

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

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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 of 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 have thusfar instituted some form of Medicaid managed care for behavioral health services.¹

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.² 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 that combines 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. Because these contracts can and do 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

¹ "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>.

² See, e.g., the vast body of fee-for-service case law in chapters 2 and 3 of Rosenblatt R, Law S, and Rosenbaum S. Law and the American Health Care System. (1997; 1999-2000 Supplement). Foundation Press. New York.

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*,³ they reflect the realm of potential legal issues that can arise in a health environment in which hybrid corporations compete for service contracts and care is allocated in accordance with insurance principles. We examine five types of legal disputes:

- 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 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, Connecticut 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 of health care workers seeking prior authorization for treatment for children who were a danger to themselves or to others who were told that no in-patient hospitalization was 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

³ See accompanying review of recent managed care-related case law in Rosenbaum S, "An Overview of Legal Developments in Managed Care Case Law." This report presents analyses of case law in the areas of: (1) claims brought by managed care enrollees against managed care companies and health plans; (2) cases related either directly or indirectly to managed care and brought by both beneficiaries and MCOs against State Medicaid agencies and other public agencies engaged in the purchase of managed care; and (3) cases brought by individual health professionals against MCOs.

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 (DSS) contract were often shifted to the Department of Children and Families (DCF) – 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 were DSS, DCF, 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 (4) 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. (PHS) and DSS alleging the PHS uses "flawed" notification procedures which prevent patients from pursuing medically necessary services.⁴ 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.

DSS is named in the suit because the complaint alleges that DSS has failed to meet its contractual duty to monitor PHS's 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

⁴ *Karen L. v. Physicians Health Services Inc.*, D. Conn., No 3:99 CV 2244, complaint filed 11/17/99.

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 and PRO Behavioral Health

In June 2000, the *Hartford Courant* reported on a financial dispute between PHS and PRO Behavioral Health, PHS's subcontractor for the delivery of managed mental health care. The dispute has led to significant 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 it was supposed to and that it is PRO's responsibility to pay the providers. Attorney General Blumenthal is investigating what 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 a co-sign by PHS.

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

Attorney General 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 that it pressured 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.⁵ 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.⁶ Attorney General Blumenthal said he would appeal the decision.

3. *State of Connecticut v. Four HMOs*

On September 7, 2000, Attorney General Richard Blumenthal filed a class action suit against four Connecticut HMOs, making Connecticut 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, the suit alleges that:

⁵ See accompanying discussion of case law regarding the effect of ERISA preemption on the liability of HMOs in Rosenbaum S, "An Overview of Legal Developments in Managed Care Case Law."

⁶ See accompanying summary of *Pegram v. Herdrich* in Rosenbaum S, "An Overview of Legal Developments in Managed Care Case Law."

- 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 Attorney General 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, the Attorney General is party to another suit against PHS, to the extent that as Attorney General he must defend DSS in a class action suit brought against PHS and DSS on behalf of Medicaid managed care enrollees served by PHS.

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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 (Vista), 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, Montana in March 1997. In June 1997, MCP, while 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., the parent company of MCP.

MCP held the contract for only 2 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 was never efficiently run as a company. 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 in a series of three reports. 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 rollout of Salud!, However, Governor Gary Johnson 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, there were five general problematic issues 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 because 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 dropped out of 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 access barriers in the program. 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 within 90 days from the date of the letter. The State was also required to submit a transition plan describing how it 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), which was 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.⁷

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 rollout 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.

⁷ 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; 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>.

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 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 then 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's 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.⁸ 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."

⁸ 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."

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.”⁹

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 5th U.S. Circuit Court of Appeals in New Orleans on October 18, 2000. Most recently, in early January 2001, the plaintiffs have 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.

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⁹ 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).”

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."

Attorney General 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, Attorney General 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, Attorney General 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 the availability of adequate data, but that concerns about the inappropriate shifting of costs to the public sector appear to merit further study.

Sources:

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