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# An Overview of Legal Developments in Managed Care Caselaw and Selected Case Studies of Legal Developments in State Contracting for Managed Behavioral Health Services

Sara J. Rosenbaum  
*George Washington University*

D. Richard Mauery  
*George Washington University*

Joel B. Teitelbaum  
*George Washington University*

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## BEHAVIORAL HEALTH ISSUE BRIEF SERIES

### Issue Brief #14

# An Overview of Legal Developments in Managed Care Caselaw and Selected Case Studies of Legal Developments in State Contracting for Managed Behavioral Health Services

Prepared for the Substance Abuse and Mental Health Services Administration,  
U.S. Department of Health and Human Services<sup>1</sup>

Sara Rosenbaum, JD  
D. Richard Mauery, MPH  
Joel Teitelbaum, JD, LLM  
The George Washington University Center for Health Services Research and Policy

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## *I. An Overview of Legal Developments in Managed Care Caselaw*

### Introduction

This analysis provides an overview of recent legal developments in managed care case law. Three types of cases are reviewed: claims brought by managed care enrollees against managed care companies and health plans; cases related either directly or indirectly to managed care and brought by both beneficiaries and managed care organizations against state Medicaid agencies and other public agencies engaged in the purchase of managed care; and cases brought by individual health professionals against managed care organizations.

As used in this analysis, the term managed care is meant to denote any health coverage arrangement in which a single entity contracts to both provide third party coverage to members and deliver covered services to members through a network of providers selected and controlled by the entity.<sup>2</sup> Managed care has become the central means by which privately insured workers and their families are covered and receive care. Approximately half of all Medicaid beneficiaries, including a

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<sup>1</sup> The U.S. Department of Health and Human Services has reviewed and approved policy-related information within this document, but has not verified the accuracy of data or analysis presented within this document. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS), or the Department of Health and Human Services.

<sup>2</sup> Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, Law and the American Health Care System (Foundation Press, NY, NY, 1997; 2000-2001 supplement). Ch. 2J.

significant proportion of non-institutionalized non-elderly beneficiaries with disabilities, are required to enroll in some form of managed care as a condition of coverage. Finally, approximately 6 million Medicare beneficiaries were enrolled voluntarily in Medicare managed care plans as of 1999.

Not surprisingly perhaps, as managed care has become a dominant form of health care and health coverage, litigation against managed care companies and (in some cases) public and private managed care group sponsors has grown. The case law is evolving rapidly, as courts apply longstanding common law (i.e., judge-made law) liability principles to HMOs and other managed care companies. Just as HMOs are hybrid entities, the liability theories that courts apply span both medical liability theory (i.e., malpractice and medical negligence) and theories related to the insurance aspects of MCO conduct (i.e., negligence in the administration of such traditional insurance functions as utilization management and coverage determination procedures). As will be discussed below, whether an MCO faces liability under these various theories can turn on whether the group health plan sponsor is a private employer covered by the Employee Retirement Income Security Act (ERISA) or a public agency or non-ERISA-covered employer (such as a state or local government).

All cases discussed in this overview are summarized in accompanying Tables 1-3 in the Appendix. Interestingly, many of the leading cases in the field involve some aspect of behavioral health care. This fact is probably not surprising, since managed care appears to have had a particularly dramatic effect on both access to behavioral health care and the amount of care that individuals receive.<sup>3</sup> The particularly strong effect of managed care on the consumption of behavioral health services may have given rise to greater levels of litigation on the part of both plans and providers. In addition, evidence from around the country suggests that the establishment and operation of publicly funded behavioral health systems has been comparatively contentious, with complaints from patients and advocacy organizations regarding the elimination of services and with protests by losing bidders against the awarding of contracts.<sup>4</sup>

## **Claims Brought Against Managed Care Organizations By Members and Patients: Leading Cases**

Table 1 sets forth the principal theories and leading recent cases involving claims against managed care organizations. Claims can vary by group sponsor; thus, for example, individuals enrolled in a Medicaid managed care arrangement may have special legal rights that differ in certain respects from persons enrolled through an ERISA-covered employer-sponsored plan. Indeed, one company that does business with an array of group sponsors (private employers, public employers, Medicare, Medicaid) may face different types of liability depending on a particular patient's sponsor.<sup>5</sup>

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<sup>3</sup> Surgeon General's Report on Mental Health (HHS, Washington D.C., 2000).

<sup>4</sup> A synopsis of Medicaid behavioral health care legal developments appears in Section II of this issue brief.

<sup>5</sup> Since 1997 Congress has debated legislation to regulate the managed care industry. This legislation is commonly referred to as the "Patients' Bill of Rights." See, e.g., H.R. 2990, Bipartisan Consensus Managed Care Improvement Act of 1999; S. 1344, Patients Bill of Rights Plus Act. While these measures, if enacted, would make federal regulation of managed care more uniform, they would by no means eliminate differences by sponsorship because of underlying differences in underlying Federal laws that authorize or fund the provision of managed care. For example, ERISA imposes almost no content requirements on employer-sponsored health plans. Medicare and Medicaid, on the other hand, entitle beneficiaries to defined benefits, to be furnished in accordance with Federal requirements. As a result,

However, although plan sponsorship can affect the legal claims available to plan members, certain types of claims against managed care organizations appear to apply regardless of plan sponsorship.

Taken together, the cases appear to support the following conclusions:

- Where liability for professional medical negligence is concerned, depending on the law of a state, an MCO can face medical liability for its own professional negligence or that of its network providers. Furthermore, medical liability can exist without regard to plan sponsor (i.e., regardless of whether membership in the MCO was purchased by Medicare, Medicaid, or an ERISA-covered employer). The concept of professional liability applies to the managed care industry as a whole in its *health care* capacity. It represents an extension of the same corporate and vicarious liability legal theories that have been held to apply to hospitals since the mid-1960s.<sup>6</sup> Courts have consistently held, as Table 1 illustrates, that Federal law does not displace longstanding principles of professional liability law. The law of health care quality continues to be governed by state common law and statutory law.
- Under concepts of professional liability, an MCO can be considered *vicariously* liable under state medical liability law for the negligence of its network physicians, if their negligence is proven and if the company is shown to have an actual or ostensible agency relationship with the provider.<sup>7</sup>
- Similarly, an MCO can be held corporately (i.e., directly) liable under state common law or statutory law for engaging in substandard professional practices that bring the provision of covered services below professional standards. Thus, if a company operates its health care programs in accordance with substandard professional guidelines and the guidelines are shown to be a proximate cause of a member's injury or death, the company may be directly liable for the harm produced.<sup>8</sup> Similarly, if an MCO fails to maintain a network with a sufficient supply of physicians or fails to oversee the practices of its physician network, it may be liable for death or injury, just as a hospital would be liable for failing to police its medical staff.<sup>9</sup>
- Medical liability for the use of professionally substandard practice guidelines, either to guide the provision of covered services or to compensate health professionals, may be among the most important emerging medical liability case law, because most MCOs today make extensive use of guidelines. To the extent that guidelines used by MCOs are not evidence-based and reliable and, even if so, are applied in cases in which they are not relevant (e.g., because the individual circumstances of a patient's case warrant a different approach to treatment), an MCO may face professional liability, depending on the state in which the case is brought.
- The fact that enrollment in an MCO is sponsored by an ERISA-covered employer or Medicare does not insulate an MCO and its providers from either corporate or vicarious professional liability. Numerous ERISA cases, and a growing number of Medicare cases, hold that injury claims related to professional medical practice and medical quality fall outside of the scope of Medicare or ERISA preemption.

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Medicare and Medicaid managed care products operate within unique legal frameworks that are not applicable to employer-sponsored or privately purchased products.

<sup>6</sup> *Law and the American Health Care System*, op. cit., Ch. 3.

<sup>7</sup> Table 1: *Boyd v Albert Einstein Medical Center*, *Shannon v McNulty*, *Petrovitch v Share Health Plan*.

<sup>8</sup> Table 1, *Moscovitch v Danbury Hospital*; *In re U.S. Healthcare*; *Lazorka v Penn Hospital*.

<sup>9</sup> Table 1, *Jones v Chicago HMO*.

- While ERISA and Medicare do not preempt injury claims under state law arising from professional negligence, the cases on Table 1 indicate that they do have a preemptive impact on injury claims based on state laws applicable to insurance administration and practices. For example, state law may make insurers liable for bad faith breach of contract, fraud, maladministration of insurance utilization management systems, and other negligent practices related to policy administration.<sup>10</sup> However, where a claim is against a managed care company for negligence in how it administers an ERISA plan or a Medicare-sponsored health plan, Federal law preempts (i.e., precludes the individual) from recovering under state law.<sup>11</sup>
- *Pegram v Herdrich* (Table 1) appears to draw a critical distinction between cases in which the injury is related to an act involving the exercise of medical judgement by plan physicians and those in which the injury claim is predicated on negligent benefits administration not involving medical judgement. This distinction is just beginning to emerge in the law.<sup>12</sup> If the distinction set forth in *Pegram* is followed by the lower courts accurately (and a recent decision by the Court of Appeals for the Third Circuit indicates that courts may begin to take this approach),<sup>13</sup> then the range of cases still covered by state medical liability law will grow, with all medical judgement cases – regardless of whether they focus on coverage or quality of care – subject to available state law remedies for the negligent exercise of professional medical judgement. A more narrow reading of the *Pegram* case would preserve the quality/quantity distinction first drawn in the *Dukes* case. Under this distinction, cases in which the complaint focuses on the quality of care actually received would be governed by state medical liability law, while ERISA and Medicare would continue to provide an exclusive remedy (i.e., preempting state common law and statutory remedies) for injuries flowing from the denial of coverage for care.
- Cases brought by plan members against MCOs under the Americans with Disabilities Act (ADA), to date, involve three types of claims. The first is that the MCO as a health provider is a public accommodation and has a duty to serve individuals in a non-discriminatory manner.<sup>14</sup> This may be a particularly powerful claim given the fact that MCOs under their contracts agree to actually furnish health care (not merely cover it) to members. Thus, an MCO cannot simply refuse to serve a member with physical or mental disabilities; it must make reasonable accommodations.<sup>15</sup> A second category of claims involves incentive arrangements that discriminate against persons with disabilities and providers who treat persons with disabilities.<sup>16</sup> The third involves challenges to contractual, across-the-board coverage limitations that pertain to a specific disability (e.g., limitations on otherwise covered services in the case of persons with HIV/AIDS or ARC). The leading case in this area places the *design and content* of health insurance (i.e., substantive coverage limits that apply to all enrollees) beyond the reach of the

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<sup>10</sup> Table 1, *McEvoy v Group Health Cooperative of Eau Claire*, *Wickline v State of California*, *Woblers v Bartgis*.

<sup>11</sup> Table 1 *Pegram v Herdrich*; *Ardary v Aetna Health Plan*.

<sup>12</sup> Table 1, *Pegram v Herdrich*.

<sup>13</sup> Table 1, *Lazorka v Penn Hospital*.

<sup>14</sup> Table 1, *Woolfolk v Duncan*.

<sup>15</sup> There are as yet no federal guidelines from the Office for Civil Rights as to what the reasonable accommodation duty under the ADA would require. See Rosenbaum and Teitelbaum, SAMHSA Issue Briefs 5 and 6: “The Americans With Disabilities Act: Implications for Managed Care for Persons with Mental Illness and Addiction Disorders.”

<sup>16</sup> Table 1, *Zamora-Quesada v Humana Health Plan*.

ADA, while simultaneously making clear that were an insurer to treat a person with a disability differently from others with respect to *covered* services, the ADA would offer protection.<sup>17</sup>

- Certain laws create additional rights against managed care plans. While ERISA preempts certain injury actions against MCOs, an MCO can be found liable for breach of fiduciary duty for failure to disclose its physician incentive plans.<sup>18</sup> Furthermore, an individual can recover benefits from his or her plan if he or she can demonstrate that the plan’s decision to withhold covered care in a particular case was arbitrary and capricious (i.e., not grounded in evidence).<sup>19</sup> However, when the plan’s denial is based on coverage limits built directly into a plan contract, a court has no authority to override the plan. To the extent that companies build practice guidelines directly into their agreements with purchasers, they may be able to avoid liability for denials of care, since the only covered services are those set forth in the guidelines. At the same time, the medical liability cases suggest that MCOs may risk medical liability for substandard care if their guidelines are negligently applied or professionally substandard.

## Cases Brought Against State Medicaid and Other Public Agencies

Table 2 sets forth cases brought against state Medicaid agencies and resulting from either their own alleged violation of law or violations committed by their managed care contractors. Table 2 also shows cases against Medicaid agencies and other public agencies brought by MCOs. Taken together, the cases suggest the following:

- Courts see MCOs as agents of state agencies and their actions as “state action” for purposes of Federal civil rights protections. Thus, when a Medicaid MCO contractor fails to follow Federally prescribed, timely and adequate notice and pre-termination hearing requirements, a state Medicaid agency is liable for violations of Federal law, including both statutory requirements and constitutional law.<sup>20</sup>
- Current and prospective MCOs have Constitutional as well as Federal and state statutory and regulatory rights against state Medicaid agencies, mental health authorities, and other public agencies. Thus, where a state agency fails to follow Federal procurement regulations, it may face liability under Federal law.<sup>21</sup> Similarly, an agency may be liable under state law for failure to

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<sup>17</sup> Table 1, *Doe v Mutual of Omaha*.

<sup>18</sup> Table 1, *Shea v Esensten*.

<sup>19</sup> Table 1, *Bedrick v Travelers Insurance*.

<sup>20</sup> Table 2, *J.K. v Dillenberg; Perry v Chen; Rodriguez v Chen; Daniels v Wadley*. A similar result was reached under federal Medicare law in *Grijalva v Shalala*, 152 F. 3d 1115 (9<sup>th</sup> Cir, 1998) (vacated and remanded, 119 S.Ct. 1573 (1999)). However, the *Grijalva* opinion was vacated and remanded for further consideration in light of the Supreme Court’s decision in *American Manufacturers Mutual v Sullivan*, 119 S.Ct. 977 (1999), a case involving state action in a workers’ compensation law—and thus private insurance—context. Because the Secretary of the U.S. Department of Health and Human Services and the plaintiffs subsequently settled the case, there is as yet no definitive Supreme Court decision regarding whether state action exists in the case of managed care contractors working for state and Federal public agencies pursuant to Federal laws governing the purchase and administration of managed care. However, the *Sullivan* decision may raise questions for future courts considering the issue of state action in the context of publicly purchased insurance.

<sup>21</sup> Table 2, *Value Behavioral Health v Ohio Department of Mental Health*.

follow its own state procurement practices.<sup>22</sup> Finally, a state Medicaid agency may violate Federal due process rights of its MCOs by summarily terminating their contracts without advance notice and the opportunity for a hearing on alleged violations.<sup>23</sup>

- Courts are willing to hold states accountable to beneficiaries for the substandard health care access performance of their managed care contractors, at least in those cases in which a state has acknowledged its obligations pursuant to a consent decree to oversee contractor performance.<sup>24</sup>

## Cases Brought Against Managed Care Organizations by Health Professionals

Table 3 sets forth cases brought against managed care organizations by health professionals. These cases suggest the following:

- Courts will save from ERISA preemption status “any willing provider” or “anti-discrimination” statutes that require health insurers to include in their networks licensed health professionals willing to adhere to a company’s rules of operation and can legally furnish covered benefits under the terms of their licenses.<sup>25</sup>
- At least one state (California) recognizes the concept of fair process in a managed care context, an approach to private conduct that has been applied to hospital staff privilege decision-making.<sup>26</sup> Under this concept, “at will” termination clauses in provider agreements are unenforceable because they potentially impair significantly a health professional’s ability to engage in his or her profession. While other state courts may not yet recognize this concept as a common law right, some states may be willing through legislation to provide for minimum due process protections, even if termination at will clauses are not prohibited, as in *Harper v Healthsource* (Table 3).

## Conclusion

These cases illustrate both the evolution of managed care case law as well as the evolving thinking by the courts about the relative rights and responsibilities of various stakeholders within the health care system: managed care companies, public and private sponsors of managed care products, health professionals, and patients and plan members. These decisions both establish new law (as in the extension of professional liability concepts to the managed care industry) and reinterpret existing law in new ways (e.g., the growing body of ERISA case law distinguishing between injuries caused by poor medical judgement and other injuries). One can expect that, as courts increasingly enter the managed care policy-making process through judicial decisions that apply existing legal principles to the modern health system, both Congress and state legislatures will draw from these cases general rules of practice that apply to the industry as a whole.

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<sup>22</sup> Table 2, *Medco Behavioral Care v Iowa Dept. of Human Services*.

<sup>23</sup> Table 2, *Medicare HMO v Bradley*.

<sup>24</sup> Table 2, *Frew v Gilbert*.

<sup>25</sup> Table 3, *Stuart Circle Hospital v Aetna; Washington Physician Services Assoc. v Gregoire*.

<sup>26</sup> Table 3, *Potvin v Metropolitan Life Insurance*.

Even in a deregulated health system, the evolution of case law carries important implications not only for members of health plans, but also for purchasers of managed care. This is particularly true for Medicaid agencies, which have a general duty under Federal law to assure the adequacy of quality services. Taken together, these cases suggest that purchasers may wish to pay particular attention to the following matters:

- A contractor's claims regarding the sufficiency of its network, the process used to select and monitor the quality of care of its network providers, and the methods used by the contractor to ensure that no individual provider has more than a professionally sound number of patients.
- The practice guidelines that the contractor uses to incentivize its network providers and to measure the quality of the services it covers. The guidelines should be examined not only for their validity (i.e., the soundness of the evidence on which they rest) but also for their application, since medical liability can flow both from the flawed design of practice and from the use of the wrong diagnostic and treatment techniques on patients, given their individual medical conditions. Practice guidelines, like compensation incentives themselves, are part of the managed care design. However, the liability cases suggest that they should be used as beginning guidelines only and not as conclusive evidence regarding how an individual patient should be managed.
- The contractor's ability to comply with notice and hearing requirements applicable to Medicaid agencies when care and services are denied, terminated or reduced. Notices should be verified for adherence to Federal standards, procedures for continuing care in cases in which pre-action hearings are requested should be in place, and the contractor should have a mechanism for verifying its adherence to federal requirements.
- The use of compensation arrangements that treat all providers similarly, that do not provide for additional payments for providers who treat patients with disabilities, and that contain incentives that could be interpreted as encouraging the under-diagnosis or under-treatment of persons with disabilities.
- The procedures the contractor has in place to ensure that its provider network members do not discriminate against persons with physical or mental disabilities through the use of inaccessible locations, the refusal to serve certain patients, or practices that discourage certain patients from receiving care.



## II. Selected Case Studies of Legal Developments in State Contracting for Managed Behavioral Health Services

### Introduction

Over the last several years, as states have designed and implemented managed behavioral health services for Medicaid beneficiaries, controversies have arisen over what effects this transition away from fee-for-service medicine would have on persons with significant illnesses and conditions such as mental illness and addiction disorders. Debates over issues such as balancing cost containment strategies against expanding access to care, reconciling and streamlining multiple (and often fragmented) funding streams, the use of large risk management corporations as health providers and the concurrent role of community-based and safety net providers, and the allocation of administrative and service accountability within state and local government agencies, have been common across the 31 states that thusfar have instituted some form of Medicaid managed care for behavioral health services.<sup>27</sup>

While the legal developments described in this paper are specific to managed behavioral health care, it should be noted that legal disputes in managed care generally are common, just as they were (and continue to be) in fee-for-service medicine.<sup>28</sup> However, the nature of the litigation changes in a managed care environment, owing to the fact that the transition from the fee-for-service health care financing and delivery system has introduced a new form of hybrid health entity combining the functions of health insurance and health care into a new service delivery model that allocates health care in accordance with insurance principles.

Patients, providers, purchasers, managed care organizations (MCOs), and other stakeholders bring different perspectives to questions about what level and scope of care are appropriate and medically necessary, and who should provide care to which patients. Managed care is a contractually-driven enterprise, encompassing multiple tiers of contracts between purchasers and MCOs, between MCOs and provider groups, between provider groups and individual health professionals, and between MCOs and individual managed care subcontractors for specialty services such as behavioral health care. Because these contracts vary significantly in their detail and specificity, contractual ambiguities and/or vagueness that serve to poorly define the mutual and discrete rights and duties of each party often require parties to seek judicial remedies when one party to the contract believes the terms of the contracts have not been met. Therefore, it should not be surprising that as the use of managed behavioral health care has proliferated, disputes that result in litigation are growing at a brisk pace.

This analysis presents case studies from five states whose recent experiences with Medicaid and private sector managed behavioral health care illustrate the tensions that can arise during the systemic transition currently underway. While the examples discussed have produced no case law *per se*, they reflect the range of potential legal issues that can arise in a health environment in which

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<sup>27</sup> “Effective Public Management of Mental Health Care: Views from States on Medicaid Reforms that Enhance Service Integration and Accountability.” The Bazelon Center for Mental Health Law and the Milbank Memorial Fund. Washington, D.C. May 2000. Available at <http://www.milbank.org>.

<sup>28</sup> See, *e.g.*, the vast body of fee-for-service caselaw in chapters 2 and 3 of: Law and the American Health Care System. (1997; 1999-2000 Supplement). *op. cit.*

hybrid corporations compete for service contracts and in which care is allocated in accordance with insurance principles. Five types of legal disputes are examined:

- Claims of inappropriate denials of care and failure to provide patients with timely notifications and rights of appeal (Connecticut);
- Claims of fraud in the state contracting process (Montana);
- Allegations of significant deficiencies in both the design and implementation of a managed behavioral health service delivery system that led to the termination of a Medicaid Section 1915(b) waiver (New Mexico);
- Failure to deliver Medicaid-mandated services such as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of sufficient level, scope, and quality (Texas); and,
- Allegations of an MCO's unlawful denials of medically necessary behavioral health care for children and alleged pressure to shift children to the juvenile justice system to avoid paying for such care (Minnesota).

## **Connecticut**

### *Children's Medicaid Managed Behavioral Health Services*

#### 1. Investigation of HealthRight and Value Behavioral Health

In 1997, Attorney General Richard Blumenthal began a 3-year investigation of HealthRight, Inc. (which held the state's contract for its Medicaid managed care program, "Husky A") and Value Behavioral Health, which was subcontracted by HealthRight to deliver mental health services to children. Following an examination of more than 100 enrollees' medical cases and thousands of pages of records, Blumenthal found that HealthRight and VBH systematically denied medically necessary inpatient treatment for children with mental illness. According to reports, there were numerous instances in which health care workers seeking prior authorization for treatment for children who were a danger to themselves or to others were told that in-patient hospitalization was not authorized. Blumenthal characterized the denials as both purposeful and systematic, resulting in a practice that was cruel and unfair in its harm to children. In his words, "The denial of care went beyond simple cost-cutting and seriously reduced mental health services for the neediest and most vulnerable of Connecticut's citizens: poor children with mental illness." In addition, the investigation established that the services the companies were being paid to provide under the Department of Social Services contract often were shifted to the Department of Children and Families – thus the state paid twice for the same services.

In January 1999, Attorney General Blumenthal announced his intention to take legal action against HealthRight, Inc. and Value Behavioral Health as a result of the investigation. In May 2000, a settlement agreement was reached before the state filed suit. By this time, Value Behavioral Health had become ValueOptions, which assumed responsibility for the settlement terms. The state agencies that were parties to the settlement included the Department of Social Services, the Department of Children and Families and the Department of Public Health. While not admitting any wrongdoing, HealthRight and ValueOptions agreed to pay the state \$4 million in the following manner: 1) HealthRight must immediately pay \$300,000 to the Department of Social Services to be used to fund a study of ways to benchmark behavioral outcomes for use in the Medicaid managed

care program and to fund a task force on the status of the state's Medicaid managed behavioral health system; 2) HealthRight must deliver to the state \$1,200,000 in U.S. Treasury Notes payable in four-year maturities of \$300,000; 3) ValueOptions must immediately pay \$300,000 to the state as well as \$1,200,000 in U.S. Treasury notes over with four-year maturities; and 3) ValueOptions must provide free of charge \$1 million worth of room, board, and related charges for Connecticut DCF clients at a ValueOptions facility called "The Pines" in Portsmouth, Virginia.

## 2. Karen L. v. PHS, Inc. and Department of Social Services

On November 17, 1999, Connecticut Legal Services and the New Haven Legal Assistance Association filed a Federal class action suit in U.S. District Court for the District of Connecticut on behalf of a 6-year-old girl identified as "Karen L." and Grisel Hernandez against Physicians Health Services, Inc. and the Connecticut Department of Social Services alleging that PHS uses "flawed" notification procedures which prevent patients from pursuing medically necessary services.<sup>29</sup> The complaint alleges that PHS routinely fails to provide required written notice of all decisions which would terminate, deny, or reduce requested or ongoing treatment, including an explanation of the right to a hearing, how to obtain a hearing, and the circumstances under which services are to be continued if a hearing is requested in a timely fashion.

The Department of Social Services is named in the suit since the complaint alleges that DSS failed to meet its contractual duty to monitor PHS' compliance with Medicaid notification laws and contract provisions. The "class" represents a group of 74,000 PHS Medicaid managed care enrollees. PHS is a division of Foundation Health Services and is the third largest health plan in the Northeast. It covers approximately 500,000 enrollees in Connecticut (including its commercial line of business) and is the second largest Medicaid managed care plan in the state.

At the time of this writing (February 2001), the case is still pending. Interestingly, Attorney General Richard Blumenthal is required to defend DSS against the allegations, while at the same time he has filed his own class action suit against four Connecticut HMOs, including PHS, for (among other things) inappropriate denials of care and lack of proper notification of rights of appeal (see No. 3 below).

### *General Managed Care Legal Developments in Connecticut*

#### 1. Dispute Between PHS, Inc. and PRO Behavioral Health

In June 2000, the *Hartford Courant* reported on a financial dispute between PHS and PRO Behavioral Health, PHS' subcontractor for the delivery of managed mental health care. The dispute has led to serious delays in payments to contracted providers. PRO has sued PHS in state superior court, accusing PHS of trying to drive it out of business by paying unreasonably low rates; PHS claims it paid PRO the money required and that it was PRO's responsibility to pay the providers. Attorney General Blumenthal is investigating the effects this dispute may be having on access and quality of care for consumers of mental health services. In the meantime, PHS has begun depositing money in an escrow account that can be accessed by PRO, but only with review and co-signature by PHS.

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<sup>29</sup> *Karen L. v. Physicians Health Services Inc.*, D. Conn., No 3:99 CV 2244, complaint filed 11/17/99.

## 2. State of Connecticut v. PHS, Inc. – Drug Formularies

Blumenthal filed suit in U.S. District Court against PHS in December 1999 alleging that PHS imposed restrictions on access to prescription drugs that posed a threat to the health of its enrollees. The complaint accused PHS of using price, rather than quality, to determine which drugs to cover and of pressuring patients to use company-preferred drugs, even when the medicine their doctors prescribed was alleged to be “safer and more effective.” The case was dismissed by Judge Stefan R. Underhill in August 2000, who ruled that regardless of the merits of the case, the state of Connecticut is barred from suing HMOs under ERISA.<sup>30</sup> In his words, “Congress carefully limited the persons authorized to bring an ERISA civil enforcement action, and any such plaintiff must be either a ‘participant, beneficiary or fiduciary.’ ... The state does not meet any of these statutory requirements.” The decision came two months after the U.S. Supreme Court’s ruling on *Pegram v. Herdrich*, another case involving HMO liability and ERISA.<sup>31</sup> Blumenthal has said he would appeal the decision.

## 3. State of Connecticut v. Four HMOs

On September 7, 2000, Attorney General Blumenthal filed a class action suit against four Connecticut HMOs, becoming the first state to take such action. The lawsuit, filed in U.S. District Court in Connecticut named as defendants Anthem Blue Cross and Blue Shield of Connecticut (and its parent Anthem Health Plans, Inc.), CIGNA Healthcare of Connecticut (and its parent CIGNA Health Plans, Inc.), Oxford Health Plans of Connecticut, Inc. (and its parent Oxford Health Plans, Inc.), and Physicians Health Services of Connecticut (and its parent Foundation Health Systems, Inc.). The suit focuses on five abuses documented by the Attorney General’s office, alleging that they violate ERISA’s requirement that health plans act solely in the interest of enrollees. Specifically,

- 1) the HMOs use prescription drug formularies to obstruct patient access to medically necessary drugs;
- 2) the HMOs fail to make timely payments to providers, thus threatening enrollees with loss of necessary care;
- 3) the HMOs fail to respond to enrollees’ written and telephone communications with answers that are timely, coherent, and fair;
- 4) the HMOs fail to disclose to enrollees essential information about prescription drug coverage and the steps necessary to submit and appeal denials of coverage; and
- 5) the HMOs use arbitrary coverage guidelines as the basis for coverage denials.

The suit does not seek monetary damages, according to Blumenthal, but rather seeks basic reforms in managed care practices to compel compliance with ERISA requirements to act solely in the interest of enrollees. As mentioned above, Blumenthal is party to another suit against PHS; as Attorney General, he must defend the Department of Social Services in a class action suit brought against PHS and DSS on behalf of Medicaid managed care enrollees served by PHS.

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<sup>30</sup> See Section I of this issue brief for a discussion of caselaw regarding the effect of ERISA preemption on the liability of HMOs.

<sup>31</sup> See Section I of this issue brief for a summary of *Pegram v. Herdrich*.

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## Montana

### *Allegations of Contract Award Improprieties*

In early 1997, Montana awarded a contract worth \$400 million for the provision of mental health services to all Medicaid eligibles in the state to Montana Community Partners (MCP), a private for-profit subsidiary of a national company, CMG Health, Inc. Three other unsuccessful bidders for the contract – Vista Behavioral Health, Merit Behavioral-Blue Cross/Blue Shield of Montana, and Options Health Care Inc.-Montana Hospital Association – filed formal complaints with the state alleging that MCP had been given an unfair advantage in the contract award process. Among the specific issues in the complaint were: 1) questions about the contract’s ability to meet Federal standards and about its validity; 2) accusations that MCP provided job offers and “inappropriate advice” to members of the contract review committee; and 3) evidence that MCP was allowed to submit a 150-page proposal, despite the fact that other bidders were limited to 100 pages.

Vista filed suit in state court in Helena in March 1997. In June 1997, MCP, admitting no wrongdoing, reached an out-of-court settlement with Vista in which it agreed to pay Vista \$1.2 million, which represented some of Vista’s out-of-pocket expenses incurred for preparing its technical proposal for the contract. The settlement further stipulated that, except in the event of termination or cancellation of MCP’s contract with the state, Vista agreed not to compete for any Montana public sector managed mental health contract nor to solicit or accept membership in the Care Coalition of Montana or the Board of Directors of MCP without first obtaining written permission from CMG Health, Inc., parent company of MCP.

MCP held the contract for only two years. During that time, its parent company was bought out twice. In 1999, the state decided to end its Mental Health Access Plan and canceled its contract with MCP. Among MCP’s failures was that it was never fully embraced by the state’s network of mental health providers and as a company was never efficiently run. It was also undercapitalized, and care management was generally ineffective.

## *Return to Fee-For-Service Mental Health Services in Medicaid*

Following termination of the MCP contract, the state returned to fee-for-service reimbursement for mental health services for Medicaid enrollees. In May 2000, the Montana Department of Public Health and Human Services (DPHHS) and the Mental Health Services Bureau contracted with the Technical Assistance Collaborative (TAC), a non-profit organization founded by the Robert Wood Johnson Foundation to assess and evaluate the Montana Medicaid Mental Health Program and the Mental Health Services Plan and to offer recommendations for program improvements. The TAC's final reports are available on the DPHHS website at <http://www.dphhs.state.mt.us>.

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## **New Mexico**

### *HCFA Denial of Renewal of Waiver for Managed Behavioral Health Services*

New Mexico began its Medicaid managed care program, known as “Salud!,” in 1997. New Mexico was one of only two states (the other being Tennessee) that mandated all Medicaid-eligible residents enroll in an MCO for their behavioral health care (with the exception of Native Americans, who can opt in to Salud! or stay in the fee-for-service system). About 200,000 New Mexicans are covered by Salud!, which has an annual budget of \$1.24 billion, 75% of which is provided by the Federal government. New Mexico contracted with three MCOs, Lovelace Health Systems, Presbyterian Health Plan, and Cimarron Health Maintenance Organization, to deliver services under the Salud! Program. New Mexico legislators attempted to carve out behavioral health services during the roll-out of Salud!, however, Governor Gary Johnson, a proponent of managed care, vetoed the measure. The provision of managed behavioral health services entailed a three-level administrative structure: the Salud! MCOs subcontracted with behavioral health organizations, such as ValueOptions, which then contracted with Regional Care Coordinators (RCCs) at the local level. These latter organizations functioned both as referral agencies for consumers and as direct providers of behavioral health services.

The Bazelon Center for Mental Health Law's involvement in studying New Mexico's problems began early after Salud!'s implementation. In August 1998, the Bazelon Center co-signed a letter with the New Mexico Alliance for the Mentally Ill recommending that the Health Care Financing Administration (HCFA) investigate access to behavioral health services for Salud! enrollees. In March 2000, the Bazelon Center urged HCFA not to renew New Mexico's request for a renewal of the behavioral health component of its Section 1915(b) waiver. On July 5, 2000, the Interim Health and Human Services Committee of the New Mexico Legislative Council held a hearing to identify problems with, and recommendations for, Salud!'s delivery of mental health services. Rafael M. Semansky, MPP, a policy research analyst with the Bazelon Center in Washington, D.C. provided testimony based on a series of analyses Bazelon had conducted of Salud!'s operations. The committee also heard testimony from a grassroots organization known as the "Human Needs Coordinating Council," a coalition of 600 health and human services clients, advocates, providers and organizations. At the request of U.S. Senator Jeff Bingaman (D-NM), HCFA sent a team to attend the hearing.

In Semansky's testimony before the committee in July 2000, he compared the problems with Salud! to the experience of TennCare, the only other state Medicaid managed care program to require immediate statewide enrollment rather than phasing eligibility groups in over time. According to his testimony, five general problematic issues were shared by TennCare and Salud!:

1. An inadequate capitation rate for the expanded benefits and the larger population covered;
2. Insufficient and non-uniform data from the health plans that hindered evaluations of quality and performance;
3. Weak enforcement of contract requirements by the Medicaid agency;
4. Lack of behavioral health providers willing to participate in Salud!; and,
5. Limited access to community-based mental health services, despite declining rates of inpatient psychiatric services.

Specific findings from the Bazelon Center's analyses related to the access, cost, and quality of behavioral health services for Salud! enrollees. Semansky found that the rate of community mental health service authorizations declined precipitously for the RCCs; for example, Presbyterian Medical Services rate per 1,000 members of authorizations for child and adolescent community based services dropped from 1,000 in August 1999 to 300 in February 2000. ValueOptions, Presbyterian's BHO, decreased utilization of inpatient psychiatric services without an offsetting increase in community-based services. The analysis also found that the utilization of inpatient psychiatric services by youth in juvenile justice custody doubled under Salud!, leading Semansky to conclude that Salud! behavioral health services for children and adolescents were inadequate, theorizing that youths become involved in the juvenile justice system since they have insufficient access to preventive services.

In addition, the three-layer administrative system proved difficult to operate, given that a large percentage of New Mexicans live in rural and frontier areas with limited numbers of providers. This both increased costs and contributed to administrative inefficiencies brought about by different health plan requirements for authorizations, billings, and claims procedures. The analysis found that excessively high administrative costs for behavioral health care amounted to 51 cents of each dollar, though state officials disputed this figure. Many behavioral health providers ended their participation in Salud!, citing low reimbursement rates and high costs of administrative compliance.

The Bazelon Center testimony called into question the validity and usefulness of the encounter data collected by the state, concluding it was insufficient to enable the Medicaid agency to monitor program performance.

Furthermore, excessive wait times and delays in completing follow-up visits after psychiatric hospitalization were cited as evidence of program access barriers. While the National Committee for Quality Assurance national average for visits within seven days following discharge is 45%, the highest average among the three Salud! MCOs was 26.44% and the low was 14.63%. Similar figures for discharge within 30 days are 68% nationally, with Salud! MCOs ranging from a high of 42.31% to a low of 27.13%.

The Bazelon Center report also found that Medicaid case management services were virtually nonexistent, that children with serious emotional disturbances were not able to access intensive services, that management of antidepressant medications was inadequate, and that overall consumer satisfaction with the quality of Salud! behavioral health services was low. The report also found that enrollee grievance and appeal procedures were poorly designed and advertised, and that utilization review decisions were untimely, resulting in delays in enrollees receiving care.

On October 19, 2000, HCFA's then-Director Timothy Westmoreland wrote to Robert T. Maruca, Director of New Mexico's Medical Assistance Division, notifying him that the state's request to renew its Medicaid section 1915(b) two-year waiver had been approved for the delivery of physical health services but not for behavioral health services. The letter instructed the state to transition all behavioral health care services from managed care to the fee-for-service system with 90 days from the date of the letter. The state also was required to submit a transition plan describing how they would communicate and facilitate the transition as well as how continuity of care would be maintained. HCFA noted it would continue to monitor the experience of the delivery of behavioral health services during and after the transition to fee-for-service. State officials negotiated a delay in the transition until February 2001.

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## Texas

### *Violations of 1996 EPSDT Consent Decree: Managed Care Aspects*

On August 14, 2000, U.S. District Judge William Wayne Justice ruled that Texas was in violation of several orders contained in a 1996 consent decree to provide EPSDT services to more than 1.5 million children eligible for Texas Medicaid, including mental health and developmental screenings (109 F. Supp. 2d 579; 2000 U.S. Dist.). The consent decree stemmed from a 1993 class action suit, *Frew et al v. Gilbert et al* (Civil Action No. 3:93CA65), filed by San Antonio lawyer Susan Zinn of the Texas Rural Legal Aid organization. Judge Justice found that the state failed to meet its requirements in several areas: 1) failure to provide dental checkups; 2) failure to provide sufficient staff to inform eligible recipients about services; 3) failure to provide needed transportation to clinics and hospitals; and 4) failure to provide adequate care to enrollees of Texas' Medicaid managed care program, known as STAR. EPSDT services are provided through STAR's Texas Health Steps program.<sup>32</sup>

The STAR program began in 1993 in Travis County and in the Gulf Coast area in and around Galveston. By 1999, it was expanded to include Southeast, Bexar, Tarrant, Lubbock, Dallas, Harris and El Paso areas and enrolled about 346,000 Medicaid recipients. In 1997, 83% of STAR enrollees were under the age of 20. The Texas legislature declared a moratorium on new enrollment as of 1999, but future continuation of the roll-out of managed care is considered likely. The plaintiffs' complaints regarding the managed care system can be grouped into four areas: 1) the receipt of services, including mental health services, by class members enrolled in managed care; 2) the treatment of the children of migrant workers enrolled in managed care; 3) the training of health care providers employed by managed care systems; and 4) the timeliness and quality of data obtained from the STAR managed care organizations used to monitor the access, quality, and cost of services.

The court held that the STAR program impedes class members' access to mental health services. It cited the words of a physician and member of the Tarrant regional advisory committee on managed care:

*They are losing services that were available three years ago; there are fewer hospital beds for children and adolescents. ... Mental health is the least served area. If there is high demand, then the providers can select their patients. They're going to select patients where they will get reimbursed appropriately. Taking a system that is weak to start with in its reimbursement and making it more difficult to administer, places further demands on those providers. They are going to drop out of the system.*

The court also cited the Dallas committee's concerns about "the adequacy of the mental health network for children, especially children with complex needs." In one particular case, that of "C.H. and Sons," an enrollee's experiences with Americaid, one of the STAR MCOs, were described. One of C.H.'s sons, James, had mild mental retardation, asthma, oppositional defiant

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<sup>32</sup> TennCare in Tennessee has also been the subject of numerous class action suits and consent decrees concerning the delivery of behavioral health services for children, particularly under the Medicaid EPSDT benefit. See, for example, *John B. v. Menke*, CA No. 98-0168 (M.D. Tenn.), *Daniels v. Wadley*, CA No.96-5887, 926 F. Supp. 1305, (vacated in part by *Daniels v. Menke*, 145 F.3d 133 (6th Cir. Apr 22, 1998); 1996 U.S. Dist., and *Grier v. Wadley*, CA No. 79-3107. Further information can be obtained from the Tennessee Justice Center at <http://www.tnjustice.org>.

disorder, and affective disorder. The psychiatrist who had been treating James decided to “drop all his Medicaid patients.” Americaid initially told C.H. that she did not need a referral code to take James to a new psychiatrist. The company later refused to pay for his care because C.H. “did not follow procedure about getting a referral code.”

Judge Justice reiterated the consent decree provision that, “Defendants may contract with individuals and entities to provide EPSDT services. But, Defendants remain ultimately responsible for the administration of the EPSDT program in Texas and compliance with Federal EPSDT law.” He further noted that a 1998 Texas Health Quality Alliance report that found that one-half of the STAR MCOs did not substantially meet the requirement that they have systems in place to ensure the delivery of Texas Health Steps services. The defendants argued that 42 U.S.C. §1396u-2 only requires the state to ensure that EPSDT services are “offered,” not that such services are received.<sup>33</sup> Judge Justice disagreed, stating that “Section 1396-u2 permits the states to utilize managed care to meet their obligations under the federal EPSDT statute; it does not free them from those obligations, or limit their responsibilities to managed care enrollees.” Further, “Defendants have a duty under 42 U.S.C. §1396 to inform ‘all’ EPSDT eligible participants about the program and to provide services to those who request them after being informed.”<sup>34</sup>

Judge Justice concluded by ordering that the state provide to the court and the plaintiffs a series of proposed corrective action plans for each of the violations of the decree by October 14, 2000. Texas Attorney General John Cornyn filed an appeal requesting a stay of the judges’ order, which was granted by the 5<sup>th</sup> U.S. Circuit Court of Appeals in New Orleans on October 18, 2000. Most recently in early January 2001, the plaintiffs’ attorney, Susan Zinn, has added two more complaints to the suit: that the state has not enrolled enough dentists in the Medicaid program and that ill children are not treated in a reasonable amount of time as Federal law requires. State health officials have requested a \$44 million increase for 2002 for children’s Medicaid programs, including \$13 million to increase reimbursements to participating dentists. The current program outlay is \$237 million.

**Sources:**

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<sup>33</sup> Title 42 U.S.C. §1396-u2(b)(5) states: “Demonstration of adequate capacity and services: Each Medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization - (A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and (B) maintains a sufficient number, mix, and geographic distribution of providers of services.”

<sup>34</sup> Title 42 U.S.C. §1396-u2(a)(5)(B) states: “Information to enrollees and potential enrollees: Each managed care entity that is a Medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following: (i) Providers: The identity, locations, qualifications, and availability of health care providers that participate with the organization. (ii) Enrollee rights and responsibilities: The rights and responsibilities of enrollees. (iii) Grievance and appeal procedures: The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service. (iv) Information on covered items and services: All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).”

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## MINNESOTA

### *Allegations of Improper Denials of Medically Necessary Children’s Behavioral Health Services*

On October 3, 2000, Minnesota Attorney General Mike Hatch filed suit against Blue Cross/Blue Shield of Minnesota (BCBSM) on behalf of the state in Hennepin County District Court. In his complaint, Hatch alleged that BCBSM, through its mental health subsidiary Behavioral Health Services, Inc., unlawfully denied medically necessary mental health, eating disorder, and chemical dependency treatment for children and young adults. The complaint stated six specific areas of BCBSM’s alleged “pattern and practice of misconduct” with respect to the coverage of this treatment:

1. “Shifting costs to taxpayers and/or families by telling subscriber’s children to seek help through the juvenile justice system rather than receive health care treatment that is covered under the subscribers’ policies with BCBSM;
2. Shifting costs to taxpayers and/or families by refusing or significantly delaying coverage for court-ordered treatment in the face of recommendations by treating physicians that the treatment is medically necessary;
3. Denying or limiting coverage for medically necessary treatment after mere ‘paper reviews,’ contradicting the sound judgements and recommendations of the only physicians who have ever actually examined and treated the patients;
4. Delaying coverage by forcing subscribers into unwarranted appeals of denials of coverage for medically necessary and pre-authorized treatment;
5. Misrepresenting and omitting material facts regarding its coverage of authorized treatment; and
6. Hiding from subscribers the true conditions, standards, and criteria for its denials of coverage, which among other things, places subscribers at an unfair disadvantage during the appeal process.”

Hatch stated that while the suit names BCBSM, other major health care companies engage in similar practices. His decision to pursue BCBSM was based on the potential for “generating more consumer complaints,” but he warned that if the other companies did not “clean up their acts” he would sue them as well.

The complaint describes the experiences of six anonymous child and adolescent patients with serious mental health conditions, eating disorders, and chemical dependency problems who had BCBSM coverage. The cases are used to illustrate one or more of the six points above as examples of the effects on their health as a result of BCBSM’s allegedly improper coverage and treatment denials. In his five-count complaint, Hatch alleged that BCBSM violated various Minnesota statutes

regulating false and deceptive advertising practices and also the provision of information concerning the basis for the denial of beneficiaries' insurance claims. Hatch's suit seeks to have BCBSM enjoined from engaging in such activities, to require BCBSM pay restitution to those affected by its practices, and to require BCBSM to pay civil penalties, attorneys' fees, and court costs. He has stated that BCBSM's actions have cost Minnesota taxpayers at least \$11 million.

BCBSM filed its answers to the complaint with the court on October 27, 2000 denying all charges. The company stated that: 1) its definition of medical necessity is consistent with the state's definition at Minnesota Statute §62Q.60; 2) it has implemented a "rigorous set of practices designed to apply conscientious medical review" to mental health services that complies with state requirements; 3) its coverage and treatment decisions regarding the six anonymous individuals were appropriate; 4) it does not inappropriately refer subscribers to the juvenile justice system; and 5) it routinely pays for virtually all (more than 94%) of requested treatment, whether reviewed or not.

In January 2001, in advance of a scheduled February 21, 2001 hearing, Hatch demanded that BCBSM turn over thousands of documents related to behavioral health claims, which the company said would be a violation of the medical privacy of its members since these individuals had not authorized the release of their records. In a press statement BCBSM said, "Instead of working with Blue Cross within the rules of the court, Attorney General Mike Hatch has unfortunately chosen to try this case through press conferences and has consistently refused to provide authorization Blue Cross legally needs to comply with his request."

As the events of this case were unfolding, a Minnesota legislative auditor released preliminary findings from a study of health insurers' payments of behavioral health insurance claims. The study found that the state's insurers have refused to pay for \$28.5 million for claims of behavioral health treatment administered by state agencies. The report characterized the state's mental health system as "fragmented and rife with conflict and dissatisfaction." According to the report, of Minnesota's \$941 million annual expenditure for behavioral health care, two-thirds is paid for by the public sector. The remaining third, \$310 million, is paid by private insurance companies, even though they insure or manage care for two-thirds of the population. The report's authors stated that their findings were limited by availability of adequate data, but that concerns about the inappropriate shifting of costs to the public sector appear to merit further study.

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## Appendix

Table 1. Relevant Legal Claims Involving Managed Care Companies: Leading Cases

Type of Claim	Leading Cases (*)
<p>Medical liability</p> <ul style="list-style-type: none"> <li>▪ Corporate liability (direct liability for failure to select and properly oversee staff, correct quality related problems or use practice standards that are professionally appropriate)</li> <li>▪ Vicarious liability (liability under various agency theories for the negligence of a network provider)</li> </ul>	<p style="text-align: center;"><b>In general</b></p> <ul style="list-style-type: none"> <li>▪ <u>Boyd v Albert Einstein Medical Center</u> 547 A. 2d 1229 (Pa. Super 1988): Under Pa. Law, HMOs are a form of health provider and can be vicariously liable for the negligent medical care of network physicians if a physician is shown to be negligent and if an agency relationship is proven. HMOs are hybrid entities that contract for the provision of health care and thus carry the attributes of both health providers and health insurers under state law.</li> <li>▪ <u>Shannon v McNulty</u> 718 A. 2d 828 (Pa. Super., 1988): PA. Law recognizes HMOs as health providers for medical liability purposes and an HMO that allegedly failed to adequately manage a member’s preterm labor care and oversee the performance of its physicians can be found directly and vicariously liable for the quality of care.</li> <li>▪ <u>Petrovitch v Share Health Plan of Illinois</u> 719 N.E. 2d 756: Under Illinois law, an HMO can be vicariously liable where agency is proved for the negligence of its network physician in a failure to diagnose cancer.</li> </ul> <p style="text-align: center;"><b>Cases brought by ERISA-sponsored health plan members</b></p> <ul style="list-style-type: none"> <li>▪ <u>Dukes v U.S. Healthcare</u> 57 F. 3d 350 (3d Cir., 1995); cert. den., 116 S. Ct. 564 (1995): cases involving allegations by an ERISA plan member of professionally substandard provision of covered services in the context of a medical emergency constitute medical negligence cases governed by state law and lie outside of ERISA preemption.</li> <li>▪ <u>Moscovitch v Danbury Hospital</u> 25 F. Supp. 2d 74 (D. Ct., 1998):* claims by an ERISA plan member related to the reasonableness of the medical judgement exercised by health plan medical staff in a psychiatric hospital discharge case amount to a quality of care claim that can be pursued under state law.</li> <li>▪ <u>Pegram v Herdrich</u>, 120 S. Ct. 2143 (2000): Claims challenging the professional soundness of the medical judgement of managed care physician who delayed the performance of diagnostic tests are not the types of decisions that are considered “fiduciary” under ERISA. Thus, even though physician incentive plans cannot be challenged as a violation of ERISA’s fiduciary duty standard, medical negligence by an HMO physician falls within the purview of state law.</li> <li>▪ <u>Lazorko v Pennsylvania Hospital</u>, 2000 WL 1886619:* Allegations by an ERISA plan member that the physician incentive plan</li> </ul>

Type of Claim	Leading Cases (*)
	<p>used by an HMO was a contributing factor to the physician's negligent decision to withhold medically necessary psychiatric care amounts to a direct medical negligence claim covered by state law</p> <ul style="list-style-type: none"> <li>▪ <u>In re U.S. Health Care</u> 193 U.S. Healthcare 193 F. 3d 151 (3d Cir., 1999); cert. den. 120 S. Ct. 2687 (2000): Claims by an ERISA plan member that an HMO's treatment guidelines were professionally substandard and encouraged negligent care that led to the death of a newborn infant amounts to a direct medical negligence claim that can be pursued under state law.</li> </ul> <p style="text-align: center;"><b>Cases brought by Medicaid beneficiaries</b></p> <ul style="list-style-type: none"> <li>▪ <u>Jones v Chicago HMO</u> 2000 WL 632790 (Ill, 2000): Under Illinois law an HMO can be held directly liable for failure to oversee the activities of a network physician in a Medicaid plan whose patient load exceeded professionally acceptable norms and contributed to the physician's failure to timely treat an infant.</li> </ul> <p style="text-align: center;"><b>Cases brought by Medicare beneficiaries</b></p> <ul style="list-style-type: none"> <li>▪ <u>Ardary v Aetna Health Plans</u> 98 F. 3d 496 (9<sup>th</sup> Cir., 1996): Claims of medical negligence against a Medicare HMO constitute claims under state law and are not preempted by Medicare.</li> </ul>
<p>Americans with Disabilities Act</p> <ul style="list-style-type: none"> <li>▪ Accessibility of care</li> <li>▪ Quality of care</li> <li>▪ Content of coverage</li> </ul>	<p style="text-align: center;"><b>Health care providers as public accommodations</b></p> <ul style="list-style-type: none"> <li>▪ <u>Bragdon v Abbott</u> 524 U.S. 624 (1998): Health care providers constitute a public accommodation under the ADA and therefore have a legal obligation to reasonably modify their practices to accommodate persons with disabilities (in this case, HIV) unless they can prove the existence of a direct threat.</li> <li>▪ <u>Woolfolk v Duncan</u> 872 F. supp. 1381 (E.D. Pa., 1995): Health plan network providers constitute a public accommodation under the ADA and thus may not discriminate in the provision of care against persons with disabilities.</li> </ul> <p style="text-align: center;"><b>Physician incentive plans as violative of the ADA</b></p> <ul style="list-style-type: none"> <li>▪ <u>Zamora-Quesada v Humana Health Plan</u> 34 F. Supp. 2d 433 (W.D. Tex., 1998): An HMO may be liable under the ADA if it is demonstrated that its physician incentive plan discouraged physicians from serving persons with disabilities by failing to adjust for a sicker caseload or acted as an incentive for the withholding of medically necessary care.</li> </ul> <p style="text-align: center;"><b>The design of insurance contracts and the ADA</b></p> <ul style="list-style-type: none"> <li>▪ <u>Doe v Mutual of Omaha</u> 179 F. 3d 557 (1999); cert. den., 528 U.S. 1106 (1999) The ADA is not violated by across the board limits in health insurance content design, even where the limits target particular disabilities (in this case, lesser coverage for AIDS and AIDS-related conditions)</li> </ul>

Type of Claim	Leading Cases (*)
<p>Insurance coverage and utilization management liability</p> <ul style="list-style-type: none"> <li>▪ Bad faith breach of contract</li> <li>▪ Fraud</li> <li>▪ Breach of good faith and fair dealing</li> </ul>	<p style="text-align: center;"><b>In general</b></p> <ul style="list-style-type: none"> <li>▪ <u>Wickline v State of California</u> 239 Cal. Rptr. 810 (Cal. App., 1986); pet. for rev. dismissed 741 P. 2d 613 (Cal., 1987): Under California law, a health insurer can be held liable for the negligent design or administration of a utilization management scheme. However, the insurer's negligence will not excuse a health professional from liability where the professional negligently fails to intervene when the insurer withholds or terminates coverage in a manner that is inconsistent with professional standards.</li> <li>▪ <u>McEvoy v Group Health Cooperative of Eau Claire</u> 570 N.W. 2d 397 (Wis., 1997): * Under Wisconsin law an HMO like other insurers may be liable for bad faith breach of contract for a plan's refusal to authorize out of network services for a patient whose mental illness could not be competently treated by an in-network provider.</li> <li>▪ <u>Wohlens v Bartgis</u> 969 P. 2d 949 (1999): An insurer who misrepresents and misleads members through deceptive description of covered services may be liable under Nevada law for bad faith breach of contract and breach of good faith and fair dealing.</li> </ul>
<p>ERISA</p> <ul style="list-style-type: none"> <li>▪ Coverage design limits</li> <li>▪ Claims for covered benefits</li> <li>▪ Breach of fiduciary duty</li> </ul>	<p style="text-align: center;"><b>Breach of fiduciary duty</b></p> <ul style="list-style-type: none"> <li>▪ <u>Pegram v Herdrich</u>: HMOs that build incentive plans into their design do not breach their fiduciary duty under ERISA, since the use of incentive plans is simply a matter of plan design; however, claims alleging professional medical negligence in health care decision-making by an HMO physician are actionable under state law.</li> <li>▪ <u>Shea v Esensten</u> 208 F. 3d 712; cert. den. 121 S. Ct. 172 (2000): Failure to disclose the terms of a physician incentive plan constitutes a breach of fiduciary duty under ERISA where the information was potentially material to a decedent's decision not to seek a second opinion regarding the need for heart surgery.</li> </ul> <p style="text-align: center;"><b>Claims for covered benefits</b></p> <ul style="list-style-type: none"> <li>▪ <u>Andrews Clarke v Fallon Health Plan</u> 984 F. Supp. 49 (D. Mass, 1998):* Where the facts of a wrongful death action against a health plan for the denial of coverage leading to a suicide on the part of a patient with mental illness and an addiction disorder show that the action is predicated on the denial of coverage rather than the quality of covered care, state law remedies are preempted under ERISA.</li> <li>▪ <u>Bedrick v Travelers Insurance Co.</u> 93 F 3d 149 (4<sup>th</sup> Cir., 1996): where coverage is denied on medical necessity grounds, the denial can be considered an abuse of discretion under ERISA if it lacks an evidentiary basis. ERISA provides courts with the power to independently construe the terms of a coverage</li> </ul>

Type of Claim	Leading Cases (*)
	<p>agreement when deciding a coverage case.</p> <p style="text-align: center;"><b>Coverage design</b></p> <ul style="list-style-type: none"> <li>• <b><u>Jones v Kodak</u> 169 F. 3d 1287 (10<sup>th</sup> Cir., 1999):*</b> When practice guidelines are incorporated directly into the terms of the contract, the guidelines limit coverage on a conclusive basis and as a matter of plan design, and a court is without the authority to hear a medical necessity based challenge.</li> </ul>
RICO	<ul style="list-style-type: none"> <li>▪ <b><u>Maio v Aetna</u> 221 F 3d 472 (3d Cir., 2000):</b> Failure to provide services in accordance with claims in member information materials does not constitute a racketeering violation under RICO</li> </ul>

\* Indicates that the case involves a patient with mental illness or addiction disorder-related condition.



Table 2. Relevant Legal Claims Brought Against Medicaid Agencies: Leading Cases

Type of Claim	Leading Cases(*)
Constitutional due process (beneficiaries)	<ul style="list-style-type: none"> <li>▪ <u>J.K. v Dillenberg</u> 836 F. Supp. 694 (D. Ariz., 1993) :* Reduction or termination of care to children with severe mental illness constitutes the type of action that triggers constitutional due process protections under Medicaid, including timely and adequate notice and a pre-termination hearing; HMOs are agents of the state and their actions thus constitute state action.</li> <li>▪ <u>Daniels v Wadley</u>, 926 F. supp. 1305 (M.D. Tenn., 1996)(vacated in part by Daniels v. Menke, 145 F.3d 133, (6th Cir. Apr 22, 1998); Accord, Dillenberg</li> <li>▪ <u>Rodriguez v Chen</u> CV-95-Tuc-RMB (D. Ariz., 1996): Accord, Dillenberg</li> <li>▪ <u>Perry v Chen</u> CV 95-140-Tuc-RMB [reprinted at } CCH Medicare/Medicaid Guide para. 44,044: Accord, Dillenberg</li> <li>▪ <u>Catanzano v Wing</u> 992 F. Supp. 593 (S.D. N.Y., 1998): Accord Dillenberg (case involves home health care)</li> </ul>
Constitutional and statutory due process in selection and de-selection (MCOs)	<ul style="list-style-type: none"> <li>▪ <u>MedCare HMO v Bradley</u> 788 F. Supp. 1460 (N.D. Ill., 1992): Failure of a state agency to give an allegedly non-performing HMO timely notice and a pre-contract termination hearing constitutes a Constitutional due process violation and state may be enjoined from allowing members to disenroll.</li> <li>▪ <u>Medco Behavioral Care Corp. v Iowa Department of Human Services</u> 553N.W. 2d 356 (1996):* State procurement laws are violated when a state Medicaid agency awards a managed care contract to an entity whose subsidiary designed the state’s RFP.</li> <li>▪ <u>Value Behavioral Health v Ohio Department of Mental Health</u> 966 F. Supp. 557 (S.D. Ohio, 1997) (Judgment Vacated, Appeal Dismissed (July 17, 1998)):* Federal grants and contract regulations create a federal right of action in the case of HMOs who allege that a state’s competitive contracting practices allegedly violate federal standards.</li> </ul>
Coverage design	<ul style="list-style-type: none"> <li>▪ <u>Rodriguez v City of New York</u> 197 F. 3d 611(2d Cir., 1999); cert. den. 148 L. Ed. 2d 104 (2000):* Across the board state plan limitations on the range of procedures covered under an optional class of Medicaid benefits are lawful, even where the coverage limitations apply to a specific diagnosis (in this case mental illness), because states are not obligated under federal law to cover all medically necessary procedures within a covered optional benefit class, as long as limitations are reasonable; in addition, non-discrimination prohibition under federal Medicaid law applies only to required benefit classes.</li> </ul>
Administration of managed care obligations	<ul style="list-style-type: none"> <li>▪ <u>Frew v Gilbert</u> 109 F. Supp. 2d 579 (E.D. Tex. 2000):* injunction against continuing state failure to ensure adequate access to EPSDT services for Texas children, including children enrolled in the state’s managed care system. Children with mental illness identified as particularly underserved.</li> </ul>
ADA/Section 504	<ul style="list-style-type: none"> <li>▪ <u>Rodriguez v City of New York</u> 197 F. 3d 611(2d Cir., 1999); cert. den. 148 L. Ed. 2d 104 (2000):* Across the board state plan limitations on a covered optional benefit that are tied to a specific condition (in this case, mental illness) do not violate the</li> </ul>

Type of Claim	Leading Cases(*)
	ADA, because they are part of the plan design and thus apply equally to all beneficiaries.
Practice guidelines	<ul style="list-style-type: none"> <li data-bbox="553 289 1341 468">▪ <u>Massachusetts Eye and Ear Infirmary v. Commissioner, Div. Of Medical Assistance</u> 705 N.E. 2d 592 (Mass., 1999): Because Medicaid prohibits arbitrary limitations on covered services, a state may not use medical practice guidelines as irrebuttable evidence of coverage and must take individual medical circumstances into account.</li> </ul>

\* Signifies a case involving mental illness or addiction disorder

Table 3. Legal Claims Against Managed Care Organizations by Health Care Providers

Type of Claim	Case
<p>Selection and de-selection</p>	<ul style="list-style-type: none"> <li>• <u>Stuart Circle v Actna Health Management</u> 995 F. 2d 500 (4<sup>th</sup> Cir., 1993); cert. den. 510 U.S. 1003 (1993): Virginia “any willing provider” statute regulating PPO products offered by insurers constitutes a law that regulates insurance and is not preempted by ERISA.</li> <li>• <u>Washington Physician Services Association v Gregoire</u> 147 F. 3d 1039 (9<sup>th</sup> Cir., 1998); cert. den. 119 S. Ct. 1033 (1999): Washington State law prohibiting health insurance carriers from discriminating among classes of qualified health professionals in coverage policies constitutes a law that regulates insurance and thus is not preempted under ERISA in the case of insured plans.</li> <li>• <u>Harper v Healthsource of New Hampshire</u> 674 A. 2d 962 (N.H. 1996): while not void for public policy, an “at will” termination clause in a managed care provider contract is unenforceable under New Hampshire state insurance law requiring minimum fair procedure standards in provider selection and de-selection.</li> <li>• <u>Potvin v Metropolitan Life Insurance Co.</u> 997 P. 2d 1153 (2000) :In light of the substantial power to affect livelihood that insurers maintain over health professionals, California common law recognizes a right to fair procedure and makes invalid as a matter of public policy a contract at will clause.</li> </ul>
<p>ADA</p> <ul style="list-style-type: none"> <li>▪ Discrimination against providers who treat patients with disabilities</li> <li>▪ Discrimination against providers with disabilities</li> </ul>	<ul style="list-style-type: none"> <li>• <u>Zamora-Quesada v Humana Health Plans</u> (see Table 1)</li> </ul>