Courts As Gatekeepers In Managed Care Settings

What happens when courts order mental health and substance abuse care? Challenges exist, but they are not insurmountable.

by John Petrila

Recently, a court ordered that a woman convicted for driving while intoxicated receive alcohol treatment. The managed care company responsible for administering the program that was to treat her denied payment. A representative of the company, commenting on its decision, was quoted as saying that “treatment is not medically necessary [simply] because it is court-ordered.” This dispute illustrates a type of conflict that may become increasingly common as government contracts with private managed care companies to administer publicly financed human services programs in which judges function as primary gatekeepers. This conflict and suggestions for resolving it are the subject of this Commentary.

Background. The impact of judicial decision making on the health care system has been the subject of debate in this journal and elsewhere. However, the courts play another role that has occasioned less comment in the health policy literature. This is the role of gatekeeper to health and human services, including alcohol and substance abuse treatment programs, foster care services, juvenile justice services, and public mental health services. These services, traditionally paid for and regulated by government, are increasingly subject to management by private managed care organizations (MCOs). As MCOs attempt to bring greater efficiencies to these programs and contain costs, in part through the application of “medical necessity” criteria, the relationship between judicial and managed care gatekeepers is assuming increasing importance. This relationship has been discussed only occasionally, primarily in the context of a recent analysis of Medicaid managed care contracts, which found that only a few states have addressed the question of who pays for court-ordered services in a managed care environment. Although the topic has received little attention, it is a significant issue in the management of human services systems. As one
group of commentators has observed, “because of the potential con-
sequences to individuals who fail to obtain care, court-ordered treat-
ment duties are a particularly important aspect of the relationship
between MCO contract coverage and interagency relationships.”

Human Services Systems

As the percentage of commercial insurance plans that are “managed”
increases, managed care companies have looked to the public sector
for new opportunities. Public mental health systems, in which
courts play a significant role through involuntary civil commitment,
were an attractive early target. Many states had relied on Medicaid
to expand community services. When states decided to contract out
the administration of Medicaid expenditures, mental health (and
sometimes substance abuse) spending was affected as well, often
through “carve-out” contracts.

Today, other markets beckon. Some represent an expansion from
early forays into mental health treatment. For example, one analysis
noted that “as revenue from the bulimic teenagers, depressed middle
managers and alcoholic executives—who have traditionally been
covered by private insurance—continues to shrink, private compa-

nies are gearing up to treat the unemployed drug addicts, crack
babies and other chronically ill people who historically have de-
pended on government funds for psychiatric care.” Governments
are contracting for the management of other health and human serv-
ces systems as well, including foster care, juvenile justice services,
and health and behavioral health care services provided in the crim-
inal justice system.

Common characteristics. These different systems share a
number of traits. The persons who become subject to these systems
are often impoverished. Family structures often are fragmented,
shattered, or nonexistent. Comorbidity is common; many persons
with mental illnesses also have an alcohol or substance abuse diagno-
sis, and inadequate access to primary and preventive health care may
exacerbate physical health problems. Another complicating factor is
the issue of risk. For example, the adolescent charged with a serious
juvenile offense may be perceived as a risk to the public; the child in
foster care may be at risk of physical abuse; the person with a serious
mental illness may be at risk of harming him- or herself or another
person; and the person addicted to crack cocaine may be human
immunodeficiency virus (HIV)–positive. Regardless of how risk is
defined, it is often the issue that results in judicial intervention.

The human services systems designed to resolve these problems
are often disorganized and underfunded, which exacerbates prob-
lems of access and continuity of care. The same person may be in the
foster care system as a small child, the juvenile justice system as a teenager, and the public mental health or substance abuse system a few years later. Yet these systems are often administered by separate bureaucracies, funded by discrete budgets, and lobbied by constituent groups that view other human services systems as competition for scarce financial resources. The same fragmentation often exists at the provider level, with hospitals, ambulatory care programs, and specialty providers competing for clients and resources. As a result, persons with serious need often have difficulty gaining access to care; if access is achieved, continuity of care may be rare. Government has turned to managed care to “guard the gate” to these systems, in part to contain costs, and in part to focus more closely on the “fit” between clients’ needs and resource allocation.

Judges as gatekeepers. A judge, often by default, also sits as a gatekeeper to these highly fragmented service systems. This is because a judge—whether adjudicating a delinquency petition, resolving a petition to move a child to a safer environment, or ordering a defendant into drug treatment in lieu of incarceration—ostensibly has the authority to gain access to care for the person whose case is before the court. A court in an individual case may be unable to resolve the systemic issues that can render even judicially ordered care inadequate. However, the authority to order access to care gives the judiciary a highly important gatekeeper role that must be considered as government contracts with private companies for the management of myriad treatment and social services.

Resource Allocation By The Courts

A court playing this gatekeeping role allocates health and human services resources in at least three ways. These include assessment, ordering treatment, and controlling discharge from treatment.

Assessment. Courts order health and behavioral health care professionals to assess thousands of persons each year. These assessments may inquire into a criminal defendant’s competency to stand trial or the rehabilitative potential of a juvenile. They may seek information regarding the existence of a substance abuse problem or recommendations regarding disposition of a case. Assessments in cases involving children may focus on the emotional or physical status of the child or may seek to determine whether a parent or custodian should be ordered into treatment.

These assessments can have enormous influence over the allocation of health and human services resources. First, the assessment itself costs money. A question may arise about whether certain types of assessments—for example, foster care assessments—are the responsibility of the managed care company administering the system.
“A managed care company may disagree with the court’s exercise of ‘clinical’ judgment.”

in question or whether financial responsibility is lodged elsewhere. Second, courts seldom deviate from the treatment suggestions offered as part of an assessment. Research in a number of areas suggests that the most significant predictor of how a court will dispose of a particular case in which there has been a psychiatric or psychological assessment is the recommendation of the examiner.

- **Ordering treatment.** After assessment, courts often order treatment. For example, courts routinely direct criminal defendants to obtain substance abuse treatment. In civil commitment proceedings, a court order often results in hospitalization, and defendants adjudicated not guilty by reason of insanity are generally committed to the public mental health system for treatment and confinement. Courts also may order parents or children into treatment as part of the resolution of a custody or other family dispute.

  In directing these placements, courts often name the specific provider that is to provide the treatment. In other cases, courts may impose conditions that govern the person’s treatment. For example, a court might order counseling three times a week for substance abuse, with weekly urine screens. When public safety is at issue, a court may direct that treatment take place in a physical environment that minimizes the opportunity for escape. These orders effectively prescribe treatment with a degree of specificity that may or may not be congruent with the medical-necessity criteria applied by a managed care company.

- **Discharge decisions.** Courts also may control the length of time that a person stays in treatment, often through legislatively granted authority. For example, in most states a judge, not the treatment provider, determines whether to discharge from treatment a person who is found not guilty by reason of insanity.

  In other cases, courts may order that a person stay in treatment a specified length of time or may insist on notice before a person’s treatment is terminated. Again, such orders may or may not match the judgment of the managed care company regarding the appropriate length of treatment, particularly in cases in which judicial concern regarding the person’s potential risk to self or third parties may cause a lengthening of treatment.

**Potential Conflicts**

While a court always anticipates that its order will be followed,
even in a fee-for-service setting, judicial orders may be imperfectly executed or ignored. The problem may be exacerbated in a managed care environment, for several reasons. One is the emphasis in most managed care plans on cost containment. This may result in reluctance to pay for long-term care, even when judicially ordered. Another may simply be disagreement between judicial and managed care plan decisionmakers: A managed care company, concerned with matching resources with its definition of need, may disagree with the court’s exercise of “clinical” judgment. The plan gatekeeper also may believe that a different provider or a different level of security than the one ordered by the court is warranted, or that no treatment is necessary.

**Conflicting goals.** In part, such disputes may result from the potentially conflicting goals of the court and the managed care plan: A court attempts to resolve an individual case, whereas a managed care plan is concerned not only with individual but with aggregate use of care. Managed care contracts typically are bounded by the benefits specified in the plan, the amount of money available for services, and the application of medical necessity criteria to control access to services. However, a court adjudicating an individual case is unlikely to be concerned with the constraints imposed upon or adopted by the managed care plan responsible for the management of the services to which the court is attempting to gain access. In addition, a court in ordering an assessment or treatment may have a motive other than securing treatment for the person; treatment may be ordered simply because the court lacks other alternatives, or because the court’s real concern is minimizing risk through the incapacitating effect of hospitalization.

**Plan structure.** The parties affected by such disputes may vary depending on how the managed care plan in question is structured. For example, if the role of the MCO is exclusively that of payer, it may argue that a provider is free to furnish care despite the denial of payment; in such a case, the provider may have to decide whether it will provide judicially ordered care without reimbursement. When the MCO also serves as a provider or, as is the case in some states, has obtained a contract from a state in affiliation with a network of local providers, the conflict may focus more directly on the court and the MCO. In either situation, the managed care company must decide whether to authorize payment for services ordered by the court.

**Enforcement and liability.** Failure to abide by the court’s order carries its own risks. An open question in such a case is whether a court would use its enforcement power (generally a contempt citation) to see that its order is carried out. Again, whether
the target of such a proceeding would be the provider or the MCO would depend on the role played by the MCO. Another question concerns the potential liability if a managed care company ignores a judicial order to provide treatment, particularly if the individual harms him- or herself or a third party. Historically, the Employee Retirement Income Security Act (ERISA) has preempted most malpractice litigation against health maintenance organizations (HMOs) in cases involving ERISA-qualified plans. Decisions in recent federal appellate cases suggest some erosion of this principle. Even more important, most publicly funded programs are not ERISA-qualified, and so a managed care plan may be at greater risk for litigation in such circumstances than it would be when an ERISA-qualified plan is at issue.

Preventing Conflict Between Gatekeepers

■ Designation of financial responsibility. There are several steps that managed care companies and governments contracting for the administration of publicly financed services may take to ameliorate the possibility of conflict between judicial and managed care plan gatekeepers. First, the managed care contract should specify which party is financially responsible for court-ordered services. A recent review of Medicaid managed care contracts conducted by Sara Rosenbaum and colleagues suggests that the handful of states that have addressed this topic have adopted different strategies. For example, Iowa makes the managed care company “responsible for provision of all Medically Necessary Covered Services ordered for Enrollees through a court action.” The contract directs the managed care contractor to work with the courts to “examine the appropriateness of [civil] commitments while developing alternatives to hospitalization.” Minnesota provides its managed care plan with the authority to conduct an assessment to determine the medical necessity of court-ordered treatment; the contractor is to provide a twenty-four-hour telephone line to expeditiously handle such cases and is also obligated to work with local social services agencies to coordinate the provision of services to persons ordered into treatment by the courts. In contrast, Wisconsin holds the HMO providing Medicaid managed care services liable for court-ordered assessments in juvenile and other cases. The health plan also is obligated to reimburse for the provision of medically necessary treatment if it is unable to provide for such treatment itself, and “the medical necessity of court-ordered services is assumed to be established and the HMO may not withhold or limit services unless or until the court has agreed.”
As these examples suggest, a state must decide whether the managed care plan retains a contractual right to conduct an independent assessment of medical necessity after the court issues its order or whether the court’s order is equivalent to a finding of medical necessity. Permitting the MCO to make an independent determination of medical necessity appears to be the better policy for achieving the goal of more rational resource allocation. At the same time, contracts that give this authority to the MCO should also include provisions such as those in the Iowa contract requiring the managed care company to work cooperatively with the judicial system to develop services that will accommodate the needs of the courts. Persons negotiating managed care contracts for public systems in which the courts play a significant role also should be aware that a failure to address the question of financial responsibility for judicially ordered treatment may invite the use of court orders as a device to shift costs from one part of a human services system to another.\textsuperscript{15}

**Choice of assessors.** Second, the MCO should inform itself regarding the manner in which courts obtain the assessments that play such a critical role in judicial decision making. Courts and attorneys often draw from professionals either directly employed by the courts (for example, in court clinics) or known to the requesting party. The persons providing the assessments may lack knowledge regarding the organization and delivery of services in the managed care plan. This in turn may result in treatment recommendations that are at odds with the philosophy of the company managing the services that the court has been advised to use. A managed care company contracting to administer publicly funded services in which the courts play a strong role may wish to assume clinical responsibility for assessments, or at a minimum take steps to educate those professionals who perform court-ordered assessments about the services offered through the plan and the clinical criteria that govern access.

**Treatment decisions.** Third, if the courts routinely order a specific provider to provide services, the managed care company and the governmental body contracting for its services may wish to attempt to negotiate with the courts for orders directing that a provider network or system provide the judicially mandated service. This would leave to the managed care company the decision as to where within the network the care is to be provided. A state or county agency moving to privatize services also might seek legislation that directs the court to name the state government (or county government if applicable) or its designee (that is, the managed care plan) as the party responsible for assuring that services are provided. This would permit the plan rather than the court to exercise...
clinical judgment regarding the specific services that the person should receive and the setting in which the services will occur, while not intruding into the court’s dispositional role.

- **Risk management.** Fourth, managed care companies involved with the administration of child welfare, criminal justice, juvenile and foster care, and other human services systems will have to develop strategies to address the various types of risks presented by the persons requiring care in those systems. These risks, whether to the client or to third parties, represent potential legal vulnerability to the managed care company and its provider network. In addition, such risks represent an important variable in judicial decision making, and so managed care companies will have to develop clinical and financing strategies that minimize these risks.

- **Dialogue.** Finally, it may be useful to create forums to discuss the relationship between managed care and the judicial system. The federal Center for Substance Abuse Treatment recently funded a six-state conference to examine the implications of managed care for providing substance abuse treatment in the criminal justice system. One topic at that conference was the potential conflict between courts and managed care plans regarding the allocation of resources. Such conferences are only one vehicle that can be used for this purpose. Managed care companies administering services in which the courts play a significant gatekeeping role will need to have ongoing discussions with local judges, district attorneys, and public defenders.

The move to managed care in many systems traditionally administered by governmental agencies has the potential to introduce efficiencies developed in the private sector to those systems. At the same time, it raises new challenges. One of the most significant is the potential for conflicts between judges, the traditional gatekeeper in many public systems, and clinical and administrative gatekeepers employed by managed care companies. The conflicts are not irreconcilable. However, managed care plans as well as government in its role as payer will need to devise a systemic response that acknowledges and accommodates the gatekeeping responsibilities of the judiciary while preserving the improvements that managed care is designed to achieve.
NOTES


2. Ibid.


5. S. Rosenbaum et al., *An Evaluation of Contracts between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders* (Rockville, Md.: Substance Abuse and Mental Health Services Administration, April 1997), 26.


9. Two federal appellate decisions suggest that in some circumstances, in which the managed care plan also provides care or leads enrollees to believe that it does, some types of malpractice claims will not be preempted. *PacificCare of Oklahoma v Burrage*, 59 F.3d 151 (10th Cir. 1995); and *Dukes v U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995).


12. Ibid.

13. Ibid., 4-22.

14. Ibid., 4-64, 4-65.
