Meeting the Needs of Female Trauma Survivors: 
The Effectiveness of the Massachusetts Mental Health Managed Care System 

Jennifer Honig and Susan Fendell†

I. INTRODUCTION

It is well documented that women with severe mental illness frequently have survived serious physical and/or sexual abuse. In recognition of this fact, there is growing understanding among trauma survivors and mental health professionals that, in order to heal, trauma survivors need specially tailored, female-centered mental health services. Despite this

© 2000, The Regents of the University of California.
† Jennifer Honig is a Staff Attorney and Susan Fendell is a Senior Attorney at the Mental Health Legal Advisors Committee, an agency of the Supreme Judicial Court of Massachusetts.
1. This article focuses on women with "severe mental illness." We use the adjective "severe" to stress that our focus is on that subset of women with mental health disorders whose psychiatric conditions are substantial and prolonged. While we do not propose scientific criteria herein to identify women with "severe mental illness" and while the clinical criteria which the Massachusetts Department of Mental Health (DMH) use to establish eligibility for services are probably more restrictive than any criteria we might set in order to further define the group of women about whom we speak, these DMH criteria offer some guidance as to the tools by which one might determine the severity of a mental illness. Pursuant to those regulations, to receive DMH continuing care services, an individual must have a mental illness that:

   includes a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and has lasted, or is expected to last, at least one year; has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic criteria specified within the current edition of Diagnostic and Statistical Manual of Mental Disorders, which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by substance related disorders, mental retardation or organic disorders.

2. See infra Part II. We use the term "trauma survivors" to refer to individuals who have survived the experience of physical and/or sexual abuse, as distinguished from the use of the term "survivor" as it is used by some individuals to describe their survival of interaction with the mental health system.
heightened awareness, the present mental health system has been largely unresponsive to calls for new treatment approaches, and the current biomedical model, for a number of reasons to be discussed below, is ill-suited to trauma survivors. Managed care, increasingly a feature in the mental health care landscape, and of the Medicaid mental health care system in particular, is heavily rooted in the biomedical model and, therefore, has not adequately met the needs of trauma survivors. To consider this problem, this article examines Medicaid managed care in Massachusetts, the first state to adopt managed care in its Medicaid mental health system.

This article has four substantive sections. In Part II, we present evidence that there is a substantial likelihood that a woman with severe mental illness has a history of physical and/or sexual abuse. In Part III, we discuss the Massachusetts mental health care system and its structure, noting particularly the changes for Medicaid recipients caused by the transition to privately managed care. In Part IV, we first examine the particular needs of female trauma survivors. We then identify the impediments within the private management of the mental health care system to meeting those needs, using the Massachusetts system as an example. In Part V, we consider various legal and political approaches to forcing the mental health managed care system to provide the requisite care and treatment.

Our examination of the privately managed mental health care system leads us to conclude that this model cannot adequately address the needs of trauma survivors. In light of rapid, apparently inexorable privatization in the health care arena, we seek to expose the harm caused by the current system of care. Until a single payor system is adopted, we explore avenues for obtaining relief from the worst excesses of for-profit management of mental health services.

---

4. We use the term "biomedical model" as shorthand; critics use a range of similar terms, such as "medical model" and "biological psychiatry." Each of these terms describes that archetype of the system of care for individuals with mental illness which emphasizes the importance of the biological origins and causes of mental illness and, correspondingly, the effectiveness, often to the exclusion of other types of treatment, of psychiatric medications in treating mental health problems. This model is distinguished from other models of mental health treatment which place a greater emphasis on the importance of social and environmental causes of mental illness and on non-medication-oriented methods of treatment, such as psychotherapy and behavioral approaches. See, e.g., Ronald Leifer, Introduction: The Medical Model as the Ideology of the Therapeutic State, 11 J. MIND & BEHAV., 247, 255-56 (1990) (describing the efforts taken by psychiatry to assert its medical identity and the costs of the "medical model" of psychiatry); Sohan Lal Sharma, Perimeter of the Medical Model (last modified Feb. 11, 2000) <http://www. enabling.org/ia/szasz/sharma_ch2.html> (critiquing the "medical model"); David Kaiser, Commentary: Against Biologic Psychiatry, XIII PSYCHIATRIC TIMES (Dec. 1996) <http://www.mhsource.com/p/t961242.html> (critiquing "biologic psychiatry"); D. B. Double, Can Psychiatry Be Retrieved from a Biological Approach? (visited Feb. 15, 2000) <http://www.uea.ac.uk/~wp276/Can.htm> (critiquing "biological psychiatry"); see also National Association for Rights Protection and Advocacy, Psychiatric Survivors at Mental Health Conference Appeal for Justice! (visited Feb. 15, 2000) <http://www.connix.com/!narpa/whitehouse.htm> (describing, in press release emanating from a break-out session at the June 7, 1999, White House Conference on Mental Health, that activists feel traditional mental health services, particularly medication, are insufficient and should be supplemented by a range of community services).
II. SUBSTANTIAL LIKELIHOOD OF ABUSE HISTORY AMONG WOMEN WITH SEVERE MENTAL ILLNESS

Men and women with severe mental illness are often survivors of trauma, particularly physical and/or sexual abuse. While the mental illness of trauma survivors may have a variety of origins, research suggests that the development of mental illness may be strongly affected by abuse history, or at the very least, frequently coexists with such a history. Studies reveal that between 50 and 80% of men and women who receive a diagnosis of mental illness have a history of sexual and physical abuse.

We use the terms "sexual abuse" and "physical abuse" to refer to assault experiences sustained in childhood and/or adulthood. See Maxine Harris, Modifications in Service Delivery and Clinical Treatment for Women Diagnosed With Severe Mental Illness Who Are Also the Survivors of Sexual Abuse Trauma, 21 J. MENTAL HEALTH ADMIN. 397, 397 (1994) [hereinafter Harris, Modifications in Service Delivery]. We use the term "trauma survivor" as shorthand in referring to those individuals who have endured either or both of those experiences. The use of the term "trauma" in this context should be distinguished from the psychiatric diagnosis of post traumatic stress disorder (PTSD), although trauma survivors often carry this diagnosis. See Dusty Miller, Women Who Hurt Themselves 173-74 (1994). Female trauma survivors receive a range of diagnoses and some receive more than one over time. Dusty Miller, who writes about women who harm themselves, a significant subgroup of women trauma survivors, notes: "these women have been diagnosed as schizophrenic, depressed, obsessive-compulsive, narcissistic, histrionic, borderline, multiple personality-disordered, alcoholic, anorexic, bulimic, drug-addicted, or suffering from more unusual compulsions such as trichotillomania (compulsively pulling out hair)." Id. at 154.

Physical and sexual abuse have a serious impact on both men and women. According to the U.S. Surgeon General, "[t]he long-term consequences of past childhood sexual abuse are profound, yet vary in expression. They range from depression and anxiety to problems with social functioning and adult interpersonal relationships." CENTER FOR MENTAL HEALTH SERVS., U.S. DEP'T OF HEALTH AND HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL—EXECUTIVE SUMMARY 231 (1999) [hereinafter MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL]. Post traumatic stress disorder and adult-onset depression are typical long-term effects of childhood sexual abuse. "Other long-term effects include self-destructive behavior, social isolation, poor sexual adjustment, substance abuse, and increased risk of revictimization." [citations omitted] Id.

Women are much more likely than men to be victims of sexual abuse. Dusty Miller notes that "significantly more girls than boys are sexually abused, according to the researcher Diana Russell (1986) in her ground-breaking study of self-reported sexual abuse—a fact that has since been confirmed by the majority of child abuse experts (for example, Herman, 1992; Courtois, 1988) . . . ." Miller, supra, at 161. Miller cites the findings of researchers van der Kolk and Kreisman that men who have been abused in childhood are likely to turn their anger outward rather than inward, and notes that the subsequent violent acts are seen as "relatively normal" while a woman's outward show of anger is seen as "out of control and not normal." Id.


See id.

Research that isolates female psychiatric patients reveals equally high or higher frequencies of abuse history. For example, a 1992 review of literature on adult female psychiatric patients found that many had survived childhood sexual abuse, including abuse in the home. While not all patients acknowledged the abuse directly, observers noted that a considerable number of the women manifested symptoms characteristic of childhood sexual abuse survivors. Similarly, one study of one hundred previously homeless women attending a Washington, D.C. non-profit mental health clinic found that 97% of the women had experienced sexual or physical abuse during their lives and 87% had been abused both as children and adults. For these women, who had survived pervasive and severe abuse, rape and physical battery had become "normative experiences" in the words of the researchers.

Discrepancies in prevalence rates are explicable, and do not undermine the general conclusion that abuse is a significant factor in mental illness. These discrepancies may be due to the methods of determining history of abuse and to the characteristics of the populations surveyed. For example, one 1984 study found a 43% prevalence of physical and/or sexual assault histories among adult and adolescent male and female psychiatric inpatients, while subsequent studies involving direct questioning found rates twice as high. In fact, real rates of abuse, particularly incest and other forms of sexual abuse, may even be higher than those reported, by reason of underreporting due to shame and lack of recall. The fact that the most severely mentally ill patients are often excluded from studies because they are unable to provide informed consent also suggests that the reported rates understate the true incidence of abuse.

---

9. While these statistics reveal that women with severe mental illness are likely to be survivors of abuse, other data suggest that there is truth to the corollary as well—that women who have experienced abuse are more likely to develop mental illness than those who have not had such experiences. For example, "[b]attered women are four to five times more likely to require psychiatric treatment than non-battered women and are five times more likely to attempt suicide than non-battered women." Karin Raye, Violence, Women and Mental Disability 3 (1999) (unpublished manuscript, on file with Mental Disability Rights International, Washington, D.C.).


11. See id.

12. See Maxine Harris, Treating Sexual Abuse Trauma with Dually Diagnosed Women, 32 Community Mental Health J. 371, 372 (1996) [hereinafter Harris, Treating Sexual Abuse]; see also Caroline W. Jacobus, Legislative Responses to Discrimination in Women's Health Care: A Report Prepared for the Commission to Study Sex Discrimination in the Statutes, 16 WOMEN'S RTS. L. REP. 153, 205 (1995) (reporting researchers' estimates that between 85 and 95% of all domestic abuse victims are women).

13. See Doob, supra note 10, at 245-46, 248. A review of these studies that directly inquired into women's histories revealed rates of childhood sexual abuse between 20 and 40%. See id. at 246.

14. See id. at 246.

15. See id.
MEETING THE NEEDS OF FEMALE TRAUMA SURVIVORS

III. LOOKING TO THE MASSACHUSETTS MENTAL HEALTH CARE SYSTEM

Massachusetts was one of the first states to fully embrace privately managed care for its Medicaid program. In this Part, we explain why managed care and Medicaid are central to the shape of care that female trauma survivors receive. We then describe Massachusetts’ managed care program and compare it to the use of managed care by other states.

A. Growth of Managed Care

Privately managed care takes two main forms: utilization review organizations (UROs) and health maintenance organizations (HMOs). UROs establish contractual relationships with providers, who must obtain pre-treatment authorization from UROs for most, if not all services to obtain reimbursement. HMOs directly employ providers, rendering them subject to direct control by these insurers. In both cases, there are financial incentives to limit care. Employers and benefits programs pay UROs on a capitated basis; insurance premiums represent capitated payments to HMOs. Capitation is the payment of a flat rate per month for each recipient independent of services actually rendered. Privately managed care seeks to limit services by paying a set amount per person regardless of the amount or type of services performed. 16

Managed care represents the largest growing portion of insureds in the United States. In 1999, almost 177 million Americans with health insurance (72%) were enrolled in managed behavioral health organizations. 17

The experience of Medicaid recipients is comparable. 18 Over 40% of the Medicaid population was enrolled in managed care programs in 1996, as compared to only 9.5% in 1991. 19 As of June 1998, approximately 12.6 million Medicaid recipients received health care through either a fully or partially capitated

---

16. For further discussion of privately managed care, see generally SOPHIE KORCZYK & HAZEL WITTE, THE COMPLETE IDIOT’S GUIDE TO MANAGED HEALTH CARE (1998).
17. See MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, supra note 5, at 422.
18. Medicaid eligibility is based on two categories established by the federal government: people receiving Temporary Assistance for Needy Families (TANF) and people receiving Supplemental Security Income (SSI) for the blind, aged, and disabled. States may establish other optional categories of eligibility. The categories established by Massachusetts, for example, are discussed infra Part III.D and accompanying notes.
19. See Health Care For All, National Summary of Medicaid Managed Care Programs and Enrollment (last modified Feb. 21, 1997) <http://www.hcfa.gov/medicaid/trendsl.htm>.
20. See id.
managed care program. Moreover, managed care programs receive more of their funds from Medicaid than from any other source, with 79% of programs receiving some Medicaid funding and 36% receiving Medicaid funding exclusively. The desire of both employers and elected officials to cut health care costs, rather than change budgetary priorities, makes managed care organizations (MCOs) an alluring alternative. Given the market share controlled by MCOs and the likelihood that managed care will continue to grow, we must examine the managed care system to determine whether this agenda adequately addresses the needs of women trauma survivors.

B. Many Trauma Survivors are Served by the Medicaid Program

There are a number of reasons for focusing on the Medicaid program in considering the mental health care concerns of women trauma survivors. First, because Medicaid is a public program, claims statistics, while limited, are nonetheless available to the public for scrutiny. Second, women are more likely than the population as a whole to need Medicaid services. Women comprise a significantly larger portion of those persons in the United States living below the poverty level than do men. Of all adults living below 100% of the poverty level in 1998, 57% were women; below 200% of the poverty level, 55% were women. Con-
sequently, women also comprise a greater portion of the Medicaid population. In 1996, 15% of the general female population was enrolled in Medicaid, compared to 10% of the general male population. In the same year, 61% of payments to vendors by Medicaid were for female recipients, as opposed to 38% for male recipients.

Third, people with severe mental illness are often unable to maintain employment, causing them to have low incomes, and making them less likely than the general population to have private forms of insurance. A recent study found that individuals with certain psychiatric disorders are three to five times more likely to be unemployed than those persons without such disorders; rates which the authors of the study contend "are not an artifact of the higher percentage of women with a mental disorder." Women with untreated mental illness resulting from trauma are particularly unlikely to be financially secure: "With her trauma history untreated, the woman's difficulties persist, her resources dwindle, and she often finds herself receiving treatment within the public system.

Finally, women are less likely than men to have private insurance. Further, some private insurers have policies that bar victims of domestic abuse from health care coverage.

Thus, in evaluating the ability of a mental health managed care system to treat women trauma survivors, we look at the Medicaid managed care program because female survivors are likely to be heavily represented in that program. Further, since privately managed care is the dominant trend in health care provision, those persons interested in the mental

30. Harris, Treating Sexual Abuse, supra note 12, at 372. Those who are chronically disabled are eligible for Social Security disability benefits and, if they have low incomes, Medicaid. In addition, chronic disability often provides for categorical eligibility for state benefits programs. See, e.g., Emergency Aid to Elders, Disabled and Children, MASS. GEN. LAWS ch. 1117A (2000).
31. Victim compensation laws, when they can be invoked, offer only a modest measure of assistance to victims of physical and sexual abuse. For example, the relevant Massachusetts statute provides crime victims with compensation for personal physical or psychological injury only if the victim reports the crime within five days (unless good cause for delay is demonstrated), cooperates with law enforcement authorities in its investigation and prosecution (unless a reasonable excuse is demonstrated), and has incurred actual loss, as specified in the statute. See MASS. GEN. LAWS ch. 258C, § 2 (1999). While compensation could be used to cover costs associated with mental health care, no compensation is available for individuals who do not assist in prosecuting the alleged perpetrator. Women often enter mental health treatment soon after abuse occurs, but are not ready at that point to pursue prosecution. Moreover, given the requirements of timely reporting and of pursuing prosecution, survivors who were abused as minors will likely find it difficult to obtain relief under this statute years later.
32. See Jacobus, supra note 12, at 166 (noting that women of all ages are approximately twice as likely to be underinsured as men in the United States).
health needs of female survivors should carefully monitor privately managed care trends.

C. The Massachusetts Experiment with Medicaid Managed Care

The Massachusetts mental health service delivery system has changed dramatically in recent years, as both privately and publicly funded mental health services increasingly are provided through managed care plans. Public insurance through Medicaid was, until 1992, provided on a "fee-for-service" basis whereby the provision of a service triggered payment. Medicaid recipients could choose any doctor, hospital, or provider who accepted Medicaid.

In 1992, the Massachusetts Department of Public Welfare, later renamed the Department of Transitional Assistance (DTA), began to implement mental health managed care for Medicaid recipients. To do so, Massachusetts obtained a section 1915(b) waiver from the federal Health Care Financing Administration (HCFA) of Medicaid's freedom-of-choice provisions. With certain limited exceptions, Medicaid recipients had to enroll in a managed care plan for mental health benefits. Recipients could select either a single primary care clinician (PCC) or an HMO. Under the PCC program, the PCC acts as a gatekeeper for physical health care services while mental health services are "carved out" to a contractor who manages behavioral health services. Under the HMO program, individuals choose among a number of HMOs and, except for a

33. See Susan Fendell, Privately Managed Mental Health Care: Shrinking Services, INT'L J. MENTAL HEALTH, Summer 1998, at 5.
35. See Section 1915(b) of the Social Security Act, 42 U.S.C. § 1396n(b). Massachusetts had a Section 1915(b) waiver until July 1997, when a Section 1115 waiver, Section 1115 of the Social Security Act, 42 U.S.C. § 1315(a), was substituted. See Substance Abuse and Mental Health Serv. Admin., Managed Care Tracking System: State Profiles on Public Sector Managed Behavioral Healthcare and Other Reforms, Massachusetts, (visited Feb. 15, 2000) <http://www.samhsa.gov/mc/StatePrfls/massachusetts.html>. Section 1115 waivers require fewer safeguards for beneficiaries than section 1915(b) waivers and, therefore, are preferred by administrations intent on privatizing the management of health care in their states. See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 7; Susan Fendell, Playing the Numbers: 1915(b) vs. 1115, ADVISOR (Mental Health Legal Advisors Comm., Boston, Mass.), Fall 1994, at 12, 12-14.
37. As of March 1993, about 650,000 Massachusetts residents were Medicaid eligible. Of these eligible individuals, 90,000 also had Medicare or other insurance coverage and, for that reason, were not enrolled in the managed care program. In addition, 85,000 were HMO enrollees, and were therefore not served by the managed care mental health carve-out. At this point, 200,000 people were enrolled in the primary care clinician program. See Wieman, supra note 24, at 19.
38. See MASS. REGS. CODE tit. 130, § 508.001(A) (1999).
39. "A gatekeeper is typically a primary care doctor. All care other than that of the primary care physician or true emergencies must be approved by the patient's primary care physician." KORCZYK & WITTE, supra note 16 at 7.
subcategory of Medicaid recipients, receive mental health services directly from the HMO or its subcontractors. Under Massachusetts’ waiver, mental health care services were carved out from Medicaid, and the Division of Medical Assistance (DMA), a division within DTA, contracted with a for-profit MCO on a capitated basis to provide mental health and substance abuse services to all Medicaid recipients in the program except those enrolled in HMOs.

The use of managed care in Massachusetts’ Medicaid program has expanded continually since its implementation in 1992. Massachusetts’ first behavioral health MCO, Tennessee-based Mental Health Management of America (MHMA), managed the care of most welfare and Supplemental Security Income (SSI) recipients from July 1992 through June 1996. MHMA contracted with inpatient and outpatient behavioral health providers who became the sole providers eligible for Medicaid reimbursement. In July 1996, emergency, acute inpatient, and diversionary care provided by the state mental health agency, the Department of Mental Health (DMH), were placed under the management of the MCO. In July

41. Presently, members enrolled in a HMO receive mental health care through the HMO if they are MassHealth Standard and MassHealth Family Assistance Members, while HMO enrollees receive mental health care through DMA’s contractor if they are MassHealth Basic Members. See Mass. Regs. Code tit. 130, § 508.001(C)(2)(a), (b) (1999). MassHealth Basic is available to individuals or members of a couple who receive cash assistance from the state under its Emergency Aid for the Elderly, Disabled and Children program, or are unemployed for a long period of time. See Mass. Regs. Code tit. 130, § 505.006(A)(1) (1999).

42. See Mass. Regs. Code tit. 130, § 508.001(C)(2)(a) (1999). Several of the HMOs contract with a behavioral health MCO similar to DMA’s current carve-out contract. Indeed, the staff of the MCO used by the HMOs includes persons originally employed by the state’s first carve-out contractor. See Susan Fendell, Notes from Dec. 3, 1999 Meeting of Behavioral Health Advisory Council (on file with authors) (noting that Betsy Patullo, formerly of MHMA, now heads up Beacon Health Strategies, LLC).

43. See Wieman, supra note 24, at 21. The popularity of behavioral health carve-outs, beginning in the late 1980s, grew concurrently with crusades to pare down social programs and to cut expenditures for employee benefits. Although the total national cost of physical health care has leveled off since 1993, mental health care costs have continued to increase. See Jesse A. Goldner, Managed Care and Mental Health: Clinical Perspectives and Legal Realities, 35 Hous. L. Rev. 1437, 1448 (1999). Massachusetts Governor William Weld and his successor, Paul Cellucci, specifically implemented Medicaid managed care to cut the state’s Medicaid expenditures. In addition, both Republican governors are adherents of privatization. See Rochefort, supra note 34, at 1; see also The Massachusetts Republican Party 1998 Platform (visited Mar. 28, 2000) http://www.massgop.com/platform.htm (stating, during Cellucci’s campaign, that “the Massachusetts Republican Party advocates health care reform through instituting competitive options including privately-run managed care.”)

44. To receive DMH continuing care services, one must meet DMH eligibility clinical criteria. See Mass. Regs. Code tit. 104, § 29.04(3) (1999). One must also be determined to be in need of DMH continuing care services. See id. at § 29.04(4) (1999). The need involves an assessment of the person’s current medical entitlements and/or insurance, and availability of appropriate services from other public or private entities. See id. at § 29.04(4)(c), (d). DMH continuing care services are defined as community-based services contracted for or operated by DMH, but which do not include services of brief duration, outpatient services, court evaluations, or acute mental health services, such as crisis intervention or emergency screening. See id. at § 29.02 (1999).

DMH’s inclusion of a needs determination in its eligibility criteria represents an attempt, as other states have done, to become a “payor of last resort,” transferring the health care costs to federally funded insurance programs whenever that option is available. See Wieman, supra note 24, at 8.
1996, the Massachusetts Behavioral Health Partnership (Partnership), then owned by Value Behavioral Health, Inc. and FHC Options, assumed the management of Medicaid mental health managed care in Massachusetts. Partnership undercut other bidders to obtain the contract, despite the fact that the company had higher administrative costs than other bidders. In 1998, DMA expanded its use of HMOs for Medicaid recipients, contracting with six HMOs to provide both physical and mental health care. By March of 1999, Massachusetts had over 500,000 Medicaid recipients enrolled in its mental health carve-out program.

D. Comparing Massachusetts to Other States

In 1992, Massachusetts was the first state to establish a statewide capitated mental health carve-out. Other states soon followed suit. By mid-1998, thirty-six states had Medicaid waivers for managed care services. Sixteen of these states had waivers for Medicaid carve-out mental health services for adults, often combined with substance abuse services.

Of DMH clients, only those who have Medicaid as their primary insurance will have their mental health care managed by DMA. Those who have Medicare as their primary insurance and Medicaid as their secondary insurance continue to have their care managed by DMH. See Susan Fendell, Mental Health Managed Care: Expansion to DMH Acute Care and Medicaid Update, ADVISOR, Fall 1995, at 12, 12.

FHC Health Systems is the parent company of Options Health Care, Inc. Columbia HCA, then under investigation for Medicaid fraud, acquired Value Behavioral Health's parent company. Due to state conflict of interest provisions (Columbia owned some Massachusetts providers), Columbia was forced by Options to sell its interest in the Partnership. On July 15, 1997, Value Behavioral Health transferred its interests in the Partnership to Options. See Susan Fendell, Partnership No More, ADVISOR, Fall/Winter 1997, at 21, 21. On June 18, 1998, FHC Health Systems completed its acquisition of Value Behavioral Health from Columbia/HCA, creating Value Options. See Value Options, Value Behavioral Health (visited Nov. 30, 1999) <http://www.phc.com/phc/firmain.htm>.

DMA initially planned to issue a request for proposals for a privately managed company to manage both mental health and physical care services. See Susan Fendell, DMA Expands its Use of For-Profit Managed Care: Current Management Unchecked, ADVISOR, Winter/Spring 1999, at 3, 6. However, public reaction to DMA's request for information apparently was sufficiently negative that DMA has rethought its strategy and the ultimate shape of the program is unclear. See, e.g., Letter from Mark Reynolds, Acting Commissioner, DMA, to All Interested Parties (Jan. 7, 2000) (on file with authors) (issuing a second request for information and announcing a "slower, more incremental approach" to changes in plan management, "in consideration of some respondents' concerns").


See id. at 2 n.7.

See id. In addition, a survey of 50 large HMOs revealed that about half of HMO enrollees were enrolled in carve-out plans. See Mental Health: A Report of the Surgeon General, supra note 5, at 422.
Carve-outs vary in their features. Some carve-outs, like the Massachusetts program, cover both mental health and substance abuse services, while others cover only substance abuse services.\(^{52}\) Whereas the Massachusetts carve-out is a statewide program, others are temporarily implemented in limited geographic areas within a state until statewide coverage undergoes expected expansion at a future point.\(^{53}\)

Carve-outs also vary in the populations served; they are likely to cover the categorically needy, but they also may be limited to certain subgroups (e.g., those with severe mental illness, children, or the medically needy). Several have explicit exclusions (e.g., individuals who become eligible for Medicaid after depleting, or “spending down,” their assets, those who are age sixty-five or older, and, commonly, those in a state institution or nursing facility).\(^{54}\) Some carve-outs offer HMOs as an alternative to enrollees.\(^{55}\) Some requests for proposals, or the state document that solicits bids, indicate that involuntarily committed patients will be covered under the program.\(^{56}\) Massachusetts excludes from its program: HMO enrollees; individuals age sixty-five or older; individuals with private insurance or Medicare coverage; individuals institutionalized in nursing facilities, chronic disease or rehabilitation hospitals, intermediate care facilities (ICF/MR) described in federal law,\(^{57}\) or state psychiatric hospitals; aliens; individuals who are presumptively eligible for Medicaid; hospice residents; and individuals eligible for Medicaid because of spend-down policies. Unlike a number of other states’ waiver programs, which only cover recipients of Temporary Assistance for Needy Families (TANF),\(^{58}\) Massachusetts’ waiver program covers people with disabilities. Because other states are expanding their coverage to include this group, it is useful to look at Massachusetts’ experience.\(^{59}\)

A state may contract with a single contractor or with multiple vendors.\(^{60}\) Some states, like Massachusetts, contract with a single statewide

\(^{52}\) See Haiden A. Huskamp, National Alliance for the Mentally Ill, State Requirements for Managed Behavioral Health Care Carve-Outs and What They Mean for People with Severe Mental Illness 3 (1996).

\(^{53}\) See id.

\(^{54}\) See id.

\(^{55}\) See id.

\(^{56}\) See id.

\(^{57}\) See id.


\(^{59}\) See Wieman, supra note 24, at 1.

\(^{60}\) See Huskamp, supra note 52, at 4.
vendor. Other states use the existing public health system and contract with community mental health centers or other local programs.61

IV. Female Trauma Survivors and the Massachusetts Mental Health Care System

The mental health managed care system described above, rooted in the biomedical treatment model and carrying the negative characteristics of private management, is not well suited to the treatment of female trauma survivors.

A. Female Trauma Survivors Have Special Needs

While the effects of abuse histories on mental health have long been understood by some within the medical world,62 these findings have been repeatedly rejected by the established medical community.63 This pattern has continued until fairly recently. As Susan Stefan notes, "[t]he vast reaction of the psychiatric profession had been to ignore entirely the matter of physical or sexual abuse in research and consequently in practice. Information about sexual abuse was rarely sought when a woman began therapy or was hospitalized."64

Change began only in the 1970s, when, emboldened by the support of a collective movement, women started speaking with a new language and openness about their histories of violence and rape.65 As Stefan writes, "[t]hey publicized the extent of the violence done to women and protested the insensitive practices and procedures by police and the judicial and medical systems that perpetuated the silence."66 In this way, women exposed how institutions continued the victimization of their patients. As women spoke up, the mental health profession began to take note: "Until 1970, there was . . . literally no professional literature at all on women's reactions to rape."67 Even today, the professional community has not fully embraced the emerging "trauma paradigm."68 In recent years, more and more mental health clinicians have recognized the need

61. See id. at 5.
62. The prevalence and import of child sexual abuse was exposed by a series of eminent figures—including Amboise Tardieu, Sigmund Freud, Sandor Ferenczi, and C. Henry Kempe—between 1860 and 1984. See Jennings, supra note 10, at 382.
63. See id. (describing how each exposure was met by the scientific community with "distaste, rejection, or discreditation").
65. See id. at 1286; see also Judith L. Herman, Trauma and Recovery 28-31 (1992).
66. Stefan, supra note 64, at 1286.
67. Id. at 1289.
68. Jennings, supra note 10, at 382 (arguing that, after 100 years and in spite of countless instances of documented abuse, the tradition of denial and victim blame continues to thrive within the scientific community).
MEETING THE NEEDS OF FEMALE TRAUMA SURVIVORS

1. Do Not Replicate Loss of Control by Using Coercion

Mental health providers routinely use coercive legal means—that is, methods that employ force or the threat of force to obtain a desired result—to obtain compliance with psychiatric treatment. Many observers have noted the problems that coercive treatment presents for women in general and for trauma survivors in particular. These observers argue that the coercive techniques and the concomitant loss of control that survivors experience within the mental health system are reminiscent of the coercion and loss of control that they experienced during physical and sexual abuse. The experience can retraumatize the individual. Among those psychiatric patients who have experienced abuse, the term “survivor” has, in light of the damaging effects of coercive treatment, assumed a second meaning: “the term ‘survivor,’ as used within the [consumer/survivor/ex-patient] movement, meant one who survived the irrelevance and frequently the harm of psychiatric interventions.”

69. Activists within the disability rights movement carried a similar message: that the established medical community needed to change its approach to treating people with disabilities. No longer should the disability be seen as the problem; instead, the system’s inability to accommodate the disability was the problem. See Jennifer Kern, Across Boundaries: The Emergence of an International Movement of Women with Disabilities, 8 HASTINGS WOMEN’S L.J. 233, 237-38 (1997).

70. See, e.g., Peter R. Breggin, From the Editor-in-Chief: Psychiatry’s Reliance in Coercion, 1 ETHICAL HUMAN SCIENCES AND SERVS. 115, 115-18 n.2 (1999) (describing modern-day psychiatry’s increasing reliance on coercive power to force treatment with drugs); William Gardner et al., Two Scales for Measuring Patients’ Perceptions for Coercion During Mental Hospital Admission, 11 BEHAV. SCI. & L., 307, 307 (1993) (citing research that legal coercion in mental hospital admission is common); see also M. Susan Ridgely et al., Women & Coercion in Mental Health Treatment: Issues, Empirical Data and Public Policy 27 (Aug. 31, 1999) (unpublished manuscript, on file with authors) (suggesting that a strong survivor movement and a critical advocacy community had been unsuccessful at stemming the increasing reliance on coercion in the mental health care system).

71. See, e.g., Auslander et al., supra note 6, at 1 (suggesting that “unless the coercive culture of psychiatry is radically altered, many persons will continue to be traumatized, whether or not such experience is repetitious of their pasts”).

72. There is an additional concern with the use of coercive treatment approaches: that they will discourage potential patients from seeking treatment. One California study found that 47% of health care system participants interviewed had avoided mental health treatment on one or more occasions because they feared being involuntarily committed. See J. Campbell, California Dep’t of Mental Health, The Well-Being Project: Mental Health Clients Speak for Themselves 118 (1989).

73. Auslander et al., supra note 6, at 1. In addition, some trauma survivors experience new incidents of physical and sexual abuse in the course of treatment in the mental health system, meaning that they are surviving not only the mental health system but also abuse within that system. See, e.g., Jacobus, supra note 12, at 328 (citing a physician testifying before the New Jersey Commission on Sex Discrimination in the Statutes who reported that “between 5 and 10% of mental health professionals admit to sexual contact with their patients”). The ex-psychiatric patient movement is referred to by multiple names to avoid having to select among the options. Some former patients like to be called “consumers,” suggesting that they should be treated with the respect that is commonly afforded consumers of any other medical service or, more generally, consumers of
woman wrote regarding her sexually abused daughter's treatment, "in spite of [the] caring [of the many mental health professionals she encountered], her experience with the mental health system was a continuing reenactment of her original trauma."

For women trauma survivors, perhaps the most serious forms of coercion are those which physically recreate the traumatic experience. Restraint is especially problematic in this respect; survivors describe connections between traumatic episodes and the experience of restraint. Unfortunately, the use of restraint in the mental health system is not decreasing; restraint use is commonplace. In fact, the economic incentives in mental health managed care may even encourage its use. Low reimbursement rates to providers result in cost-cutting measures, often including lowering of staffing levels. Low reimbursement rates also contribute to low salaries, which in turn result in high staff turnover. Both of these patterns—low staffing levels and staff who are not familiar with patients—can contribute to increased rates of restraint. Staff tend to turn

any non-medical product. See, e.g., Annette Hanson & William Crane, The Customer is Always Right, in HUMAN RIGHTS HANDBOOK 57-59 (Massachusetts Dep't of Mental Health ed., May 1999).

Some former patients prefer to be called "survivors," for the reasons discussed in the text. Others prefer the term "ex-patient." The movement of these activists in the United States began in approximately 1970, growing out of a number of groups across the country, and today incorporating a number of national, as well as many more local, organizations. See Chamberlin, supra note 3, at 2.

75.  Jennings, supra note 10, at 377.

76.  See, e.g., Andrea K. Blanch, Opening Remarks, in PROCEEDINGS FROM FORUM ON SEXUAL ABUSE SURVIVORS IN THE MENTAL HEALTH SYSTEM 2, 4 (Mental Health Ass'n in N. Y. State and N.Y. State Office of Mental Health Community Support, Jan. 11, 1994) (hereinafter PROCEEDINGS); see also MASSACHUSETTS DEP'T OF MENTAL HEALTH TASK FORCE ON THE RESTRAINT AND SECLUSION OF PERSONS WHO HAVE BEEN PHYSICALLY OR SEXUALLY ABUSED, REPORT AND RECOMMENDATIONS 4 (1996) (describing loss of control trauma survivors experience during restraint); Caroline C. v. Johnson, at 11-12 (D. Neb. Oct. 29, 1998) (No. 4: CV95-22) (consent decree) (ordering therapeutic facility to implement policies to alleviate trauma to women with history of sexual abuse including: 1) prohibition of mechanical restraints requiring legs to be spread; 2) requirement that staff person in attendance be female or be observed by a woman (unless the perpetrator of abuse was female or the survivor requests otherwise); and 3) requirement that staff ask patients about and use alternatives to restraint and means to make restraint less traumatizing).

77.  Restraint is permissible in Massachusetts at public and private facilities for the care and treatment of mentally ill persons pursuant to statute. See MASS. GEN. LAWS ch. 123, § 21 (1999). The Massachusetts Department of Mental Health monitors restraint use at facilities it licenses. For reported months in 1998, the department calculated an average of 12.41 episodes of restraint or seclusion per 100 individuals served by the facility. See facsimile from Michael Weeks, Director of Licensing, Department of Mental Health (Jan. 18, 2000) (on file with authors) (containing statistics compiled by the Department for restraint and seclusion for calendar year 1998).

While there do not appear to be clear gender differences in rates of restraint and seclusion, one study has found that the experience of being sexually abused increases the likelihood that a woman will be restrained when hospitalized. See Susan Stefan, Issues Relating to Women and Ethnic Minorities in Mental Health Treatment and Law, in L., MENTAL HEALTH & MENTAL DISORDER 266 (Bruce Sales & Dan Shuman eds., 1996) (on file with authors) [hereinafter Stefan, Issues], and researchers have not adequately explored the role of important factors, including gender and diagnoses. See Ridgely et al., supra note 70, at 35. For instance, in one study there was a higher rate of seclusion and restraint of persons diagnosed with borderline personality disorder, a diagnosis which has a higher prevalence in women, and which has been tied to possible sexual abuse. Also, "para-suicide," a behavior which is associated with sexual abuse, has been reported to be a precipitant of seclusion or restraint. Id. at 35 (citations omitted).
to restraint when they feel unsafe (which is augmented by feeling overpowered) and lacking in alternatives (which is augmented by lack of knowledge of what actions help the patient deescalate.)

In addition to restraint, many other encounters that trauma survivors experience in the mental health system may recreate the abuse history. To demonstrate the potential for conventionally accepted psychiatric practices and institutional environments to trigger memories of abuse and retraumatize the patient, Ann Jennings has charted the connections between such practices and her daughter's sexual abuse history.

Other coercive measures, while perhaps not as directly reminiscent of abuse as restraint, also repeat and recreate the loss of control experienced during abuse. For example, the use of a judicial order to enforce medication compliance removes from individuals their power to make decisions regarding participation in treatment. In many states, individuals living in the community also may be deprived of this liberty through outpatient commitment statutes. Similarly, the involuntary civil commitment process may be used either to force individuals into or threaten admission into inpatient psychiatric facilities. The use of these legal mechanisms is extremely common.


79. See Jennings, supra note 10, at 378, 379-381. For example, Jennings draws parallels between being trapped in an institution and the experience of being unable to escape a perpetrator's abuse, between losing one's privacy in an institution and having boundaries violated by an abuser, and between being injected with medications against her will and being sexually violated. See id. at 379-80.

80. Judicially authorized medication orders are permissible in Massachusetts pursuant to case law and statute. See Rogers v. Commissioner of the Dep't of Mental Health, 458 N.E.2d 308 (Mass. 1983) (holding that an individual may not refuse treatment if a judge has found that the individual is not competent to make treatment decisions and that, if the individual were competent, he or she would consent to the proposed treatment); MASS. GEN. LAWS ch. 123, § 88B (1999) (medical guardianship pursuant to the civil commitment statute); and MASS. GEN. LAWS ch. 201, § 6 (1999) (medical guardianship pursuant to the guardianship statute). Forced medication is also permissible in emergencies to prevent irreversible deterioration pursuant to Rogers v. Commissioner, 458 N.E.2d at 321-22, aff'd, Rogers v. Okin, 738 F.2d 1, 6 (1st Cir. 1984), and pursuant to the state's restraint statute, MASS. GEN. LAWS ch. 123, § 21 (1999).

81. While outpatient commitment statutes vary in their details, they generally combine an order to comply with a medication treatment plan with a mechanism to enforce compliance, such as detention in the event of non-compliance. See, e.g., N.H. REV. STAT. ANN. 1992, § 135-C:45; 405 ILL. COMP. STAT. ANN. 5/3 - 812(a) (West 1999); ARIZ. REV. STAT. ANN. § 36-540 (West 1999). In Massachusetts, probate court medication guardianships effectively serve the same purpose. See MASS. GEN. LAWS ch. 201, § 6 (1999).

82. Civil commitment is permissible in Massachusetts pursuant to statute. See MASS. GEN. LAWS ch. 123, §§ 7, 8 (1999).

83. Obtaining a judicial order to provide mental health treatment (usually medication) to individuals whom the court deems incompetent is common nationwide. In Massachusetts, for example, a
An increasingly popular yet potentially similarly coercive feature of the mental health system is the use of assertive community treatment (ACT) teams. ACT teams are composed of groups of clinicians who work together to treat certain subpopulations of mental health consumers, often high service users or “treatment resistant” persons, in an effort to avoid hospitalization. ACT teams typically provide continuous and intensive medical, psychosocial, and rehabilitative services, similar to those a survivor might receive in the hospital. While the ACT team model is praiseworthy in that it puts resources into community based care, the model often remains slanted toward ensuring medication compliance through home delivery of medication and monitoring of its acceptance. For this reason, the teams have been criticized for their biomedical approach. In addition, ACT teams’ reliance on intrusive interventions de-

survey of between 55 and 57 private and general hospitals (depending on the month), all licensed by the Massachusetts Department of Mental Health, revealed that, from January 1998 through June 1998, the hospitals filed a total of 339 petitions for orders for antipsychotic medication and other medical treatment in the district court and that, during the same time, district courts allowed 171 such petitions. In the same period, these hospitals filed 125 petitions to authorize treatment in the probate courts and probate courts allowed 86 such petitions. See An Act to Reform the Civil Commitment Process for Persons with Mental Illness: Hearing on S. 613 Before the Joint Human Servs. and Elderly Affairs Comm., 181st Leg., 1st Reg. Sess. 4 (Mass. 1999) (statement of Mary-lou Sudders, Commissioner, Department of Mental Health).

The use of civil commitment of psychiatric patients is also common nationally. The same survey revealed that district courts approved 216 out of 549 petitions filed by these hospitals. See id. A study conducted in the 1980s found that men and women were admitted for being a threat either to themselves or to property in equal numbers. See Ridgely et al., supra note 70, at 10 (citations omitted). Another study found that before the passage of tighter legal restrictions on civil commitment, men were more likely to be involuntarily hospitalized than women, but that after such reforms, the rates have been the same. See id. at 28.

84. See Robert T. Quinlivan, Treating High-Cost Users of Behavioral Health Services in a Health Maintenance Organization, 51 Psychiatric Servs. 159, 159, 161 (2000) (reporting that “assertive community treatment services have been used extensively in public mental health settings” and suggesting that ACT services also are becoming increasingly relevant for HMOs as the number of care users in HMOs rises and diagnostic profiles more closely resemble those of public sector programs). The prototype of assertive community treatment teams is the Program for Assertive Community Treatment (PACT), which derived from the Training in Community Living Program (TCL) in Madison, Wisconsin in the late 1970s. In 1998, the National Alliance for the Mentally Ill (NAMI) began a campaign to promote the expansion of this model nationwide. See NAMI, NAMI Announces Major National Initiative to Promote a Treatment Program With 25-Year Successful Track Record (visited Jan. 26, 2000) <http://www.nami.org/pressroom/981006215423.html>. In Massachusetts, DMH and the Partnership implemented PACT teams on a pilot basis in Worcester on January 1, 2000 and the agencies are attempting to start up another team in the northeastern section of the state. See Telephone Interview with Angelo McClain, Vice President, Regional Operations and Integrated Network Management, Partnership (Jan. 20, 2000); see also NAMI, State-by-State Availability of PACT Model Programs (visited Jan. 20, 2000) <http://www.nami.org/about/chart.htm>. If the financial model works, DMH and the Partnership intend to expand the model statewide. See Telephone Interview with Angelo McClain, supra.

85. One study revealed that 88% of over three hundred U.S.-based ACT programs had teams of both nurses and psychiatrists providing treatment. See Patricia Spindel & Jo Anne Nugent, The Trouble with Pact: Questioning the Increasing Use of Assertive Community Treatment Teams in Community Mental Health 2 (visited Aug. 10, 1999) <http://www.madnation.org/papcttrouble.htm> (citations omitted).

86. See id.

87. See id.

nies individuals basic autonomy and privacy rights.99 While participation may be technically voluntary, consent is obtained under threat of legally enforced hospitalization or treatment compliance.

2. Train Clinicians to Ask About and Treat Abuse

Historically, absent protocols, clinicians have only infrequently asked their patients about violence.90 Consequently, trauma histories are not uncovered, trauma survivors frequently are misdiagnosed, and those individuals for whom a trauma history is identified are mistreated.91 Female survivors argue that, with the growing recognition of the prevalence of violence against women, diagnostic tools should change to reflect the probability of an abuse history.92 Researchers and clinicians recommend that all patients be asked routinely about abuse during and after intake.93

Even once an individual's trauma history is identified, poor training often results in poor treatment. Mental health professionals lack sufficient training to understand the central effect of abuse on individuals.94 Elaine Carmen observes: "Despite the large numbers of victims/survivors

90. See Spindel & Nugent, supra note 85, at 3 (noting that the embrace of PACT "points to the absence of a grounding philosophy in community mental health practice, which has, at its base, a solid respect for the autonomy and rights of individuals, and which considers the serious personal and social consequences of removal of these rights").

91. See Herman, supra note 65, at 123.

92. See Laura Prescott, Women Emerging in the Wake of Violence 12 (1998) (arguing that providers should ask questions about abuse histories during intake).


94. See Carmen, supra note 8, at 52-53 (noting that regardless of the particular diagnosis given to a trauma survivor, the experience of abuse remains the central feature of her symptomatology).
found in psychiatric settings, mental health professionals remain gener-
ally unaware of the social and psychological consequences of abuse. The
standard training for mental health professionals does not include
education regarding the identification and treatment of patients with a
history of trauma. Professionals themselves have identified this weak-
ness in their education; in a 1994 report, the Office for Women's Ser-
vices of the Substance Abuse and Mental Health Administration reported
that health professionals wanted more specific training about treating
physical and sexual abuse. Focusing on female sexual abuse survivors,
Maxine Harris calls for staff training to understand these survivors' spe-
cial needs and to master techniques for working with them. This educa-
tion, she writes, "should address clinical theory in such areas as post
traumatic stress disorder, sexuality and female identity, group facilitation,
cognitive therapy, and nonverbal, expressive therapies.

Despite recent efforts, trauma-based services remain inadequate. Care in
the public mental health system is particularly lacking. As one
survivor explains: "I can’t find anyone to work with who understands what is going on with me, who knows what they are doing and can help me work on trauma. Those who can don’t qualify for Medicaid." The specialty units for the treatment of women trauma survivors that do exist tend to be located in private hospitals, which historically have been more difficult for poor and uninsured or underinsured people to access. As another abuse survivor describes:

Two months after my first hospitalization [at a private hospital], I required a second in-patient stay during a brief crisis period. With my private insurance exhausted, I was unable to return to the same progressive facility. I was . . . in a large, respected research hospital in the city, yet my treatment at this second program was decades behind my earlier treatment.

Similarly, a clinician observed in 1994: "Of the few specialized inpatient or day programs that exist in New York City, most are located in private facilities, not accessible to the patient on public assistance or without health insurance." At a 1995 meeting at the New York State Office of Mental Health, among the barriers that participants identified to working with survivors was that "[e]ffective trauma assessment and treatment approaches are being offered almost exclusively at private mental health programs and are therefore effectively inaccessible to individuals in the public mental health system."

The problem of lack of training is exacerbated by privately managed care. While in some states, like Massachusetts, the primary care clinician (PCC) is not the gatekeeper for mental health services, in general, women are more likely than men to seek mental health services from PCCs. These physicians are under financial pressure to keep their visits short; they also rarely receive specialized training to recognize general mental health issues, let alone issues concerning trauma. Research on local policy-makers so that they may improve the care delivery systems serving the target population. See id.

103. See, e.g., Jennings, supra note 10, at 383 (noting that new therapeutic approaches to trauma can be found on dissociative disorder units of private psychiatric hospitals). However, there are public facilities where trauma work is being done. The Victims of Violence Program, affiliated with Cambridge Hospital in Cambridge, Massachusetts, is one example. See CAMBRIDGE HEALTH ALLIANCE, COMMUNITY CRISIS RESPONSE TEAM (undated).
104. Heather Huckeba, Testimony, in PROCEEDINGS, supra note 76, at 13 (on file with authors).
106. Brennan, supra note 96, at 12.
108. See Sherry Glied, The Treatment of Women with Mental Health Disorders Under HMO and Fee-for-Service Insurance, 26(2) WOMEN & HEALTH 1, 71 (1997) (reporting that in her study of data on office visits of women between 1990 and 1994, the majority of people suffering from mental health issues are women, and women disproportionately look to their PCCs in an effort to obtain mental health services).
primary care physicians found that the rate of failure to detect psychiatric disorders ranged from 45 to 90%, depending on criteria used for detection.\footnote{110} Thus, while managed care promised to provide more holistic care,\footnote{111} the failure to train these physicians to recognize women trauma survivors' mental health needs has likely resulted in limiting women's access to needed care.

3. **Tailor Treatment for Women with Abuse Histories**

Clinicians concerned with the needs of women trauma survivors argue that traditional models of treatment—even those directed to trauma survivors—are inadequate.\footnote{112} One such clinician observes that women who have experienced sexual, emotional, and/or physical abuse in childhood and who are marginalized as adults only seldom can be helped by the treatment options presently available for trauma work.\footnote{113} Another clinician writes:

> The trauma literature generally focuses on treatment models developed for individuals with less disabling psychological impairments and more external resources. Many mentally ill victims may have neither the internal resources nor the external (social) supports needed to recover memories, grieve losses and work through the trauma . . . . There is an urgent need to develop new treatment strategies designed for victims with severe psychological disabilities.\footnote{114}

In place of the existing model of care, survivors and clinicians call for tailored treatment approaches for women who have been severely

\footnotesize{
110. See Goldner, supra note 43, at 1454.  
112. The deficiencies in appropriate care for trauma survivors are compounded by the lack of attention given women's health needs in general. Health care providers tend to treat women differently from men. The differences are noticeable in a number of areas: providers give women less thorough evaluations, minimize their symptoms, provide fewer treatments for the same diagnoses, prescribe certain medications more frequently, and offer more meager responses to their female patients' questions. See U.S. Pub. Health Serv.'s Office on Women's Health, Women's Health Issues: An Overview 2 (July 1998) (citing a 1993 survey of women's health concerns). Medical care also is compromised by inattention to gender-related biological and psychosocial factors when considering the causes, experience and treatment of medical problems. See, e.g., Nat'l Inst. of Health, U.S. Dep't of Health and Human Servs., 2 Agenda for Research on Women's Health for the 21st Century: A Report of the Task Force on the Nat'l Institutes of Health Women's Health Research Agenda for the 21st Century 113 (1999) [hereinafter Agenda for Research] (noting that researchers can learn much about mental illness through the examination of gender differences in biology, behavior, epidemiology, and treatment of these problems, as research conducted in the 1990s has revealed).  
114. Carmen, supra note 8, at 53.
}
traumatized. Common to these approaches is an effort to address patients with greater compassion and respect than people with psychiatric diagnoses historically have been addressed. These reformers also seek a number of specific treatment techniques so that survivors may confirm their recollections of abuse and confront and “recontextualize” the trauma. In other words, treatment must recognize and address the history of trauma.

When this course is taken, chances of recovery are promising. One clinician, referring to recovery from incest, explains that “[w]hen treatment is directed toward resolving the emotional and psychiatric sequelae of incest, the prognosis is good . . . [and] when the posttraumatic nature of the symptoms is disregarded in diagnosis and treatment, the professional response mimics the context of the original abuse and the prognosis is generally poor.”

In the last decade, an increasingly comprehensive treatment philosophy for women trauma survivors has emerged. According to Dusty Miller, a clinician/survivor involved in the evolution in treatment, these new researchers “are all experts in the trauma treatment field who recognize that the therapy needs of the child abuse survivor are far more complex than simply recovering and reworking the trauma memories.”

Some clinicians have offered hands-on, practical manuals to guide clinicians in treating certain groups of trauma survivors. Maxine Harris and the Community Connections Trauma Work Group (a private, not-for-profit mental health clinic in Washington, D.C.) has produced such a

115. See, e.g., Ann Jennings & Ruth O. Ralph, Maine Trauma Advisory Groups Report, In Their Own Words (1997) (reporting conclusions of Trauma Advisory Groups, composed of recipients of mental health services who were also survivors of physical and sexual abuse, as to what trauma-sensitive services, treatment approaches, and supports were needed for recovery).

116. See Auslander et al., supra note 6. Some individuals have expressed concern, however, with the trend toward treating trauma survivors more gently, while continuing to treat other psychiatric patients with inhumane and coercive methods. See, e.g., id. One survivor/professional, Patricia Deegan, has expressed concern with this emerging trend toward a two-tiered caste system and service delivery system developing in the mental health arena. One set of services is for people we once called the “chronically mentally ill” and who we now refer to as “the severely and persistently mentally ill.” The second tier in this emerging caste system is the proliferation of specialized services, often in private sector hospitals, for survivors of abuse. See Patricia E. Deegan, Before We Dare to Vision, in DARE To VISION, supra note 8, at 6, 11. Deegan criticizes the implication of this two-tiered system: that there are “really crazy” people in the service system who should be kept separate from trauma survivors. See id. at 11-12.

117. See Doob, supra note 10, at 250.

118. See, e.g., Jennings, supra note 10, at 383 (citing studies showing that a history of childhood sexual trauma is extremely relevant to the diagnosis and treatment of a patient and that questioning to reveal such a history should happen routinely across all treatment settings, including emergency, inpatient, and outpatient).

119. See id. (citing to increasing data demonstrating that when trauma is identified and treated with specific therapeutic interventions, recovery is possible even for sexual abuse survivors who have been diagnosed as schizophrenic, depressive, or having borderline personality disorder).

120. Doob, supra note 10, at 245 (citations omitted).

121. Miller, supra note 5, at 176. Miller nonetheless goes on to note an absence of focus on the needs of a significant subgroup of women trauma survivors, a group she identifies as sufferers of “Trauma Reenactment Syndrome.” Id.
Marsha Linehan has also produced a practical manual, laying out her treatment model of dialectical behavior therapy. While Linehan's model predates Harris', Linehan's was recently chosen, as discussed in more detail below, for use with individuals served by the Massachusetts Medicaid managed care system. Although researchers and clinicians have created a varied range of treatment protocols, they generally concur that a successful treatment program of trauma survivors shares certain features.

First, the program should include a range of service options, so that the survivor has access to the particular types of services she needs. Maxine Harris suggests that trauma survivors need access to a broad range of services including "intensive case management, crisis intervention, residential support (including safe housing), and medical and psychological services." Similarly, Dusty Miller, focusing on women trauma survivors who self-abuse, has noted that even the wide range of traditional forms of treatment including individual psychotherapy, hypnotherapy, therapist and peer-led group therapy, inpatient hospitalization, and couples and family therapy, as well as less clinical approaches including spiritual groups, reading, meditation, wilderness activities, massage therapy, movement therapy, psychodrama and self-defense courses, may not be sufficient to address these women's treatment needs. Miller argues that these women may need specially-tailored services, including individual and group therapy, peer support and extensive collateral contacts (contacts which the treating professional makes with individuals other than the patient, such as with family members and other service providers).

Second, the program must be flexible in a number of respects. For example, programs should be open to women who might not always follow traditional rules of treatment. Further, because a survivor's needs may change over the course of recovery, her treatment should include non-traditional arrangements, such as unlimited group therapy and access to therapists by phone in the beginning. As one female survivor notes: "At different stages of recovery, we need different things."

Third, treatment should be community-based, so that women can access services without the disruption, coercion, and loss of rights inherent

122. See Harris, Trauma Recovery and Empowerment, supra note 113.
124. See Harris, Treating Sexual Abuse, supra note 12, at 373 (discussing the needs of dually diagnosed female trauma survivors); see also Harris, Modifications in Service Delivery, supra note 5, at 398-405 (discussing the needs of female survivors of sexual abuse who have severe mental illness).
125. See Miller, supra note 5, at 154.
126. See id. at 154, 181-262.
127. See O'Brien, supra note 96, at 32.
129. Id. at 28.
in inpatient care. Alternatives to inpatient care are obviously needed yet are frequently lacking, resulting in needless hospitalization: "All too often, I've heard from women in institutions who tell me that they went back into the hospital because there weren't any alternatives, options, or access to groups in which they could participate in the community."\textsuperscript{130}

Fourth, treatment should include peer-led, female-centered services.\textsuperscript{131} Female survivors of sexual abuse who attend female-only therapy groups are more likely to attend and finish treatment than are their counterparts who attend groups which also include men.\textsuperscript{132} Similarly, although there are crisis hot lines, trauma survivors also need peer-run "warm" lines: "Crisis hot lines lack in-depth skills and training necessary for these complicated issues."\textsuperscript{133} Further, trauma survivors need peer-run "safe houses" as an alternative to hospitalization and intrusive interventions.\textsuperscript{134}

Fifth, as described in the following subsection, because survivors need time to develop trusting relationships with caregivers, the model should allow for long-term therapeutic relationships.

4. Include Long-Term Treatments

Many activists urge the availability of long-term therapy with therapists trained to treat women who have suffered physical and/or sexual abuse:

Consumers, especially women who have histories of sexual assault and trauma, should have a choice of staff members as well as a choice of service options. These women need to engage in long-term clinical relationships and choice of clinician (especially the right to choose a woman therapist) is particularly important.\textsuperscript{135}

A survivor explains: "We are talking about lifetime recovery. You cruise, all is fine, then boom—you may need 30 sessions or ten years of therapy."\textsuperscript{136} Long-term therapy provides time for patient and therapist to

\begin{footnotes}
\item[130] Prescott, supra note 92, at 26.
\item[131] See Ridgely et al., supra note 70, at 46; see also Harris, Treating Sexual Abuse, supra note 12, at 374-75 (noting that group interventions (both peer and leader-led) are highly effective for survivors of sexual abuse trauma, even for severely dysfunctional women) and at 377-79, 380-84 (suggesting that such groups should provide both cognitive reframing and social-skills training, the latter including education about sexual and physical abuse, female identity, sexuality, safety, self-soothing, and parenting).
\item[132] See Ridgely et al., supra note 70, at 45. Additionally, professionals need to recognize these types of services as valid and important service options. See id. at 46; Prescott, supra note 92, at 26.
\item[133] Lynch, supra note 96, at 24; see also Daniel Fisher, Warm Lines: An Alternative to Hospitalization, NEC Newsl. (Nat'l Empowerment Ctr., Lawrence, Mass.), undated (available at <http://www.power2u.org/selfhelp/warm_lines.html>) (arguing that people who were afraid to call a crisis team for fear that they would be hospitalized against their will would instead willingly contact a warm line).
\item[134] See Lynch, supra note 96, at 24.
\item[135] Ridgely et al., supra note 70, at 45.
\item[136] Jennings & Ralph, supra note 115, at 54.
\end{footnotes}
establish trust and uncover a traumatic history. As another survivor explains:

Time-limited groups are another concept that makes no sense for adults who have lived with their silence of sexual abuse. Survivors have had a lifetime of not trusting. It is hard to imagine how anyone would think that a 9 or 12 week group will give enough time to learn to trust a group and to share with it. 137

One professional working specifically with survivors states clearly that “[s]hort term, time limited interventions are not helpful.” 138 Another, speaking about battered women in particular, explains: “The chronicity of domestic violence and theories including the cycle of violence suggest that the ongoing relationship between provider and patient may be more helpful to many women than the crisis intervention approach of the emergency department.” 139

Studies of recipients of psychiatric services support these observations about trauma recovery. An examination of studies of psychotherapy effectiveness suggests a positive association between length of treatment and treatment outcomes. 140 Indeed, “those who are in treatments of longer duration experience greater symptom reduction and more improvements in domains of interpersonal, occupational, and social functioning.” 141 The U.S. Surgeon General’s recent report similarly concludes that, while few treatments specifically for adult survivors of childhood abuse have been studied in randomized controlled trials, “group therapy and Interpersonal Transaction group therapy were found to be more effective for female survivors than an experimental control condition that offered a less appropriate intervention.” 142

One clinician further explains that long-term therapy is needed to allow a survivor of abuse to establish a working relationship with a therapist:

---

137. Crouse, supra note 128, at 27.
138. Jennings & Ralph, supra note 115, at 40; see also Shelley Neiderbach, Getting From Talk to Action: Money and Plans, in DARE TO VISION, supra note 8, at 39 (suggesting that promising trauma survivors thirty hours of psychotherapy will actually make them worse, because survivors will receive a promise that cannot be met since trauma cannot be reduced in such a short time interval).
141. Hennessy & Hennessy, supra note 140, at 344.
142. MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, supra note 5, at 231.
MEETING THE NEEDS OF FEMALE TRAUMA SURVIVORS

The development and use of the therapeutic relationship is never more important than in work with people whose existence is awash in betrayal and violation. A critical piece of the work is the development of a non-sexualized relationship that will translate out into the world of the survivor. This is not well served by a six to ten session therapeutic "sound bite."  

However, unlimited therapy is not necessarily the answer for all trauma survivors. Clinician Judith Herman, in her seminal 1992 book on trauma survivors, describes recovery as a three-stage process involving safety, remembrance, and mourning, and carefully delineates the work that should be done with the survivor at each stage before proceeding to the next; this work is not open-ended. More specifically, in stage two, the story of abuse is reconstructed and, while reconstruction is never entirely complete, this task is accomplished "when the patient reclaims her own history and feels renewed hope and energy for engagement with life." Stage three, reconnection, is an open-ended and ongoing process that may take decades. It is signaled by a decline in fear and a corresponding renewed ability to derive pleasure from the present and to develop relationships with others. Moreover, Herman instructs that group work in stage two be structured and time limited. She notes that a key feature of these groups were their time limits: mostly twelve weeks, but some four, six, or nine months long.

5. **Curb Overreliance on Medication**

Psychiatric survivors are frequent critics of the mental health system's heavy reliance on the biomedical approach: "For over twenty years, the biomedical approach has been repeatedly criticized by psychiatric survivor groups and numerous authors, as being too drug-oriented and too controlling." Observers of the psychiatric care provided to trauma survivors have similarly noted that the services survivors need are not medication-based, but that medication nonetheless seems to be the predominant treatment approach.

In fact, medication may be a particularly inappropriate treatment for women trauma survivors, as drugs are frequently used to suppress an-

---

143. O'Brien, supra note 96, at 33.
144. See Herman, supra note 65, at 156, 160, 172.
145. Id. at 195.
146. See id. at 212.
147. See id. at 222. Herman notes that while most participants complained after the fact about the time limits, most also stated that they would not have preferred or could not have tolerated a group that did not have such limits. See id.
149. See Jennings & Ralph, supra note 115, at 48.
150. As one mother wrote of the care her daughter, a survivor of sexual abuse, received: "The use of psychotropic drugs comprised 93% of the treatment approach to her." Jennings, supra note 10, at 376.
ger, an emotion which is often unwelcome in the mental health service system. Trauma survivors and those who work closely with them recognize the value in letting survivors express their anger: "Strong feelings are a necessary part of coping and recovery." One survivor writes:

Much too often women are not encouraged to express their anger in mental health and substance abuse programs. They’ve been told, “There is no place for your anger here. It would be too upsetting for the milieu to allow you to express your rage.” . . . Far too many women turn inward and either give up, silently resort to self injury, or succumb to the pressure to alter their behavior by taking massive quantities of medication which dulls their faculties . . .

6. Investigate the Effects of Gender Differences on Mental Illness and Receptivity to Treatment

To better address the needs of trauma survivors, it is essential that researchers further investigate the effects of gender differences on both the manifestation of mental illness and on receptivity to various forms of treatment.

Until recently, researchers have excluded or underrepresented women in almost all clinical research. As is frequently noted, “little empirical data exist on gender differences between men and women with severe mental illness.”

Gender differences regarding reaction to medication also require attention. Women are more likely than men to experience side effects to psychoactive, particularly antipsychotic, medications. Research also suggests that women face a significantly disproportionate risk of suffering from tardive dyskinesia. Further, “[s]tudies have shown . . . gender variations in drug sensitivity, rate of metabolism, and the presence or absence of enzymes necessary for breakdown of the chemical agents in the body.” Despite these gender differences and even as women are pre-

151. See Prescott, supra note 92, at 18; see also Miller, supra note 5, at 161 (noting that women who react to their abuse with anger are seen as “out of control and not normal” while men who react to abuse with subsequent violent acts are seen as “relatively normal”). The reliance on medication as treatment for women trauma survivors is further troubling when one considers the limited information on the effects of medication on women. See discussion infra, Part IV.A.6.
152. Ridgely et al., supra note 70, at 51.
153. Prescott, supra note 92, at 11.
154. See Jacobus, supra note 12, at 269 (noting, in a 1995 report to the New Jersey Commission on Sex Discrimination, that the U.S. research establishment has excluded or underrepresented women in almost all clinical research in the area of health care).
155. Ridgely et al., supra note 70, at 10.
156. See id. at 49. Women also experience more adverse reactions. See id. at 8.
158. Mahin Hassibi, Why Change the World . . . When You Can Have a Prozac Moment? (last modified June 12, 1995) <http://mosaic.echonyc.com/~onissues/prozac.htm> (observing that, despite the fact that women experience different responses to psychotropic drugs than do men, economic incentives have severely curtailed the extent of drug trials focusing on women).
scribed psychotropic medication at higher rates than men, women have historically been underrepresented in drug trials. The National Institutes of Health have recognized the need for increased research to address these deficiencies: “With new awareness about the ways in which the differences between women and men affect both physical and mental health, it is critical to present, study, evaluate and implement changes derived from gender-based research to positively influence the treatment of mental disorders in women.”

7. Question the Hierarchical Features of the Treatment Model

Activists have challenged the hierarchical treatment model, noting the particular problems it creates for women trauma survivors. The power differential between patient and clinician, particularly that which exists in the doctor/patient relationship, often leaves patients unwilling and unable to challenge the current treatment model. Meanwhile, professionals take such input as an affront to their credentials. Indeed, the status quo often mimics the dominator/victim roles of the original abuse.

Unfortunately, mental health professionals are unlikely to initiate changes in (or even speak out against injustices within) a system in which they were trained and in which they have vested interests. Thus, even as women seek a consumer-led, female-centered alternative model, they are stymied. For example, the very feminists who had first supported

159. See Ridgely et al., supra note 70, at 7; Goldner, supra note 43, at 1479 (citing study in which women received 73% of prescriptions for psychotropics). Similarly, a 1986 study of 320 hospital records of people with severe mental illness in seven community and state Michigan institutions found that women were prescribed 2.1 psychiatric and other medications for every 1.7 prescribed to men. See Ridgely et al., supra note 70, at 10-11.

160. See Ridgely et al., supra note 70, at 8. In 1993, the Food and Drug Administration (FDA) found itself faced with mounting pressure from the Women's Congressional Caucus and the Working Group on Clinical Trials regarding drug trials in women. This resulted in a revision of some of the FDA's policies related to drug trials for women. See Hassibi, supra note 158; see also Women's Drug Studies Up 32% over '91, Industry Says, BOSTON GLOBE, Nov. 26, 1999, at B20 (reporting that because drug companies are working to make sure enough women are included in clinical trials, they have gained a better understanding of how certain diseases affect men and women differently).

161. AGENDA FOR RESEARCH, supra note 112, at 111.

162. See, e.g., Auslander et al., supra note 6, at 1 (citing a 1998 study by Kalinowski and Penney as evidence for her observation that consumers “fear that a system so entrenched in punitive ways will not be able to incorporate the kind of work necessary to heal from trauma”).

163. See, e.g., JEFFREY MOUSSAIEFF MASSON, AGAINST THERAPY 13 (1994) (asserting that in psychotherapy, as in psychiatry, there exists a hierarchy, based on the psychotherapist's apparent knowledge, training, and insight, in which the clinician is superior to the patient); see also MICHAEL J. DEAR & JENNIFER R. WOLCH, LANDSCAPES OF DESPAIR: FROM DEINSTITUTIONALIZATION TO HOMELESSNESS 56 (1987) (arguing that the power enjoyed by professionals in the social service system over individuals is rooted largely in the strong historical links between the state and these professions).

164. See, e.g., MASSON, supra note 163, at 293-94 (commenting that, although the training that therapists receive is rather limited, members of the profession nonetheless respond to criticism with indignity and retaliation).

165. See Stefan, The Protection Racket, supra note 64, at 1289-98.
women abuse victims were subsequently excluded from the treatment systems: "As treatment of raped and battered women became a legitimized area of professional expertise, women activists who had started crisis centers and shelters began to be marginalized and were pressured to withdraw."166

The feminist movement has exposed clearly the mental health needs of women in general and women trauma survivors in particular. That the mental health system must change to meet these needs is now well accepted even within the traditional medical establishment. Yet despite the movement’s success, control over the model of care has not shifted to the movement’s leaders. Instead, ironically, as feminists made more people aware of the situation facing abuse survivors, to a certain extent, they lost control over the remedies.

B. The Detrimental Effects of Private Management on the Mental Health Care of Female Trauma Survivors

1. An Introduction to Managed Care’s Impact on Treatment

Privately managed care’s financial incentives and administrative procedures significantly impede adequate treatment of women trauma survivors.

First and foremost, the economics of privately managed care warps treatment decisions. Capitation creates undeniable financial pressures on the for-profit MCO. The MCO seeks to reduce costs because payment is pre-set and does not vary depending upon the extent to which an individual accesses services. This reduction is accomplished by placing controls on the sites at which services are offered and limits on the amount of services provided, such as requiring prior authorization.167 Utilization review by MCOs results in treatment decisions weighted more toward the financial health of corporations than the mental health status of patients. The federal General Accounting Office has recently noted that capitation creates the risk that the MCO may inadequately address the health problems of Medicaid beneficiaries in order to contain costs or increase profits, and that this result is particularly problematic for those persons needing mental health services.168

The financial interests of MCOs favor medical management of mental illness over long-term therapy. The MCO is more likely to choose the

166. Id. at 1294; see also Salasin, supra note 101, at 3 (describing the early 1980s repeal of the federal Mental Health Systems Act, terminating the mandates and support for federally sponsored mental health services and community mental health center legislation and related initiatives, and phasing out research programs on issues such as rape and domestic violence).
167. See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 1.
168. See id. at 2.
less expensive option of one fifteen-minute medication monitoring ses-

sion per month than to choose weekly individual therapy. One study

found a tendency for psychiatrists and neurologists receiving HMO pay-
mount to substitute medications for psychotherapy in their treatment of

women with mental health problems; the odds of receiving psychotherapy

were consequently twice as great in the fee-for-service system as in the

HMO system.169

One observer explains the conflict between managed care and long-
term therapy:

Clinicians think in terms of the course of an illness, which, although it may
appear in episodes, often extends over the life of the patient. Managed care con-
tacts go from year to year. Managed care executives often think in terms of the
quarterly reports and yearly bonuses. At this point in our understanding of ill-
ness and management, there is no evidence to suggest that what is cheapest in
the short term maintains its advantage in the long term for many disorders.170

Similarly, according to the chairperson of the Coalition of Mental
Health Professionals and Consumers:

In psychotherapy, only “brief therapy” (2 to 12 sessions) is considered good
therapy. The focus is on a quick fix of symptoms and getting the patient “func-
tioning.” Some patients are forced to take medication under threat of denial of
reimbursement for psychotherapy. Medication is sometimes necessary, often
helpful, but used inappropriately, it can mask real problems, leaving patients
in endless cycles of crises.171

The process of utilization review inherently discourages long-term
therapy. The reason is that the determination of what constitutes medi-
cally necessary treatment is done by assessing the patient’s presenting
problems, largely in terms of current level of functioning and concerning
observable and objectifiable symptoms. Root causes of prob-
lems—historical antecedents—are not considered relevant in the determi-
nation of whether a service should be continued or provided.173

Likewise, the financial interests of MCOs constrain beneficiaries’
access to appropriate clinicians and quality care. These interests encour-
age the limitation of networks resulting in networks that may not include

169. See Glied, supra note 108, at 12.
IMPACT OF MANAGED CARE ON MENTAL HEALTH SERVICES 65 (Robert K. Schreter et al. eds., 1994).
Schreter adds: “Clinical experience suggests that short-term interventions are inadequate for as
many as 20 to 30% of all patients.” Id. at 66.
172. See Standard Contract between the Commonwealth of Massachusetts Executive Office of Health
and Human Services Division of Medical Assistance and the Massachusetts Behavioral Health
Partnership, at App. E (June 28, 1996) (on file with authors) [hereinafter DMA-Partnership
Contract].
173. See Goldner, supra note 43, at 1463-64.
Further, these interests also encourage reductions in
the reimbursement rates paid to providers, resulting in understaffing
(which may contribute to poor quality care and increased use of restraint)
and high rates of staff turnover (which impedes the provision of continuous care).
In addition, MCOs are reluctant to pay for services (such as collateral contacts and report-writing) that are not conducted in person, but which are important to trauma survivors.

Second, privately managed care results in the loss of choice of one's treatment professional. Indeed, the right of choice is guaranteed to Medicaid recipients and, prior to 1997, only could be abrogated through a federal waiver process. This lack of choice is especially significant to trauma survivors who are likely sensitive to revealing painful details of their history to the mental health caregiver.

Third, managed care places an uninvited third party, the utilization reviewer, in the midst of treatment decisions. The presence of the utilization reviewer makes establishing the trust necessary for successful treatment more problematic by increasing the number of parties to whom private affairs must be revealed.

Fourth, the privatization of the management of Medicaid mental health results in the loss of independent review of treatment denials or modifications. This result is due to what the authors consider to be a misinterpretation of federal statutory and constitutional law on what constitutes state action. Denial of care by the state, not by a private entity, is what triggers the right to independent review under Medicaid law. Even if independent review were available, there is a larger issue. There are disincentives under the system—threats of additional paperwork, fear of network exclusion, or even more direct financial incentives or disincentives—for caregivers to even ask for certain services. Therefore, the usual

---

174. See generally Jennifer Honig, Downwaging Mental Health Workers: Down-sizing Mental Health Services, ADVISOR, Fall/Winter 1997, at 1.
175. See generally id.
177. See KORCZYK & WITTE, supra note 16, at 5.
178. The waivers were a managed care waiver pursuant to section 1915(b) of the Social Security Act, 42 U.S.C. § 1396n(b) (1999), and a “demonstration” waiver pursuant to section 1115 of the Social Security Act, 42 U.S.C. § 1315(a) (1999). States were required to apply for the Health Care Financing Administration's approval to implement managed care. After the implementation of section 1932 of the Balanced Budget Act of 1997, P.L. 105-33, state Medicaid agencies have greater authority to create managed care programs and insist upon enrollment in them under their state plans. See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 6.
179. See Alison Bass, Some Who Need Help Fear Secrets Will Be Revealed, BOSTON GLOBE, Apr. 28, 1993, at 10; see also John Petrila, Medical Records Confidentiality: Issues Affecting the Mental Health and Substance Abuse Systems (visited Mar. 29, 2000) <http://lists.essential.org/med-privacy/msg00291.html> (quoting Jaffe v. Redmond, 518 U.S. 1 (1996) about the importance of trust and confidentiality to successful treatment, and concluding that the lack of confidentiality protections, including the lack of limitations on the disclosure of information to third parties, such as utilization reviewers, causes some individuals to forego treatment).
triggering event for notice of appeal rights—denial of coverage—would never occur, as the provider would not request the care in the first place. Additionally, even if the patient could appeal for provision of services not requested by the caregiver, these appeals would be almost impossible to win without a professional caregiver’s support.

2. The Massachusetts Managed Care System Has Features That Are Specifically Problematic for Female Trauma Survivors

a) Heavy Reliance on Medication

Despite the above reasons for caution in the use of medication to treat women trauma survivors, statistics suggest that the Massachusetts mental health managed care system relies heavily on medication as treatment. Between July 1992 and October 1994, the number of recipients using mental health clinic medication increased by 38% and total expenditures by 81%, yet the number of recipients enrolled in the program only increased by 5%. The number of recipients using medication and the expenditures for medication services continued to rise through 1996.

The following table shows the initial movement to reliance on medication services as opposed to talk therapy:

<table>
<thead>
<tr>
<th>Service Type</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Medication</td>
<td>29.1</td>
</tr>
<tr>
<td>Psych. Treatment</td>
<td>27.0</td>
</tr>
<tr>
<td>Clinic Treatment</td>
<td>10.6</td>
</tr>
<tr>
<td>Clinic Evaluation</td>
<td>4.8</td>
</tr>
<tr>
<td>Inpatient MH</td>
<td>-2.4</td>
</tr>
</tbody>
</table>

182. See Peter Breggin, Toxic Psychiatry (1991) (describing the negative and sometimes irreversible side effects associated with drugs used to treat the symptoms of mental illness).
183. See MHMA, Mental Health/Substance Abuse Program (MH/SAP) Enrollment July, 1992 to Dec., 1993 (undated) (internal data, on file with authors); MHMA, MH/SAP 1994 (Dec. 14, 1994) (unpublished report, on file with authors) (showing that the proportion of recipients categorized as disabled increased from 15.7 to 16.7% during that time period).
184. See MHMA, Expenditure Report Based on Date of Service (Dec. 31, 1996) (internal data, on file with authors).
185. See James J. Callahan & Donald S. Shepard, Evaluation of the Massachusetts Medicaid Mental Health/Substance Abuse Program, Table 2.3 (Heller School for Advanced Studies in Social Welfare, Brandeis University, Jan. 24, 1994) [hereinafter Brandeis Report]. It should be noted that "Psychiatrists" includes talk therapy performed by psychiatrists. Most medication was dispensed by clinics.
Medication services under the Partnership appear to be continuing their march upward with respect to the number of recipients using the services and the percent of enrollees using medication services. If one looks solely at the experience with the Partnership, between July 1996 and March 1999, the number of enrollees grew by 44.9% and the number of users of medication services grew by 69.6%.

However, it appears that expenditures per recipient for these services have decreased dramatically since the Partnership assumed the helm. From the inception of the Medicaid managed care program in 1992 through June 1999, expenditures for medication services increased by 6.5%, the number of enrollees in the carve-out increased by 61%, and the number of enrollees using medication services increased by 131.9%. MHMA’s preference for medication and aversion to therapy were highlighted by its increase in rates for medication services. Medication rates for clinics were raised in April 1995 from $24.27 to $37.50 for each fifteen-minute unit. In addition, when outpatient protocols were amended in May 1994, the protocol for medication was increased by six

---

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care</td>
<td>-10.5</td>
</tr>
<tr>
<td>Community Health Center</td>
<td>-10.5</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>-12.0</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>-13.5</td>
</tr>
<tr>
<td>Outpatient (hospital)</td>
<td>-19.2</td>
</tr>
<tr>
<td>Psychologists</td>
<td>-29.6</td>
</tr>
</tbody>
</table>

---

187. See id. MHMA and the Partnership collected data in different ways, the former according to who provided services and the latter according to the service provided. Due to the lack of comparability of data, it is difficult to determine the exact relationship of certain MHMA and Partnership patterns of care. If one adjusts the number of unduplicated recipients to reflect rough estimates of provider service patterns (as opposed to enrollee usage patterns), the Partnership may have initially cut the number of recipients using medication services, but exceeded MHMA levels by the end of FY 1998. In addition, both DMA and Partnership have stated that the Partnership enrollment data included in its claims reports are erroneous and overstate enrollment. They suggest that the error worsens over time, although the data are corrected periodically. See Notes from Behavioral Health Advisory Committee meeting (Mar. 3, 2000) (on file with authors).

188. See Partnership Monthly Cost Report, supra note 48. Using DMA’s enrollment figures, between July 1996 and June 1999, the number of enrollees grew by 26%, and the number of users of medication services grew by 41%. See DMA, MBHP Enrollment Days Per Reconciliation Reports (undated) (on file with authors); Partnership Monthly Cost Report, supra note 48.

189. As noted above, MHMA and Partnership data are not directly comparable. Hence, comparisons between the two companies are best estimates based on conversations with providers and information provided by DMA.

190. See MHMA, MH/SAP Enrollment July, 1992 to Dec., 1993, supra note 183; MHMA, Expenditure Report Based on Date of Service, supra note 184; Partnership Monthly Cost Report, supra note 48. Since 1996, the percent of enrollees using medication services, the expenditures for medications services, and the units per user of service have increased under the Partnership’s management. See id.

191. See Memorandum from MHMA to MHCM Members (Nov. 15, 1994) (on file with authors); Memorandum from MHMA to Susan Fendell (Mar. 23, 1995) (on file with authors).
MEETING THE NEEDS OF FEMALE TRAUMA SURVIVORS

hours. On the other hand, maintenance for all diagnoses, which had previously been permitted on an indefinite basis, was limited to twenty-six hours in fifty-two weeks.\textsuperscript{192} Medication visits did not count toward the number of hours allowed under the protocol for therapeutic services.\textsuperscript{193}

Rate changes adopted by the Partnership\textsuperscript{194} encourage shorter medical management visits for most recipients. The incentive to reduce session length came in the form of reducing medical management by a physician from $76 for thirty minutes to $38 for "standard" visits and $52 for "complex" visits.\textsuperscript{195}

The performance standards under which the private MCO receives substantial bonuses place the focus of the company on obtaining medication for clients rather than supplying necessary outpatient therapy. In FY 1998, the highest single potential bonus awarded ($700,000) was for attendance by recipients, including children and adolescents, at an outpatient medication service within twenty-one days of their discharge from a psychiatric inpatient setting.\textsuperscript{196} The two standards in the FY 1999 contract between DMA and the Partnership, for which the Partnership could be awarded over $1 million, required the Partnership to ensure that more adults, children, and adolescents were given a medication appointment within fourteen business days of discharge from a mental health inpatient setting.\textsuperscript{197} In fact, one of the two standards in the FY 2000 Partnership contract that actually requires a quantitative improvement over the prior year involves medication monitoring.

\textsuperscript{193} See id.
\textsuperscript{194} The rates were scheduled for adoption on May 1, 1997. See Letter from Richard Sheola, Chief Executive Officer, Partnership to Providers (March 28, 1997) and attachments. Simultaneously to changing medical management rates, the Partnership had planned to reduce therapy rates. See id.
\textsuperscript{195} A prior Partnership proposal reduced medical management by a physician from $76 for 30 minutes to $41 for anything over 20 minutes. See Mental Health Corp. of Mass., Outpatient Practices and Rates (Mar. 12, 1997) (on file with authors); see also, Partnership Monthly Cost Report, supra note 48.
\textsuperscript{196} See DMA-Partnership Contract, supra note 172, First Amendment, at § 5.1.1C.5.b.5. (July 1, 1996).
\textsuperscript{197} The DMA-Partnership contract included standards with respect to medication monitoring. During the period between Oct. 1, 1998 and June 30, 1999, for adults, the Partnership would get a $550,000 bonus if it obtained a 25% increase over the FY 1997 baseline in the number of medication appointments scheduled within 14 business days of discharge from mental health inpatient. The Partnership would get another $550,000 if it were able to obtain a 25% increase over the FY 1997 baseline in the number of medication appointments scheduled within 14 business days of a child's or adolescent's mental health inpatient and acute residential treatment discharge between Oct. 1, 1998 and June 30, 1999. DMA could impose an optional penalty of $150,000 if the increase were less than 22% and of $360,000 if the increase were less than 18%. See id.
b) Limited Access to Long-Term Therapy and Corresponding Reliance on Short-Term Interventions and Time-Limited Therapy

One of the initial promises of privatization in Massachusetts was that savings in inpatient expenditures would be utilized to bolster outpatient services, thereby maintaining more recipients in the community. This shift in expenditures did not occur unless one includes the drastic increase in the use of medication. The number of recipients receiving outpatient therapy closely tracked the total number of recipients.

198. See, e.g., Brandeis Report, supra note 185, at vi (observing that DMA had believed that a new system that controlled admission to expensive hospitals and contracted with lower cost providers would both save money and provide an acceptable level of care); Rochefort, supra note 34, at 8-9 (observing that among the stated goals of implementing Medicaid mental health managed care are both expanding access to preventative services and making the Medicaid program more cost-effective).

199. According to the Brandeis Report, outpatient expenditures declined by $2.8 million, representing a 3% decline in the utilization and mix of services predicted without managed care. See Brandeis Report, supra note 185, at 2-19. The predicted levels of care were based in part on a trend of increased outpatient utilization of 3.9% per year. See id. Expenditures for outpatient care fell by 12.9% from predicted values. See id. However, $7.3 million (7.7%) of the savings was due to the lack of inflation in the charges for these services and another $2.5 million was due to the inclusion of payments for psychiatric services, psychological evaluations, and other professional services in hospital rates. See id. MHMA itself found that a substantial number of recipients discharged from hospital units were not seen by outpatient providers "within a reasonable number of days of discharge." MHMA, Quality Management Program 31 (Mar. 29, 1994) (on file with authors).

200. Outpatient therapy is defined by the authors to include treatment at mental health clinics, hospital-based clinics, and community health centers. It does not include evaluation services, crisis-counseling, or medication services.

201. See Partnership Monthly Cost Report, supra note 48. This may be partly attributable to the rise in the proportion of TANF recipients (54%) and the decrease in recipients with disabilities (-13%). See id. The Commonwealth categorizes persons with disabilities as those persons receiving Medicaid as a result of their eligibility for Supplemental Security Income or those receiving assistance due to their disability. See Division of Med. Assistance, Executive Office of the Health and Human Servs., Quarterly Report to the House and Senate Committees on Ways and Means (May 1999) (on file with authors). One might expect that "non-disabled" enrollees would rely more on outpatient services than their counterparts with disabilities. Women who are victims of sexual and physical abuse, and who are in need of mental health services, fall within both the disabled and non-disabled categories. See, e.g., Carmen, supra note 8, at 52-53 (noting that women diagnosed with mental illness are not a homogenous group, but one displaying important differences in, among other areas, functional capacity). Available data indicate that recipients with disabilities experienced decreased access to outpatient services; use of outpatient services by recipients of TANF actually increased. The breakdown is as follows:

<table>
<thead>
<tr>
<th>6-month data comparing July 1992 to Jan. 1996</th>
<th>Disabled</th>
<th>Other (TANF/AFDC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditures</td>
<td>-37%</td>
<td>30%</td>
</tr>
<tr>
<td>Expenditures per Recipient</td>
<td>-24%</td>
<td>-6%</td>
</tr>
<tr>
<td>Recipients Using</td>
<td>-17%</td>
<td>39%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Units</td>
<td>-21%</td>
<td>54%</td>
</tr>
<tr>
<td>Units per Recipient</td>
<td>-4%</td>
<td>11%</td>
</tr>
</tbody>
</table>

MHMA, Expenditure Reports (undated) (internal data, on file with authors); Partnership Monthly Cost Report, supra note 48. MHMA did not correctly allocate claims data between disabled and
Not clearly attributable to enrollment is the 27% drop in expenditures per recipient for outpatient therapy. The latest contractor, the Partnership, pays for even fewer units of counseling than the prior contractor.

Rate changes adopted by the Partnership also encourage shorter group and family therapy sessions by failing to specify that sessions should last 1.5 hours. Additionally, the rates continue to reward group over individual therapy. Individual therapy is, and will continue to be, reimbursed at $66 per hour. Group therapy will be reimbursed at a rate of $23 per recipient per sixty to ninety minutes, an increase over the MHMA rate of $21 for 1.5 hours. Thus, the clinic gains $184 for an eight-person group session, compared with $66 for individual therapy.

Another service for which the Partnership has raised outpatient rates is family consultation, although it lowered the rate for other forms of case consultation to $59 per hour from MHMA’s $65 per hour.

Partnership expenditures per recipient for outpatient individual therapy did not change much between July 1996 and June 1999, although general expenditures increased slightly as the number of recipients using these services increased. Nevertheless, enrollment increased by 48%, other recipients for at least the last six months of its tenure. However, since it is likely that this error exists for all its expenditure data, the trend in reduced expenditures for outpatient therapy for persons with mental illness may still be real. Reduced expenditures for outpatient therapy for persons with disabilities is also consistent with managed care’s reluctance to provide therapy to persons with chronic mental health problems and preference for maintenance through medication. See supra, Part IV A.

See MHMA, Expenditure Reports, supra note 201; Partnership Monthly Cost Report, supra note 48.

Using various estimates based on anecdotal information as to service patterns of relevant providers, it is clear that the enrollees are receiving less individual, group, and family counseling than they did under MHMA. See Susan Fendell, Partnership/Medicaid Managed Care Update, ADVISOR, Summer 1998, at 1, 1-2.

See Letter from Richard Sheola, supra note 194.

The Partnership rates referred to herein are for master’s level professionals.

Instead of specifying that session lengths should be 1.5 hours, the Partnership permits group and family therapy to range from 60 to 90 minutes. See Letter from Richard Sheola, supra note 194. It is unlikely, given the financial situation of most providers, that they will opt for the longer sessions absent additional reimbursement. See, e.g., Honig, supra note 174, at 4 (describing how economic pressures on mental health clinics resulted in pressure on staff clinicians to increase productivity, including requiring that staff see more patients per day).

In its network procurement documents, the Partnership initially proposed a rate of $60 per hour for individual therapy. See Partnership, Outpatient Procurement Document, App. 2 (Nov. 4, 1996) (on file with authors). The group therapy rate was tentatively suggested at $25 per hour. See id.

The Partnership does not explicitly limit group size, but expects that a group with one clinician will range from 8 to 10 persons and with two clinicians from 12 to 15 persons. See Telephone interview with Michelle Sipe, Partnership (Jan. 28, 1998).

Under MHMA, one hour of family consultation was reimbursed at a rate of $52. See Mental Health Corps. of Mass., Outpatient Practices and Rates (Mar. 12, 1997) (on file with authors). The Partnership reimburses 50 to 60 minutes of family consultation at a rate of $59. See Letter from Richard Sheola, supra note 194.

As mentioned supra note 199, DMA stated that Partnership data on enrollment is incorrect. According to DMA enrollment data, enrollment only increased 35% during this period. See Partnership, Enrollment Days per Reconciliation Reports (Jan. 3, 2000) (on file with authors). Even
while expenditures increased by only 36%, primarily due to the increasingly limited access to individual therapy under this MCO.\textsuperscript{212} The number of enrollees using outpatient individual therapy grew by only 32%.\textsuperscript{213}

Since July 16, 1998, the Partnership has funded a program that may provide specialized therapy and related services for those trauma survivors with a diagnosis of borderline personality disorder (BPD) or, more precisely, those who meet five of nine criteria included in DSM-IV\textsuperscript{214} for this diagnosis.\textsuperscript{215} This treatment, called dialectical behavior therapy (DBT), is based upon a model developed by Marsha Linehan.\textsuperscript{216} While Linehan has since applied the model to groups of individuals other than those with a diagnosis of BPD, the Partnership is only offering this treatment option to those with a BPD diagnosis, as current research has addressed only the application of the program to this group.\textsuperscript{217} The Partnership reimburses the eight providers who thus far have been designated to offer these services at a rate of $146 per week for the following package of services: outpatient individual therapy (typically sixty minutes); skills training group (typically two hours); fifteen minute telephone consultation with the therapist; and meeting of the provider team (typically one hour).\textsuperscript{218} This arrangement allows for reimbursements in previously uncovered areas—prior providers only received reimbursement for one and a half hour skills groups and received no reimbursement for consultation or a team meeting.\textsuperscript{219} The full $146 currently is provided even if a client misses some portion of the weekly sessions.\textsuperscript{220}

The Partnership requires that a standardized outcome assessment tool be administered at the eighth week and every ninety days thereaf-
MEETING THE NEEDS OF FEMALE TRAUMA SURVIVORS  197
ter.221 The Partnership has not set a time limit on this service, and the Partnership administrator has said that it is hard to imagine doing this program in less than one year.222 Originally, initial authorization was for a period of four weeks; now it is for six months for experienced providers.223

However, the use of DBT services by Partnership managed Medicaid recipients is minimal, ranging from three to seven enrollees per month out of an enrollee base of over one-half million.224

c) Limited Access to Appropriate, Female-Centered Treatment Options

Evidence indicates that managed care limits access to certain types of clinicians, to continuous care, and to female-centered treatment. For example, under Medicaid managed care in Massachusetts, sessions with psychologists are principally directed to children and adolescents.225 Further, the Partnership restricts standard medication monitoring visits to an average of fifteen minutes, thereby limiting access to psychiatrists.226

Continuity of care is compromised by low reimbursement rates, an ongoing concern within the Massachusetts mental health service system. For example, in December 1996, the Partnership told members of the Massachusetts Legislature that it planned to cut $4.4 million from outpatient services by, among other measures, reducing the rates for some key forms of services.227 The Partnership proposed reducing the fee it paid to social workers for individual therapy by $2 per hour and continuing to pay less for family therapy and case consultation by social workers than

221.  See New Outpatient Benefit: Dialectic Behavior Therapy, supra note 216, at 2.
222.  Id.
223.  See Telephone Interview with Joseph Passeneau, supra note 215.
224.  See Partnership Monthly Cost Report, supra note 48. Admittedly, the enrollee base includes a large number of Medicaid recipients for whom such services would be inappropriate. Nevertheless, like most of the innovative services created by the Medicaid MCOs, they are offered to very few people. For example, community support services were offered to less than one-tenth of one percent of enrollees in FY 1999. See id.; Partnership, Enrollment Days per Reconciliation Reports (Sept. 8, 1999) (on file with authors). One wonders whether the public relations value of the services are more important to the MCO than the actual treatment value.
227.  See Memorandum from Elizabeth Funk, Executive Director, Mental Health Corporations of Massachusetts (MHCM), to MHCM members (Jan. 6, 1997) (on file with authors) (providing Partnership document Systems Strengthening: Systems Savings Through Effectively Targeted Care (undated) with attached Appendix 2 (Dec. 12, 1996) containing revisions to the outpatient fee schedule).
had its predecessor, MHMA.\textsuperscript{228} The following May, the Partnership adopted a new rate schedule; while the proposed $2 per hour cut for therapy by social workers was not adopted, the reimbursement rate for family therapy and case consultation remained at rates below those paid by MHMA.\textsuperscript{229}

Specialty care for trauma survivors is also limited. For example, in the metropolitan Boston area, the Partnership has no contracts with any of the few existing inpatient trauma specialty units. Rather, the Partnership expects the hospitals with which it does have contracts to provide specialists on general units who can appropriately treat trauma victims.\textsuperscript{230} Further, while the Partnership is not averse to using clubhouses,\textsuperscript{231} a form of peer support, this is likely because clubhouses are funded separately by the Commonwealth; it is in the Partnership’s financial interest to funnel persons into programs for which it does not have to pay.

\section*{V. Legal Approaches to Challenge the Unfair Treatment of Trauma Survivors}

This section describes possible legal approaches to respond to deficiencies in mental health managed care systems with respect to women trauma survivors. The approaches are grouped into three areas: administrative processes; avenues for policy change; and legal theories. Options will vary with differences in state law and models of mental health managed care.

\subsection*{A. Administrative Processes to Challenge Individual Decisions}

Any administrative appeal process within the privately managed care system is hampered by inherent financial incentives. These incentives diminish the availability of evidence to win an appeal because the provider is discouraged from providing information to support the ap-
peal. First, managed care appeal processes generally do not recognize a physician’s failure to make a request for service as an appealable action. Instead, notice usually is triggered only by the denial of a physician’s request for service. However, under managed care, staff and network clinicians have financial incentives of their own to limit care, such as actual bonuses, fear of network exclusion, and increased paperwork if they render more services than the norm. Thus, the service may never be requested by the clinician in the first place.

Second, even if an individual could appeal the denial or discontinuation of services absent a clinical request, the likelihood of success on appeal is almost nil. Without the testimony of the professional caregiver, a layperson’s conclusion as to the need for services has little weight.

These problems are compounded by the fact that many mental health patients, especially women trauma survivors, find it difficult, given their life and treatment histories, to challenge service providers through formal, hierarchical processes.

1. HMO Appeal Process

When managed care is provided by or through a federally qualified HMO, federal law requires that the HMO provide “meaningful procedures for hearing and resolving grievances.” Further, all Medicaid participating HMOs are required to have internal grievance procedures to appeal referral denials. State law and regulations may also require that HMOs develop grievance procedures. Massachusetts law requires that each member receive “a description of the health maintenance organization’s method for resolving member complaints.”

232. See Korczyk & Witte, supra note 16, at 256 (noting that MCOs have a financial incentive to discourage appeals because of the costs of the appeal process itself and of the result if the MCO loses).

233. See, e.g., Partnership, Provider Handbook, at 34 (June 14, 1996) (stating that “any non-authorization decision made by the Partnership Peer Reviewer may be appealed” (emphasis added)).

234. See Olmstead v. L.C., 119 S.Ct. 2176, 2188 (1999) (commenting on the appropriateness of the state’s reliance on the reasonable assessments of its professionals in determining whether an individual is entitled to certain government services).

235. See, e.g., Daniel Fisher, The Empowerment Model of Recovery: Finding Our Voice and Having a Say, NEC News. (National Empowerment Center, Lawrence, Mass.), Winter 1994-95, at 5 (“For most of us consumer/survivor/expatients (c/s/x’s) our central issues are discrimination, helplessness, and isolation. We need to overcome discrimination to gain access to the arenas of policy formation.”). See also Harris, Modifications in Source Delivery, supra note 5, at 399 (stating that, for some sexual abuse survivors, involvement in relationships as less than equal partners may remind the survivor of the past abuse and may result in wariness).

236. 42 U.S.C. § 300e(c)(5) (1999); see also 42 C.F.R. § 417.124(g) (1999).


While HMO policies differ to some extent, "most have a two or three step process including a complaint to member services, a paper review, and an opportunity to present the case to an appeals committee." Complainants who are not satisfied with the appeal determination may appeal to DMA. Some providers also require that complainants participate in binding arbitration (precluding litigation) if they cannot resolve their disputes through internal processes.  

2. Partnership's Appeal Process

When enrolled in the PCC program, a recipient may complain through the Partnership's clinical appeal process. The Partnership process has two levels of review, which are available to the enrollee, the enrollee's representative, and the enrollee's treating provider. Another Peer Reviewer, not the individual who made the first determination, conducts the Level I appeal. The specialty of the reviewer will be matched to the needs of the case in review. Appeal determination will be made within one to fifteen business days of request for appeal, depending on the recipient's treatment status. A Level I decision may be appealed through a Level II appeal. Level II appeals are scheduled between one and fifteen business days from the conclusion of the first appeal, depending on the recipient's treatment status and are performed by the Partnership's Medical Director and/or Assistant Medical Director. A Board of Hearings review, discussed below, is available if the DMA recipient is dissatisfied with the Level II review decision.

3. Fair Hearing Process

Pursuant to DMA regulations, recipients enrolled in a MassHealth managed care plan are entitled to a fair hearing, before DMA's Board of Hearings, to appeal: 1) the requirement to enroll in a managed care plan; 2) a prior authorization denial; 3) denial of services provided by an out of area managed care provider; and 4) disenrollment or denial of transfer from a MassHealth managed care provider. DMA's fair hearing regulations define an "appealable action" as

241. See id. at 54; see also Toney v. U.S. Healthcare, Inc., 37 F.3d 1489 (3d Cir. 1994).
242. See Partnership, Provider Handbook, supra note 233, at 34.
243. See id.
244. See id.
245. See id. at 34-35.
246. See id. at 35.
247. See id.
248. See id. at 34.
an action by the Division to deny, reduce, suspend, terminate, or restrict assistance to an individual receiving or seeking such assistance. No action by a provider shall constitute an appealable action, except as otherwise provided herein with regard to a transfer or discharge by a nursing facility.\textsuperscript{250}

Thus, if DMA denies, reduces or modifies services and the provider objects, DMA should send a notice to the recipient of appeal rights.\textsuperscript{251}

Appeals of denials of service are particularly important; however, such denials are appealable only if they involve state action. As the above regulation reveals, DMA does not consider an HMO’s denial of services to be state action triggering a right to fair hearing. However, state action does exist where DMA or its agent denies prior authorization for services.\textsuperscript{252} Despite DMA’s position, an argument can be made that because DMA has delegated its authority to the Partnership and HMOs, denials by these entities also constitute a denial by DMA and trigger the right to appeal to the Board of Hearings, at least to the extent that the denials simply enforce policies established by DMA.

The meaning of “state action” in the context of privately managed care is a central issue in women’s challenges, yet case law has not provided a clear definition. Recent federal court decisions have found state action when private companies provide services pursuant to a state’s Medicaid plan. These courts have distinguished the facts before them from the Supreme Court’s decision in Blum v. Yaretsky, in which the Court found that a nursing home’s decision to discharge or transfer patients was not state action despite the substantial government funding that the home had received.\textsuperscript{253} In J.K v. Dillenberg, for example, the court concluded that private agency provision of Medicaid-funded behavioral health services to eligible children was state action.\textsuperscript{254} In distinguishing the facts of the case from those in Blum, the court noted that the private providers in Blum, while conducting business with the state, were not performing state responsibilities.\textsuperscript{255} By contrast, the court stated, Arizona had “delegated the entire responsibility for its mandated health care duties” to the regional health authorities.\textsuperscript{256} In a similar finding, the Sec-


\textsuperscript{253} 457 U.S. 991, 1011 (1982).


\textsuperscript{255} See Dillenberg, 836 F. Supp. at 698.

\textsuperscript{256} Id.
ond Circuit concluded in 1995 that decisions by home health care agencies to deny or reduce the amount of home health care provided to Medicaid recipients were state actions.\textsuperscript{257} The court noted that, unlike in \textit{Blum}, the agencies were not simply making medical judgments, but were assuming the responsibility for the state's mandated health care duties, including decisions around denying or reducing services and around prior approval.\textsuperscript{258}

More recently, a district court in Tennessee concluded that MCOs providing medical assistance under Tennessee's Medicaid program were state actors.\textsuperscript{259} Although the portion of the decision explaining its holding was vacated on other grounds, the reasoning behind the court's conclusion is instructive. The court noted the extensive contacts between the state and private MCOs and the state's delegation to MCOs of the duty to provide health care.\textsuperscript{260} Relying on \textit{J.K v. Dillenberg}, the court noted that the MCOs were required to comply with all federal and local legal provisions, including provisions of the Medicaid Act and regulations and, pursuant to these provisions, were empowered to deny, terminate, suspend, reduce, and delay Medicaid services.\textsuperscript{261}

A Massachusetts court also has found state action by a private agency providing Medicaid-funded services. In \textit{Mansfield v. Commissioner of the Department of Public Welfare}, the state appeals court held that a personal care agency decision to reduce the amount of Medicaid personal care services that had been approved by the Department of Public Welfare was state action.\textsuperscript{262} In distinguishing the case from \textit{Blum}, the court explained that the regulations at issue required the Department of Public Welfare to "specifically approve or deny a prior authorization request submitted by the personal care agency. This is not the 'mere approval or acquiescence' [of provider decisions] held insufficient [to establish state action] in \textit{Blum}."\textsuperscript{263} The appeals court further noted that the challenged decisions in \textit{Blum} were medical judgments by private parties according to professional standards not established by the state, not state commanded reductions in benefits or state regulations or procedures.\textsuperscript{264} By contrast, in \textit{Mansfield}, the regulation was imposed by the state and represented a policy, as opposed to a medical, decision. For these reasons, the appeals

\begin{itemize}
\item \textsuperscript{257} See \textit{Catanzano v. Dowling}, 60 F.3d 113 (2d Cir. 1995).
\item \textsuperscript{258} See \textit{id.} at 119.
\item \textsuperscript{259} See \textit{Daniels v. Wadley}, 926 F. Supp. 1305 (M.D. Tenn. 1996), \textit{vacated on other grounds}, Daniels v. Menke, No. 96-5887, 1998 U.S. App. LEXIS 7973, at *7-8 (6th Cir. 1998). The appeals court found that it was unnecessary to reach the constitutional issue because the case could be decided on other grounds. See \textit{id}.
\item \textsuperscript{260} 926 F. Supp. at 1311.
\item \textsuperscript{261} See \textit{id}.
\item \textsuperscript{262} 660 N.E.2d 684 (Mass. App. Ct. 1996).
\item \textsuperscript{263} \textit{id.} at 686.
\item \textsuperscript{264} See \textit{id.} at 686-87 (citing \textit{Blum}, 547 U.S. at 1008, 1009 n.19).
\end{itemize}
contest, the court found sufficient nexus between the provider's actions and the Department to require a hearing before the Department.\textsuperscript{265}

The 1999 Supreme Court remand of \textit{Grijalva v. Shalala},\textsuperscript{266} in which the Third Circuit had concluded that HMO denials of medical services to Medicare beneficiaries constituted state action, casts doubt on other federal and state court rulings finding state action. The Supreme Court remanded \textit{Grijalva} in light of its decision in \textit{American Manufacturers Mutual Ins. Co. v. Sullivan}.\textsuperscript{267} In that decision, the Court determined that a private insurer that reviewed workers' compensation claims was not acting under color of state law because employers, not the state, were the party required to provide workers' compensation benefits; the insurer was using standards not established by the state; and the state had limited participation in the review process.\textsuperscript{268}

These cases suggest that when MCOs make decisions that are not simple medical judgments, but instead represent the delegated authority of state powers, particularly around the denial or granting of services, there may well be state action. However, while recent federal and state court decisions provide some guidance in determining into which of these categories a particular MCO decision will fall, the distinction is not always clear. The determination appears to be largely fact-specific, making it difficult to predict the success of appeal.

Appeal processes are innately difficult for trauma survivors to pursue. In addition, an HMO may administer its appeal process in a way that creates particular problems for survivors. For example, the HMO may not facilitate or may even discourage appeals of denials of care. Further, because the HMO appeal processes tend to have several steps, complainants may never reach the more independent forum of DMA. These problems, combined with the state action barriers discussed above, make the use of appeal processes a questionable advocacy approach for female trauma survivors.

\subsection*{B. Avenues for Policy Change}

In addition to the administrative processes discussed above, avenues exist for pursuing policy change. Unfortunately, current state and federal legislatures tend to be dominated by well-funded business interests. The same can be said for most states' executive branches as well. Thus, the potential for meaningful legislative and regulatory change will be possible only with a strong, persistent consumer movement and extensive, informed media coverage.

\begin{itemize}
\item \textsuperscript{265} See 660 N.E.2d at 687.
\item \textsuperscript{266} 152 F.3d 1115 (3d Cir. 1998), \textit{vacated and remanded}, 119 S. Ct. 1573 (1999).
\item \textsuperscript{267} 526 U.S. 40, 119 S. Ct. 977 (1999).
\item \textsuperscript{268} See id. at 985-89.
\end{itemize}
1. Interventions into the Development of Medicaid Policies

There are several avenues by which advocates can influence the development of public mental health care systems.

One avenue for policy change in public mental health managed care is to press for stronger government oversight and public accountability. Advocates could ask HCFA, which grants Medicaid waivers to states, to impose conditions on the operation of the waivers. Because both the executive branch of the federal government and state governors have agreed to streamline the granting of such waivers, advocates will have to lobby many levels of government.\(^{269}\) Advocates also could pressure HCFA to provide ongoing, aggressive oversight to mental health carve-outs once waivers have been granted.\(^{270}\) For example, advocates could seek more extensive reporting requirements by the private contractor, triggers for review when service cuts are statistically significant, and independent review of administrative costs.

One current problem is that HCFA oversight of the carve-outs tends to be most intensive at the time of waiver development and approval and at points of continuation or renewal, and oversight is less intensive at other points and tends to be reactive and limited to problem issues.\(^{271}\) The time and experienced staff necessary to investigate and oversee the numerous private contractors or even the state agencies that contract with private entities is far beyond the current capacity of HCFA.\(^{272}\) Given the vogue of disparaging government regulation, it is unlikely that HCFA’s budget will increase to enable it to perform its current functions and adequately oversee privatized Medicaid programs.\(^{273}\) However, a small

\(^{269}\) See, e.g., National Governors’ Ass’n, Governors Urge President to Support State Waivers to Pursue Innovations in Children’s Health (visited Jan. 19, 2000) <http://nga.org/releases/pr024 sept97supportstatewaivers.htm> (containing a Sept. 24, 1997, press release that urged the Clinton Administration to support waivers of Medicaid requirements).

\(^{270}\) State Medicaid agencies are required to contract with External Quality Review Organizations (EQRos) to perform annual reviews of managed care organization quality, access and timeliness of care. See 42 U.S.C. § 1396a(a)(30)(C) (1999); U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 22. HCFA exempts mental health carve-outs from the requirement of conducting these annual reviews. See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 21, 24. However, pursuant to a September 29, 1998, proposed rule implementing the Medicaid portion of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (codified as amended in scattered sections of 42 U.S.C.), HCFA signaled a change in this policy to require prepaid health plans to have external quality reviews. If this requirement is included in the final rule, and it appears likely that it will, future mental health carve-outs will have to undergo external quality review, absent waiver by the Secretary of HHS. See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 24.

\(^{271}\) See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 30.

\(^{272}\) See id. at 31; see also Health Insurance: Legal and Resource Constraints Complicate Efforts to Curb Fraud and Abuse: Before the Subcomm. on Crime and Criminal Justice of the House Comm. on the Judiciary, 103rd Cong. (1993) (statement of Janet L. Shikles, Director of Health Financing and Policy Issues, GAO).

\(^{273}\) See Sean Martin, Provider Fees, Charges for Paper Claims All Key Elements in 1999 Clinton Plan, Am. Med. News, Feb. 16, 1998 (available at <http://home.earthlink.net/~austinxmd/Pages/bad0298b.html>) (stating that the Clinton budget relies heavily on user fees as part of an overall goal of achieving a budget surplus in 1999 and that HCFA’s own budget hardships were necessitating reliance on Medicare provider fees).
amount of good would be achieved if HCFA required such privatized entities to disclose meaningful information, such as disaggregated claims data. 274 Such disclosure would enable stakeholders (e.g., trade organizations like psychological or psychiatric associations) to look at data relevant to their particular concerns.

In addition, advocates could encourage states to follow HCFA's quality assurance guidance, now known as the Quality Improvement System for Managed Care (QISMC). 275 The guidance was developed for comprehensive managed care programs but is optional. 276 HCFA instructs: "For Medicaid, the QISMC standards and guidelines are tools that States may choose to use to ensure that Medicaid managed care organizations meet the comparable quality assurance requirements that the BBA and its implementing regulations establish for them." 277 Massachusetts does not use the standards. 278

Advocates also might intervene in the process by which the state solicits bids from and negotiates with private entities seeking to manage the state's mental health care systems. For example, when a state asks for bids, it may issue a statement on the general parameters of the program to which the contractors respond. Advocates can seek to structure the program so as to exclude capitation and subcapitation, require notice of the right to independent appeal procedures even when providers do not request particular services, and require the provision of and payment for services beneficial to trauma survivors, even if those services do not fit traditional definitions of medical necessity.

2. Legislative Initiatives

Improving the mental health managed care system through legislative initiatives is extremely difficult given that legislative bodies are increasingly controlled by business interests. For example, in Massachusetts, it is estimated that the health care industry will spend a record $7 million lobbying the Legislature this year, a $1 million increase over last year's

274. An oft-used ploy of MCOs is to lump data together, thus making it impossible to see trends in treatment planning, or to exclude pertinent data. For example, MCOs often present expenditure data on "outpatient services." By lumping all outpatient services together—e.g., individual therapy and medication services—one cannot tell whether enrollees are being steered toward quick fix medication or toward therapy. Likewise, by excluding the number of unduplicated enrollees using the services, it becomes unclear whether increases in expenditures are due to increases in the number of enrollees or to increases in the amount spent on care per enrollee.

275. See HCFA, Quality of Care Information, Project Activities, Quality Improvement System for Managed Care (QISMC) (currently in interim final form) (last modified Dec. 21, 1999) http://www.hcfa.gov/quality/3a.htm. The predecessor to QISMC was the Quality Assurance Reform Initiative (QARI). See Telephone Interview with Phyllis Thorburn, Assistant Director, U.S. General Accounting Office (Jan. 21, 2000).

276. See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 21.

277. HCFA, Quality of Care Information, supra note 275.

278. See U.S. GEN. ACCOUNTING OFFICE, supra note 21, at 21.
spending.\textsuperscript{279} By comparison, the utility industry spent $2 million leading up to the state Legislature's 1997 vote on deregulation.\textsuperscript{280}

Despite these obstacles, recent successes in a number of states suggest the need to continue advocating for legislative change. One area in which legislative change has been successful has been in passing state laws that provide individuals with private industry employer-paid health coverage the right to sue their HMO. The first such law took effect in Texas on September 1, 1997.\textsuperscript{281} It imposes liability on MCOs for harm that is proximately caused by the failure of the MCO or its employees, agents, ostensible agents, or representatives to exercise ordinary care when making health care treatment decisions.\textsuperscript{282} On September 28, 1999, California enacted a comparable law, to become effective January 2001.\textsuperscript{283} Georgia also enacted a liability law in 1999, but, unlike the Texas and California statutes, it does not allow for punitive damages.\textsuperscript{284} In 1997, Missouri patients gained a limited state law remedy to sue their HMOs for malpractice and for recovery of damages.\textsuperscript{285} As of February 1999, twenty-three other states were seeking similar legislation.\textsuperscript{286} In Massachusetts that same month, a state Senator added language modeled after the Texas law to the Senate omnibus bill to reform managed care, providing patients with a right to sue their HMOs.\textsuperscript{287}

In addition to laws that establish the right to sue, advocates in a number of states have been successful in passing legislation to address the specific problems arising in the mental health managed care arena. For example, Rhode Island legislators, in response to complaints regarding improper gatekeeping and utilization review decisions, enacted a patients'
rights bill in 1996. In 1994, Vermont legislators established standards for mental health utilization review and created an independent appeals panel for mental health treatment denials.

The Health Administration Responsibility Project (HARP), an advocacy organization, has suggested a number of other statutory changes at both the federal and state levels. At the federal level, HARP suggests eliminating the preemption of claims relating to medical benefits and the preemption of state regulations that the Employee Retirement Income Security Act of 1974 (ERISA), discussed below, imposes. At the state level, HARP suggests establishing vicarious liability of MCOs, removing MCO control of utilization review, establishing expedited arbitration, and outlawing physician gag clauses (provisions by which MCOs prohibit physicians from disclosing to patients information regarding the MCO, such as the MCO's refusal to cover particular forms of treatment, regardless of their medical advisability or necessity). One observer of the Massachusetts mental health system has suggested the following possible legislative objectives: guaranteed access to mental health specialists with a right of self-referral for consumers; establishment of a mental health ombudsman; special internal and external appeals processes geared to mental health treatment issues with decision-making by mental health clinicians; protection against disenrollment and curtailment of services and medications for mental health consumers due to compliance problems; delineation of mental health concerns as part of mandated access to emergency services; guaranteed access to all effective and potentially beneficial psychotropic medications; and specification of a concept of "medically necessary" services that incorporates social supports and services recognized to meet standards of good practice for mental health conditions.

Both legislators and consumer advocates are thwarted in their efforts to meet these objectives because they feel pressured to agree to bills that soothe public anger about the impact of privately managed care, but that ultimately are no more than a public relations tool. For example, the media touts panaceas like independent review, but fails to note that access to independent review is dependent upon completion of three prior levels of internal review and the up-front payment by the patient of $50.

288. See Health Care Accessibility and Quality Assurance Act, R.I. GEN. LAWS § 23-17.13 (1999); see also Rochefort, supra note 34, at 14.
289. See VT. STAT. ANN. tit. 8, § 4089a (1999); see also Rochefort, supra note 34, at 14.
293. See Rochefort, supra note 34, at 14-15.
294. See A Bill Protecting Patients in the Commonwealth, H. 4525, 181st Leg., 1st Reg. Sess. (Mass. 1999) (currently pending in the Massachusetts House); see also A Bill Protecting the Health and Safety of Massachusetts Consumers from Certain Managed Care Practices in the Insurance In-
Legislation proposed by the Advocates for Quality Care does just that. It prohibits MCOs, HMOs, and other insurers from:

enter[ing] into any compensation arrangement with a mental health care provider that provides additional compensation to the provider in the form of wages, bonuses, or other incentive payments, or offers direct or indirect inducements to the provider if the provider limits medically necessary services or expenditures for medically necessary services . . . ;

enter[ing] into any contractual arrangement . . . that imposes any liability on the provider or group of providers for expenditures for medically necessary services or that permits the provider or the group of providers to retain a greater proportion of payments made by the insurer if services or expenditures for services are limited; . . . [or]

condition[ing] participation of a mental health care provider in the insurer’s or entity’s plan(s) on the number of or expenditures for medically necessary services rendered by the provider . . . .

The legislation also includes a definition of medically necessary services such that implementation of the law is not hampered by restrictive MCO definitions of medical necessity.

3. Accreditation and Licensure

While government agencies increasingly are accepting the review, evaluation, and certification of private accreditation organizations as a substitute for their own oversight responsibilities, accreditation organizations are not an adequate replacement for public regulation. Accreditation organizations are funded by the very programs they monitor, usually conduct infrequent and pre-announced reviews of programs and facilities, rarely take cognizance of individual complaints, and do not provide their standards to the public except at substantial cost (for example, the National Committee on Quality Assurance (NCQA), an organization that reviews and accredits benefits plans in the managed care sector, markets its standards and surveyor guidelines for the accreditation of managed care behavioral healthcare organizations for $210). The result is that advocates and observers often do not have copies of these standards and there-

---

296. See id.
fore cannot monitor organizations' compliance with them on an ongoing basis. Further, standards tend to be vague and accreditation is rarely withheld.  

Nevertheless, for those states that lack any quality standards, advocates might begin by looking at the measurement tools developed by NCQA. While these standards are minimal (for example, the standards require plans to make timely utilization management decisions, but the health plan, not NCQA, has discretion to define what is timely), advocates may want to press for a mandate that their state contract only with NCQA accredited health plans.  

Alternatively, advocates may pressure the state to measure the performance of managed care health plans serving Medicaid beneficiaries using an adaptation of no less than NCQA's Health Plan Employer Data and Information Set (HEDIS), as is done in some other states. Note, however, that HEDIS covers both physical and mental health, and does not necessarily reflect best practices (for example, the report requires plans to disclose the number of persons who received outpatient care within thirty days of discharge from hospitalization; most clinicians believe that it is preferable for outpatient care to occur within seven days of discharge). More specifically, advocates should press for accreditation standards that take into account the extent to which health plans meet or impede the access of women trauma survivors to appropriate treatment. However, the bottom line is that accreditation by organizations like NCQA and state performance measures are valuable only if (1) they are specific enough to be enforceable, preferably objectively measurable; (2) they are enforced by agencies with knowledgeable and motivated staff.

An excellent critique of private accreditation can be found in the testimony of Claudia Schlosberg, of the National Health Law Program, before the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. See Schlosberg, supra note 297. See also First Amended Class Action Complaint, Holstein v. Magellan Behavioral Health, Inc., No. 98 CV 9201 (S.D.N.Y. 1999) (available at <http://www.nohmo.com/AmendedClassAction11_10_99.html>) (alleging, as one piece of evidence in case alleging antitrust activities by nine MCOs, that the MCOs effectively bought self-serving accreditation standards through the payment of thousands of dollars in "donations" or "fees" to NCQA). 

Using its Managed Care Behavioral Health Care Accreditation Standards, the NCQA began accreditation surveys for managed behavioral health organizations in January, 1998. See Goldner, supra note 43, at 1521.

Presently, no managed behavioral health plans in Massachusetts are accredited and only two, Beacon Health Strategies, LLC and Magellan Behavioral Health, are slated for survey. See NCQA, Managed Behavioral Health Organization Accreditation Status List (visited Nov. 22, 1999) <http://www.ncqa.org/pages/policy/accreditation/mbho/mbho2.htm>.


See NATIONAL COMM. FOR QUALITY ASSURANCE, BOOK II – HEDIS 3.0, 64 (1997).

See MICHAEL J. ALEF & BRENDAN BRIDGELAND, CTR. FOR INS. RESEARCH, A HOLE IN THE BUCKET: MASSACHUSETTS' FAILURE TO POLICE INSURANCE COMPANY MARKET PRACTICES LEAVES CONSUMERS VULNERABLE NATIONALLY (1999) (exposing deficiencies in the enforcement efforts of Massachusetts Division of Insurance).
and (3) they are backed by effective (i.e. monetary) penalties for failure to comply. The sad reality is that accreditation organizations and licensing agencies tend not to enforce their standards, both because their reviews tend to be brief and infrequent on-site visits, supplemented by paper reviews (which are less accurate and effective), and because the only penalties available to the enforcers to inspire correction, such as denial of accreditation or termination of contracts, are so Draconian that the enforcing agencies are reluctant to impose them.

C. Legal Theories

When the administrative avenues and policy suggestions presented above are unsuccessful, individuals have an array of legal theories to consider. The more prominent of these are discussed here.

1. Discrimination

One legal approach available to female trauma survivors is the claim of discrimination in provision of mental health care. Such a claim might be brought under state or federal provisions and while none is guaranteed to be successful, case law suggests that women trauma survivors should pursue claims of discrimination.

Female trauma survivors may fall within the definition of disabled persons for purposes of the Americans with Disabilities Act (ADA), in-
introducing several avenues of legal challenge to managed care. Although the success of these claims remains undetermined, case law supports claims brought under: 1) Title I, which applies to employers who employ more than fifteen workers; 309 2) Title II, which prohibits discrimination against individuals with disabilities310 in the provision of services by public entities;311 and 3) Title III, which prohibits discrimination by public accommodations.312 While claims of disparate impact theoretically may be brought to challenge decisions to deny services if they are inconsistent with non-disability specific provisions, such as pre-existing treatment clauses or medically necessary clauses, recent ADA case law makes the pursuit of such claims difficult. In 1998, the Sixth Circuit held that a long-term disability plan obtained through an employer and administered by an insurance company is not a public accommodation; therefore, the court concluded, Title III of the ADA did not apply.314 Further, the Sixth Cir-

equally effective they need not produce an identical result or level of achievement for both groups. Instead, the services simply must afford individuals with handicaps equal opportunity to gain the same benefit. Thus, the Court concluded, the state is not required to ensure that Medicaid recipients with handicaps will be as healthy as those without handicaps and, therefore, the 14 day coverage period was permissible. See 469 U.S. at 304-06. Another piece of legislation intended to inform discrimination claims in mental health is the Mental Health Parity Act of 1996. Although it was intended to prohibit limitations on mental health care coverage, it has not provided a solution to the problem of unequal levels of care. The Act merely says that group health plans that do not place an aggregate lifetime or annual limits on medical and surgical benefits cannot impose such caps on mental health benefits. See 42 U.S.C. § 300gg-5(a)(1)(A)(1999). Further, the Act requires plans that include annual and aggregate lifetime limits for medical or surgical benefits to offer the same or better coverage for mental health benefits, if mental health benefits are offered. See id. § 300gg-5(a)(1)(B)(1999). Insurers still can limit what services are provided, and have skirted the law by placing limits on the number of treatment and hospitalization days a person with mental illness is allowed each year. The result is less mental health coverage. See Carl Ginsburg & Helen Demeranville, Sticks and Stones: The Jailing of Mentally Ill Kids, NATION, Dec. 20, 1999, at 17. Further, even with parity, it is likely that HMOs and carve-out plans will use utilization review to limit access to mental health services. See David S. Salkever et al., Mental Health Benefit Limits and Cost Sharing Under Managed Care: A National Survey of Employers, 50 PSYCHIATRIC SERVS. 1631, 1633 (1999) (concluding that both HMOs and carve-outs would limit mental health services despite parity legislation).


310. See 42 U.S.C. § 12102(2) (1999) (providing that an individual with a disability is one who has a physical or mental impairment that substantially limits one or more of the major life activities of such individual; has a record of such an impairment; or is regarded as having such an impairment); see also Sutton v. United Air Lines, Inc., 119 S. Ct. 2139, 2146-47 (1999) (holding that determination of substantial impairment under the ADA should be made with reference to measures that mitigate the individual's impairment).


cuit concluded that Title I of the ADA did not prohibit plans that treat categories of individuals with different disabilities differently, but only discrimination of disabled individuals vis-a-vis their non-disabled counterparts. In reaching this latter conclusion, the court followed, as had other circuits, the Supreme Court’s reasoning in certain cases interpreting Section 504 of the Rehabilitation Act of 1973, particularly Traynor v. Turnage and Alexander v. Choate. The Sixth Circuit noted that in those cases the Supreme Court held that nothing in Section 504 required that benefits given to one class of handicapped persons be given to all other categories of handicapped persons.

However, the proposition that inter-disability discrimination does not violate the ADA is rendered less certain by the Supreme Court’s 1999 decision in Olmstead v. L.C. In that case, the Supreme Court opened the door for claims that discrimination between differently disabled groups is illegal. The Court wrote:

The dissent is driven by the notion that “this Court has never endorsed an interpretation of the term ‘discrimination’ that encompassed disparate treatment among members of the same protected class,” that “[o]ur decisions construing various statutory prohibitions against ‘discrimination’ have not wavered from this path,” and that “a plaintiff cannot prove ‘discrimination’ by demonstrating that one member of a particular protected group has been favored over another member of that same group.” The dissent is incorrect as a matter of precedent and logic.

Choate itself presents another barrier to disparate impact cases by seeming to permit facially neutral limitations on benefits even if they disparately impact persons with disabilities. The claim in Choate was based upon Tennessee’s reduction of the number of inpatient days covered by its Medicaid program. In that case, the Supreme Court interpreted Section 504 to mean that, while programs need to provide “meaningful” and “equal” access to benefits, they can narrowly define those benefits. The Court found that since people with disabilities had

---

denied, 120 S. Ct. 845 (2000) (holding that lifetime benefits limits for AIDS treatment in health insurance policies did not violate the public accommodations provisions of the ADA, since to find a violation would discriminate among diseases because most health insurance policies limit benefits for many diseases; also stating that common sense interpretation of the ADA suggests that goods and services offered within the place of public accommodation are not regulated by the act). But see Carparts, 37 F.3d at 21.

315. See Parker, 121 F.3d at 1019.
318. See Parker, 121 F.3d at 1019.
320. See id. at 2186 n.10 (citations omitted).
322. See id. at 289.
323. See id. at 302-06.
meaningful and equal access to the Medicaid hospitalization benefit, even though they were disparately impacted by the reduction in coverage, the reduction was permissible since increasing the number of covered days would have fundamentally altered the program. The court further noted that Medicaid programs did not guarantee that each recipient receive a “level of health care precisely tailored to his or her particular needs” or even “adequate health care,” but instead simply provided those services that constituted “necessary medical care.” The fact that the Court in Choate defined benefit in terms of the service offered, and not in terms of actual need of the individual, makes difficult the use of disparate impact analysis in the context of discrimination in a benefits plan.

To avoid the difficulty of a disparate impact claim, women trauma survivors seeking mental health services from the public system might claim intentional discrimination. Unlike disparate impact challenges, federal regulations regarding intentional discrimination do not reference “undue burden” or “readily achievable” as defenses. However, a legitimate, non-discriminatory reason for the disparate treatment may serve as a defense; the safe harbor provision of the ADA instructs that the statute shall not be construed to prohibit or restrict an insurer, hospital, HMO, or entity administering a benefits plan from underwriting, classifying, or administering risks that are based on or not inconsistent with state law. The statute explicitly states that the provision cannot be used as a subterfuge to evade the purposes of Titles I and III. Thus, for example, cost-effectiveness may provide a defense if it does not have a particular exclusionary effect on trauma survivors.

To prove intentional discrimination, one must present evidence that a person or group of persons in a protected class has been singled out for less advantageous treatment on the basis of that status. Such evidence is

324. See id. at 303.
325. See id.
327. “Undue burden” is defined in regulations interpreting Title III of the ADA as “significant difficulty or expense in making an accommodation.” 28 C.F.R. § 36.104 (1999).
328. “Readily achievable” is defined in Title III of the ADA as “able to be carried out without much difficulty or expense.” 42 U.S.C. § 12181 (9) (1999) (also listing factors to be considered in making the determination as to whether a task is readily achievable).
329. See Rubenstein, supra note 326, at 341-42. Unfortunately, the ADA and its regulations do not always clearly distinguish the intentional discrimination and disparate impact analyses. See id. at 342. “This blurriness, combined with the influence of Choate as a basis for analyzing discrimination in health plans generally, has led to the inappropriate use of disparate impact analysis when disparate treatment reasoning should apply.” Id. at 343.
331. See id.
332. See id.
333. The Supreme Court has identified factors to consider when looking for intentional discrimination: “discriminatory effect of the defendant’s action, the historical background of the decision, the specific sequence of events leading up to the decision, departures from the normal procedural sequence, departures from the normal substantive criteria, and the legislative and administrative
usually hard to come by. In public policy decisions, proof may well be circumstantial. To prove that the MCO is intentionally discriminating against them because of their type of illness, female trauma survivors may argue that the MCO is denying them medically necessary mental health services, such as on-going therapy, that are provided for persons with other mental illnesses. However, the evidence needed to prove this claim, such as internal memoranda or recollections of policy discussions, may be difficult to obtain.

Women trauma survivors also could argue that the Medicaid mental health managed care program specifically excludes them by failing to provide adequate mental health services, or “meaningful and equal access.” While the ADA permits benefits to be offered to a particular group of disabled individuals without them being offered to all people with disabilities, a program of general applicability cannot single out a particular group of people with disabilities for exclusion. Thus if women trauma survivors required more or different services than others seeking mental health services, a uniform cap on amount or type of services across populations could be discriminatory. In fact, insurance companies already have recognized that differential treatment may be necessary to provide equal coverage, such as in the provision of gynecological and obstetrical care to women.

Despite Choate, cases under the ADA still recognize that most discrimination is not intentional but the result of stereotype and neglect. Thus, claims of disparate treatment are untested but viable under the ADA. Relying on Kathleen S. v. Department of Public Welfare of Pennsylvania, a claim also might be possible regarding discrimination caused by program administration. In Kathleen S., a district court held that under ADA regulation a public entity could not utilize criteria or methods of administration that had the effect of discriminating against qualified individuals on the basis of disability. Pursuant to that case, a violation of Ti-


334. See id.

335. See, e.g., Hudson Sangree, Cracks Appearing in HMO Armor: $13 Million Verdict Shows Depth of Public Animosity Toward Managed Care, Law. Wkly., Inc. USA, Nov. 30, 1998, at 1002 (reporting on Kentucky jury award to woman who brought suit after having been denied coverage for a hysterectomy by her health plan, while paying for the surgery out of pocket, and quoting her attorney as saying that discovery was key to learning that the insurance company’s subcontractor systematically denied coverage for hysterectomies for company clients).


337. See Goldner, supra note 43, at 1480.

338. In addition to disparate treatment claims under the ADA, individuals may have viable disparate impact claims under the Massachusetts consumer protection statute, Chapter 93A. See infra note 382 and accompanying text.

Women trauma survivors might also pursue discrimination claims under equal rights provisions of state constitutions. As of early 2000, twenty states had adopted constitutional provisions or constitutional amendments prohibiting the denial of equal rights on the basis of sex. Of these states, all but California had provisions broad enough to encompass discrimination of the types discussed herein. For example, Massachusetts' provision states:

All people are born free and equal and have certain natural, essential and unalienable rights; among which may be reckoned the right of enjoying and defending their lives and liberties; that of acquiring, possessing and protecting property; in fine, that of seeking and obtaining their safety and happiness. Equality under the law shall not be denied or abridged because of sex, race, color, creed or national origin.

Women living in a state with such a constitutional provision could pursue a claim of discrimination on the basis of disparate impact. However, if a policy is facially neutral, its disparate impact may not constitute discrimination. It is yet to be tested whether a neutral business determination not to provide particular health care services, a decision protected by the safe harbor provision of the ADA, would survive such a constitutional attack. For example, protocols that limit the number of individual therapy sessions to an amount below that typically needed by trauma survivors may constitute a discriminatory business practice in violation of these state constitutional provisions.

---

340. See id. at 466, 471 (citing ADA regulation, 28 C.F.R. § 35.130(b)(3) (1999)).
341. While in-depth analysis is beyond the scope of this article, the authors note that even states without such explicit constitutional protections may apply a fairly high level of scrutiny to claims of sex-based discrimination. See Telephone Interview with Paul B. Linton (Jan. 24, 2000). In addition, some state statutes may be helpful in addressing sex-based discrimination. See id.
342. See Paul B. Linton, State Equal Rights Amendments: Making a Difference or Making a Statement?, 70 TEMPLE L. REV. 907, 908 (1997) [hereinafter Linton, State Equal Rights Amendments]; Telephone Interview with Paul B. Linton, supra note 341 (explaining that since 1997 two states, Iowa and Florida, have added equal rights provisions to their state constitutions).
343. See Linton, State Equal Rights Amendments, supra note 342, at 941-44 (appendix containing text of state constitutional provisions); IOWA CONST. art. 1, § 1; FLA. CONST. art. 1, § 2. Some states do limit the scope of equal protection, prohibiting only governmental discrimination. See, e.g., ILL. CONST. art. 1, § 18; VA. CONST., art. 1, § 11.
344. MASS. CONST. Pt. 1, art. 1.
345. See Hardy v. Stumpf, 21 Cal. 3d 1, 9 (1978) (holding that the test for police officers, which was facially neutral but which disparately impacted women applicants, did not constitute sex discrimination prohibited by Title VII of the Civil Rights Act of 1964 because test was significantly correlated to important elements of the job).
2. ERISA

Those claimants who challenge health insurance plans provided by employers in the private sector also may assert violations of ERISA. ERISA permits a beneficiary to bring an action in state or federal court against a fiduciary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." A beneficiary also may bring an action in federal court "(A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief." While ERISA provides for attorneys’ fees and equitable relief (typically injunction, mandamus, and restitution), it excludes compensation for harm and punitive damages.

These features of ERISA limit its usefulness for women trauma survivors. As ERISA applies only to health insurance plans provided by employers in the private sector, it is inapplicable to other insurance plans, including the Medicaid system. Further, since redress is limited to equitable relief, an ERISA action should be brought before the damage is done, in order to enforce the right to treatment. Yet women trauma survivors may not recognize the injury at such an early stage. In addition, the minimal relief available may not be sufficient to remedy the harm incurred. Finally, ERISA is not helpful when the plain language of an ERISA plan discriminates against a particular disability, which may be the case for women trauma survivors. In challenging such language, plaintiffs must rely upon the ADA, as discussed above.

In addition to the limitations of ERISA as a claim, attorneys must consider the possibility of ERISA preemption when bringing malpractice, common law, and state law claims against insurers of employee benefit plans. ERISA preempts nearly all state laws affecting such plans (except those laws directly regulating the insurance business), as well as common

347. 29 U.S.C. § 1132(a)(1)(B) (1999). For example, one might argue that, under section 1104(a)(1)(A) of ERISA, an HMO has a fiduciary duty to plan participants, and that, when a fiduciary’s cost containment policies negatively affect patient care, that duty has been breached. In February, 2000, the Supreme Court heard arguments in a case raising such a claim. See Pegram v. Herdrich, 154 F.3d 362 (7th Cir. 1998), cert. granted, 120 S. Ct. 10 (1999). While Herdrich claims harm as a result of decisions made by her doctor, she argued that, because her doctor and other physicians actually managed the plan, the HMO controlled patient care to such an extent that a fiduciary duty existed between her and the plan. Whether the Supreme Court will agree with Herdrich and the 7th Circuit that the HMO had a fiduciary duty is uncertain; even if it were to agree, the decision may have limited import due to the substantial and somewhat unusual control physicians had in this case over plan administration. See Pegram, 154 F.3d at 370.
law causes of action, which are based on allegations of improper processing of benefits claims. The ERISA statute contains two types of preemption. First, the complete preemption of § 502(a) creates an exception to the well-pleaded complaint rule; thus, if a state law claim is within ERISA’s § 502(a) civil enforcement provisions, the state law claim is preempted and the case removed to federal court. Second, pursuant to the broader conflict preemption of § 514(a), ERISA “supercede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”

Section 514(a) preemption has proved particularly troublesome for those seeking redress from insurance companies. Analysis of § 514(a) preemption has focused on interpretation of the clause “relate to.” Historically, courts have broadly interpreted the clause, resulting in the preemption of state law claims. More recently, however, the Supreme Court signaled a new course by looking not solely at the “related to” language of § 514(a) but also to the objectives of ERISA. In response to this holding, circuit courts began to develop different approaches to interpret the “related to” language of § 514(a). Common to the circuits’ approaches are: 1) a recognition of the dual functions of HMOs as care providers and as administrators of health plans; and 2) a determination that HMOs acting in the role of provider, as opposed to administrator, do not enjoy complete preemption under ERISA. Consistent with this judicial trend, Third Circuit courts have drawn a distinction between claims based upon failure to provide benefits or negligence in utilization review (which would be preempted) and claims based upon negligence in the provision of care (which would not). This is sometimes described as a quantity versus quality distinction. As the Third Circuit court recently explained, ERISA will not trump a malpractice suit against an insurer where the manner in which the care was provided or denied is at issue. The court found that the suit was not preempted because in the

355. See, e.g., Pilot Life, 481 U.S. 41 (holding that because the phrase “relate to” is to be given a broad, common sense interpretation, ERISA preempts state law tort and contract claims for improper processing of benefit claims); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 139 (1990) (finding that a state law claim may “relate to” an employee benefit plan, and therefore be preempted, even if the law was not designed to affect such plans, or if the effect is only indirect).
357. For a detailed discussion of the various analyses undertaken by the circuits, see Morris, supra note 281, at 982-90.
358. See Morris, supra note 281, at 989.
360. See id.
plaintiff's complaint, [there is] nothing to indicate that plaintiff claims a denial of a benefit due under the health plan issued by defendant [HMO]. Rather, the complaint revolves around the recommendation of [the HMO] that [the plaintiff] "required only outpatient care as opposed to inpatient care despite the recommendations of her physician to the contrary." Nowhere does the plaintiff claim that [she] was entitled to inpatient care under the health plan, nor does the plaintiff claim that inpatient care was specifically denied . . . .

Plaintiff's allegations thus attack the quality of the health care provided by defendants . . . and not the quantity of the care provided . . . . [A] claim attacking the quality of health care is not completely preempted by ERISA. 361

The Third Circuit analysis is helpful for women trauma survivors seeking to avoid ERISA preemption. While trauma survivors might not be able to bring claims challenging a utilization review process which limits access to certain services (such as a decision not to approve additional therapy sessions), they could argue that providers have been negligent in the provision of trauma related services (such as not offering certain forms of treatment). Also, claims about coercive treatment would not be preempted. 362

3. Medical Malpractice 363

Another approach to establishing trauma survivors' rights is to bring a claim of medical malpractice against a clinician or an MCO for the denial of services. 364 Women trauma survivors might bring a medical malpractice claim against an MCO based upon evidence that the services offered by the managed care health plan do not meet a professionally recognized standard of care for women with abuse histories, either because they exclude important services for survivors or because they rely upon services which are inappropriate for survivors.

In medical malpractice claims, negligence is the predominant theory of liability. Proof of negligence requires the demonstration of: 1) a duty to the patient; 2) a violation of the applicable standard of care; 3) a com-

361. Id. at *8.
362. See, e.g., Roessert v. Health Net, 929 F. Supp. 343, 351 (N.D. Cal. 1996) (finding that woman's claim of general and medical negligence in treatment, based upon her commitment to psychiatric facility, was not totally preempted by § 514(a) of ERISA).
363. In response to this and other direct legal attacks, MCOs may attempt to employ the defense of immunity traditionally accorded to public entities. While beyond the scope of this article, the issue of whether MCOs running public systems under contract enjoy the immunities that traditionally have been accorded public entities is an important and complex one. See Ira Burnim & Claudia Schlosberg, National Ass'n of Protection and Advocacy Sys., Inc., Protecting Consumers in Managed Care: Resources for Legal Advocates (last modified Feb. 20, 1998) <http://www.bazelon.org/mclegal.html>.
364. Plaintiffs would likely benefit from bringing the malpractice claim against both the clinician and the MCO in order to prevent a defendant's attempt to avoid liability by pointing the finger at the other defendant.
pensable injury; and 4) a causal connection between violation of the standard of care and the harm.\textsuperscript{365}

A claim of medical malpractice in the mental health arena generally is based upon evidence of failure to provide treatment that conforms to a professionally recognized standard of health care.\textsuperscript{366} When bringing such claims against MCOs, one must establish that the MCO, as opposed to the clinician, owes a duty to the patient. Where a denial of services compromises the level of care provided, the MCO may be held directly liable.\textsuperscript{367}

In the first medical malpractice case to address managed care liability, \textit{Wickline v. California}, the California Court of Appeal declined to find the MCO liable for its refusal to authorize the full extension of hospital days requested by the physician.\textsuperscript{368} However, the court noted that

\begin{quote}
[t]hird party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms as, for example, when appeals
\end{quote}


\textsuperscript{366} See Paul Appelbaum, \textit{Legal Liability and Managed Care}, 48 Am. Psychologist, 251, 252 (1993). Appelbaum argues that the identification of professional judgment standards in mental health care is made difficult by the limited opportunities clinicians and the courts have had to deal with such questions. See \textit{id}. In addition, the lag between the time professionals adopt a practice and the time professional literature and appellate courts recognize it as the standard hinders the identification process. See \textit{id}. Further, Appelbaum argues, the introduction of managed care into the mental health care system has, itself, led to changes in professional standards, such as reductions in the number of outpatient sessions per episode of treatment. See \textit{id}. Even when professional standards are identified in the mental health care realm, they may be suspect. See Susan Stefan, \textit{Leaving Civil Rights to the "Experts": From Deference to Abdication Under the Professional Judgment Standard}, 102 Yale L.J. 639, 657 (1992) (suggesting that norms of professional mental health care may not be based upon research, evidence, or fact, but upon a more questionable process of professional consensus).

\textsuperscript{367} While, in general, medical malpractice claims against MCOs may be brought under direct and vicarious theories of liability, the potentially actionable problems identified in this article would suggest claims based upon direct liability theories for the following reasons. Cases against MCOs that rely upon theories of vicarious liability have been of two types: those based upon respondeat superior theories and those based upon ostensible agency/apparent authority theories. Respondeat superior liability, that an employer is vicariously liable for negligence of employee acting within the scope of his employment, is most likely established in a staff model MCO, (a model in which an MCO directly employs clinicians as opposed to contracting with a provider agency which then employs the clinicians), or when an MCO's control over providers is established by contract terms, practice guidelines and protocols, quality assurance programs, or capitation agreements. See, e.g., Dunn v. Praiss, 606 A.2d 862, 868-69 (N.J. Super. Ct. App. Div. 1992) (finding agency relationship where HMO exercises substantial control over independent physicians by controlling the patients they must see and by paying on a capitated basis). This approach is most useful where staff are clearly unprepared or ill-trained to deal with trauma victims; these are not the types of problems upon which this article has focused. Instead, we have identified problems which are more systemic in nature. While respondeat superior liability does not apply if providers are independent contractors, these are the circumstances we are focused upon. Alternatively, an MCO may be found vicariously liable under an ostensible agency/apparent authority theory if an MCO holds out a physician as its employee or agent, the patient relies on such representation, and the physician commits malpractice. In such a case, the standard is whether a reasonable person would conclude that the practitioner is an employee of the facility, even if other financial arrangements actually exist. See, e.g., Petrovich v. Share Health Plan of Illinois, Inc., 719 N.E. 2d 756 (Ill. 1999). This article does not focus on that type of problem.

\textsuperscript{368} 239 Cal. Rptr. 810 (Cal. Ct. App. 1986).
made on a patient's behalf are arbitrarily or unreasonably disregarded or over-
ridden.369

Four years later, the same court held in Wilson v. Blue Cross that an
MCO might be liable for a negligent decision in failing to approve further
hospitalization of a psychiatric patient who later committed suicide.370 In
Wilson, the court found sufficient evidence to warrant a trial on whether
the MCO's decision to deny further hospitalization was a substantial fac-
tor in bringing about harm, even absent a defect in the administration of
the utilization review process.371 A trauma survivor could allege that a de-
cision to deny a particular amount or form of care was a substantial factor
in harm suffered.

In pursuing claims of negligence in the quality of care, a plaintiff
also might allege that the MCO has a specific duty to select and retain
appropriate providers whose staff have been trained in identifying and
treating trauma survivors. In light of this duty, the MCO could be held
directly liable if the provider network did not include appropriately
trained staff. To the extent that administrative mechanisms, such as ap-
peals, bonuses, reviews, or policy enforcement, result in inappropriate
care decisions, these facts also might constitute medical malpractice.372

In addition to the barrier raised by ERISA, individuals bringing mal-
practice claims must consider the possibility of a state law cap on liability.
For example, Massachusetts state law imposes a $20,000 cap on non-
profit tort liability.373 In suits against MCOs and HMOs, there may be
strategies to circumvent the liability cap. Essentially, the claimant must
challenge the non-profit status of the insurer, or must assert that the ac-
tivity complained of was not carried on within the charitable purpose of

369. Id. at 819.
371. Id. at 884-85.
discussed in Barry R. Furrow, Litigation over Quality in Managed Care: Individual Malpractice/Negligence Claims in Arbitration and Litigation, in Litigating Managed Health Care Disputes 59, 66 (Mass. Continuing Legal Ed. ed., 1999). Plaintiff argued that the system of in-
centives used by an HMO deterred the PCC from giving her a timely pap smear. While the court
concluded that HMOs and their utilization review practices are not against public policy, it also
found "a genuine issue of material fact presented as to whether [the HMO's] system in and of it-
self proximately contributed to the malpractice." Id.
immunity defense and removing cap of liability on grounds that a discovery sanction was equita-
ble and fair in light of the hospital's failure to produce records of care for infant who suffered
brain damage); Mac Daniel, Family Awarded $6.5 M in Hospital Suit, BOSTON GLOBE, Mar. 30,
2000, at B1 (reporting that judge in Keene awarded $6.5 million to family of infant victim Dylan
Keene); An Act Relative to the Liability of Charitable Corporations, H. 808, 181st Leg., 1st Reg.
Sess. (Mass. 1999) (eliminating the liability cap on charitable corporations in cases of willful,
wanton or reckless conduct or gross negligence).
the organization. As it is difficult to challenge the "charitable purposes" of these organizations, survivors face obstacles in pursuing their interests through malpractice claims.

4. Corporate Negligence

The theory of corporate negligence is that a health care organization has a duty to its patients to ensure the competency of its medical staff and the quality of medical care provided. This duty can be satisfied through prudent selection, review, and continuing evaluation of the physicians granted staff privileges.

There is an argument that the MCO's duties include not only proper selection of staff, but also the broader duty to ensure that patients receive good quality care. Courts have found health care entities liable for the breach of a non-delegable duty to provide a certain level of care. Thus, even if a health care entity contracts to provide medical care, there may be certain duties that, due to statutorily or contractually imposed obligations, the entity cannot delegate. For example, one state court has found that a hospital has a non-delegable duty to provide non-negligent physician care under state licensing standards, bylaws of the hospital, and accreditation standards. Since physicians were acting as apparent agents of the hospital, the hospital could be held liable for their negligent acts.

The fact that the court looked to state licensing statutes, corporate bylaws, and accreditation standards to find a non-delegable duty may be helpful in cases where there are comparable provisions governing MCO conduct.

In addition to the duty to provide treatment conforming to a professionally recognized standard, MCOs also may have a duty with respect to plan administration. As quoted above, the court in Wickline indicated that MCOs could be held liable for deficiencies in care caused by defects in plan

374. See Phipps v. Aptucxet Post No. 5988 V.F.W. Bldg. Ass'n, 389 N.E.2d 1042, 1042-43 (Mass. App. Ct. 1979) (holding that because funds derived by charitable corporation were obtained from commercial activity, the defense of charitable immunity was not applicable); see also Linkage Corp. v. Trustees of Boston Univ., 679 N.E.2d 191, 209-10 (Mass. 1997) (finding that limitation of damages to $20,000 against charitable entities for tort liability does not apply to liability under the state consumer protection statute since that statute creates an independent statutory basis of liability).


376. See Jackson v. Power, 743 P.2d 1376 (Alaska 1987). Although the court distinguished the claim from one of corporate negligence since it did not involve the selection, retention, or supervision of the physician, concluding instead that violation of the duty rendered the hospital vicariously liable for the acts of the physician, see id. at 1378, 1385, this case appears more similar to a claim of corporate negligence than one of vicarious liability.
design or implementation of cost containment mechanisms.\textsuperscript{377} One legal observer has suggested that MCOs may have duties relating to the interpretation of benefits; payment of claims; quality improvement; utilization review; credentialing of providers or oversight of any delegated credentialing functions; and monitoring access and availability issues.\textsuperscript{378} For example, one state court has found that an insurer's covenant of good faith and fair dealing created a non-delegable duty of fair processing.\textsuperscript{379} As part of this duty, the insurer was obligated to interpret the definition of "medical necessity" in a way that was consistent with community medical standards.\textsuperscript{380}

Usually, a claimant will assert corporate negligence in conjunction with a malpractice claim because success in a claim of corporate negligence requires proof that the physician performed a negligent act.\textsuperscript{381}

5. Unfair Consumer Practices

In challenging a private MCO for denial of services, a claimant might raise claims of fraud, misrepresentation, contract of adhesion, or unfair or deceptive trade practices. In Massachusetts, the state consumer protection law, Chapter 93A, provides a private right of action to challenge unfair methods of competition, as well as unfair or deceptive acts and practices in the conduct of trade or commerce.\textsuperscript{382} In addition, Massachusetts law governing health care insurance companies expressly provides that the dissemination of untrue, deceptive, and misleading materials regarding health care insurance constitutes a violation of Chapter 93A.\textsuperscript{383} Such a claim might be appropriate if a claimant could allege that the MCO falsely advertised that it had a network of providers that was specially suited for women or that it offered services specifically tailored to women; if the MCO had described certain procedures for review and appeal which then were not followed; or if the MCO had not fully and accurately disclosed coverage limitations. A plaintiff can look at various materials provided by the MCO, including public statements, advertising, brochures, the subscriber certificate, and the policy to determine what benefits are promised. Of course, this action also may be brought for failure to render medically necessary services promised in a policy.

\textsuperscript{377} 228 Cal. Rptr. 661, 671-72 (Cal. Ct. App. 1986).
\textsuperscript{378} See Margaret Ann Metzger, Legal Primer on Managed Care, in REPRESENTING CLIENTS IN MANAGED CARE 23, 29-30 (Mass. Continuing Legal Ed. ed., 1996) (discussing legal obligations between patients and HMOs, which are a subset of the entities that manage health care, i.e., MCOs).
\textsuperscript{380} See id. at 857.
\textsuperscript{381} See Kevin J. Burke & Thomas R. Mulroy III, Managed Care Update: Developments and Trends, in LITIGATING MANAGED HEALTH CARE DISPUTES, supra note 372, at 11, 22.
\textsuperscript{382} MASS. GEN. LAWS ch. 93A (1997). There are incentives to bring actions under Chapter 93A; the statute provides a right to attorneys' fees and treble damages. See id.
Even more helpful to female trauma survivors is Massachusetts' statute governing health maintenance organizations. This statute contains an explicit prohibition of discrimination against abuse victims in the terms of a health maintenance contract and states that such discrimination constitutes a violation of Chapter 93A. The statute provides that health maintenance organizations may not cancel, refuse to issue or renew, or in any way make or permit any distinction or discrimination in the amount or payment of premiums or rates charged, in the length of coverage, or in any other of the terms and conditions of a health maintenance contract based on information that an individual has been a victim of abuse.

The statute further prohibits HMO practices that may result in disparate impact. The disallowed practices include "not only those overtly discriminatory but also practices and devices which are fair in form but discriminatory in practice." MCO enrollees also have begun to bring allegations of consumer fraud under the Racketeer Influenced and Corrupt Organization (RICO) Act. The Supreme Court recently ruled that beneficiaries of group health insurance policies may seek recourse in RICO for fraud by their insurance company. In *Humana*, plaintiff beneficiaries alleged that their insurance company violated RICO through a pattern of fraudulent racketeering activity whereby, pursuant to a concealed agreement, the hospital where beneficiaries received medical care gave the insurance company discounts on the insurer's portion of the hospital's charge for care and did not pass the savings on to beneficiaries. The Court rejected an argument that reliance on RICO was precluded by the McCarran-Ferguson Act, which provides that no federal statute shall be construed to invalidate, impair, or supersede any state law enacted for the purpose of regulating the business of insurance. The court allowed the claim, finding that RICO, particularly its private right of action and treble damages provision, advances the state's interest in combating insurance fraud.

---

384. *See id.*, § 19 (1998). The statute also provides that such discrimination constitutes a violation of the state statute, *MASS. GEN. LAWS* ch. 176D, that defines unfair methods of competition and unfair and deceptive acts and practices in the insurance business and outlines the actions required of the Commissioner of Insurance when such practices occur. *See id.*

385. *Id.* Abuse is defined pursuant to the state's abuse prevention statute. *See id.* (referencing *MASS. GEN. LAWS* ch. 209A, § 1 (1998)).

386. *Id.*


389. *See id.* at 714.


fraud and does not frustrate the state’s policy or disturb the state’s administrative regime. 393

Despite the Supreme Court’s holding in *Humana*, in order to be successful in bringing claims against their MCOs under RICO enrollees will need to surmount a number of hurdles. In a recent federal district court case brought under RICO, a class of MCO enrollees alleged that the insurer violated RICO when it represented that its primary commitment was to maintain and improve the quality of healthcare services it provided to its members when, in fact, it was driven primarily by fiscal and administrative considerations. 394 The court concluded that the plaintiffs’ alleged injury, that they had paid more for their MCO policies than the policies were worth, was too hypothetical (absent an allegation that the quality of care provided had suffered) to provide standing. 395 Regarding the issue of fraud, the court stated that “it is highly doubtful that advertising one’s commitment to ‘quality of care’ can serve as a predicate for a fraud claim.” 396

6. Breach of Contract

A challenge to an MCO’s denial of services also can be cast as a claim for breach of contract. 397 Success of the claim depends upon whether the MCO specifically promised a certain level of care to subscribers and then did not provide that level of care. A key issue will be whether the service desired fits within the policy’s definition of medical necessity. In many cases, there will be several levels of contracts to consider: contracts between the state (or employer) and the MCO, the MCO and the HMOs, and the HMOs and the individual. The issue of whether the plaintiff is a third-party beneficiary also may arise. 398 Thus, a trauma survivor who is enrolled in a privatized Medicaid program must show that she is a third-party beneficiary of the contract between the state and the private

393. See *Humana, Inc.*, 119 S. Ct. at 718.
395. See id. at *2.
396. Id. The court also asserted that plaintiffs had not plead a proper RICO “enterprise” in the association between Aetna and its various plans or between Aetna and various providers associated with the plans. See id.
397. See, e.g., *Natale v. Meia*, No. CV 9600054915, 1998 Conn. Super. LEXIS *1230* (Super. Ct. Conn. 1998) (holding that health care providers, who enter into express contract to provide adequate and qualified medical care in accordance with the generally accepted standards of the community, may be sued for breach of contract; patient who receives written contract and oral representations from doctor and then receives inadequate treatment not in accordance with representations may bring breach of contract claim against the promisor HMO); see also *Taylor v. Blue Cross/Blue Shield of Mich.*, 517 N.W.2d 864 (Mich. Ct. App. 1994) (finding breach of contract, court concluded that the term “experimental” in the health insurance contract is ambiguous and declined to construe it in the narrow way the insurer suggested).
398. See, e.g., *St. Charles v. Kender*, 646 N.E.2d 411 (Mass. App. Ct. 1995) (finding that the patient is the intended beneficiary of contract between the physician and HMO, but ultimately holding physician not liable to patient for failing to return telephone calls because, although there may have been a breach, there were no actual damages).
MEETING THE NEEDS OF FEMALE TRAUMA SURVIVORS

entity managing health care services in order to benefit from any protections for enrollees in that contract.

7. Obtaining Relief from Government Programs

In general, individuals do not have a legal right to mental health services provided by the government. However, the federal government has elected to provide certain mental health services to Medicaid recipients and has listed a broad array of services in its Medicaid law, including prevention, treatment, rehabilitation, and support services, which a state may choose to provide. A state also may elect to provide additional mental health services under its own Medicaid plan, although if the state has a waiver issued by HCFA exempting it from compliance with federal requirements, the waiver's specific scheme replaces the state plan. Even when operating under a waiver, however, certain aspects of Medicaid law still apply, including federal requirements concerning the provision of "medically necessary" services. While the Medicaid Act gives no definition of medical necessity, the Supreme Court has provided some guidance in interpreting the term.

Pursuant to federal regulation, the state may define the "amount, duration and scope" of a Medicaid covered service and may "place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures," but "may not arbitrarily deny or reduce the amount, duration or scope of required service . . . solely because of the diagnosis, type of illness, or condition." Service must be provided in suf-

399. There is no broad constitutional or statutory right to government-provided mental health services; the government provides these services at its discretion. However, an exception exists for persons involuntarily confined by the state, who have a limited right to treatment. See Youngberg v. Romeo, 457 U.S. 307 (1982); see also DeShaney v. Winnebego County Dep't of Soc. Serv., 489 U.S. 189 (1989).


401. See Robert D. Fleischner, Mental Health Care and Services, in ACCESS TO HEALTH CARE, supra note, 313 at 127, 135 (citing 42 U.S.C. § 1396(d) (1999)).

402. See Chris Koyanagi et al., Bazelon Ctr. for Mental Health Law, Protecting Consumer Rights in Public Systems: Managed Mental Health Care Policy, in ACCESS TO HEALTH CARE, supra note 313, at 157. While the medical necessity determination is a fundamental element of managed care plans, this determination was integral to the Medicaid program long before it became a managed care system. See id. at 159.

403. See Timothy A. Sindelar, Medicaid Coverage Principles, in ACCESS TO HEALTH CARE, supra note 313, at 97, 99; see also, Doe v. Bolton, 410 U.S. 179, 192 (1973) (instructing that professional judgment as to whether an abortion is necessary should be based upon a number of factors relevant to the patient's well-being, including: emotional, psychological, and familial considerations, and the patient's age).


405. Id. § 440.230(d).

406. Id. § 440.230(c). States may have additional duties with respect to the administration of Medicaid-funded health insurance programs. For example, systems operating pursuant to a state Medicaid plan must provide safeguards to ensure "that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients." 42 U.S.C. § 1396a(a)(19) (1999).
ficient "amount, duration and scope to reasonably achieve its purpose." 407
Thus, while states "may not arbitrarily deny or reduce the amount, dura-
tion, or scope of a required service . . . to an otherwise eligible recipient
solely because of the diagnosis, type of illness or condition," 408 they may
impose amount, duration and scope limitations that may affect some in-
dividuals more than others, as long as care and services are provided in the
"best interests of the recipients." 409 Further, states do not have to fund
"every medical procedure that falls within the delineated categories of
medical care." 410

However, it is possible to use a state Medicaid definition of medical
necessity to challenge service limitations. 411 For example, pursuant to the
regulations of the Massachusetts Medicaid agency, DMA, a

service is medically necessary if it is (1) reasonably calculated to prevent, diag-
nose, prevent the worsening of, alleviate, correct or cure conditions in the
recipient that endanger life, cause suffering or pain, cause physical deformity or
malfunction, threaten to cause or to aggravate a handicap, or result in illness or
infirmity; and (2) there is no comparable medical service or site of service
available or suitable for the recipient requesting the service that is more conser-
vative or less costly. Medical services shall be of a quality that meets profes-
sionally recognized standards of health care. 412

Since this definition has two parts, decisions regarding medical neces-
sity may not be based simply on cost, but also must involve a considera-
tion of whether the service is reasonably calculated to prevent, diagnose,
prevent the worsening of, alleviate, correct, or cure conditions. 413 Further,
this definition is fairly broad, including preventative and social models of

408. Id. § 440.230(c).
411. Advocates have also pressed for more detailed definitions of medical necessity as a way to
challenge mental health service limitations in public sector managed care systems. See Koyanagi
et al., supra note 402, at 162-76.
sary service" is very similar:
[T]hose mental health and/or substance abuse services which are: 1) reasonably calculated to
prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the
Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction,
threaten to cause or to aggravate a handicap, or result in illness or infirmity, and 2) there is no
other equally effective course of treatment available or suitable for the Enrollee requesting the
service that is more conservative or substantially less costly. Medical services will be of a
quality that meets professionally recognized standards of health care. Those records shall be
made available to the Division upon request.
Partnership, Provider Policies and Procedures Manual: Mental Health/Substance Abuse Program
174 (June 1, 1997).
413. See Gatto v. Bullen, No. 9702787-G (Super. Ct. Mass. 1998) (finding that, given two part defini-
tion, DMA's rejection of prior authorization request for specialized lift was in violation of regu-
lations).
In arguing that a service is medically necessary, one still needs to argue that the treatment meets "generally accepted" medical standards, that the setting and level of care are appropriate, and that the treatment is cost-effective. Advocates may be able to argue that providers and the Medicaid agency are violating the requirement that Medicaid services be sufficient in amount, duration, and scope to reasonably achieve their purpose. For example, trauma survivors could attack the Medicaid plan as not providing a sufficient number of therapy sessions to resolve the illness caused by the trauma.

VI. CONCLUSION

Privately managed care cannot adequately treat victims of physical and/or sexual abuse because of the financial incentives inherent in a private system. Mental health managed care is unable to provide the evaluation and long-term treatment that trauma survivors need to heal. Instead, privately managed mental health care relies on short-term treatment methods, largely biomedical in nature and enforced through coercion, that are not appropriate for trauma survivors.

The authors do not believe that allegedly independent appeal procedures, disclosure provisions, utilization review by credentialed clinicians, the right to self-referral to specialists, or the establishment of a managed care ombudsman will even begin to loosen the tightening noose on access to quality mental health care. Rather, while legislative efforts in these directions are commendable, the only effective remedy is to limit the financial incentives that spur the disastrous business decisions of MCOs.

Legislative initiatives and legal theories may provide pressure points to redress this failure, but the legislative initiatives must overcome politi-

---

414. See Huskamp, supra note 52, at 60.
415. See Clare D. McGorrian, untitled handout, in ACCESS TO HEALTH CARE, supra note 313.
416. See 42 C.F.R. § 440.230 (1999); see also, Dodson v. Parham, 427 F. Supp. 97, 108-09 (N.D. Ga. 1977) (finding that Georgia program to provide prescription drugs to Medicaid recipients lacked a medically sound and effective prior approval system to make drugs available and thus was not sufficient in amount, duration, and scope to reasonably achieve its purpose of mitigating or preventing disease); Mitchell v. Johnston, 701 F.2d 337, 348 (5th Cir. 1983) (finding that Texas program to provide children with dental services was insufficient in amount, duration, and scope to reasonably achieve its purpose, the provision of comprehensive, preventative dental care).
417. While improving the mental health managed care system for trauma survivors is critical, ultimately, as Patricia Deegan has pointed out, physical and sexual abuse is not only a medical and treatment issue, but also a political issue. She writes: "We must not allow ourselves to be content with treating the victims of violence. Rather we must work toward ending violence against women." Deegan, supra note 116, at 10. In addition, doing this work must include understanding the person who abuses as well as treating the person who is abused.
418. For example, Tufts Health Plan plans to withhold 20% of physician fees if the doctors spend too much on their patients, and states that part of the reason is the HMO's need to build its financial reserves. See Tufts doubles docs' penalties, DAILY NEWS TRIB., Jan. 20, 2000, at A3. The authors contend that this kind of financial pressure on the treaters alters the bases for care decisions. See id.
cally powerful business interests and the legal theories remain untested. However, strong media campaigns may fuel public anger and, in time, result in legislation that prohibits the financial incentives that corrupt the system and impede the care of women trauma survivors.

Ultimately, the best managed system would be one in which no private, for-profit entities managed utilization or diverted funds from services to profits. The financial incentives associated with for-profit enterprises are too difficult to control. A public system, using public employees, would be more responsive to the entire populace it serves, not just those wealthy enough to afford stock.