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The State of EPSDT and Behavioral Healthcare for Children Served by Tenncare

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The purpose of this paper is to provide insight into the current state of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate as it relates to the supply of mental health services to children enrolled or eligible in Tennessee's Bureau of TennCare state health organization. The central concern is whether or not EPSDT in Tennessee is effective in screening and providing treatment for the health needs and specifically the behavioral health needs of eligible children in Tennessee. Information will be presented which reviews the functionality of EPSDT and characteristics of the population served by EPSDT.

Background

In 1994 Tennessee withdrew from the fee-for-service state healthcare plan known as Medicaid, and implemented a managed care health plan named TennCare. TennCare is currently comprised of eight MCOs (managed care organizations) and two BHOs (behavioral health organizations) which are Tennessee Behavioral Health and Premier Behavioral Systems of Tennessee. The behavioral health component of TennCare is known as TennCare Partners. People who are eligible for TennCare services may choose which MCO to use according to their region of residence. If mental health or substance abuse services are needed, the enrollee uses the BHO that corresponds and works with their chosen MCO. Enrollees whose income places them above the poverty level pay premiums, deductibles, and co-payments based upon the degree to which their income exceeds the poverty level. As of February 26, 2001, the Bureau of TennCare had 1,369,645 statewide enrollees. Enrollment can be classified into two categories, people who are Medicaid eligible and people who are categorized as uninsured or uninsurable (www.state.tn.us/tenncare).

An especially important aspect of any healthcare plan is the way it cares for children, especially those whose parents cannot afford or do not have the knowledge to procure adequate medical intervention for their children. A plan of action for insuring children's medical care can be most effective at a national level. It is for this reason that the United States Congress in 1967 included legislation within the federal Medicaid statute requiring state Medicaid programs to provide a certain minimum level of health service to Medicaid eligible persons under the age of 21. This part of the Medicaid statute dealing with children's health is known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (TJC Reference Manual 1). The intended purpose of the EPSDT program is to make sure that Medicaid-eligible children receive regular screenings in the areas of physical, developmental, and behavioral health. The primary function of these screenings is to identify symptoms and intervene with appropriate preventive or remedial treatment before they manifest into problems that become serious or even catastrophic. Thus EPSDT's main emphasis is on preventative healthcare (Bureau of TennCare: Overview... 1-3). Not only can this benefit the children who are served by the program it can also benefit the state and its citizenry who fund and implement the program. When health problems are addressed early considerable savings in the cost of care for those problems is realized as opposed to a worsened condition later in time. It is generally recognized that good physical and mental health begins in childhood. When childhood problems are cared for during childhood, it is an investment that pays off in the future mental and physical heath of an individual. As this individual becomes a contributing member of society, positive externalities benefiting society can be seen to exist as a result of the sustained good health of this individual.

Over the passage of time it was apparent that states were not implementing the EPSDT

program as was intended in the 1967 Medicaid statute. By 1988, less than 1/3 of eligible children were receiving the screenings that they were due. As a result, congress updated EPSDT by making some changes to it in the Omnibus Budget Reconciliation Acts of 1989 and 1993. These changes made more parts of EPSDT mandatory and codified many of the existing regulations within EPSDT. Another effect of these changes was to require states to implement aggressive information outreach programs to inform those persons potentially eligible for the health benefits that the state provides (TJC Reference Manual 1). Also, section 1905(r)(a) of the Social Security Act says that services provided under Medicaid to treat or ameliorate a physical or mental illness, defect, or condition must be given to EPSDT enrollees whether or not it is covered by the state's own Medicaid program (Bureau of TennCare: Overview... 1-3). All of the regulations concerning EPSDT apply to the Bureau of TennCare due to the fact that TennCare took the place of the state Medicaid program in terms of a state health organization.

EPSDT in Detail

EPSDT screenings are also known as well-child check-ups. These screenings are the foundation of the EPSDT program, and they should be performed at set intervals in accordance with guidelines set forth by the American Academy of Pediatrics. It is recommended that the screenings occur at the following intervals: birth, 2-4 days, at the first, second, fourth, sixth, ninth, twelfth, fifteenth, eighteenth, and twenty-fourth month, and yearly thereafter to age twenty-one (Early Child Health Outreach). A study recently published in the Journal of Pediatrics found that when a child consistently visits with a regular doctor that the child will be 60% less likely to visit an emergency room and 54% less likely to be

hospitalized. From analyzing 46,000 patients, the researchers based at the University of Washington concluded that it is very important for children to have regular contact with the same health provider (Christakis et al.). According to the federal statute, the state is required to "provide or arrange for" [42 U.S.C. §1396a(a)(43)] medical, vision, hearing, and dental screenings. The medical screens consist of several different components.

The first component is a comprehensive history that assesses the development of physical and mental health. This assessment serves to identify whether a child's developmental progression is in check with what is normal for the child's age and cultural background. For young children, a physician's job may be to evaluate such factors as motor development, communication skills, cognitive skills, and emotional development. Evaluations for older children should include visual-motor and visual spatial skills, attention skills, visual and auditory memory skills, peer relations, learning disabilities, and psychological problems. The Health Care Financing Administration (HCFA) provides federal oversight regarding the nation's healthcare. In the *State Medicaid Manual* they identify certain actions that screeners should take. The provider must look at information gathered during the screen. The provider should try to obtain information by speaking with people who are familiar with the child such as the child's parents or teachers. The provider should take cultural issues into consideration when evaluating the child. Lastly, the provider should guard against any premature labeling of a suspected condition (TJC Reference Manual 4).

The second component of the medical screen is a comprehensive unclothed physical exam. The purpose of this component is to compare the child's growth against what is considered normal for their age. There is an examination of all organ systems and an assessment is made of the child's overall appearance. The third component of the medical

screen makes sure that the child receives proper immunizations according to the guidelines recommended by the American Academy of Pediatrics.

A diagnostic fourth component to the medical screen is a laboratory test sequence. According to the *State Medicaid Manual* the state should identify certain minimum laboratory tests that must be performed. These should include tests for anemia, sickle cell, tuberculin infection, blood lead level, cholesterol, and metabolic function. Certain factors specific to the child such as health history or clinical symptoms can also make other tests necessary. For example, an especially important concern facing poorer children, especially in cities, is lead poisoning. It is for this reason that Congress has placed in the Medicaid Act a mandate for lead blood level testing when it is appropriate to do so given age and risk assessment (TJC Reference Manual 5).

A fifth component to the medical screen is health education. Health education is any type of information provided to the parent or guardian concerning health, hygiene, nutrition, safety, and normative behaviors relevant to the child's developmental level. (TJC Reference Manual 6) (Tennessee Voices for Children: Fact Sheet)

Another key part of EPSDT is treatment. When problems are identified through screenings, the state is under obligation to arrange treatments either directly or through referral. According to federal statute, EPSDT covers "necessary diagnostic and treatment services to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screen." [42 U.S.C. §1396d(r)(5)] Many times this is limited to what the state deems to be a medically necessary service (TJC Reference Manual 7).

Whereas EPSDT's main purpose is to provide for regular screenings as mentioned above, EPSDT also provides for interperiodic screens to be covered. Interperiodic screens

occur when someone in contact with the child feels that he or she has a symptom indicating a condition that might require further care. They then can request to bring the child in for a check-up to specifically address identified symptoms (Bureau of TennCare: Overview... 3). This can apply to physical as well as mental health concerns.

The Health Care Financing Administration (HCFA) lists specifically the required activities of the state. It must inform all medically eligible persons under the age of 21 that these EPSDT services are available. Specific periodic schedules must be identified and implemented for screening dental, vision, and hearing needs. The state must also report its EPSDT performance annually to HCFA including the number of children provided health screening services, the number of children referred for corrective treatment, the number of children receiving dental services, and the states performance as compared to the goals it set for that given period (HCFA website).

Behavioral Health Concerns

The mental health assessment component of EPSDT seems to have a greater degree of difficulty in being applied effectively as opposed to other components of EPSDT. The importance of having behavioral health screening and treatment, however, cannot be argued. Children who are enrolled in TennCare tend to be from lower socioeconomic levels of society, and therefore are at a greater risk for developing mental health problems (Costello). Many providers and organizations indicate that they are uncertain as to which screening methods they should use, and many primary care physicians do not feel that they have been adequately trained in conducting mental health evaluations. If the adequate training was present, there would still be limitations in time due to the fact that the average health check

screening lasts around six to thirteen minutes (TJC Reference Manual 4-5). Sometimes there may be a lack of information on the part of the parent or guardian as well as a lack of awareness in regard to availability and importance of the services offered. Another concern is that the people responsible for making the system work within the structure of the organizations may not have sufficient knowledge and the level of connectivity to make things run smoothly and effectively. The Bureau of TennCare holds the ultimate responsibility for the amelioration of problems and deficiencies in the EPSDT system.

The EPSDT Consent Decree (*John B. v. Menke*)

In early 1998 a lawsuit was brought against the Tennessee state government officials responsible for the administration of TennCare and the Department of Children's Services on behalf of all individuals under the age of 21 who were enrolled or would be enrolled as beneficiaries of TennCare. As stated in the introduction, "This case challenges the adequacy of children's health services provided by TennCare and the Tennessee Department of Children's Services". At the time of this litigation, the Bureau of TennCare was comprised of 1.2 million enrollees, 500,000 of which were children. In the background to the case it mentions federal EPSDT requirements in state Medicaid programs. It also mentions that EPSDT is included as part of the agreement in the state's TennCare contracts with MCOs (Consent Decree 2).

The complaint was filled on behalf of TennCare children as a group by the Tennessee Justice Center whose prosecuting attorneys were Gordon Bonnyman and Michele Johnson. The complaint alleged that TennCare failed to fulfill its EPSDT obligations in several ways. It charged TennCare with having systematic failures to screen children with respect to adequate

periodicity schedules, to properly diagnose the medical needs of the children, and to provide the full range of health services that the children required. Another concern of the plaintiffs was the specific healthcare situation of children in state custody under the Department of Children Services (DCS). It was alleged that the general problems of EPSDT within the TennCare system were worsened by poor coordination between MCOs, BHOs, and state custodial agencies. They claimed that not only did these problems violate the EPSDT mandate requirements, but that the problems also violated state and federal laws concerning children in DCS custody.

The defendants disputed the allegations made by the plaintiffs, however they did not dispute that certain enhancements needed to be made to fully comply with federal law requirements. Rather than continuing costly and time-consuming legal defense in this case, the State decided that it would develop a more effective use of its resources to identify and correct problems. As a result, the responsible state officials negotiated with the plaintiffs over several months to develop a plan that would remove any deficiencies and maintain compliance between TennCare and EPSDT. The resulting plan from these negotiations is known as the Consent Decree for Medicaid-Based Early and Periodic Screening, Diagnosis, and Treatment. Both parties determined that the state would have five years with which to reach full compliance with EPSDT regulations.

The court gave the state specific policies and procedures on which to focus. With regard to outreach and public information, the state has a responsibility to aggressively and effectively inform enrollees of EPSDT. The state must also inform parents and guardians about the MCO's acceptance of the child's enrollment in the plan, and explain the program in a non-technical manner through a mixture of oral and written information. Regarding those

individuals who are blind, deaf, illiterate, or cannot speak English, the state has an obligation to effectively inform them of EPSDT as well. The state should conduct outreach to inform eligible individuals and their parents of the services available within EPSDT, why the services are important, where to obtain the services, and even that transportation and scheduling assistance is available. Also, the family must be informed if there are any costs to these services. It was recommended a system be set up to provide families with current names and phone numbers of contract providers accepting TennCare. If needed, the state is required to offer assistance in scheduling appointments and arranging transportation before the date of the periodic examination. When a parent, guardian, or competent enrollee refuses services, the state must record the non-acceptance of service. Records must be maintained detailing the steps taken to reach out to children who have missed screening appointments. Outreach and public information requirements also include considering an eligible woman's request for prenatal services through EPSDT as a request for services for the child at birth. The Consent Decree then goes on to spell out the specific federal guidelines that the state should adhere to regarding regular and interperiodic screens. A few specific steps are identified for the state to follow in order for each periodic screen to accurately identify children that might need further assessment in the areas of behavioral, developmental, hearing, or vision health (Consent Decree 10-11).

As part of the agreement with the Consent Decree, the parties involved determined methods for obtaining screening performance standards and what their improvement should look like. A major part of the Decree deals with evaluating current screening levels and setting screening compliance percentage levels as long-range goals. The long range goal established in the Consent Decree for screening compliance was a level of 80% overall

compliance by September 30, 2001 (Consent Decree 16-17).

The Consent Decree also goes in to detail regarding behavioral health service requirements. Primarily the state is to involve parents and family members as much as possible, and to provide the range of services that the population requires. Also highlighted is a need to insure ample follow up procedures after the initial treatment, to provide equal behavioral healthcare services to those children not listed as severely emotionally disturbed, and to facilitate clear identification of service limits. The report then goes on to discuss more monitoring and compliance issues and special concerns for children in DCS custody (Consent Decree 22-23).

EPSDT Progress Report Pursuant to the Consent Decree

In late July of 1998, the state defendants filed a follow up progress report with the plaintiffs and the court regarding the Consent Decree. The content of this follow-up report detailed the Bureau of TennCare's progress in correcting many of the problems identified and carrying out the court orders issued in the Consent Decree. The overview highlighted some improvements that had been made. The progress report section indicated for each topic which organizations were responsible for which changes. It also noted what was currently being done and what was planned for the future. The overview section mentioned that a study conducted in the Nashville area earlier in the year found that 97% of children eligible for EPSDT services had visited a doctor in the past year. It found that 69% of these children had received a checkup in the past year. The study also said that just 4% percent of TennCare children reported an untreated health problem. In accordance with the Consent Decree, however, the overall screening compliance was calculated for the progress report and found to

be at 21.9%. This is in sharp contrast to the mutually established long-term goal of 80%. Many of the court directives were being addressed by amending the TennCare Standard Operating Procedure (TSOP). The TennCare Quality Improvement Unit analyzed several focus areas. One of their conclusions was that problems in regard to geographical access existed within child and adolescent BHO provider networks. The progress report also stated that there was an agreement reached with the Vanderbilt Institute for Public Policy Studies to collect and monitor information on service adequacy (Bureau of TennCare: Progress...).

Recent Developments with the Consent Decree

On April 7, 2001, the Tennessee Justice Center (the prosecuting organization in the Consent Decree) sent an e-mail out to individuals and agencies on its distribution who work with EPSDT in Tennessee. The correspondence was sent in order to develop updated information relative to the EPSDT Consent Decree, also known as the John B. case. On June 18, 2001, the U.S. District Court under Judge John T. Nixon will be making a decision as to whether or not the state is in contempt of court regarding the John B. case. The e-mail from the Tennessee Justice Center alleges that the state and its contractors have "violated every provision" of the Consent Decree "including simple things like meeting with plaintiffs counsel." In addition, it cites that since the case was settled that the screening rates have actually dropped below 20%, and that many children continue to be denied treatment. The Tennessee Justice Center is requesting in their e-mail information on children that have been harmed by "lack of treatment services for health or behavioral health services" from the people who have contact with children in the system. The letter then goes on to list examples of possible violations. Four example violations that pertain to mental health are (1) children

who are denied behavioral health services because there is not a continuum of care within the BHO network (2) Children with physical or behavioral issues who do not have case management and for whom it is medically necessary, (3) children discharged form inpatient psychiatric hospitals without appropriate aftercare, and (4) children denied services because the HMO or BHO say they just never cover a particular service (Johnson e-mail).

The IMPACT Study

A study very relevant to TennCare children's behavioral healthcare issues known as the IMPACT study looked at the status of behavioral health, health, service use, and consumer satisfaction among TennCare children and adolescents. The IMPACT study is a strong illustration of the need for effective mental health coordination through EPSDT. This study was carried out under the direction of Dr. Craig Anne Heflinger of the Center for Mental Health Policy at Vanderbilt University's Institute for Public Policy Studies. The focus of the study was specifically on behavioral health services in TennCare. Funding for the research came from the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. The IMPACT study is part of a national study evaluating the effect of managed care on vulnerable populations; two of which populations are children with serious emotional disorders and adolescents with substance abuse problems.

Using random sampling, the research team selected children and adolescents to be used as the basis for this report. In the baseline interview, about 500 cases of TennCare children were analyzed. The analysis was divided into three parts. The first part was a standardized interview with the parents or designated most knowledgeable caregiver. The would also be an interview session with the child provided that the child was over age 11.

These interviews occurred at two or three points in time over the course of a year separated by a time of approximately six months. The second part of the analysis was done more in-depth with a smaller group of subjects. For a subsample of children the standardized interview was enhanced by professional interviews related to treatment and a record review to give a more complete picture of the child's experiences in the past six months. The third part of the analysis compiled administrative data for children on a statewide level and for the subsample of children that had participated in the in-depth interview (Heflinger et al. 1-4).

From the TennCare children interviewed, the IMPACT study derived a weighted sample of the total TennCare population. It was found that 26% of the representative population met the federal criteria for having a serious emotional disorder (SED). This means that it is likely that there are over 80,000 TennCare children in Tennessee between the ages of 4 to 17 who meet the criteria for having a serious emotional disorder (Heflinger et al. 15-16). This statistic alone stresses the importance of having well coordinated behavioral health services through the EPSDT program in conjunction with TennCare. Out of this representative TennCare total several other statistics were isolated. Of the representative interview sample, 39% of the children scored in the impaired range of psychosocial functioning. About half of the caregivers of SED children reported that their children had ever received any type of formal mental health diagnosis. Less than half of the caregivers whose children had been given a mental health diagnosis in the past were aware that their child had any sort of mental health diagnosis. The study found that children with SED were consistently rated with a poorer health status that children without SED. The respondents were also questioned about limitations to activity as a result of health problems. Children with SED were much more likely to report activity limitations due to health problems. Around 46% of

SED children had co-occurring chronic illnesses. Among these children in Tennessee, there is a clear and convincing need for helpful mental and physical health services regardless of whether or not any causal relationship exists between SED and illness. Further findings in the impact study even show that SED children are more likely to require involvement with law enforcement than non-SED children (Heflinger et al. 15-31).

Regarding the use of behavioral services, the IMPACT study found that 55% of children with serious emotional disorders had not received any type of health service within the past six months from when the study was carried out. The four most common problems with obtaining the behavioral service needed were inconvenient locations, lack of money, transportation problems, and refusal of payment by TennCare. Among the children with SED who were being seen for treatment, two-thirds of their parents (caregivers) reportedly felt that the children were being helped by the behavioral health treatment they were receiving (Heflinger et al. 65-75).

To follow up on this study's input to this particular writing, Dr. Heflinger was contacted via e-mail and asked for any additional input that she would care to provide concerning children's behavioral health issues, TennCare, or EPSDT. Specifically, she was asked two main questions. One question dealt with her opinion of compliance levels among health providers when the illness was related more to mental health than physical health. It was written as follows:

> EPSDT screenings are probably more likely to detect physical health problems than mental health problems, and managed care organizations are probably more likely to cover treatment related to physical health problems. Do you feel that TennCare, BHO's and MCO's do a good job of complying with EPSDT in behavioral health areas or does there seem to be a difference between coverage and treatment of physical health needs and behavioral health

needs?

Dr. Heflinger's answer:

> No, the TCB [TennCare Bureau], BHOs, and MCOs are not doing a good job complying. Providers are not well trained, screening tools are not in place, and procedures for referral once potential problems are identified are not in place. The physical health side is a little better coordinated since it is all within the MCOs and referrals don't have to cross to the BHOs, where lots of problems occur. But on the physical health side, getting parents to bring their kids in for screens and doctors to do even the physical health screens is a problem – do you know what the current screening rate is? I think it's still in the 20% range although by federal statute and the Consent Decree TN is supposed to be up in the 85% range.

Another question dealt with her opinion of the state's ability to change and improve its existing services to children. It was written as follows:

> The May 2000 impact study appeared to find that problems with TennCare or TennCare enrollees (such as the amount of children with SED) were only slightly higher than the average from other states. Do you think that we are near our potential capacity and efficiency in Tennessee regarding children's behavioral health services, or are there some major problems and things that could be changed?

Dr. Heflinger's response:

> We have dropped our capacity for serving children significantly since 1996 when the TennCare Partners program started – we appear to only be serving about 1/3 as many children as pre-partners. So yes, there are some major changes that need to be made.
>
> Are you aware of the EPSDT consent decree and all the reports from that? (My DCS report was done for that lawsuit)

Children's Advocacy Convention

One way to improve the system of TennCare for children is to increase the level of communication among those persons who work with children in Tennessee. One way to do this is through holding conventions where specific issues can be addressed and discussed. In order to gain a better understanding of topics contained in this report, the author attended a children's advocacy convention organized by the Tennessee Commission on Children and Youth in Nashville on March 13, 2001. This convention hosted a variety of speakers who spoke on issues of children's health and well being in Tennessee. Dr.Gerald Hickson, Chief of the Vanderbilt Hospital Pediatric Department, provided the keynote address for the day. While he did touch on some of the problems that TennCare has in supporting children, the main emphasis of his speech was the need to call attention to some of the positive aspects of TennCare. He noted that among children with chronic conditions in Tennessee the problem of gaps in treatment provision has decreased significantly. He also highlighted six needs within the system. The first is a need for a vision statement within the system of care that can bring focus to collective efforts. The second is that there needs to be constant dialogue between the patients, physicians, healthcare coordinators, and healthcare management. The third need mentioned was the imperative that all these organizations function together in service provision. It is important that all the parties involved work with and not against each other. The need for accountability was the fourth point mentioned. In many situations a coherent and adequate level of accountability is not present, resulting in breakdowns within the healthcare system for children. Related to accountability was the need according to Dr. Hickson for tracking systems to identify provision of care and its quality assessment. Sixteen empirical

studies have been done on TennCare, and our methods of tracking outcome among those served though its processes are reportedly weak. As a result, we are left with a limited knowledge of the effective aspects as well as the weak aspects of the system. Lastly, Dr. Hickson mentioned the need to speak of the positive impact TennCare has made instead of only focusing on shortcomings.

Following Dr. Hickson's address, Dr. Fredia Wadley, commissioner of the Tennessee Department of Health, spoke about children's health issues in Tennessee. Dr. Wadley felt that there are three main areas of children's health provision that are showing weaknesses in the current system. The first is in making sure children are born healthy. The rate of low birth weight in Tennessee has stayed fairly constant and has not shown any improvement over the past few years. This is important because low birth weight is a predictor of mental health problems in addition to physical health and learning problems. A study done 25 years ago in West Tennessee showed that the problem with low birth weights among Medicaid qualified mothers was significantly decreased when the proper medical attention and education was given to them during pregnancy. The second area Dr. Wadley stressed was keeping children as healthy as possible as they are growing which includes bettering the rates of immunization among children. Improving the quality of mental health services for children was the third area of focus. This is an area of need in which early intervention and identification can make a serious difference in later outcomes. To improve statewide mental health services, Dr. Wadley highlighted the need for a sufficient number of mental health treatment providers along with knowledgeable and willing support from caregivers within the school, home, and other environments within which the child leads his or her daily life.

Children in state custody often do not have the necessary supportive environment available to their non-custody peers. Additional speakers were Mary Beth Franklyn, Director of Health Care Advocacy, and Lisa Faehl, Director of Contact Services for the Department of Children's Services. They discussed health care for children in state custody and EPSDT issues concerning these children. They explained that for children in the custody of the DCS it is very critical that EPSDT be put into action. The first thing that should happen when a child is enrolled in DCS custody is that they should receive a comprehensive screening. From this point, referrals should be made for appropriate services. As of November 1, 2000, about thirty percent of children in DCS custody had not received a screening, although it is known that BHO services, community and residential, often keeps individuals out of DCS custody. Many times it is difficult for DCS and non-DCS children to get psychological exams. According to Ms. Faehl, the use of appeals to obtain needed psychological services is crucial. Citing a child's EPSDT rights when filing appeals to the Bureau of TennCare can often bring about orders from the Bureau that successfully facilitate access to those psychological services.

The next speaker, Commissioner Elisabeth Rukeyser of the Department of Mental Health and Developmental Disabilities, also spoke of the need for mental health prevention. Ms. Rukeyser felt that there was considerable work that needed to be done to improve mental health prevention services. She mentioned one statistic from a report released under Surgeon General David Satcher finding that of the one in ten children needing mental health services only twenty percent of those children were actually receiving treatment.

Overall, when children's mental health was spoken of during the convention, emphasis was placed on the preventive care approach to mental health. EPSDT, as it was planned, has a role in this preventive process. Considering the financial difficulty TennCare is reportedly

experiencing, preventive care in mental health and in other healthcare areas may be the key to forming both a goal effective and cost effective process for serving the populations in need.

E-mail Correspondence

Based on the attendee list from the Tennessee Commission on Children and Youth in Nashville, e-mail correspondence regarding children's behavioral health, TennCare, and EPSDT was sent to a sampling of people who might have opinions on these issues based upon their line of work. The e-mail was a form letter in which the name of the person and their organization could be inserted. An example is as follows:

Name Here,

Hello, I am a senior at the University of Tennessee in Knoxville. For my senior thesis project through the UT Honors Program I am looking at the way TennCare and Early and Periodic Screening, Diagnosis, and Testing (EPSDT) work together to provide mental and behavioral health services to children under the age of 21 who fall under the EPSDT mandate and are eligible for TennCare.

I recently attended the TCCY advocacy convention in Nashville and noticed on the attendee list that you work with ****. I'm not sure how much **** and you specifically work with behavioral health services for children, EPSDT, and TennCare, but I wanted to e-mail you and ask for any input or experiences on these issues that you wouldn't mind sharing with me. I realize that your time is probably very limited, and I would appreciate any input that you could provide at your convenience. (if this is outside your field of work, I apologize, and please disregard this e-mail)

A few specific questions (if needed)...

- What is your opinion of the effectiveness of EPSDT related to mental and behavioral healthcare?

- What changes need to be made to the TennCare system and/or EPSDT that would better serve the mental health needs of children and adolescents eligible for TennCare?

- How would you rate the awareness of EPSDT and behavioral health services by your colleagues and providers in the system?

- Are there any problems with EPSDT's effectiveness in screening for behavioral health needs and providing treatment for those needs?

Thank you for you time and input,

Lee Goan

P.S. If you know of anyone who might be interested in talking about their experiences regarding EPSDT and TennCare please send this to them. Thanks!

Thirty-four questionnaires were sent. There were thirteen responses, and several e-mails were returned due to faulty addresses. Responses varied from not having any familiarity with the subject to having opinions in response to the issues raised in the questionnaire. Several replies contained the same theme of opinion. The view was that TennCare and EPSDT intend to improve the quality of physical and mental healthcare for eligible children yet do not reach the level of care intended due to several reasons. The two main reasons are noted as being inadequate funding and a general lack of awareness of the programs. Here is an excerpt from one response highlighting these issues from someone that works with a children's advocacy organization:

> ...My personal opinion of TennCare, based on the experiences of other families is this. TennCare has a very extensive and well-intentioned plan for children. Most providers and advocates are aware of EPSDT, while many families have no idea what their rights or benefits should be. EPSDT includes mental health and dental care. Most private insurance companies don't. TennCare is under funded and most doctors have been so burned by TennCare

> experiences that finding a doctor who will accept what TennCare considers appropriate and timely payment is becoming nearly impossible. Patients are experiencing about a 3-month wait for and between services. This is not adequate. The ideal situation for a special needs child is to have private insurance and supplemental TennCare. In this situation I have learned that the majority of medical providers will simply waive the difference after they have been paid insurance by TennCare. With average hospital stays of 10 – 20 thousand dollars occurring about twice a year for a child with major mental illness, the cost to families who have only private insurance can be devastating to the family's economic stability. Making TennCare available as a supplement to any child with a major disability (use SSI standards) would be a great improvement...

A reply from someone who works within a state organization dealing with children and TennCare echoes the problem of funding and reimbursement:

> ...the biggest problem with this issue and TennCare revolves around the fact that a QUALITY EPSD&T takes time and should always include a mental health screening. Because of the reimbursement being so low per capita, the physicians are very reluctant to do these. They cannot meet overhead costs in many cases. I would suggest that ALL PCP's [primary care providers] accept TennCare – but only require 10 – 15% of their clients to be TennCare patients. That spreads the responsibility among the many and would create a more uniform system, allowing other physicians to take on more if they like. Also, it would allow them to meet overhead expenses, if they have a small practice or lots of staff. It has to be a user-friendly system FOR EVERYONE! The doctors don't need to take the fall, nor do the MCO's...

Most Recent Developments in EPSDT and TennCare

On Thursday April 19, 2001 the Tennessee Department of Health announced that

EPSDT responsibilities would be shifting back to the health departments much like during the time period before the TennCare program was instituted. This came following an action earlier this year by the Tennessee Academy of Pediatrics. The Academy standardized EPSDT physical forms so each physical completed for EPSDT would be consistent among all participating physicians. In return for instituting these forms, the Academy of Pediatrics requested that TennCare provide a higher level of reimbursement per physical. TennCare agreed under the condition that the doctors would agree to contract with all of the available TennCare plans in their region.

At the same time, letters have been sent out to families of TennCare giving them the opportunity to change their TennCare Managed Care Organization. Included in each mailing is information about EPSDT intended as information outreach for those persons in accordance with the EPSDT Consent Decree. Within the information it indicates that one of the functions of EPSDT is to screen for and treat mental health problems. It also emphasizes the importance of bringing the child in for regular checkups and that the parent or guardian should contact a doctor or nurse anytime it appears that the child might have a problem. The update also notes that EPSDT checkups are free (TennCare Update). As of May 1, 2001, certain high-risk children have been chose for a new MCO called TennCare Select. These high-risk populations have been identified as children on Supplemental Security Income (SSI) which is a disability benefit program administered by the Social Security Administration and children in state custody. The goal of the TennCare Select plan is to improve access to service for children who have chronic behavioral and health issues. The state will carry a greater amount of the financial risk for this MCO. To date, the full operating procedures for TennCare Select have not been worked out. The start date for TennCare Select is July 1, 2001, but due to the

plan's incomplete status many doctors may be reluctant to contract with it. This may result in families with high-risk children refusing to accept TennCare Select assignment (BlueCross).

Conclusions

It is apparent from the information presented that there are deficits in Tennessee's compliance with EPSDT and that this affects behavioral health intervention access for children on TennCare. Since the evaluative process inherent in the screening regimen is vital to reaching those with needs, EPSDT coverage should be increased. In addition, more attention should be given to including an adequate mental health screen along with the extensive physical screenings. The current overall EPSDT screening rate has fallen below 20%. One can only speculate as to the adequacy of those evaluations within that 20% especially in regard to identifying behavioral health needs. The idea of the Tennessee Academy of Pediatrics in creating standardized forms could by its requirement of consistency also be laying the groundwork for improved mental health evaluations in identifying problems. If the Bureau of TennCare and its providers created and promoted standardized behavioral health screening techniques for primary care physicians to implement for EPSDT, there could be a more effective system of behavioral health screening and prevention.

As was noted during the youth advocacy convention mentioned above, the appeal process in TennCare can be very helpful in getting needed treatment that has been denied. Appeals are especially effective in situations where behavioral health services have been denied. Another constructive feature of appeals is that they inform the Bureau of TennCare of existing problems. The public information aspect of TennCare and EPSDT needs to enlighten users and providers on how and when to file appeals for denied services.

Perhaps the inclusion of public health departments in providing EPSDT screening may help to provide better coverage, community education, and patient advocacy services. This may help to reduce some of the present problems related to EPSDT non-compliance on the part of community primary care providers contracted with TennCare managed care organizations. Given the scope of difficulties in Tennessee it is unlikely that such a change will be a complete fix for the problems with EPSDT. Even with the new policy, any recommendations for further testing, treatment, or specialty care would be referred back to the primary care provider within the MCO. Behavioral health care would still be obtained by a physician referral or by caregivers contacting the BHO directly when there is a mental health concern.

Clearly one of the biggest problems for the TennCare system that holds back EPSDT from attaining its full effectiveness is the lack of money. As echoed in the responses above, inadequate reimbursements for physicians continue to be a barrier in attaining cooperation from providers. It is important to note, however, that the main thrust of EPSDT is a preventive one. This means that in the long run costs for the state are reduced because more problems are identified and treated earlier. Improving the EPSDT system would take an increase in funding, but it would be a long-term investment that would improve the financial future of TennCare by means of reduced future expenditures. Even more importantly, it would improve the future of long-term health in Tennessee's children.

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