require coordination with TennCare, Tennessee Department of Commerce and Insurance, and the Department of Mental Health and Developmental Disabilities (“TDMHDD”)

Comparative Analysis of HEDIS/CAHPS Results

- Review and analyze HEDIS/CAHPS data submitted to TennCare by MCCs
- Report on:
 - Best practices in the MCC
 - Opportunities for improvement on an MCC-specific level
 - State-wide opportunities for improvement

Validation of Plan of Correction (“POC”) Projects

- Assess and improve processes and outcomes of care. Federal protocol specifies procedure for EQROs to use in evaluation the soundness and results of POCs implements by MCCs.
- Plan-specific reports summarizing the results of the evaluation process state-wide opportunities for improvement

Validation of Performance Measures

- Evaluate accuracy of measures reported by MCOs and BHOs (1-2 day on-site visit)
- Determine the extent that measures calculated by MCOs and BHOs follow TennCare specifications
- Evaluation to include:
 - Pre-assessment of baseline assessment tool
 - On-site activities, including live system and procedure documentation, primary HEDIS data source verification, programming logic review/inspection of job logs, computer database/file structure review, interviews with key MMC personnel (e.g. HEDIS Coordination, IS staff, medical records review staff, claims processing staff, membership staff, HEDIS vendors)

EQRO Technical Report

- Summary report on external quality review activities conducted throughout the year, including
 - A description of how data was aggregated/analyzed
 - How conclusions were drawn for quality, timeliness and access to care provided
- Report includes the following information for each MCC activity conducted: objectives, strengths and weaknesses for each MCC, recommendations for improving quality, comparative information (as methodologically appropriate), and assessment of MCCs attention to prior recommendations

Healthcare Policy Reports (monthly)

- Provide articles or summaries of information related to national/state issues, standards for Medicaid managed care populations, and changes in requirement under the BBA
- Provide information on best practices or information that could improve financial stability of the TennCare program and quality of care provided to the TennCare population

Health Plan Meetings

- Host quarterly meetings with TennCare Quality Oversight Committee of the Bureau, health plans and related organizations for training to discuss MCC contract/policy requirements, best practices, and continuing education
- Scheduled consultation with the Division of Quality Oversight

Technical Assistance and Ad Hoc Reports

- Assist TennCare and MCC with performance improvement activities, provided at the Bureau's or the health plans' requests
- Adhoc reports at Bureau's request

Since 2002, EQRO evaluations have become progressively more detailed at the request of TennCare.¹⁶ New activities performed in 2006 included:

Validation of Provider Information Submitted by the MCCs

- Quarterly telephonic survey of active, in-plan MCC providers to determine/verify provider address/specialty, status of contract with MCC, panel age restrictions, telephone number, ESDT services provided for enrollees, panel status (open/closed), appointment availability for routine and urgent care, and prenatal and delivery services
- Quarterly reports that include detail regarding errors and discrepancies identified for each MCC during the survey

MCO Utilization Management/Quality Improvement Plans Review

- Summary report evaluating program description, work plans, and annual evaluations

Monthly, quarterly, and annually, QSource surveys and audits MCC compliance with certain requirements of the Consent Decree and the results are provided to TennCare.¹⁷ MCCs with annual scores less than 80% (four out of five stars) for any of the EPSDT standards being

¹⁶ See EQRO August 2006 Report at 4.

¹⁷ EQRO August 2006 Report at 9.

reviewed are required to submit a POC to TennCare.¹⁸ QSource staff evaluate the effectiveness all POCs recommended by MCCs. Once approved by TennCare, the MCC implements the POC. Thereafter, QSource conducts an on-site review of all MCCs with any overall rating of less than 80%, reviews those areas of the audit that resulted in a rating less than 80%, and evaluates the effectiveness of any POC that was implemented.¹⁹

In addition to the information required by QSource, each MCC submits to TennCare quarterly reports which provide information about enrollee screening that, in part, specifies the number of enrollee screening encounters received during the reporting quarter, as well as the number of overdue enrollee screening identified during the reporting quarter. The report also provides information about outreach efforts and provider education initiatives, describing the key elements of each outreach activity that occurred in the reporting quarter. The reports additionally describe the methodology in place for contacting members regarding overdue screenings and any metrics associated with the outreach. Furthermore, the reports provide information about the activities undertaken (i) to remind enrollees of overdue screening dates and upcoming screening due dates, and (ii) to follow-up with enrollees who have not received screens within one year.²⁰

¹⁸ EQRO August 2006 Report at 10.

¹⁹ Prior to the onsite visit, the MMC receives a request to send desk documents demonstrating its progress toward improvement. The request for substantiating documentation is directed toward those areas where an individual MCC scored 3 stars or less. The EQRO conducts a desk review for an MCC receiving an overall rating of 80% to 89% or 4 stars. These health plans receive a request to send desk review documents that demonstrate their progress toward improvement. The request for substantiating documentation is directed toward those areas for which the individual MCC scored 4 stars or less. A focused on-site review may be necessary if the MCC does not demonstrate progress toward improvement in the desk review documents. No further follow-up regarding the current evaluation is required for health plans receiving an overall rating of 90% to 100% or 5 stars. EQRO August 2006 Report at 10,13.

²⁰ See Quarterly EPSDT Reports.

MCOs and BHOs are required to develop and maintain the capability of tracking each enrollee for the purpose of monitoring receipt of the required screening, diagnosis, and treatment. The tracking system must have the capacity to generate an immediate report on each enrollee's EPSDT status. The 2006 survey included an evaluation of MCO and BHO performance activity: EPSDT Medical Tracking System and an evaluation of BHO performance activity compliance with standards: Medical Records Review.²¹

The 2006 EQRO performance survey rating ranged between 79.1% and 100% for compliance with the Consent Decree. Even though each MCC scored consistently high in the majority of the elements of the Consent Decree, there is opportunity for improvement in tracking of EPSDT screens and encounters, given that the average score was 17.2 out of a possible 20.0 points.²² Notwithstanding the need for improvement, QSource reported that there was no single criteria that stood out as an opportunity for a majority of the MCOs.²³

The 2006 EQRO BHO audit ratings were 75.9% and 77.4%.²⁴ The EQRO found that both of the BHOs needed to develop of a policy guaranteeing that only qualified personnel with education, training, or experience in child and adolescent health are employed to make utilization review and prior authorization decisions for EPSDT enrollees²⁵ and that both of their tracking systems needed improvement.²⁶

²¹ EQRO August 2006 Report at 6.

²² EQRO August 2006 Report at 16.

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.* at 73.

QSource found that the BHOs were partially compliant in the requirement that they distribute annually to each enrollee or family a minimum of: 1 member handbook, 4 newsletters, and 1 reminder before a screening due (handbook is to be sent within 30 days of enrollment; annually thereafter, the member is sent a reminder of EPSDT services). QSource recommends that one of the BHOs develop a process for tracking the mailing of new member handbooks within 30 days of enrollment. In summary, the 2006 survey reveals that 8 out of the 11 MCCs require POCs for compliance with CRA contractual obligations.²⁷

Defendants assert that simply because a DBM needs to develop policies regarding education of providers about EPSDT services does not establish that the education of and notification to enrollees did not occur throughout the year and asserts that, in fact, it did. Defendants assert that the fact that QSource identifies opportunities for MCC improvement is not an indication of TennCare's or its MCCs' failure to comply with the Consent Decree, arguing that in many instances the CRA contractual requirements that are audited by QSource go beyond what is required for compliance under the Consent Decree.

QSource auditors noted the following observations during the 2006 annual quality survey:

- (a) The MCCs continue to work collaboratively with efforts to reach eligible enrollees. The focus of the collaboration was to reach young adolescents using methods geared toward the age group;
- (b) More of the MCCs had a dedicated EPSDT coordinator(s) in calendar year 2005 and some MCCs have an EPSDT Program Description with written goals and timelines, which seem to be the largest contributing factors in compliance with the Consent Decree as these MCCs are more easily able to show evidence of compliance and seem to have a better understanding of the requirements of the Consent Decree;
- (c) Four MCOs had a CMS 416 screening rate of 80% or greater;

²⁷ See EQRO August 2006 Report at 14-15.

- (d) Most MCCs scored 97% or higher on the Quality Process Standard: EPSDT, and scored 100%;
- (e) Evidence of commitment was demonstrated by (i) one MCC through the establishment of a provider outreach program, using faxes to facilitate effective and efficient communication related to EPSDT services between the MCC and its providers, and (ii) two MCCs continued to integrated their EPSDT tracking systems by providing access to this information to customer service associates which has led to an even greater facilitation of delivery of EPSDT services to eligible enrollees; and
- (f) Overall, surveyors continued to note a high level of commitment, dedication and enthusiasm among MCCs to ensuring the enrollees are made aware of the encouraged to use EPSDT benefits.

These additional observations tend indicate that TennCare continues to improve the effectiveness of its efforts to comply with the Consent Decree.

Convincingly, the defendants argue that simply because QSource generates a recommendation for improvement does not necessarily indicate that the MCC does not comply with the Consent Decree. The likelihood that every MCC will score 100% on every element of the EPSDT standard is an unreasonable expectation to impose on TennCare and does not constitute an overall failure to comply with the Consent Decree.

Arguing that quality is a work in progress, TennCare asserts that it is continually identifying ways to improve upon what the MCCs, other state departments, and agencies are currently doing. In fact, substantial compliance may be the only realistic expectation given the nature of the requirements of the Consent Decree.

Defendants assert that compliance with the rules and guidelines of paragraphs 41 and 42 of the Consent Decree is not optional for the MCCs, because the CRAs require such compliance.²⁸ Although certainly a potentially strong vehicle for enforcement of Consent

²⁸ Specifically, the CRA provides for several types of sanctions that can be assessed against an MCC in violation of CRA contractual terms, including but not limited to liquidated damages, suspension of enrollment in the contractor's MCO, limitation of the contractor's service area, civil monetary penalties, and even termination for breach of the contract (defined to include: failure to perform in accordance with any term or provision of the contract; partial

Decree compliance, the CRA alone cannot guarantee compliance (or even substantial compliance) with the training and numbers requirements. The State must establish that it is willing to enforce contractual provisions against an MMC that violates contract terms and or conditions related to EPSDT compliance.

The Defendants assert that TennCare assesses penalties against MMCs for failure to comply with contracts terms that affect EPSDT services. For example, TennCare assessed penalties against the BHOs for Geo access deficiencies in violation of contractual obligations.²⁹ TennCare also assessed penalties against MCOs for appeal-related deficiencies in EPSDT cases that have come to the State's attention through an individual enrollee's appeal.³⁰ Certainly, enforcement of CRA provisions through penalties and sanctions against the MCCs, including but not limited to termination of contract, will tend to assure enforcement of Consent Decree requirements.

Pursuant to CRA contract amendment in July 2005, MCCs were required to obtain accreditation with the National Committee on Quality Assurance ("NCQA") by January 2007.³¹ NCQA is an independent, non-profit organization that assesses and scores managed care organization performance in the areas of quality improvement, utilization management, provider

performance of the contract; or engagement in any act prohibited or restricted by the contract). *See* CRA § 4-8.a and b and § 4-2.b.

²⁹ *See* Defendants' Response to Plaintiffs' Interrogatories at 127-29.

³⁰ *See* TCJB0406-D-08049-51.

³¹ *See* Semi-Annual Progress Report, July 31, 2006 (Doc. No. 675) at 2. Beginning in 2007, all MCOs must be accredited with the National Committee for Quality Assurance ("NCQA"). The requirement for accreditation and its accompanying performance standards ("HEDIS") allows TennCare to compare the performance of the individual health plans to each other and to the performance of other Medicaid managed care companies through the nation. MCOs failing to achieve NCQA accreditation by December 31, 2006 will have their contracts terminated. As part of the accreditation process, each MCO is required to contract with a NCQA certified vendor to conduct the Consumer Assessment of Health Plan Survey ("CAHPS"). CAHPS is a set of standardized surveys that measure patient satisfaction with the experience of care

credentialing and member rights and responsibilities. While NCQA accreditation will not guarantee compliance the Consent Decree, it will likely provide another objective assessment of many aspects of MCC efforts related to compliance with the Consent Decree.³² Notwithstanding, the record is unclear as to whether NCQA accreditation will result in compliance with the Consent Decree by the MCCs. At a minimum, however, it tends to indicate TennCare's desire to improve outcomes related to compliance and child health program delivery.

TennCare appears to substantially comply with the federal laws related to the screening requirements set forth in paragraphs 41 and 42 of the Consent Decree given the results of the EQRO surveys, reviews, findings and TennCare's continuous identification of ways to improve upon what the MCCs are currently doing. Additionally, TennCare appears to be willing to enforce the requirements of the CRA through sanctions and penalties against the MCCs.³³

Issue: Whether MCC Networks are Adequate in Qualification, Training, and Numbers in Order to Properly Screen Children in Conformity with Federal and State Guidelines

The State formed the Provider Education and Participation Workgroup to address issues related to provider education and participation. This workgroup focuses on network adequacy, appropriate delivery of EPSDT services, provider education, and technical assistance.

Defendants contend that the MCC networks are adequate in qualification, training, and number. They point to the terms of the CRA as proof, because the relevant requirements of CMS guidelines and federal and state regulations are addressed in the CRA contracts.³⁴ As addressed above, pointing simply to language requiring compliance with federal or TennCare

³² The NCQA accreditation relates most particularly in the area of diagnosis and treatment, since the NCQA surveyors review MCO utilization management programs and assess performance against a variety of standards.

³³ Defendants have not produced documentation to confirm their representation that TennCare has assessed penalties and sanctions against certain MMCs due to their failure to comply with certain CRA provisions.

³⁴ See CRA §§ 2-3.b.1 and 2-3.b.2.

screening network guidelines is not, by itself, sufficient to establish compliance with the Consent Decree. To establish compliance, defendants should present evidence that TennCare monitors, assesses, enforces, and improves, as needed, its activities related to establishing adequate networks. As more thoroughly discussed below, with respect to screening provider networks, TennCare appears to have established adequate screening networks.

TennCare implemented credentialing policies and procedures designed to assure that MCCs only contract with qualified, appropriately trained providers. MCCs are required to monitor provider compliance and take corrective action for failure to comply. QSource audits those policies and procedures for compliance. Pursuant to the terms of the CRA, TennCare has the option to penalize an MCC that fails to complete the credentialing process according to the contract, assessing \$5,000 and/or \$1,000 per day for each day beyond the required credentialing completion date.³⁵

Additionally, Section 2-3.b.1 of the CRA states that the MMC shall assure that there are primary care providers willing and able to provide the level of care and range of services necessary to meet the medical needs of the enrollees including those with chronic and acute diseases and that there shall be a sufficient number of primary care providers who accept new TennCare enrollees with each geographical location in which the plan is marketed so that each primary care provider has a reasonable caseload not to exceed 2500 patients for a physician and one-half of this for a physician extender. The MCC is required to monitor provider compliance and take corrective action for failure to comply.

³⁵ See CRA § 4-8.b.2.

Screening provider network consists of the network of primary care providers (“PCPs”) and dentists.³⁶ The specific distance standards referenced in the Consent Decree relative to PCPs are those contained in the TennCare Waiver terms and conditions for access. These standards require that PCPs be available within 30 miles or 30 minutes in rural areas and within 20 miles or 30 minutes in urban areas. A dental distance standard is indirectly implied in the waiver terms and conditions, because of a requirement that transport time to a general dentist should not exceed 30 minutes, except in rural areas where the community standard applies.

Compliance with network distance standards is assessed via Geo access mapping of providers and enrollees conducted by both QSource and TennCare. The defendants report that Geo mapping demonstrates that the screening provider network of all MCOs and DBM are currently in compliance (and have consistently been in compliance in the past) with the distance requirements of the Waiver and Consent Decree.³⁷

Defendants must ensure that MMC networks are adequate to terms of numbers to properly screen children in conformity with the requirements of the State Medicaid Manual (“SMM”) and other federal regulations.³⁸ The 2006 EQRO Report found that three of the seven MCOs and both BHOs were found not to have satisfied Consent Decree requirement related to network numbers. However, as discussed above, the deficiencies identified by QSource relate to the network of specialists and not primary care providers necessary for screening

³⁶ The 2006 EQRO Report results are not necessarily informative related to screening network requirements. Even though the Report finds that the MCC networks are only partially compliant in terms of training and numbers, those findings relate not to primary care providers, but to specialist networks. *See* EQRO August 2006 Report at 135, 144, 154, 178, 186.

³⁷ *See* Geo access mapping reports (TCJB0406-H-00391).

³⁸ Consent Decree, *supra* note 2, at 24, ¶43.

compliance.³⁹ There appears to be no evidence in the record that defendants have failed to comply or at least substantially comply with the screening network numbers requirement of the Consent Decree.

One objective of the Provider Education and Participant Workgroup is to support the provider community with educational programs about EPSDT.⁴⁰ Activities planned to enhance knowledge about screening procedure for ESPDT include: (i) continuing current provider education activities; (ii) continuing provider education activities for dental services; and (iii) building on current activities and strengthening education efforts.⁴¹

Defendants also point to their contract with the Tennessee Chapter of American Academy of Pediatrics (“TNAAP”). The primary purpose of the contract of the TNAAP is to work with providers, MCCs, and other groups to identify barriers to, and improve compliance with EPSDT requirements and associated performance standards by conducting EPSDT and coding office visits and trainings; developing and distributing EPSDT educational materials; and conducting developmental and behavioral training and outreach programs.⁴² TNAPP (i) participates and contributes in meeting and dialogue with TennCare and the Governor’s work groups; (ii) interacts with GOCCC; and (iii) engages in dialogue/outreach with other professional

³⁹ The EQRO standard related to specialists exceeds any requirement included in the Consent Decree because neither the Waiver nor the Consent Decree mandates any distance requirement for specialty providers.

⁴⁰ Other issues related to network sufficiency are that small clinical practices may lack support for quality of care improvements and may not have the operational capacity to make changes in their practice patterns or record-keeping procedure, such as implementing electronic medical records or re-designing patient flow to use time more productively. Many providers may have neither the technical means nor back-up support to participate in educational programs offered, for example, through interactive, web-based venues. *See* Henry T. Ireys & Tara Krissik, Mathematic Policy Research, Inc., *The EPSDT Program in Tennessee; Strategies for Enhancing Screening Percentages* (Apr. 29, 2004) at 20 [hereinafter Ireys' 2004 Screening Report].

⁴¹ *Id.* at 21.

⁴² *See* JB 015770 (TNAAP Quarterly Progress Report at 2).

organizations.⁴³ TNAAP trains healthcare providers, training thousands of healthcare providers annually.⁴⁴ TNAAP additionally provides updated resource materials regarding EPSDT services to providers, EPSDT manuals and videos, and periodicity schedules.⁴⁵

The Quarterly EPSDT Reports summarize provider education conducted by the MCCs. The evidence establishes that MCC provider education is on-going, mainly through monthly and bimonthly newsletters covering relevant topics; provider administration manuals; reference guides; remittance advice messaging, clinical audits of medical record reviews and training session with provider; one-on-one education with the provider and/or healthcare staff; group training sessions; interactive provider websites; office manuals; disease management tools; EPSDT orientation for newly contracted providers; annual provider in-service training, and CMS Form 416 Report sharing.⁴⁶

Reported in the 2006 EQRO Report was that two of the MCOs did not have processes requiring providers to document specific EPSDT services declined, implying that providers were not capturing that information as required by the Consent Decree.⁴⁷ Also reported was that an MCO failed to demonstrate that certain encounters with health professionals were not reported as interperiodic screens as required by the Consent Decree.⁴⁸ Based on the 2006 EQRO Report

⁴³ See JB 015770 (TNAAP Quarterly Progress Report at 2).

⁴⁴ See JB 015769 – 015806 (Quarterly Progress Report, Oct. 1, 2005 through Dec. 31, 2005).

⁴⁵ *Id.*

⁴⁶ See MCC 2006 Quarterly EPSDT Reports, 1st and 2nd Quarters, § IV.b.

⁴⁷ See EQRO August 2006 Report at 42, 68. Preferred Health Partnership and Unison Health Plan failed to comply with Paragraphs 39 (i) and 40 of the Consent Decree.

⁴⁸ See EQRO August 2006 Report at 47. Preferred Health Partnership of Tennessee failed to comply with Paragraph 42 of the Consent Decree.

findings, all other MCCs appear to be in compliance with the training requirements of the Consent Decree.

The results of the EQRO Reports and *The University of Tennessee Survey of Primary Care Providers* (“The UT Survey”)⁴⁹ may indicate the existence of Consent Decree compliance. The UT Survey results indicate that primary care providers have gained a better understanding of the benefits available through their offices to enrollees.⁵⁰ A comparison of the percentage of respondents in the baseline survey who said they did not know about certain key screening services to those in the second survey who said they did not know about those same services indicates that the level of knowledge of primary care providers has increased on six of eight key services – the exceptions being (i) the percentage of people who do not know that TennCare recommends a schedule of health services for children under the age of 21, and (ii) people who do not know whether or not TennCare offers developmental and behavioral health screening.

The Provider Education and Participation workgroup developed methods to assess adequacy of provider networks through (i) conducting surveys with primary care providers across the State to gather information on participation or non-participation; and (ii) expanding the dental provider network.⁵¹ Given the large amount of provider education and because education appears to be effective given the increased knowledge reported in the UT Survey, substantial compliance related to the training of providers appears to be likely. Continued surveying of PCPs will determine whether the work of TennCare and its agents in providing

⁴⁹ See TCJB0406-L-00037 (*Measuring the Success of TennCare’s Public Awareness Campaign: Results of the Second Survey of Primary Care Providers with Comparisons to the Baseline Survey*, Aug. 7, 2006 Draft Survey prepared by the Center for Business and Economic Research, College of Business Administration, The University of Tennessee). Based on the sample size of the survey, the margin of error for the estimates reported is approximately 10 percentage points.

⁵⁰ See TCJB0406-L-00037 at 7-8.

⁵¹ See Ireys' 2004 Screening Report, *supra* note 40, at 21.

provider education is effective and results in full compliance with the Consent Decree requirements.

Issue: Whether MCCs Take Steps to Ensure that Periodic Screens Accurately Identify Enrollees Who Should be Referred for Further Assessment

The Consent Decree requires the State to take certain steps to ensure that each periodic screen accurately identifies children who should be referred for further assessment of behavioral/developmental problems and/or possible hearing or vision impairment.⁵² Paragraph 44 of the Consent Decree requires the following:

- (a) Establish a committee of EPSDT providers and MCO medical directors to develop and assist with implementation of a plan to assure the children in need of more in-depth developmental/behavioral assessments and/or hearing assessments are identified through the periodic screening examinations;
- (b) Assure that developmental, behavioral, hearing and vision assessment experts are consulted and are active participants in the process described and (a) above, as their areas of expertise are addressed by the committee;
- (c) Facilitate the process of piloting the implementation of the recommendations developed by the committee in one or more large pediatric practices on the State;
- (d) Reconvene the committee to review the pilot results and make necessary modifications to the recommendations;
- (e) Conduct statewide training on implementation of committee recommendations; and adopt committee recommendations as components of TennCare ESDT screening guidelines for providers.

The State appears to have implemented the steps outlined in the Consent Decree. In 1998, it established the Screening Guidelines Committee to develop a plan to assure that children in need of additional assessments were identified. A plan was constructed in consultation with experts in relevant fields. The pilot of the plan was conducted, and the results of the pilot were

⁵² See Consent Decree, *supra* note 2, at 24-25, ¶ 44.

studied by the Committee. Statewide training was conducted in 2000, 2001, and 2002 in the form of web-based and group session training.⁵³

Implementation of the identified steps may not guarantee that periodic screens accurately identify enrollees who should be referred for further assessment. Again, continuous monitoring and evaluation of the plan will better ensure that enrollees are referred for further assessment. TennCare requires that the MCC direct its network providers to notify the MCC if a screen reveals a need for additional health care and the provider is unable to make an appropriate referral. QSource audits whether that communication has occurred and TennCare requires the MCC to document such contacts and follow-up with the enrollee to secure the referral and offer scheduling assistance and transportation assistance. QSource reviews the required documentation to assure that the MCC is functioning in accordance with this contractual requirement and reports the same to TennCare.

II. Screening Performance Standards

The Consent Decree requires TennCare to conduct a statistically valid medical records review of a sample of encounters (coded as periodic screens)⁵⁴ to determine whether or not the required components of a screen are documented.⁵⁵ The proportion of the required components

⁵³ Information related to the Screening Guidelines Committee's recommended plan, piloting of that plan, and training on the plan is reported in the Semi-Annual Reports ("SARS") July 1998, January 2000, January 2001, January 2002, and January 2005.

⁵⁴ The encounters included in the medical record review are selected from the most recent encounter data available to TennCare at the time of the sample selection, resulting in some of the sample encounters representing dates of service more recent than the dates of service associated with the encounters included in the calculation of the periodic screening percentage which the medical record review results will be used to adjust.

⁵⁵ The required components are:

- (a) Comprehensive health (physical and mental) and developmental history;
- (b) Comprehensive unclothed physical exam;
- (c) Appropriate immunizations according to age and health history;
- (d) Appropriate laboratory tests according to age and health history;
- (e) Health education;
- (f) Hearing screen, and
- (g) Vision screen.

present in each medical record reviewed is documented and an overall proportion is calculated for the entire sample. The screening percentage reported to CMS on Form 416 is multiplied by the overall proportion to determine the adjusted periodic screening percentage (“APSP”). TennCare is also required to calculate a dental screening ratio (“DSP”). The DSP utilizes a screening frequency standard of one screen per year, per child for ages three through twenty, CMS Form 416 methodology, and dental encounter codes specified by TennCare.⁵⁶

The Consent Decree requires the APSP and DSP to be no less than 80%.⁵⁷ Even if TennCare fails to meet the APSP or DSP requirement, it will be presumed to be in compliance with the screening requirements in any year in which all enrollees who have not received complete screenings have been the subject of outreach efforts reasonably calculated to ensure their participation.⁵⁸ Moreover, in any year in which TennCare fails to achieve the screening rates established in the Consent Order, it may demonstrate its compliance by a showing that the failure to achieve screening levels was due to factors beyond its control or that of its agents.⁵⁹

Issue: Whether TennCare Accurately Calculates Screening Percentages

The Consent Decree requires the periodic screening levels be calculated using CMS Form 416 mathematical methodology and enrollment and encounter data.⁶⁰ Federal agency instructions specifically set forth the method required to prepare the Form 416 Report.⁶¹ TennCare asserts that it carefully follows the federal agency instructions when calculating its

Consent Decree, *supra* note 2, at 25, ¶ 46.

⁵⁶ *See id.* at 27, ¶ 46.

⁵⁷ *See id.* at 28, ¶ 50.

⁵⁸ *Id.* at 29, ¶ 51.

⁵⁹ *Id.*

⁶⁰ *Id.* at 29, ¶ 46.

⁶¹ *See* <http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/Downloads/CMSForm-416Instructions.pdf>

CMS Form 416 and that it consulted with CMS staff when building the software program that performs the calculation.

Plaintiffs question whether, by itself, CMS Form 416 (as reported to CMS) is the appropriate factor to use when calculating APSP and allege that use of CMS Form 416 alone overestimates screens in some age categories, arguing that “enrollment and encounter data” must also be utilized in some manner (presumably outside of the CMS 416 calculation process).⁶² Defendants contend that the methodology that TennCare uses is mandated by the Consent Decree.

TennCare calculates the expected number of visits for a child based upon the enrollee’s age at the end of the federal fiscal year, rather than the actual number of screening visits that should have been scheduled for the enrollee. CMS Form 416 instructions require TennCare to report age based upon the enrollee’s age as of the end of the federal fiscal year. Clearly, calculating expected screens using ages at anytime other than at the end of the federal fiscal year would be in violation of the Consent Decree requirements.

For purpose of determining actual screens, TennCare captures the age of an enrollee as of the date of service. Defendants argue that its method is the only way one can calculate screens that would be consistent with the periodicity schedule.

Plaintiffs argue that the methodology used by TennCare underestimates the expected number of visits for most age groups. Defendants appear to admit that the method does potentially introduce some inconsistencies at the recipient level between expected and actual screens, arguing however that the underlying goal in reporting these numbers at the aggregate level is to capture estimates. Defendants contend that (on average) for every child that is

⁶² Plaintiffs’ contention seems peculiar, considering enrollment and encounter data is used in the calculation of CMS Form 416 data.

counted in a higher age category because of the date expected screens are calculated (federal fiscal year end) but has screens that were performed prior to his/her birthday in the lower age category, there is another child that ages into a lower category - - effectively minimizing any overestimation. In other words, the methodology is not meant to be perfect with respect to the integrity of age categories between expected and actual screens, but rather is meant to yield an indicator or average of screening percentages within each age category.

Defendants' contention is persuasive, given (i) the nature of the CMS Form 416 calculation methodology (calculation is based upon annualized aggregates and average periods of eligibility vs. actual); (ii) the number of required screens does not consistently decrease from one category to the next (in some cases, moving from one category to another could result in an overestimation of expected screens, or no change whatsoever); and (iii) TennCare consulted with CMS staff in determining how to set up its method of calculating Form 416.

Plaintiffs additionally assert that TennCare must be inappropriately counting screening encounters, because data produced by the State for fiscal years 2004 and 2005 indicate that a small percentage of enrollees are recorded as receiving many more screens than the maximum amount required for any age category, some as much as 50 in one year. TennCare asserts that its encounter data does not support plaintiffs' contention, stating that a review of its 2005 Form 416 encounter data found no instance where any enrollee's data indicated that he or she received such a large number of screens. TennCare asserts that its screens are counted based on the agreed procedure codes derived from the Consent Decree and CMS⁶³ and reports that it records only

⁶³ The periodic screening level will be calculated as follows: The CPT-4 AND ICD-9-CM codes specified in HEDIS 3.0 as well-child visits and adolescent well-care visits will be the primary determinants of which encounters are counted as periodic screens. The baseline periodic screening ratio for the period from October 1, 1995 through September 30, 1996 was calculated using HCFA Form 416 methodology. Subsequent periodic screening percentages are to be calculated using methodology identical to the used in calculation of the baseline periodic screening percentage. See Consent Decree, *supra* note 2, at 25, ¶¶ 45-46.

encounters for eligible enrollees that meet the HEDIS specifications (it only counts one screen per provider, per recipient, per day).

TennCare reports that the 2005 encounter data reveals that less than 2% of the enrollees identified as having screens and counted in the screening rate received more the 5 screens (the maximum number of yearly screens under the periodicity schedule).⁶⁴ Arguably, less than 2% of total screens is not a significant deviation. Whether the method used by TennCare to calculate APSP does not comply with the Consent Decree remains at issue, given plaintiffs' allegation.⁶⁵

Plaintiffs also challenge the manner in which TennCare determines dental screening percentages, alleging that TennCare fails to determine that the screens counted meet the statutory description of an EPSDT dental screen. The Consent Decree requires TennCare to calculate the dental screening ratio utilizing a screening frequency standard of one screen per year, per child for ages three through twenty, [CMS] 416 methodology, and dental encounter codes specified by TennCare.⁶⁶ TennCare reports that it uses CMS Form 416 Line 12a methodology (eligible enrollees receiving any dental services) to calculate DSP.

⁶⁴ The results of the State's review of 2005 encounter data revealed that 24 enrollees received more than 10 encounters that were coded as periodic screens during that year (12 enrollees received 11 screens; 8 enrollees received 12 screens; 3 enrollees received 13; and 1 enrollee received 19 screens).

⁶⁵ Previously in dispute was whether the annual calculations of the CMS Form 416 were accurate. Defendants discovered that in 2002, TennCare began calculating periodic screens in a manner that was inconsistent with the manner in which it originally applied the CMS Form 416 methodology. Since that discovery, TennCare changed the manner in which it determined the CMS Form 416 calculations to be consistent with the original methodology. Additionally, the manner in which TennCare was counting unique visits resulted in duplication of screens. The Special Master recommended that TennCare change the methodology used to capture those unique visits. After review and consideration of the recommendation, TennCare changed its methodology.

⁶⁶ See Consent Decree, *supra* note 2, at 25-27, ¶ 46. TennCare adopted the periodicity schedule recommended by the American Academy of Pediatric Dentistry which provides for dental screening services furnished by direct referral to a dentist for children beginning at three years of age. Dental services shall be performed by or under the supervision of dentists and can be met in settings other than a dentist's office. Although an oral screening may be part of a physical examination, it does not substitute for examination through direct referral to a dentist. A direct dental referral is required for every enrollee in accordance with the established periodicity schedules and at other intervals as medically necessary. *See also* TSOP 036 Addendum 3.

TSOP 036 Addendum 3 describes “dental screening services” in terms of a direct dental referral for an encounter with a dentist, or professional dental hygienist under the supervision of a dentist, for diagnosis and treatment.⁶⁷ Furthermore, TSOP 036 Addendum 3 provides that dental screening must include preventive dental care and screening in accordance with the dental periodicity schedule, at a minimum, to include relief of pain and infections, restoration of teeth and maintenance of dental health.⁶⁸

Given the apparently broad description guidelines for dental screening services,⁶⁹ use of CMS Form 416 Line 12a methodology (eligible enrollees receiving any dental services) to calculate DSP seems reasonable. Use of either Line 12b calculation methodology (eligible enrollees receiving preventive dental services only) or Line 12c calculation methodology (eligible enrollees receiving dental treatment services only) appears to be inappropriately limiting.

Issue: Whether the State Conducts Statistically Valid Medical Record Reviews

In addition to calculating the percent of expected screens that were actually provided in a given fiscal year, the Consent Decree requires TennCare to calculate the APSP. This calculation was developed to account for the fact that standard diagnosis and billing codes do not always accurately reflect the number of EPSDT-related screens that were actually provided. The APSP is designed, therefore, to reflect the true percentage of enrollees who received all components of an EPSDT screen.⁷⁰

⁶⁷ See TSOP 036 Addendum 3 at 9-10.

⁶⁸ See *id.* at 2.

⁶⁹ See 42 U.S.C. § 1396d(r)(1)(A), (3)(A)(i) where federal Medicaid law designates that states can determine “screening services” after consultation with recognized dental organization involved in child health care.

⁷⁰ See Ireys' 2004 Screening Report, *supra* note 40, at 8–9.

Defendants worked with the National Committee on Quality Assurance to determine the sample size necessary to conduct a statistically valid medical records review of the seven screening components. TennCare contends that random sample size of 411 medical records is suitable to statistically determine the statewide proportion of seven EPSDT components, within 10% points of the actual population proportion.⁷¹ The State reviews the randomly selected records to determine whether all regions of the State are represented. If all regions are not represented, another random selection is conducted.

TennCare worked with the TNAAP in designing the medical records audit tool. The audit tool consists of the seven components of an EPSDT screen and their properties. In addition to identifying the components in the medical record, the reviewer records information within the medical record that captures whether any referrals were made by the provider.⁷² The proportion of the required components present in each medical record is documented and an overall proportion is calculated for the entire sample. Plaintiffs do not appear to challenge the sample size utilized by TennCare or the audit tool developed by TNAAP.

Issue: Whether the MCOs are Aware that the Screening Components Must Be Present in Order to Utilize the Diagnosis Codes

TennCare is required to provide education to MCOs about the screening components that must be present in order to utilize the required diagnosis codes. By correspondence dated May 18, 1998 and follow up memoranda, TennCare notified its MCOs they are required to use the

⁷¹ The sample size calculation was verified by Nena Sanchez MS, Arkansas Foundation for Medical Care (AFMC), V.P. Medicare and Medicaid Operations and Dawn FitzGerald, MS, MBA, QSource, COO.

Once the medical review audit is scheduled, the providers whose records were selected will be sent 2–3 weeks notification as to the date of audit and a list of the records for audit. Plaintiffs question the integrity of the information contained in the medical records, because providers are given advance notice of the review date and the specific records to be reviewed.

⁷² See JB000227 at 2.

EPDST procedure and diagnosis codes that are being used in computing the CMS Form 416 Report and that a screen is consider incomplete if it does not include the required screening components.⁷³ In addition, the CRA requires MCOs to use the appropriate procedure and diagnosis codes when reporting the EPDST screens and to train provider on the coding.⁷⁴ EQRO annual medical records reviews require MCCs that do not address deficiencies in any of the required screening components to submit corrective action plans to address those deficiencies. The corrective action plans are reviewed by the State prior to implementation.

One could question the effectiveness of the MMCs' training on utilization of the appropriate encounter codes, given the existence of even less than 1% of enrollees receiving greater than 10 screens in 2005. Notwithstanding, it would be unreasonable to hold the State to a standard of perfection in this regard. Therefore, because of its varied and on-going conduct of training, it appears that TennCare provides the necessary education to the MCOs to comply (or at least substantially comply) with this requirement.

Issue: Whether All Enrollees Who Did Not Receive Complete Screenings Have Been the Subject of Outreach Efforts Reasonably Calculated to Ensure Their Participation.

The Consent Decree requires both APSP and DSP to be no less than 80%. The State has not met either of these minimum requirements.⁷⁵ When the State fails to achieve the minimum screening rates, it, nevertheless, is presumed to be in compliance with those requirements when all enrollees who did not receive complete screenings have been the subject of outreach efforts

⁷³ See JB015680–0156685.

⁷⁴ See CRA at 79–90, ¶ 2-3.u. Additionally, TNAAP provides many training sessions to providers and other healthcare staff. See JB 015770 at 2.

⁷⁵ See SARs, 1997–2006 (APSP rates: 21.9 (1996), 19.8 (1999), 31.5 (2000), 38.0 (2001), 42.0 (2002), 56.0 (2003), 67.2 (2004), and 65.9 (2005). DSP rates: 28.2 (1996), 28.5 (1999), 33.0 (2000), 38.3 (2001), 35.7 (2002), 45.8 (2003), 51.0 (2004), and 52.8 (2005)).

reasonably calculated to ensure their participation.⁷⁶ Because federal regulations do not define “reasonable outreach”, there is no universal standard by which to measure TennCare outreach efforts.

State Medicaid agencies are required to “provide a combination of written and oral communication methods designed to inform effectively all EPSDT eligible individuals about the EPSDT program.”⁷⁷ The SMM states that a combination of face-to-face, oral, and written informing activities is a most productive form of outreach.⁷⁸ TennCare alleges that its EPSDT outreach efforts have been designed to accomplish all of the above purposes, choosing a broad approach that brings together all child-serving state departments, as well as outside contractors in implementing EPSDT outreach.⁷⁹

TennCare model for EPSDT outreach involves five levels of activity: (i) Level 1 outreach efforts (inform the general public about EPSDT and generate interest in the program); (ii) Level 2 systemic outreach efforts (build a system of care that makes accessing EPSDT services as easy as possible); (iii) Level 3 general outreach efforts to TennCare enrollees (reach TennCare families, as opposed to the general public); (iv) Level 4 targeted outreach to specific populations (focus on specific groups of TennCare enrollees, such as children in custody, families with special needs); and (v) Level 5 hands-on outreach (engage in one-on-one and face-to-face contacts with enrollees).

⁷⁶ Consent Decree, *supra* note 2, at 29.

⁷⁷ 42 CFR § 441.56(A)(1).

⁷⁸ State Medicaid Manual § 5121A.

⁷⁹ The components of outreach include: (i) enrollee outreach workgroups; (ii) departmental outreach coordinators; (iii) MCC EPSDT coordinators; (iv) regional and local DOH EPSDT coordinators; and (v) combinations of the groups among themselves and with others.

Clearly, TennCare conducts numerous outreach efforts.⁸⁰ Notwithstanding, there is no conclusive evidence to support defendants' position that "all" children who did not received complete screens have been subject to reasonable outreach efforts. An analysis of outreach focusing on each specific non-screened enrollee seems appropriate, because the Consent Decree designates that "all" non-screened enrollees must be subject to reasonable outreach efforts. Accordingly, at a minimum, it appears that defendants would need to prove that it and/or its MCOs have specifically identified each non-screened enrollee and the outreach communication to that enrollee that resulted in the effective communication about the importance of screening.

Defendants allege that TennCare can, and does, track whether every enrollee has been screened. And furthermore, they argue that TennCare knows that it has conducted outreach to all non-screened children or their families to encourage them to get screened. Defendants allege that, because MCOs (i) are required by contract to make a minimum of six outreach attempts each year to every enrollee; and (ii) track the delivery of EPSDT screens through the receipt of claims/encounter information from providers and such activities are monitored by the EQRO, and that, because TennCare recently begun sending a letter at the end of the month in which an enrollee's birthday occurs who has not received a screen in the preceding 12-month period, reasonable outreach efforts are therefore established.

In addition, defendants point to the Department of Health ("DOH") Call Center outreach efforts, pursuant to a contract with TennCare. Operators in the Call Center attempt to contact the caretakers of all newly enrolled and recertified enrollees to inform them, in part, about available screening services. It is important to note that while the call center "attempts" to contact all enrollees, DOH records reveal that a large percentage of those calls do not actually make contact

⁸⁰ See Monitor's report on Outreach.

with the intended recipients. Clearly letters or calls directed to an enrollee's home do not necessarily establish reasonable outreach efforts, without proof that contact with the enrollee or an enrollee family member actually occurs in a manner that plainly communicates the need for screening services. In the case of special-needs children, TennCare must utilize methods tailored to the needs of the particular enrollee. The State has not established that it actually knows which of the enrollees (who failed to receive screening services) are special-needs children and that it customized its outreach approach to those individuals because of such. In summary, the record does not support a finding that "all" children who did not received complete screens have been subject to reasonable outreach efforts.

Issue: Whether TennCare's Failure to Meet the APSP and DSP Screening Requirements is Due to Factors Beyond Its Control.

Defendants argue that TennCare's failure to meet the minimum screening requirements is due to factors beyond its control and as a result, demonstrate their compliance with the screening mandates of the Consent Decree. Defendants point to the fact that notwithstanding its numerous outreach efforts, the State cannot force parents to bring their children in for screens.⁸¹ Obviously, defendants are correct. Defendants also allege that another barrier to achieving compliance with the required APSP is the standard itself.⁸² Certainly, the required 80% APSP requirement is a difficult standard to achieve. However, defendants agreed to that standard when it agreed to the terms of the Consent Decree.

Again, until defendants can clearly establish that all non-screened enrollees have been subject to reasonable outreach efforts, they cannot establish that they are taking all necessary steps to ensure that enrollees obtain the screens required under the Consent Decree. Therefore,

⁸¹ Defendants' Objections and Response to Plaintiffs' Third Set of Interrogatories at 72.

⁸² *Id.* at 73.

there is no rational basis to find that TennCare's failure to achieve the minimum screening requirements is the result of factors beyond its or its agents' control.