

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

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. 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: and  
GEORGE HATTAWAY, Commissioner,  
Tennessee Department of Children's Services,

Defendants.

**CONSENT DECREE  
FOR MEDICAID-BASED EARLY AND PERIODIC SCREENING, DIAGNOSIS  
AND TREATMENT SERVICES**

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## **I. INTRODUCTION**

1. This is an action brought on behalf of all individuals under the age of 21, who are or will be enrolled as beneficiaries in TennCare, Tennessee's Medicaid Managed Care program. The defendants, who are sued in their official capacity only, are Tennessee state government officials responsible for administration of TennCare and Department of Children's Services.

2. This case challenges the adequacy of children's health services provided by TennCare and the Tennessee Department of Children Services (DCS). Pending before the Court is the parties' application for approval of an agreed order settling the claims raised in the complaint. The Court has reviewed the complaint, the parties' joint motion and the terms of their proposed settlement, which is embodied in this order. The Court concludes that the agreement is proper, that it adequately protects the interests of the plaintiff class whose rights it affects, and that it should be approved and entered by the Court.

## **II. BACKGROUND**

3. Tennessee has operated a Medicaid program for more than a quarter of a century. In January, 1994, the state converted the program from fee-for-service to managed care,

and changed the name from Medicaid to TennCare. TennCare is funded jointly by the federal and state governments pursuant to Title XIX of the Social Security Act, also known as the Medicaid Act, 42 U.S.C. § 1396 et seq. The state administers the program under the terms of a special demonstration waiver granted by the federal Secretary of Health and Human Services, as authorized by Section 1115 of the same Act, 42 U.S.C. § 1315, and under those provisions of the

Medicaid Act which have not been waived and remain in full force and effect.<sup>1</sup> The agency within the Department of Health and Human Services which administers Medicaid, and which is therefore responsible for direct federal oversight of the TennCare waiver, is the Health Care Financing Administration ("HCFA").

4. TennCare finances and manages medical care for more than 1.2 million Tennesseans statewide. Approximately 500,000 of TennCare's enrollees are children. Most beneficiaries are poor, and qualify for coverage because they satisfy the eligibility criteria established by Title XIX. An additional 383,000 beneficiaries qualify under the special terms of the TennCare waiver. Those terms extend benefits to individuals who, though ineligible under Title XIX, are unable to obtain health insurance coverage on their own. Some qualify because they lack access to insurance through a group health plan. Others qualify as 'uninsurable', that is, they have been denied commercial coverage because they have a preexisting medical condition.

5. The Bureau of TennCare (hereinafter "Bureau") is the state agency responsible for administration of the program and its approximately \$3.5 billion budget. The Bureau contracts with managed care organizations (MCOs) to deliver necessary medical care to beneficiaries through networks of subcontracting health care providers. In a component of TennCare known as the Partners Program, each MCO is currently paired with a behavioral health organization (BHO). The BHO provides the mental health services, as well as alcohol and drug dependency treatment benefit, for the MCO's TennCare enrollees.

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<sup>1</sup>The parties recognize that the recent passage of the Balanced Budget Act of 1997 may affect duties under the instant Decree. ~ Balanced Budget Act of 1997, Pub. L. No.105-33 (August 5, 1997). The Defendants acknowledge their obligation to comply with controlling federal law and any HCFA requirements properly imposed upon the TennCare Demonstration Waiver.

6. Specialized services for children in state custody or at risk of coming into state custody as identified by a court pursuant to Title 37, Tenn. Code Ann., are funded by TennCare and managed by the custodial agency, DCS.<sup>2</sup> For children in physical custody, these DCS-administered benefits include the treatment components provided

during residential care and targeted case management as well as mental health and substance abuse services in excess of the "basic benefits package" in the TennCare Partners program. For children at risk of coming into state custody, these DCS-administered benefits are limited to targeted case management, including state family preservation.

7. The scope of benefits covered by TennCare is the same for all children, regardless of their eligibility category and regardless of whether they are in, or at risk of entering DCS custody.<sup>3</sup> The MCO benefits package currently covers a comprehensive array of medical-surgical services, including physician and hospital treatment, prescription drugs and durable medical equipment, and rehabilitation services. The specific services for any given child are based upon medical necessity.

8. Thus, under TennCare, a child is entitled to needed medical-surgical care from the MCO to which he is assigned, some behavioral health services from its counterpart BHO. and--if he is in DCS custody or at risk of entering DCS custody, other services as set out in 6, above.

9. As part of these benefits, TennCare-covered children under age 21 receive early and periodic screening, diagnosis and treatment ("EPSDT") under 42 U.S.C. § 1396a(a)(43), 1396d(a) and (r) and the state's TennCare contracts with MCOs. As the name suggests, the

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<sup>2</sup>Approximately 10% or less of children in DCS custody are ineligible for TennCare due to their confinement in correctional facilities for delinquent youth, or for other technical reasons.

<sup>3</sup>See Paragraph 17, *infra*.

purpose of EPSDT is to ensure that all Medicaid children receive regular screening, vision, hearing, dental and treatment services consistent with established pediatric standards. They must receive 'such other necessary health care, diagnostic services, treatment and other measures described in [§ 1396d(a)] . . . to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan." 42 U.S.C. § 1396d(r)(5). Specific EPSDT requirements have also been elaborated upon in federal regulations, and in such documents as the federal State Medicaid Manual, and policy transmittals of general applicability issued by HCFA.<sup>4</sup>

10. The verified complaint, filed on behalf of TennCare children as a group, alleges that TennCare fails to fulfill its EPSDT obligations in several respects. The complaint charges that there are systemic failures to screen children according to the prescribed periodic schedule, to properly diagnose their medical needs, and to provide them the full range of health services which they require.

11. In the case of class members who are in DCS custody, the plaintiffs allege that these general problems are compounded by poor coordination of TennCare services by the MCOs, BHOs and the state custodial agency, among which EPSDT responsibilities are shared. The plaintiffs claim that the same deficiencies which constitute violations of the EPSDT mandate also violate separate federal and state laws governing the rights of children in DCS custody. Those laws include Title [V(E) of the Social Security Act, also known as the Adoption Assistance and Child Welfare Act, 42 U.S.C. § 621 et seq. The laws in question impose broad

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<sup>4</sup>The parties recognize that "official pronouncements of agency policy such as manuals and administrative rulings . . . are entitled to deference." See *Linton by Arnold v. Commissioner*, 779 F. Supp. 925, 933 (Tenn M.D. 1990).

obligations regarding social and other services which are generally outside the scope of this litigation. However, the plaintiffs only invoke those aspects of the laws which implicate access to appropriate screening, diagnosis and treatment of their health and behavioral health needs.

12. The plaintiffs invoke the Fourteenth Amendment. Due Process Clause, which establishes minimal standards for health and mental health treatment of individuals in non-criminal state custody. See

Youngberg v. Romeo, 457 U.S. 307, 315 (1982), Meador v. Cabinet for Human Resources, 902 F.2d 474,475-7 (6th Cr. 1990). cert. den., 498 U.S. 867 (1990).<sup>5</sup>

13. The parties recognize that these longstanding problems existed prior to TennCare and. rather than being peculiar to Tennessee, are commonplace nationwide. Indeed, in 1989, Congress directed HCFA to set participation goals for states to improve EPSDT programs. 42 U.S.C. § 1396d(r); see State Medicaid Manual at 5360, setting annual EPSDT participation goals of 80% for all states by 1995. Plaintiffs do not claim that violations of these laws have been intentional. By joining with the defendants in requesting judicial approval of this agreed order, the plaintiffs acknowledge defendants' present commitment to fully and faithfully implement the law, in accordance with the provisions set out herein.

14. State officials deny that there has been any intent to deprive the plaintiffs of EPSDT services, or to deny them the protection of laws cited herein regarding treatment of children in state custody. On the contrary, those laws are in keeping with the state's own goals for the TennCare program, and for related programs serving children in DCS custody. While defendants dispute the allegations contained in plaintiffs' complaint, they do not dispute that present EPSDT processes require the enhancements contained herein to fully comply with federal law requirements. In keeping with their commitment for ensuring the full and effective implementation of EPSDT and laws incorporated herein, the defendants have devoted the state's

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<sup>5</sup>But see *DeShaney v. Winnebago County Dept. of Social Services*, 49 US. 189, 109 S.Ct. 998. 1006. In. 9, 103 L.Ed.2d 249 (1989), reserving whether a child harmed in a foster home could raise such claim.

resources to the identification and correction of deficiencies, rather than to costly and time-consuming litigation. To that end, officials have negotiated with the plaintiffs

over a period of months to develop a plan that will enable TennCare to achieve and maintain compliance with its EPSDT obligations.

### **III. INTENT STATEMENT AND DEFINITIONS**

15. Extensive negotiations have developed a basis for this Consent Decree. Defendants recognize that Medicaid recipients under age 21 have a right under the early and periodic screening, diagnosis and treatment provisions of the Social Security Act, 42 U.S.C. §§ 1396a(a)(43) and 1396d(r) to receive the services enumerated therein.<sup>6</sup> Moreover, children in DCS custody, as defined herein, are entitled to health and mental health services which meet constitutional minimums, as set forth herein, and to identification and treatment of their health and behavioral health needs under the terms of the Adoption Assistance and Child Welfare Act, 42 U.S.C. §§ 671(a)(16), and 675(1) and (5), as provided herein. This decree is intended to define the state defendants' duties for effectuation of such rights in the context of the TennCare Demonstration Waiver.

This consent decree is premised upon the assumption that the EPSDT requirements of 42 U.S.C. §§ 1396a(a)(43) and 1396d(r), and 42 U.S.C. §§ 671 (a)(16) and 675(1) and (5) of the Adoption Assistance Act are enforceable in an action under 42 U.S.C. § 1983.<sup>7</sup> Defendants do

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<sup>6</sup>See Paragraph 17, *infra*.

<sup>7</sup>While *Suter v. Artist M.*, 112 S.Ct. 1360, 503 U.S. 366, 118 L.Ed.2d 1 (1992) held that 42 U.S.C. § 671(a)(15) does not create rights enforceable in an action under 42 U.S.C. § 1983, *Suter's* application was subsequently limited by Congress to 42 U.S.C. § 671(a)(15). See Public Law 103-382, 108 Stat. 3518, 4057-8, codified at 42 U.S.C. § 1320a-2. Sixth Circuit precedent, predating *Suter*, established that §§ 670-76 of the Adoption Assistance Act are enforceable pursuant to 42 U.S.C. § 1983. *Timmy S. v. Grady Stumbo*, 916 F.2d 312 (6th Cir., 1990) (citations omitted). Thus, precedent continues in this jurisdiction as to enforceability of §§ 670-76 except as to § 671(a)(15),

Similarly, existing precedent in this jurisdiction establishes that the Medicaid Act creates rights enforceable in an action under 42 U.S.C. § 1983 to enforce the EPSDT requirements of 42 U.S.C. § 1396a(a)(43). See *Brandie Hinds, by next friend, Marie Wright v. Blue Cross and Blue Shield and the Tennessee Department of Finance and Administration*, U.S.D.C. (M.D.) Tenn. No. 3-95-0508 (order entered December 28, 1995) (citations omitted). See also *Daniels v.*



Wadley. 926 F. Supp. 1305, 1310 (U.S.D.C., MD.. Tenn. 1996) (plaintiffs have a private right of action to bring statutory claims under the Medicaid Act) (citations omitted).

not waive any right to seek modification of this consent decree if controlling precedence establishes lack of § 1983 enforceability as to any of these provisions.

16. This Consent Decree identifies specialized services provided to children who are in state custody, or who are at risk of coming into state custody under Title 37, Tenn. Code Ann. See Tenn. Code Ann. § 37-3-601, et seq. These references are solely for the purpose of identifying services and children which are the subject of the instant Consent Decree and are not intended to confer jurisdiction over any pendent state claim. Moreover, the parties intend that this Consent Decree shall have no impact upon any judicial proceedings relating to Title 37, Tenn. Code Ann., and shall not be interpreted to include jurisdiction, in any manner, related to such State court proceedings.

17. The state has currently elected, with HCFA approval, to provide non-Medicaid children with the same services provided to Medicaid eligibles. The parties recognize that the state retains the authority, with HCFA approval, to treat non-Medicaid eligibles differently. See *Daniels v. TDH., et al.*, 79-3107-NA. (M.D. Tenn., order entered 6/24/94, Docs. 316, 317). But, to date, the state has not sought or obtained a waiver of EPSDT for waiver eligible children.

18. "Defendants" shall mean the state agency designated to administer the Tennessee Medicaid Program, now known as 'TennCare,' the Tennessee Department of Health ("TDH") and its successors; and the agency designated by interagency agreement to effectuate components of the TennCare program as to children in its custody, the Department of Children's Services ('DCS'). The parties acknowledge that TDH is assisted by other agencies of state government in the administration and supervision of the TennCare program. Any requirement placed upon defendants by this Consent Decree, unless otherwise stated, may be accomplished by defendants, or their agents, employees, and representatives.

19. The term 'medical assistance' means care, services, drugs, equipment and supplies prescribed as medically necessary to prevent, diagnose, correct, or cure conditions in the person that cause suffering, endanger life, result in illness or infirmity, or interfere with or threaten some significant impairment and which are furnished in accordance with Title XIX of the Social Security Act and Tenn. Code Ann. § 71-5-101, et seq.

20. The phrase 'Tennessee Medicaid Program' or 'TennCare' shall refer to the joint federal/state medical assistance program administered pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. (hereinafter 'Medicaid Act'), including

Tennessee's Medicaid Demonstration Project No. 11-C-99638/4-03, referred to as 'TennCare.'

21. The term 'enrollee' or 'recipient' shall mean any present or future TennCare participant who has been found to be eligible for TennCare and who is under the age of 21 years. An authorized or legal representative of an 'enrollee' or 'recipient' has the right to act on behalf of that person under the provisions of this Order where such right would be available to the 'enrollee' or 'recipient' to the extent that defendants have been notified of such authorized representative status. While the state has currently elected, with approval of the Health Care Financing Administration (HCFA), to provide non-Medicaid children with the same services provided to Medicaid eligibles, the parties recognize that the state retains the authority, with HCFA approval, to treat non-Medicaid eligibles differently. See *Daniels v. TDH, et al.*, No. 793107-NA. (M.D. Tenn., Order entered 6/24/94).

22. The term 'managed care organization' (hereinafter 'MCO') means any person, institution, agency, or business concern that contracts with the State of Tennessee to provide medical assistance to TennCare enrollees. For purposes of this Consent Decree, it also includes Behavioral Health Organizations ('BHOs') which contract with the State of Tennessee to provide medical assistance to TennCare enrollees as part of TennCare.

23. The term 'EPSDT' refers to Early and Periodic Screening, Diagnosis and Treatment pursuant to 42 U.S.C. §§ 1396a(a)(43), and 1396d(a) and (r) and implementing regulations.

24. 'HCFA' refers to the Health Care Financing Administration of the U.S. Department of Health and Human Services which administers the Medicaid program and approved the TennCare Demonstration waiver. HCFA retains supervisory control over all aspects of TennCare.

25. 'Behavioral health' refers to mental health and substance abuse services.

#### **IV. FINDINGS**

26. The court finds jurisdiction under 28 U.S.C. §§ 1331 and 1343, which confer jurisdiction over the plaintiffs' federal law claims.

27. Upon independent review of the facts of this case and the standards for class certification set forth in the Federal Rules of Civil Procedure, the Court further finds that this case is appropriate for certification as a class action under Fed. R. Civ. P. 23(a) and (b)(2). to be maintained on behalf of a plaintiff class represented by the named plaintiffs. The plaintiff class, which shall be bound by the terms of this order, is defined as all present and future TennCare enrollees under the age of 21 years. One subclass is also certified. The subclass consists of plaintiff class-members who are in the custody of the Department of Children's Services, State of Tennessee, or who have been identified pursuant to Title 37, Tenn. Code Ann. as being at risk of coming into DCS custody.

28. Notice of the terms of this order shall be provided in the manner prescribed in Section V(J), below. The Court finds that such notice is sufficient to satisfy the requirements of Fed. R. Civ. P. Rule 23(d) and (c), and of Due Process.

29. The Court further finds, pursuant to Rule 23(e), that the substantive provisions of the agreed order adequately protect the interests of the plaintiff class. The timetable negotiated by the parties affords the state a period of more than five years within which to achieve full compliance with EPSDT and related laws. Settlement thus gives the state a grace period within which to achieve compliance, thereby countenancing partial noncompliance for five more years.

30. Nonetheless, present officials cannot correct problems overnight which have been years in the making. Their development of the remedial plan is itself evidence of their genuine commitment to reform. Class members will immediately begin to derive partial, and steadily increasing, benefits from the remedial plan, even before all of its terms are implemented. Given those benefits, and in light of the magnitude of the reforms which the state is obligating itself to achieve, the timetable does not appear unreasonable.

31. Special problems attend the coordination and delivery of care for children in DCS custody. These children often have challenging medical and behavioral health needs which would benefit from the coordination of services managed by three separate entities: an MCO, a BHO, and the Department of Children's Services ('DCS'). While other federal and state laws outside the instant consent decree require services for children, the EPSDT requirements related to coordination, which apply herein, are set forth in 42 C.F.R. § 441.61. To further complicate matters, placements often change as the child's needs change, and the child's custodial status as ward of the state is usually temporary. For children who remain TennCare eligible, treatment should be managed throughout such transitions to provide continuity of care.

32. The Partners Program, which restructured the delivery of behavioral health services under TennCare, began July 1, 1996. Establishment of the Department of Children's Services, which consolidated children's custodial services that had previously been fragmented among several different state agencies, became effective on the same day. The state has taken some steps to coordinate children's TennCare services among these agencies, and with the MCOs. But those new relationships are still under development, as are the policies and procedures needed to ensure appropriate care for the subclass children in DCS custody, or at risk of entering DCS custody.

33. The fact that state policy is still being developed poses special challenges for the drafting of an appropriate order in this case. On the one hand, authority for initiating and developing policy belongs to the state. Moreover, the plaintiffs and their representatives lack the information or resources to effectively evaluate policies, much less develop them on their own. On the other hand, present problems point up the need to afford immediate protection to children who plaintiffs allege are not now receiving the care to which the law entitles them, and who are liable to suffer serious, irreparable harm if such care is not provided. They cannot be asked to wait for additional months or years to know if the policies now under development by the defendants will someday adequately protect their rights.

34. The parties recognize that EPSDT services are provided in the context of a federal managed care Demonstration Waiver, an important consideration in designing policies which will ensure compliance with the requirements of federal law.

35. The parties have agreed, therefore, on the establishment of a remedial process which recognizes the primacy of the state's authority and responsibility, while giving the plaintiff class a means of evaluating and influencing state policies as they are developed. The proposed processes of contracting with a consultant to identify and make recommendations regarding problems with the systems which affect the delivery of mental and physical health care for children in DCS custody or at risk of going into DCS custody appears to be reasonably calculated to correct current deficiencies in the delivery of EPSDT services required under federal Medicaid law and laws incorporated herein.

## **V. ORDER**

THEREFORE, THE FOLLOWING PROSPECTIVE INJUNCTIVE RELIEF IS ADJUDGED, ORDERED AND DECREED based upon the foregoing premises and findings, and based on an independent review of the parties' proposed remedial provisions, which the Court finds adequately protects the members of the class and the subclass.

## **A. Definition of Legal Standard**

### **(1) EPSDT**

36. Federal law, 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), (r)(5) and regulations promulgated thereunder, 42 C.F.R. § 441, et seq., entitle some members of the plaintiff class to Early, Periodic, Screening, Diagnosis, and Treatment ('EPSDT') services. See 15, *infra*. The scope and nature of those services are elaborated upon in the federal State Medicaid Manual and policy transmittals issued by HCFA. See *Linton v. Commissioner*, 779 F. Supp. 925, 933 (M.D. Tenn. 1990); 65 F.3d 508 (6th Cir. 1995); cert denied \_\_\_ U.S. \_\_\_ (April 22, 1996). These relevant authorities include Part 5 of the HCFA State Medicaid Manual, § 5010, et seq. (hereinafter 'State Medicaid Manual'), and the HCFA transmittals and policy clarifications that are contained in Attachment 1 and incorporated herein by reference. The TennCare Demonstration waiver extended EPSDT services to non-Medicaid children.<sup>8</sup>

Under these authorities, Medicaid eligible class members are entitled to EPSDT services as follows:

- (a) periodic screening in accordance with professional standards,
- (b) diagnostic services, and
- (c) medically necessary treatment described in 42 U.S.C. § 1396d(a), see pp. 30-31, *infra*, which are listed in § V(C)(2)(a) herein.

37. The defendants shall ensure that the MCOs will timely provide all medically necessary care, diagnostic services, treatment and other measures covered by subsection (a) of 42 U.S.C. § 1396d, consistent with the standards in 42 C.F.R. 440.230 to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.' 42 U.S.C. § 1396(d)(r)(5); see State Medicaid Manual, § 5021, et seq.

### **(2) Other Authorities Pertaining to Children in DCS Custody**

38. Independently of the federal Medicaid rights which they share with other members of the plaintiff class, TennCare enrolled children in DCS custody enjoy the protection of other

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<sup>8</sup>See paragraph 17, *infra*.

federal authorities which require services to meet the child's needs. Specifically, children in DCS custody eligible to receive federal foster care maintenance payments are entitled to have their health and behavioral health needs identified and treated under the terms of the Adoption Assistance and Child Welfare Act, 42 U.S.C. § 671(a)(16), as defined by 42 U.S.C. § 675(1) and (5),<sup>9</sup>. Children in DCS custody are also entitled to health and behavioral health services which meet constitutional minimums established by the Due Process Clause of the Fourteenth Amendment, as set forth herein.

## **B. Ensuring Compliance with the Outreach and Screening Mandate**

### **(1) Outreach and Informing**

#### **(a) Outreach and Informing Requirements**

39. Within 180 days of entry of this decree, the state shall adopt any policies and procedures necessary to ensure that TennCare rules and guidelines clearly describe and allocate responsibility for, and require compliance with, each specific outreach and informing requirement under federal law, including, but not limited to, the following:

(a) "aggressively and effectively" informing enrollees of the existence of the EPSDT program, including the availability of specific EPSDT screening and treatment services (e.g. lead blood assessment, anticipatory guidance, immunizations, case management);

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<sup>9</sup>The parties acknowledge that although DCS follows the same planning process for most children, but see footnote I, *infra*, the requirements of 42 U.S.C. § 671(1)(16) and 675(1) and (5) are only triggered as to children eligible to receive foster care maintenance payments. See 15.



(b) "effectively informing individuals [and others, set forth in (e) below], in a timely manner, generally within 60 days" of the TennCare MCOs receipt of notification of the child's enrollment in its plan and "if no one eligible in the family has utilized EPSDT services, annually thereafter.... " State Medicaid Manual. § 5121(C):

(c) use of clear and non-technical terms to provide a combination of written and oral information so that the program is clearly and easily understandable, see Id.;

(d) use of effective methods (developed through collaboration with agencies who have established procedures for working with such individuals) to inform individuals who are illiterate, blind, deaf, or cannot understand English, about the availability of EPSDT services; see 42 C.F.R. § 441.56(a)(3);

(e) designing and conducting outreach to inform all eligible individuals and their biological or foster parents about what services are available under EPSDT. the benefits of preventive health care, where the services are available, and how to obtain them; and that necessary transportation and scheduling assistance is available; for children in institutions, this should include the administrator of the institution; see State Medicaid Manual § 5121(B), (C);

(f) creation of a system so that families can readily access an accurate list of names and phone numbers of contract providers who are currently accepting TennCare; see 42 C.F.R. § 441.61;

(g) offering both transportation and scheduling assistance prior to the due date of a child's periodic examination; see 42 C.F.R. § 441.56(a)(iv) and State Medicaid Manual at § 5121(b);

(h) providing recipients assistance in scheduling appointments and obtaining transportation prior to the date of each periodic examination as requested and necessary; Id.;

(i) documenting services declined by a parent or guardian or mature competent child, specifying the particular service declined so that outreach and education for other EPSDT services continues:

(j) maintaining records of the efforts taken to reach out to children who have missed screening appointments when scheduled or who have failed to schedule regular check-ups, which shall be available to defendants and plaintiffs' counsel;

(k) informing families of the costs, if any, of these services;

(l) establishing criteria for determining when an MCO may be required to target specific informing activities to particular 'at risk' groups, for example: mothers with babies to be added to assistance units, families with infants, or adolescents, first time eligibles, and those not using the program for over two years, who might benefit most from oral methods of informing; see the State Medicaid Manual, § 5121(a);

(m) providing information on covered services to adolescent prenatal patients who enter TennCare through presumptive eligibility; and offering them, on the day eligibility is determined, assistance in making a timely first prenatal care appointment for a woman past her first trimester; this appointment should occur within 15 days;

(n) treating a TennCare eligible woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth; see State Medicaid Manual, § 512 1(B);

(o) for institutions or homes with a number of eligible children, informing them annually, or more often when the need arises, including when a change of administrators, social workers or foster parents occurs. See State Medicaid Manual, § 5121(B); and

(p) for families of uninsured children who are enrolled in TennCare through county health departments, informing them regarding benefits covered under TennCare and the importance of accessing preventive services.

## **(b) Outreach Performance Standard**

40. The Defendants or their contractors shall achieve within 240 days and shall maintain thereafter. EPSDT outreach efforts designed to reach all members of the plaintiff class with information and materials which conform with Section V(B)(1)(a).

### **(2) Early and Periodic Screening**

#### **(a) Screening Requirements**

41. TennCare rules and guidelines shall clearly describe, allocate responsibility for, and require compliance with, each specific screening requirement under federal law, including but not limited to the following:

(a) establishment, after consultation with recognized medical and dental organizations involved in child health care, of distinct periodicity schedules for periodic screening, vision services, hearing services and dental services;

(b) provision of screening, vision, dental, and hearing services (including making arrangements for necessary follow-up, if all components of a screen cannot be completed in a single visit);

(c) requiring that a screening service include the following five elements: (1) comprehensive health and developmental history, which includes assessment of physical and mental health development; (2) a comprehensive unclothed physical exam; (3) appropriate immunizations according to age and health history; (4) laboratory tests (including at a minimum, lead blood level assessment appropriate to age and risk and other tests as indicated in the American Academy of Pediatrics 'Recommendations for Pediatric Health Care;' and for adolescents, the American Medical Association's 'Guidelines for Adolescent Preventive Screening,') and (5) health education, including anticipatory guidance;

(d) requiring that each child be assessed by reviewing dietary practices and height and weight;

(e) requiring that the comprehensive unclothed physical exam compare the child's physical growth against that considered normal for the child's age;

(f) requiring that the medical screen include appropriate childhood immunizations as recommended by the Center for Disease Control's Advisory Committee on Immunization Practices (currently EPSDT must cover diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, varicella zoster (for chicken pox) and hemophilus b conjugate (HIB) vaccines);

(g) requiring that the medical screen include laboratory tests consistent with HCFA minimum standards (HCFA currently requires at least the following, as medically appropriate: anemia test, sickle cell testing, and tuberculin test. In addition to the tests listed above, the child's age, sex and health history, clinical symptoms and exposure to disease can make additional tests necessary, such as urine screening, pinworm slides, urine cultures, serological tests, drug dependence screening, stool specimens for parasite and ova, blood and HIV screening);

(h) requiring that a child below the age of six shall be assessed for lead blood poisoning in accordance with current Center for Disease Control and/or American Academy of Pediatric recommendations.

Children who test high (consistent with Center for Disease Control measures) and children who are deemed to be 'high risk' as a result of the verbal risk assessment must receive follow up consistent with current Centers for Disease Control, and/or American Academy of Pediatrics recommendations:

(i) requiring that the medical screen include health education and anticipatory guidance, i.e., counseling to both parent and child to 'assist in understanding what to expect in terms of the child's development and to provide information about the benefits of healthy life style and practices as well as accident and disease prevention;' see State Medicaid Manual at § 5 123.2(E);

(j) requiring that vision and hearing screens shall be age appropriate and sufficient to diagnose defects in accordance with HCFA guidance;

(k) requiring that the child be referred to a dentist for preventive dental care and screening in accordance with the dental periodicity schedule;

(l) requiring that dental services shall be performed by or under the supervision of dentists;

(m) prohibiting MCOs from imposing prior authorization on periodic screens conducted by the primary care provider, and requiring MCOs to provide all medically necessary, TennCare covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the MCO or by an in-network provider;

(n) requiring that MCOs ensure that developmental screenings comply with any assessment protocols or procedures developed in accordance with this Decree, and that the following principles contained in § 5 123.2( . )(l)(h) of the State Medicaid Manual are reconsidered:

(i) Consideration of information on the child's usual functioning, reported by the child, teacher, parent, health professional, or other familiar person, subject to appropriate releases;

(ii) Review of such information in conjunction with the comprehensive health and developmental history and information gathered during the physical examination, in order to make a professional judgment whether a child's developmental processes are normal in relation to his or her age group and cultural background;

(iii) Use of culturally sensitive developmental assessments:

(iv) Avoidance of premature diagnosis labeling; and

(v) Referral to appropriate child development resources for additional assessment, diagnosis, treatment or follow-up should occur whenever concerns or questions remain after the screening process. See Section 51 23.2(A)( 1)(b).

42. With regard to interperiodic screens. TennCare rules and guidelines shall clearly describe and allocate responsibility for, and require compliance with, each specific requirement of federal law governing the provision for interperiodic screening, vision, hearing, dental and diagnostic services which are medically necessary to determine the existence of suspected physical or mental illnesses or conditions. See 42 U.S.C. § 1396d(r) (1)-(4); State Medicaid Manual, § 5040, et seq. The state's policies shall include the following provisions:

(a) a requirement that any encounter with a health professional practicing within the scope of his practice is a interperiodic screen and that any person (such as an educator, parent, or health professional) who suspects a problem may refer a child for an interperiodic screen; and

(b) a provision that an interperiodic screen does not have to include any screening elements required for a periodic screen. Any encounter with a Medicaid or non-Medicaid participating health care professional practicing within the scope of his or her practice is to be considered an interperiodic screen; and

(c) a provision, prohibiting MCOs from imposing prior authorization on interperiodic screens conducted by the primary care provider, and requiring MCOs to provide all medically necessary, covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the MCO or by an in-network provider.

43. The defendants shall ensure that their contractors' networks are adequate in terms of qualifications and training, as well as in numbers, to properly screen children in conformity with the requirements of the State Medicaid Manual, the Medicaid statute and regulations, and relevant policy directives from HCFA.

44. The state will take the following 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:

(a) establish a committee of EPSDT providers and MCO medical directors to develop and assist with implementation of a plan to assure that children in need of more in-

depth developmental/behavioral assessments and/or hearing assessments are identified through the periodic screening examinations;

(h) assure that developmental, behavioral, hearing and vision assessment experts are consulted and are active participants in the process described in (a) above, as their areas of expertise are addressed by the committee;

(c) facilitate the process of piloting the recommendations developed by the pediatric practices in 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

(f) adopt committee recommendations as components of TennCare EPSDT screening guidelines for providers. The parties recognize that the behavioral/developmental component of this process represents a substantial undertaking which will be subject to refinement and which will require up to approximately 18 months to accomplish. Thus, the state has flexibility under this consent agreement to modify this process in consultation with the plaintiffs, as necessary, to accomplish the goal of assuring identification of children in need of additional evaluation following the screening process. Development of guidelines to assure that children with possible hearing or vision impairment are referred for further evaluation will be completed within six months.

### **(b) Screening Performance Standards**

45. Within 120 days after this order is entered, a baseline percentage of screening compliance shall be determined. The defendants, in consultation with the plaintiffs, shall determine the percentage based on the best available data on recent screening levels.

46. A baseline periodic screening level will be calculated by the TennCare Bureau using HCFA 416 mathematical methodology and enrollment and encounter data to determine the number of periodic screens that should have occurred in the federal fiscal year ending September 30, 1996. 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 will be calculated using HCFA 416 methodology. This baseline periodic screening ratio will be multiplied by 100 to calculate the baseline periodic screening percentage. Subsequent periodic screening percentages will be calculated using methodology identical to that used in calculation of the baseline periodic screening percentage.

The TennCare Bureau will conduct an annual statistically valid medical record review of a sample of encounters coded as periodic screens to determine whether or not the following required components are documented:

- 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.

The proportion of these required components present in each record will be documented and an overall proportion calculated for the entire sample. The periodic screening percentage will be multiplied by this overall proportion to produce an adjusted periodic screening percentage (APSP).

The encounters included in each medical record review will be selected from the most recent encounter data available to the state at the time of sample selection. As a result, the sample encounters may represent 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.

In addition, utilizing a screening frequency standard of one screen per year per child for ages three through twenty, HCFA 416 methodology, and dental encounter codes specified by TennCare, the TennCare Bureau will calculate a baseline dental screening ratio for the period from October 1, 1995 through September 30, 1996. This baseline dental screening ratio will be multiplied by 100 to calculate the baseline dental screening percentage (DSP). Subsequent dental screening percentages will be

calculated using methodology identical to that used in calculation of the baseline dental screening percentage.

47. The TennCare Bureau shall require the MCOs to use the procedure and/or diagnosis codes specified herein above when reporting the EPSDT screens. The TennCare Bureau will provide education to MCOs concerning the requirement that the previously listed five screening components must be present in order to utilize these codes.

Following the annual medical record review, for each of the required seven screening components, the TennCare Bureau will report the percentage of periodic screening encounters which included documentation of that component. MCOs will be required to submit corrective action plans to address deficiencies in any of the seven required screening components which are identified during the medical record review process. Corrective action plans must be reviewed and approved by TennCare prior to implementation. TennCare will monitor implementation of such plans and may impose financial penalties for failure to follow through with implementation.

48. If the baseline APSP for the federal fiscal year ending on September 30, 1996 is less than 25, the APSP shall increase by no less than 30 percentage points during the federal fiscal year ending September 30, 1999. If the baseline APSP for the federal fiscal year ending on September 30, 1996 is more than 25, the APSP shall increase by no less than 20 percentage points during the federal fiscal year ending September 30, 1999.

If the baseline DSP for the federal fiscal year ending on September 30, 1996 is less than 20, the DSP shall increase by no less than 15 percentage points during the federal fiscal year ending on September 30, 1999. If the baseline DSP for the federal fiscal year ending on September 30, 1996 is more than 20, the DSP shall increase by no less than 10 percentage points during the federal fiscal year ending September 30, 1999.

The APSP and DSP for the federal fiscal year ending on September 30, 1999 will be calculated by TennCare and made available to the plaintiffs by April 30, 2000.

49. If the APSP is less than 55 for the year ending September 30, 1999, the APSP shall increase by no less than 20 percentage points during the year ending on September 30, 2000. If the APSP is more than 55 for the year ending September 30, 1999, the APSP shall increase by no less than 15 percentage points during the year ending September 3, 2000.



The DSP shall increase by no less than 10 percentage points in each year beginning with the year ending on September 30, 2000 through the year ending on September 30, 2002.

The APSP and DSP for the federal fiscal year ending on September 30, 2000 will be calculated by TennCare and made available to the plaintiffs by April 30, 2001. The DSP for the federal fiscal years ending on September 30, 2001 and September 30, 2002 will be calculated by TennCare and made available to the plaintiffs by April 30, 2002 and April 30, 2003, respectively.

50. For the period of October 1, 2000 through September 30, 2001, the APSP shall be no less than 80. The APSP for the federal fiscal year ending on September 30, 2001 will be calculated by TennCare and made available to the plaintiffs by April 30, 2002.

For the period of October 1, 2002 through September 30, 2003, the DSP shall be no less than 80. The DSP for the federal fiscal year ending on September 30, 2003 will be calculated by TennCare and made available to the plaintiffs by April 30, 2004.

51. The Defendants shall be presumed to be in compliance with their screening obligation under the law and the terms of this order in any year in which:

- (1) the above applicable standard has been met, or
- (2) all children who have not received complete screenings, consistent with this Order, have been the subject of outreach efforts reasonably calculated to ensure their participation.

In any year in which the Defendants fail to achieve the screening rates established in this Order, they may nonetheless demonstrate their compliance by a showing that the failure to achieve screening levels was due to factors beyond the control of the defendants or their agents.

52. The Defendants shall achieve complete screening of 100% of TennCare children in DCS custody within S months of the entry of this order, and shall maintain that level of screening thereafter. The tracking system developed by DCS shall be the system which shall be used to report compliance with this standard.

DCS shall maintain responsibility for the EPSDT screens for TennCare-enrolled children in the legal, but not physical, custody of DCS. Children who have been placed in a permanent setting, i.e., birth, adoptive, relative or other permanent home, but whose legal custody has not been transferred from DCS to said permanent custodian/guardian are defined as being in the legal, but not physical, custody of DCS.

For this group of children. DCS shall have the responsibility for informing the family about the child's EPSDT screening needs and providing reasonable assistance so as to empower the family to obtain said screens. Good cause for failure to screen a child in the legal, but not physical, custody of DCS can be demonstrated by a showing that the defendants and their contractors took all actions that could reasonably be expected to achieve compliance with regard to such child, and that failure to screen the child was a result of factors outside of the control of the defendants or their contractors.

## **C. Ensuring Compliance with the Diagnosis and Treatment Mandate**

### **(1) Diagnosis**

53. Within 120 days of the entry of this order, the defendants shall establish and maintain a process for reviewing the practices and procedures of the MCOs and DCS, and require such modifications of those practices and procedures as are necessary to ensure that children can be appropriately referred 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.

### **(2) Treatment - General Requirements**

#### **(a) Scope of Benefits**

54. Defendants shall ensure that, within their respective spheres of responsibility, TennCare, the MCOs and DCS provide children all medically necessary EPSDT services as listed in 42 U.S.C. § 1396d(a) and as defined in corresponding Medicaid regulations. Services which are required under EPSDT law, when medically necessary, are as follows:

- (a) Inpatient hospital services (other than services in an institution for mental diseases):
- (b) Outpatient hospital services: rural health clinic services: and services offered by a federally-qualified health center;
- (c) Other laboratory and x-ray services;
- (d) EPSDT services, and family planning services and supplies;
- (e) Physicians' services; medical and surgical services furnished by a dentist;

- (f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;
- (g) Home health care services;
- (h) Private duty nursing services:
- (i) Clinic services;
- (j) Dental services;
- (k) Physical therapy and related services;
- (l) Prescribed drugs, dentures, and prosthetic devices; eyeglasses;
- (m) Other diagnostic, screening, preventive, and rehabilitative services;
- (n) Services in an intermediate care facility for the mentally retarded (other than in an institution for mental diseases):
- (o) Inpatient psychiatric services for individuals under age 21;
- (p) Services furnished by a nurse-midwife;
- (q) Hospice care:
- (r) Case management services and TB-related services;
- (s) Respiratory care services;
- (t) Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner;
- (u) Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease; and
- (v) Any other medical care, and any other type of remedial care recognized under state law, specified by the Secretary of the United States Department of Health and Human Services.

In addition to the services identified in the above list, the TennCare waiver allows the use of cost-effective alternative services in certain situations. These cost-effective alternative services are identified as services which may or may not be included in the above list and which are medically appropriate and cost-effective when delivered in place of other services on the list which have been determined to be medically necessary for an individual enrollee. The parties recognize that there are many kinds of services which fit under the above list of covered services and that delivery of medically necessary services may involve different service delivery mechanisms.

(b) Medical Necessity

55. The defendants shall review MCO practices with regard to making decisions about medical necessity and identify any practices that are inconsistent with the federal laws cited herein. The defendants shall issue clarifications and ensure compliance with such federal law, regarding medically necessary treatment, including but not limited to, the following clarifications:

(a) That prior authorizations and medical determinations shall be made on a case-by-case basis for each service sought for a class member.

b) That services are provided if necessary to correct or ameliorate defects and physical and mental illnesses and conditions 42 U.S.C. § 1396d(r)(5).

(c) That the definition of medical necessity shall be applied so that services are covered if they correct, compensate for, improve, or prevent a condition from worsening, even if the condition cannot be prevented or cured.

(d) That medically necessary services shall 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.

(e) That defendants and their contractors and subcontractors are 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. (See Attachment 1)

56. The defendants will ensure that the MCOs and DCS use only the definition of 'medically necessary' in the TennCare MCO contracts when making medical necessity decisions. [See Attachment 2 for the current definition.] Nothing in this section shall be interpreted to limit an MCO's ability to use or establish mechanisms to apply the TennCare contractual medical necessity definitions or to direct patients to medically

appropriate, more cost effective alternatives, provided these services would adequately address the patient's medical needs.

57. The defendants and their contractors shall not impose the absolute amount limitations that were previously listed in the benefit plan, nor shall they impose duration and scope limitations or monetary caps upon EPSDT services. Rather, such services shall be required to be provided based upon each child's individual needs. This is not intended to limit the ability of a managed care organization to place 'tentative' limits on a service (e.g. prior authorization of 30 days of home health services). However, any such limits must be consistent with the 'preventive 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. Any denial of a timely request from the provider who originally prescribed an ongoing service for continuation of the service beyond tentative limits shall be attended by notice to the beneficiary prior to reduction or termination of the services; if the denial is appealed in a timely fashion, the services shall be continued pending appeal, without regard to the managed care contractor's tentative limits. See *Daniels v. Wadley*, No. 79-3107-NA-CV (M.D. Tenn.). A request from a provider for continuation of a service shall be considered timely if it is made prior to termination of the treatment interval previously approved by the MCO. The state or its contractor will review- the MCO prior approval/utilization review process on an annual basis to assure that tentative limits approved by the MCOs are appropriate.

58. The defendants and their contractors shall require that utilization review and prior authorization decisions be made only by qualified personnel with education, training, or experience in child and adolescent health. Within 120 days of the entry of this order, the defendants shall establish standards and procedures for monitoring their contractors' utilization review and prior authorization activities to ensure compliance with this requirement.

#### c) Prior Authorization

59. The MCOs shall provide all medically necessary, covered services regardless of whether or not the need for such services was identified by a provider whose services had received prior authorization from the MCO or by an in-network provider.

#### (d) Access to Treatment

60. Within 120 days of entry of this decree, TennCare shall develop a provider handbook to specify the responsibilities of MCOs and DCS related to provision of medically necessary services for children in DCS custody. This handbook should assist in delineating service duty responsibilities in the area where there is the most potential for overlap. Said provider handbook shall:

(i) Provide definitions, where federal law specifies them, for all covered services specified in 42 U.S.C. § 1396d(a);

(ii) Specify coverage of vision, hearing and dental services;

(iii) Allocate clear responsibility for provision of each service:

(iv) Provide general instructions for obtaining MCO approval for referral to out of plan providers performing EPSDT services:

(v) Require that MCOs demonstrate that their networks include providers with cultural and linguistic competency, or access to translators, as may be needed for the effective treatment of children from ethnic minorities: and

(vi) Require that each MCO have a sufficient array of services and specialists to meet the medical and behavioral health needs of class members, including durable medical equipment and medical supplies.

61. The defendants shall ensure that they or their contractors:

(i) Include in MCO contracts a requirement that provider agreements, after the next amendment process, inform providers of the package of benefits that EPSDT offers and require providers to make treatment decisions based upon children's individual medical and behavioral health needs;

(ii) Demonstrate within 180 days of entry of this Order, that provider networks currently comply with the 'Terms and Conditions for Access' (See Attachment 3) issued with the HCFA approved TennCare Demonstration Waiver, which ensures the availability of timely comprehensive primary, preventive, behavioral health, and inpatient and outpatient substance abuse services; and

(iii) Require MCOs to demonstrate beginning no later than 180 days after entry of this Order, that the reasonable promptness requirement of 42 U.S.C. § 1396a(a)(8) and the geographic comparability requirement of 42 U.S.C. § 1396a(a)(30)(A) are being met.<sup>10</sup> To be in compliance, the MCOs must meet the HCFA 'Terms and Conditions for Access', as may be amended by HCFA, for the class certified herein. The parties

recognize that the reasonable promptness standard requires provision of medically necessary services. This requirement does not guarantee a residential treatment program solely based upon beneficiary or provider preference unsupported by medical necessity.<sup>11</sup> Where a specific residential placement is recommended, and there is a waiting period for such placement, during the interim a MCO must

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<sup>10</sup> 42 U.S.C. § 1396a(a)(30)(A) provides that there must be '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. ...'

<sup>11</sup> Moreover, the TennCare Waiver waived the freedom of choice of provider provision contained in 42 U.S.C. § 1396a(a)(23). See Attachment 3 at paragraph 4.

provide the medically necessary TennCare services required, consistent with the above HCFA Terms and Conditions and may not simply place the child on a wait listing for the specific residential placement.<sup>12</sup>

62. Beginning no later than 180 days after the entry of this Order, the defendants shall require MCOs to provide each primary care provider participating in the EPSDT program an up-to-date list of specialists to whom referrals may be made for screens, laboratory tests, further diagnostic services and corrective treatment. This list shall be supplemented quarterly to indicate additions or deletions and shall comply with the access/availability standards of the 1115 waiver.

### (3) Treatment- Requirements for Specific Services

#### (a) Rehabilitation

63. Rehabilitation includes, unless otherwise provided under Subpart A of Part 440 of 42 C.F.R. ., 'any medical or remedial services recommended by a physician or other licensed 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 an recipient to the best possible functional level.' 42 C.F.R. §440.130(d); See 42 U.S.C. §1396d(13) . Rehabilitation services may, and where medically necessary to do so, shall, be delivered in conjunction with the services listed in paragraph 54.<sup>13</sup>

<sup>12</sup>The parties recognize that several issues which appear similar to those raised herein are not at issue in this lawsuit. Accordingly, this Consent Decree is not intended to address nursing home facilities, nor does it apply to services to be provided under the Home and Community Based Waiver, under 42 U.S.C. § 1915.

<sup>13</sup>In recognizing that medical necessity may require that rehabilitative services be provided in conjunction with other covered medical services, the parties do not intend to imply any 'right' to a particular location for delivery of services.



64. Covered services include maintenance services which prevent or mitigate the worsening of conditions or prevent the development of additional health problems. HCFA Program Issuance Transmittal Notice IV(Sept.1, 1992)(MCD-89-92). (See Attachment 1)

65. Within 130 days of entry of this Order, the state shall issue any necessary policy clarifications so that the defendants or their contractors understand their duty to provide EPSDT diagnosis and treatment services consistent with 42 U.S.C. § 1396d(r), quoted above. Thereafter, the defendants shall inform, in a timely manner and on an ongoing basis, all of their contractors about what federal Medicaid law requires with respect to specific screens, diagnoses and treatments.

(b) Case Management

66. Defendants and their contractor will provide case management services consistent with federal law by:

(i) assisting children for whom case management is medically necessary 'in gaining access to needed medical, social, education and other services;' [42 U.S.C. § 1396n(g)(2); see Letter from Christine Nye, HCFA Medicaid Director to Lourdes A. Rivera and Sara Rosenbaum, CDF (May 21, 1992) See Attachment 1].

(ii) The defendants shall ensure that the case management provided "center[s] on the process of collecting information on health needs of the child, making and following up on referrals as needed,...activating the examination/diagnosis/treatment 'loop'." Notifying recipients of the time they are due to receive a screening service "is an essential part of case management." State Medicaid Manual. § 5310; See Attachment 1.

67. The defendants have also exercised an option using federal Medicaid funds to provide targeted case management services for children in state custody or at risk of entering state custody as identified by a juvenile court pursuant to Title 37, Tenn. Code Ann. It is anticipated that these services will continue to be offered through DCS.

68. Medical case management services have been required under the state's contracts with MCOs since January 1, 1994. The defendants shall continue to require that these services be provided to all TennCare children for whom they are medically necessary, subject to relevant change in the TennCare waiver.

69. Mental health case management services for children whose behavioral health needs require these services have been required under the state's contracts with BHOs since July 1, 1996. The defendants will continue to require that these services be provided to all TennCare children for whom they are medically necessary, subject to relevant change in the TennCare waiver.

70. The defendants acknowledge that provision of case management activities is a central function of a managed care program. As such, case management activities are integrated throughout the operations of the MCOs. The particular case management activities conducted by an MCO will vary depending on the medical needs of the child, which is consistent with EPSDT regulations. However, the case management services must address the needs of the child and cannot be used exclusively as a tool for prior authorization. The state will continue to monitor MCO case management activities to assure they are consistent with federal law through, for example the EQRO surveys and other program monitoring activities. See also Section D, *infra*, related to coordination with other programs.

c) Behavioral Health Services

71. The defendants shall ensure that they and their contractors:

(i) Involve parents and family members, to the greatest extent possible, in the determination of behavioral health services to be delivered to a particular child;

(ii) Provide a comprehensive and appropriate scope of geographically accessible child and adolescent behavioral health services and in a range of treatment settings:

(iii) Provide for appropriate continuity of care and services following psychiatric or chemical dependency inpatient facility services or residential treatment as specified in a realistic discharge plan in which the patient and his family or other caregivers, clinicians, and social worker have participated. This discharge plan shall include, but not be limited to, an outpatient visit, which must be scheduled within clinically appropriate time period before discharge which assures access to proper physician/medication follow-up and other medically necessary services. Within 120 days of the entry of this Order the defendants shall enhance their current monitoring of contractors' adherence to this requirement in order to assure their compliance; and

(iv) Arrange for provision of all medically necessary behavioral health services for a child, without regard to whether he is designated as Severely Emotionally Disturbed (SED). However, the defendants may use the SED designation as a basis for focusing enhanced quality assurance and monitoring activities, in order to ensure EPSDT compliance with regard to this vulnerable population.

72. Within 30 days of the entry of this Order the defendants shall submit a notice of proposed rulemaking to withdraw state rules establishing lifetime dollar limits and absolute service limits on behavioral health services to children under 21.

73. Within 120 days of the entry of this order, the state or the state's contractor shall monitor a sample of children entering DCS custody and assess the adequacy of services provided to them by TennCare contractors prior to their entry into custody. The review will include an assessment of the effectiveness of the services provided to the child prior to the custody arrangement being made.

#### d) Non-Emergency Transportation

74. The defendants shall ensure that the MCOs meet their responsibilities to provide non-emergency transportation services under *Daniels v. Wadley*, No. 79-3107- NA-CV (M.D. Tenn.).

75. The defendants shall prohibit MCOs from imposing blanket restrictions or requirements on transportation to plaintiff class members because of their age or lack of parental accompaniment.

76. The defendants or their contractors shall provide non-emergency transportation in accordance with 42 U.S.C.β 1396d(a)(25); 42 CFR.ββ 440.170(a), 441.62: State Medicaid Manual, β 5150. Transportation assistance includes 'related travel expenses,' cost of meals and lodging in route to and from care and the cost of an attendant to accompany a child if necessary.

77. The defendants or its contractors shall develop and implement protocols and procedures by which MCOs will make referrals to TennCare transportation providers.

#### **D. Ensuring Compliance with the Mandate to Coordinate EPSDT Services with Other Programs Services**

78. The defendants shall coordinate EPSDT services with other children's health and education services and programs in accordance with State Medicaid Manual, β 5230. See Attachment 1.

79. Within 180 days, the state will provide to its contractors a statewide list of services available through state agencies for which EPSDT coordination is appropriate.

80. Within 240 days, the Defendants and their contractors shall coordinate EPSDT outreach, screening, and treatment services with services or programs on such statewide comprehensive list.

81. Within 180 days, the state shall require use of a process to provide information to MCOs when children have been identified as needing to receive medically related services in an educational setting, to facilitate MCO coordination of EPSDT services. The TennCare Bureau will notify the Local Education Agencies ("LEAs") that MCOs are responsible for requesting the individual educational plans ("IEPs") for children enrolled in each MCO. Such IEPs will be shared with the primary care physician ("PCP"). The state will develop a release form to provide to LEAs for parents to consider. MCOs shall accept the IEP indication of a medical problem or shall have the child appropriately tested. Coordination by the MCO should be calculated to reduce gaps and overlaps in services. The state's review of the adequacy of such coordination is guided by 42 C.F.R. § 441.61(c) which says that the agency:

must make appropriate use of state health agencies, state vocational rehabilitation agencies, and the Title V Grantees (Maternal and Child Health/Crippled Children's Services). Further, the agency should make use of other public health, mental health, and educational programs and related programs such as Head Start, Title XX (social services) programs, and the Special Supplemental Food Program for Women, Infants and Children ("WIC"), to ensure an effective child health program.

(Emphasis added).

82. Within 180 days, the defendants shall issue regulations and policy guidance to their contractors which incorporate strategies for ensuring coordination of EPSDT services among contractors, and with the other programs and services enumerated above.

83. The defendants will create and maintain a Commissioner's Task Force, establish dispute resolution and coordination processes and develop interagency agreements and referral agreements to facilitate the ongoing coordination and integration of EPSDT services administered by the managed care contractors and DCS.

## **E. Coordination and Delivery of Services for Children in DCS Custody**

Paragraphs 84-93 pertain to the Department of Children's Services.

### **(1) Title IV-E of the Social Security Act (the "Adoption Assistance and Child Welfare Act")**

84. The Department of Children's Services shall ensure that the case planning and case review required under the relevant portions of the Adoption Assistance and Child Welfare Act for TennCare children in DCS custody who are subject to such Act shall identify and provide for the treatment of the behavioral health and medical needs of these children in accordance with 42 U.S.C. § 671(a)(16) as defined in § 675(1) and (5), as set out herein:

(i) The instant order is meant to ensure only that adequate plans are made and implemented to address the behavioral health and medical needs of children in DCS custody;

(ii) The case plans and reviews dealing with these issues shall include, but not be limited to, information on medically necessary EPSDT screening and services that the state must provide for each child enrolled in TennCare; and

(iii) The parties specifically reserve the issue of whether case plans are adequate with regards to those services which do not address a child's medical or behavioral health needs.

## **(2) Due Process**

85. The parties also recognize that the state must comply with constitutional requirements established by the Due Process Clause of the Fourteenth Amendment to the United States Constitution, which includes the health and behavioral health treatment of children in non-criminal state custody. The parties recognize that the Sixth Circuit Court of Appeals in *Meador v. Cabinet for Human Resources*, 902 F.2d 474, 476 (6th Cir. 1990). cert. den. 498 U.S. 867 (1990). concluded that children in state-regulated foster homes have a substantive due process right to be free from infliction of unnecessary harm and are entitled to personal safety in such foster homes.<sup>14</sup>

86. When a person is civilly institutionalized, he or she has constitutionally protected liberty interests under the Due Process Clause to reasonably safe conditions of confinement,

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<sup>14</sup>But see footnote 5, *infra*.

freedom from unreasonable bodily restraints, and such minimally adequate training as reasonably might be required by those interests. *Youngberg v. Romeo*, 102 S.Ct. 2452, 457 U.S. 307, 73 L.Ed.2d 28 (1982).

87. This Consent decree adjudicates children's constitutional rights only with respect to adequate health and mental health treatment.

### **(3) Formulation of Coordination Plan**

88. Within 120 days, the service testing process, currently performed by the Tennessee Commission on Children and Youth, which assesses all services (medical, and non-medical) provided to children in DCS custody, shall include on an ongoing basis an audit of EPSDT compliance with regard to the children sampled. Such testing may be conducted by the state or a DCS contractor(s).

89. The defendants shall create an expert review process which will provide for evaluation of the defendants' EPSDT compliance plan to determine whether said plan is reasonably calculated to ensure compliance with EPSDT law, and relevant portions of laws contained herein, and to provide the required coordination of EPSDT with other non-medical services. The state shall select a contractor within 45 days who has appropriate expertise in the design, coordination and delivery of medical services to children in DCS custody, or at risk of coming into DCS.<sup>15</sup> It is anticipated that a contract will be executed within 100 days of entry of this Order. The Subcontractor will serve as a resource to both sides and, if need be. the Court. as Set forth herein.

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<sup>15</sup>While the parties have identified a mutually satisfactory contractor, they recognize that state contracting law must be complied with in effectuating closure of a state contract.

90. The evaluator/s are to become familiar with Tennessee's current arrangements and prospective plans for delivering EPSDT and related services to children in DCS custody, or at risk of coming into DCS' custody as defined in paragraph 6 herein. The evaluator('s') function is to assess those present or proposed arrangements in terms of their likelihood of producing, in a timely fashion, a system which can adequately meet children's needs for medically necessary care as defined herein. If the evaluators conclude that there are policy alternatives which would achieve compliance in a more timely or effective manner, they shall identify those alternatives and make appropriate recommendations regarding their implementation. While it is anticipated that the evaluator(s) will provide recommendations as to matters not required herein, only those specifics required by this Consent Decree shall be enforceable under this Consent Decree.

91. Upon request, the evaluators shall be afforded access to such records (including electronic data files) or persons as necessary to fulfill the responsibilities imposed by this order. Each party shall have access to information and materials obtained by the evaluators: however, except for information which originated with the parties' counsel, the evaluators may withhold the source of any information they have received. The evaluators may communicate ex parte with the parties, their agents or counsel; upon request, the evaluators shall disclose to the opposing party the general substance of such communications. The evaluators shall otherwise treat all records as confidential.

92. The evaluators shall report their initial findings in writing to both parties within 90 days of contract execution with the state. Such findings shall not contain identifying information regarding any TennCare enrollee. Within 60 days thereafter, the parties shall submit to the Court a proposed agreed order containing a specific remedial plan addressing the coordination and delivery of services under EPSDT law and laws contained herein for children in state custody. In the event the parties are unable to agree by the 60th day, the state shall thereafter file a proposed remedial plan within 30 days along with the evaluator's report. Plaintiffs may file any response in opposition with 30 days thereafter. The evaluators will review any subsequent substantial or material alterations to the plan, and to review the defendants' progress in implementing the plan. The evaluators shall provide semiannual written reports to the parties and to the Court regarding such reviews.

93. It is the parties' intent that the evaluator contract will be maintained to effectuate the requirements contained herein, including retention of the evaluator during the term of this consent decree, who, it is intended, will continue to be available as an evaluative resource until resolution is mutually agreed upon. In the event that the state or the plaintiffs challenge the continued effectiveness of the contractor, the parties shall meet to mutually agree upon modification to this process.

## **F. Monitoring and Enforcement of MCO and DCS Compliance**

### **(1) Individual Tracking**

94. Within 180 days, the Defendants shall require their contractors to achieve and maintain the capability of tracking each child in the plaintiff class, for purposes of monitoring that child's receipt of the required screening, diagnosis and treatment. The tracking system shall have the capacity of generating an immediate report on the child's EPSDT status, reflecting all encounters reported to the contractor more than 60 days prior to the date of the report.

95. Within 150 days, DCS shall achieve and maintain a tracking system as reflected above. The tracking system shall have the capacity to generate a report on the child's EPSDT screening status and shall reflect all screens received by the child more than 30 days prior to the report. DCS shall establish a procedure for notification of TennCare if a DCS case manager suspects that action or inaction by an MCO in performing its duties under the TennCare contract has caused a child to inappropriately enter DCS custody. TennCare shall receive such notification as part of its complaint processes and take whatever action is appropriate. DCS shall include this procedure as part of its departmental training.

### **(2) Systems Monitoring**

96. The defendants shall establish within 120 days an ongoing process for monitoring and reporting their compliance with the requirements of this order. That process shall include the elements set forth in paragraphs 97-103 below for monitoring the different aspects of the EPSDT obligation.

#### **(A) Screening**

97. The state shall compile, in a standardized electronic format capable of supporting flexible, customized analysis and reporting, data on all pertinent provider encounters which involve children, and which are covered by the TennCare program.

98. The state shall conduct ongoing audits for the purpose of authenticating such encounter data. In order to ensure the integrity of the audit reports, such audits shall be conducted by qualified personnel and shall meet generally accepted standards regarding sample size and selection.

#### **(B) Diagnosis and Treatment**



99. Within 60 days, the state will select a contractor who will be a qualified, independent person, persons or entity to conduct services testing on a sample of plaintiff class members, to determine whether they have received necessary diagnoses and medical/behavioral treatment in conformity with the requirements of this order. It is anticipated that this contract shall be executed within 120 days. Such testing shall include reviews of patient clinical records by personnel with appropriate clinical training. The testing shall also elicit from family members and other nonmedical sources, subject to obtaining proper releases, any important information which they might have, relating to the adequacy of the children's diagnoses and treatment. The contractor/s who perform such testing shall be mutually acceptable to both sets of parties. This testing shall cover a representative group of beneficiaries, selected according to generally accepted standards regarding sample size and selection; provided, however, that the parties may approve the over sampling of any subgroups of children (e.g., children with chronic illness) whom the parties mutually identify as requiring special attention. The medical record review of a sample of children receiving EPSDT periodic screens described in 46, *infra*. and the monitoring of a sample of children entering DCS custody described in 73, *infra*, may constitute a portion of this service's testing study.

100. The TennCare Bureau shall issue policy clarifications and interpretations as necessary to guide the MCOs and DCS in interpretation and application of the EPSDT mandate. The Bureau shall modify such policies from time-to-time as necessary to conform with TennCare Appeals Unit experience, and final administrative law and final judicial rulings pertaining to the TennCare program.

101. Within 120 days, the state shall conduct the first of semiannual reviews of appeals filed under the TennCare Program to determine whether deficiencies or repeated violations necessitate financial penalties upon managed care contractors which have inappropriately denied EPSDT services to children. The state shall financially penalize any managed care contractor as indicated.

102. Within 60 days of this Order, the External Quality Review Organization ('EQRO') or other contractor designated by the state shall perform review of provider contracts, to specifically determine any provisions which would encourage violations of the EPSDT mandate. The plaintiffs shall have access upon request to the slate to any provider contracts reviewed for compliance by the EQRO or other contractors designated for this purpose.

103. Within 60 days of identification, by the state or its contractor(s), of a contract provision which encourages violation of the EPSDT mandate, corrective action shall be taken.

## **G. Reporting and Plaintiff Access to Public Records**

### **(1) Semiannual Reports**

104. The defendants shall file semiannual reports with the court and plaintiffs' counsel regarding their compliance with the terms of this order. These reports shall be filed on July 31st and January 31st of each year. They shall contain information, validated by the applicable audit and testing procedures outlined herein, which accurately and fully reflects the status of the state's compliance with each of the applicable requirements of this order. References to numbers of beneficiaries shall be unduplicated.

### **(2) Plaintiff Access**

105. Upon 30 days prior notice to TennCare, plaintiffs' counsel shall have access during normal business hours to any public records relating to the state's compliance with the terms of this order, or to the monitoring, auditing or testing of such compliance. Subject to any applicable federal laws limiting the authority of a court to grant access to such records, plaintiffs' counsel shall have access to the records of members of the plaintiff class. All information related to plaintiff class members provided to plaintiffs' counsel shall be considered to be confidential and shall not be used for functions other than those directly related to compliance with this order. All such records shall be obtained, if necessary, and provided to plaintiffs' counsel through TennCare, rather than through individual MCOs.

### **(3) Meetings of Parties**

106. The parties will meet at least quarterly to monitor the progress of implementation of this decree, in order to identify and resolve obstacles to implementation at the earliest practical point. Any motion seeking further relief, either by modification or for enforcement of this order, shall be accompanied by a certificate of counsel attesting that a good faith effort has been made to resolve, through negotiation, the issues which are the subject of the motion, and shall describe such effort.

## **H. Attorney Fees**

107. Defendants shall pay all allowable costs, including plaintiffs' reasonable attorneys' fees pursuant to 42 U.S.C. ~ 1988. The parties shall make a good faith effort to resolve the questions regarding plaintiffs' attorneys' fees and other costs before submitting that issue to the court for resolution. Within 60 days of entry of this decree, plaintiffs' counsel shall submit itemizations of fees and expenses to

defendants' counsel. If the parties cannot reach a resolution and agreement, plaintiffs' counsel shall file affidavits and itemizations of attorneys' fees expenses to the court within 60 days of providing such itemizations with defendants' counsel. Defendants shall file objections to the fees request within 60 days of plaintiffs filing the affidavits and itemizations- These time periods may be extended by the court for good cause shown.

## **I. Reservation of Rights**

108. With respect to the non-Medicaid provisions of federal law cited herein, this order adjudicates the parties' rights and responsibilities only to the extent that such laws affect the delivery of health services (including behavioral health services) to members of the plaintiff class. The parties do not intend this case to govern any other aspect of the implementation of such laws.

109. This Order is not meant to adjudicate any claims under the Americans with Disabilities Act and regulations (42 U.S.C. §§ 12131-12334; 28 C.F.R. §41.51) which class members may have if their physical or behavioral health needs are addressed in a segregated setting.

110. As to the members of the plaintiff class, the systemic remedy established in this order shall not deprive an individual of rights afforded by the laws cited herein. Specifically, the fact that the defendants are in compliance with the overall requirements and timetables adopted in the decree shall not relieve them of their obligations to individual class members, nor abrogate the rights of any individual class member to the full range of health and behavioral health services guaranteed to him by law. This Consent Order shall not affect the right of any individual class member to seek any and all relief that is otherwise available through administrative review proceedings authorized by state and federal law, or through proceedings against the State before the Tennessee Claims Commission based upon alleged actions or omissions of the defendants. The parties acknowledge the State may assert any and all defenses available in any such administrative, Claims Commission or other litigation. It is the intent of the parties that any individual cases, now under jurisdiction of state courts, remain in such courts. and that the remedies provided under this consent are limited to cases presenting class-wide civil rights violations under 42 U.S.C. § 1983 rather than adjudications of individual claims. It is not intended by the parties that individual class members may seek the remedy of contempt in absence of demonstration of significant violations under this order. It is the intent of the parties that, recognizing the enormity of the responsibilities under this order, the parties will attempt to informally resolve disputes, including individual disputes when the individual cases are parties represented by plaintiff's counsel.

111. This Decree is intended to adjudicate with respect to the plaintiff class and its individual members those claims for class-wide equitable relief which were made on their behalf in the complaint, and to thus bar separate proceedings against these defendants by class members seeking the same relief under 42 U.S.C. § 1983. However, in the event that it appears that the plaintiff class is threatened with irreparable harm, the plaintiffs may apply for a modification of this order as necessary to prevent such harm, so long as such modification remains consistent with federal law, the intent of this consent decree, and the applicable standards for modification of a consent decree. Either party may seek modification of this order as permitted by existing law.

112. The parties recognize that HCFA has the authority to grant future waivers of specific requirements of the Medicaid Act, and to interpret existing Medicaid requirements, and its exercise of such authority governs the TennCare Demonstration Project.

#### **J. Notice to Class Members**

113. The defendants shall notify the members of the plaintiff class, or their parents/guardians, of this order by including in the next quarterly newsletter of each MCO the attached article which describes in general terms the EPSDT rights which are the subject of this settlement, and refers the reader to the toll free TennCare Hot Line for further information if desired. See Attachment 4. The defendants shall ensure that personnel who staff the TennCare Hot Line, as well as MCO personnel who staff their patient service phone lines, are sufficiently familiar with the terms of this order to be able to answer questions of a general nature. A more detailed description of the settlement, written in simple terms, shall be offered to those who contact the Hot Line or the MCOs to request further information.

114. The defendants, with the assistance of organizations which advocate on behalf of TennCare beneficiaries with disabilities, shall use reasonable alternative methods to afford notice of this settlement to class members who, due to their disabilities, are unable to benefit from the notice procedures outlined in the preceding paragraph.

115. Defendant shall notify all future class members of EPSDT services by attaching information in newly approved TennCare eligibles' notice of eligibility.

#### **K. Expiration**

113. This Consent Decree shall expire upon proof that Defendants have reached an Adjusted Periodic Screening Percentage ('APSP') and a Dental Screening Percentage

(DSP) of 80% and are in current, substantial compliance with the requirements herein.

ENTER this 11th day of March, 1998.

DISTRICT JUDGE

APPROVED FOR ENTRY:

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ATTACHMENT I

Medicaid Regional Memorandum No. 93-139 to all Title XIX State Medicaid Agencies (December 17, 1993);

Medicaid Regional Memorandum Na 92-80 to all Title XIX State Medicaid Agencies (August 10, 1992);

Letter from Christine Nye, Director, HCFA, Medicaid Bureau, to Deborah A. Randall ( );

Letter from Robert J. Taylor. Associate Regional Administrator, Division of Medicaid. to Sherry Knowlton (December 9, 1992);

HCFA Program Issuance Transmittal Notice IV (Sept. 1, 1992) (MCD-89-92);

HCFA Region III Letter No. 07-91 (April 3, 1991);

Region IV Transmittal Notice (MCD-1 11-91) (Oct. 29, 1991):

Dallas Regional Medical Services Letter No. 91-37 (May 15, 1991):

Region VII Medicaid State Bulletin No. 204;

Letter from Christine Nye, Director, HCFA. Medicaid Bureau, to Sara Rosenbaum. Children's Defense Fund (April 10, 1991);

Title XIX State agency Letter No. 91-33 (Region X) (April 30, 1991);

Title XIX State Agency Letter Number 92-12 (Region X) (Dec. 10, 1991);

HCFA Medicaid State Bulletin- 231 (Sept. 10, 1992);

HCFA, Letter to Region VIII (Oct. 2, 1991):

HCFA, Missouri OBRA 1989 EPSDT Implementation Review (July 5, 1991);

Medicaid State Operations letter #93-09 (DMD:MOB:5) (Feb. 18, 1993);

HCFA Medicaid Review Report HCFA Region LX Review of California's

Administration of its Managed Care Program (FY 1993);

Letter from Christine Nye, HCFA Medicaid Director, to Lourdes A. Rivera and Sara Rosenbaum. CDF (May 21, 1992);

Chicago Regional State Letter No: 75-91 (Region V) (November 1991);

Letter from Christine Nye, HCFA Medicaid Director, to Regional Administration Regional III(FME-42) (Oct. 8, 1991);

Region IV Transmittal Notice (MCD-62-91, June 13, 1991);

Memorandum from Christine Nye, HCFA Medicaid Director, to Regional Administrator Region VIII (FME-42) (1991);

HCFA Regional Medicaid Letter No. 13-90 (Region III) (Aug. 3, 1990); and

Letter from Rozann Abato, Acting Director Medicaid Bureau, to All State Medicaid Directors (Aug. 2, 1990).