

Volume Five:

# Ethical Issues for Behavioral Health Care Practitioners and Organizations in a Managed Care Environment

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## Introduction

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Ethical principles permeate health care. The admonition to "do no harm" is an ethical statement, as is the idea that a patient's welfare must come before the financial interests of the treatment provider. Ethical concerns also are central to debate regarding the overall allocation of health care resources. For example, is the Oregon Medicaid plan, which explicitly rations health care, a "just" approach? If resources are limited, should our allocation policies favor individuals with illnesses that might be cured at the expense of individuals at the end of life?

Ethical issues also are at the core of behavioral health care. For example, two important issues are capacity and autonomy. Individuals are presumed to be able to make decisions regarding health care; however, that right is limited to those with the capacity to make an informed choice.

In the past, the ethical issues most affecting behavioral health care practitioners were those involving the exploitation of clients--for example, sexual or financial exploitation. In addition, the fee-for-service system may have created financial incentives to "overtreat" individuals. As a result, ethical and legal principles typically were concerned with protecting patients from decisions motivated by clinicians' self-interest. Examples include Federal and State laws prohibiting physicians from referring patients to laboratories in which the physician has a significant financial interest.

Managed care presents different challenges. Its emphasis on cost containment changes in fundamental ways the therapist-client relationship. The therapist in today's behavioral health care system often enjoys less discretion than he or she enjoyed in the traditional fee-for-service system. Cost is a much more explicit concern; payers may involve themselves in individual treatment decisions. The central ethical questions in a managed care environment flow from this changed therapist-client relationship. For example, what is the therapist's obligation if he or she believes the client needs additional care but there is no money available to pay for such care? Is the therapist obligated to discuss with the client economic limitations on treatment if the client decides to enter a therapeutic relationship? What role does coercion play in a managed care environment?

There are also ethical issues for the behavioral health care organization in this new environment. What impact might business decisions have on ethical issues faced by therapists who implement those decisions? Are there ethical issues involved in the marketing of a managed care plan? Is there a role for an ethics committee in a behavioral health care organization? The debate regarding the ethical principles that should inform the overall allocation of health care resources also has intensified as the view that health care expenditures must be limited has gained strength. For example, should health care be rationed? If so, for whom and by whom? Should the treatment provider be expected to consider societal interests within the context of the therapeutic relationship?

This monograph explores a number of core ethical issues in managed behavioral health care. The first section discusses briefly the ethical principles underlying debate regarding the overall allocation of health care resources. The second discusses in general terms key ethical principles informing the treatment relationship. These include the fiduciary obligation of treatment providers to their clients, autonomy of the individual in making health care decisions, and informed consent. The third section discusses the impact of managed behavioral health care on these principles, and the fourth discusses ethical issues confronting the behavioral health care organization in a managed care environment. The monograph concludes with a discussion of how individual practitioners and behavioral health care organizations might respond to these ethical dilemmas.

One ethical/legal topic not addressed in this monograph is confidentiality, which is covered in a separate monograph in this series. In addition, this monograph does not concern itself explicitly with ethical issues from the perspective of the managed care company; rather, it focuses on issues from the perspective of the practitioner and behavioral health care provider.

## Section 1: Ethics and the Overall Allocation of Behavioral Health Care Resources

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The debate over whether and how to ration health care resources is an issue of major national concern. Some would hold that any limitation on access to health care services should be eliminated. One obvious problem with this absolutist position is that it would provide no check on health care expenditures relative to other societal priorities. There is also no evidence that unlimited expenditures on health care necessarily yield better health outcomes, regardless of how "better health outcomes" is defined.

If health and behavioral health expenditures are to be limited, by what criteria should limits be set, and by whom? Many argue that health care expenditures effectively are rationed now, pointing to the millions of Americans with no or too little health insurance,

the disparities in care based on socioeconomic status, and the uneven distribution of health care resources. However, to the degree rationing may exist, it is not based on any agreed-upon criteria. The State of Oregon, which after a lengthy and comparatively open public process assigned priorities in its Medicaid program for the treatment of various conditions, might provide an exception. However, no other State to date has followed Oregon's lead.

In the absence of explicit criteria, we have allocated health care through the exercise of "medical" or "clinical" judgment in millions of individual cases. However, while it might theoretically be possible to construct practice guidelines of sufficient scientific merit and force that the exercise of judgment would fall within comparatively narrow and predictable parameters, reliance on this criterion does little to meet other principles (fairness, equitable access) that most believe should characterize a health care system.

Criteria for allocating health care resources can also be created by government, or by the market; the health care system today is an uneasy amalgam of market forces, government regulation, clinical judgment, and widely varied consumer behavior. Government has been reluctant to assume the task of establishing formal criteria to allocate health care resources at a macro level. Private providers and payers have been less reluctant to create criteria to govern allocation of the resources they control. However, those decisions have not tended to make the health care system more equally accessible, particularly given the inclination of providers and payers to avoid the undue risk often perceived as characteristic of serving the uninsured, or those with chronic needs.

The Clinton administration attempted to address this problem by prefacing its health care reform proposal with a statement of ethical principles and values (Brock and Daniels 1994). It relied on four core principles: universal access, equal and comprehensive benefits, quality care, and individual choice. The statement of ethical principles and values also held that a society reforming its health care system should:

1. Consider health care to be of fundamental importance;
2. Spread costs and burdens equally across the community, with payments based on ability to pay;
3. Provide for "generational solidarity" with benefits and burdens being shared fairly across generations;
4. Balance health care expenditures wisely with other national priorities;
5. Provide effective services, while avoiding ineffective services;
6. Be managed efficiently;
7. Reward personal responsibility;
8. Protect professional integrity and the integrity of the professional-patient relationship; and
9. Provide fair procedures for making decisions about the health care system and for resolving disputes.

As Michael Graetz and Jerry Mashaw (1994) observed in a commentary on the Clinton plan, a number of these ethical principles and values are at odds. For example, the

emphasis on universal and equal access to comprehensive benefits suggests that health care is an entitlement or right, while the emphasis on balancing health care expenditures against other priorities suggests that health care is something less. However, as Graetz and Mashaw also point out,

No single ethical perspective is likely to provide an acceptable solution to either of the two critical issues that confront any health care system: the determination of the total proportion of national resources to be expended on health care, and the allocation of health care resources within that global resource commitment...the choice of a single ethical principle to guide global budget-setting in a health care system would lead fairly quickly to the unworkability or moral bankruptcy of that system.

Therefore, Graetz and Mashaw saw the effort to frame the health care plan in a set of seemingly irreconcilable ethical principles as an overdue recognition of the impossibility of anchoring something as complex and varied as the health care system on one or two core ethical bases.

The task of creating a coherent ethical base for the behavioral health care system is also complicated by two additional factors. The first is that, despite recent parity legislation, behavioral health care benefits have lagged behind general health care benefits in both privately and publicly insured plans (Hastings Center 1993). Questions of equal access, and of a "just" allocation of resources, are perhaps even more difficult to address in behavioral health care systems. The second is the issue of coercion. The availability of coercion and the conditions under which it properly may be used have long been significant issues in public behavioral health policy debates; in the views of at least some consumers, the availability of coercion calls into question the ethical foundations of behavioral health care. This is not to endorse that view, but it is clear that coercion is an issue of great significance in ethical and legal debates regarding behavioral health care.

While it may not yet be possible to create a generally agreed-upon ethical framework for the health or behavioral health care systems, there are certain principles to which most would agree a health care system should aspire in allocating resources. Many of these are the principles that prefaced the Clinton health care plan; regardless of one's judgment about the merits of that plan, those principles are likely to be the touchstone of society's continuing debate regarding the future allocation of health and behavioral health care benefits.

## Section 2: The Core Obligations of Treatment Providers

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## **The Provider's Fiduciary Responsibility to Clients**

There are several core ethical principles that govern the relationship between treatment provider and client. The first is that the practitioner is a fiduciary, whose primary obligation is to act in the client's best interest. This principle is embedded in the ethical standards of the behavioral health care professions. For example, the Code of Ethics of the National Association of Social Workers notes that "social workers' primary responsibility is to promote the well-being of clients" (National Association of Social Workers 1996, Code of Ethics, Standard 1.01).

This relationship creates a responsibility for the provider to refrain from certain types of actions, for example, those that exploit the client or do harm to the client. The fiduciary responsibility to act in the client's best interest also creates affirmative obligations. The practitioner, acting within the scope of his or her competence, must seek to provide the treatment he or she believes is best suited to the client's needs. This obligation exists even if the economic interests of the treatment provider are at odds with the interests of the client. The Code of Ethics of the American Medical Association reminds physicians that "[a] physician has a duty to do all that he or she can for the benefit of the individual patient" but that if the "economic interests of the hospital are in conflict with patient welfare, [then] patient welfare takes priority."

The fiduciary obligation to the client is not absolute. The interests of third parties may take precedence in some situations. For example, if the practitioner suspects that his or her client has abused a child, that suspicion must be reported, despite the principle of confidentiality. If the practitioner concludes that the client presents a real harm to third parties, many States require or permit the practitioner to take steps to protect the third party (and the ethical principles of each of the professions contemplates such an exception to confidentiality as well). However, in such cases, society has deemed the interests of a third party to have greater importance than those of the client; the interests of the treatment provider rarely, if ever, take precedence over those of the client, and never do if the interest at stake is the economic interest of the provider.

### **The importance of autonomy**

*Dr. Lewis, treating Mr. Darwin for depression, prescribed an antidepressant and suggested that he come for an hour of therapy once a week. Dr. Lewis also gave Mr. Darwin her home phone number and pager number and told him on several occasions to call her if he was depressed, anxious, or simply needed someone to talk with. Mr. Darwin, feeling much better after three weeks of this regimen, quit taking his medication and canceled two appointments with Dr. Lewis. Shortly after Thanksgiving, he attempted to kill himself. He suffered permanent brain damage in the attempt, and later sued Dr. Lewis for negligent treatment. Dr. Lewis wants to know whether Mr. Darwin's failure to follow her treatment recommendations will absolve her of all or partial liability in the case.*

In this vignette, Dr. Lewis has prescribed the care she believes to be in her patient's interest. However, the patient has not acted on her recommendations, and then has attempted suicide. In such a case, the patient may claim that Dr. Lewis should have prescribed different treatment, more or less of it, or taken steps to get him back into treatment. However, Mr. Darwin's failure to follow treatment recommendations made by a competent treatment provider probably will reduce significantly the amount of damages he might win in a malpractice case, and in the vignette presented, would greatly reduce the prospect of any recovery, particularly given that Dr. Lewis, in addition to the treatment she proffered, gave the patient both her phone number and pager number and told him to call her anytime he wished to talk.

At the same time, Mr. Darwin had the right to reject Dr. Lewis's advice, because the ethical and legal principle of autonomy holds that competent individuals as a general rule have control over health care decisions. The treatment provider may suggest, may attempt to persuade, may cajole the patient in an effort to ensure that the patient follows his or her advice. However, as long as the patient is competent, except in certain situations where the law permits the use of coercion, the treatment provider may not force the client to act on the treatment recommendations.

One of the first recognitions of autonomy as a legal principle occurred in *Schloendorff v. Society of New York Hospital* (105 N.E. 92 (N.Y.1914)). New York's highest court wrote that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his body." Historically, the right of people with mental illness to exercise autonomy in decisionmaking has been limited because of a categorical assumption that mental illness robbed individuals of the capacity or competence to make decisions. However, in the last 30 years that categorical assumption has eroded, and people with mental illnesses generally are assumed until proven otherwise to have the same right to autonomy in health care decisionmaking as that enjoyed by other citizens.

While the principle of autonomy has been extended to people with mental illness, the law still permits the use of coercion in at least two situations. First, all States permit involuntary civil commitment, based on a combination of mental disorder and behavior (typically defined as either danger to self or others or an inability to care for oneself). While commitment on the basis of mental illness and behavior is permitted in each State, a 1996 review found that only 31 States and the District of Columbia permitted civil commitment on the basis of alcohol or substance abuse. In addition, the commitment of children in many States may be accomplished through parental rather than judicial decision.

Coercion also is permitted in some situations to administer treatment over the objection of an individual, most commonly in cases where the person does not wish to take psychotropic medication. Medication may be administered without a court hearing in an emergency (usually defined as a situation where harm to self or others is imminent without the use of medication). In other situations, most States require a judicial hearing into the person's competency; individuals who are competent and refuse medication have the right to do so, even after civil commitment.

## **Informed consent as a mediating principle**

Informed consent has both legal and ethical roots. It assumes that individuals cannot exercise autonomy and choice in health care decisionmaking unless they have adequate information and can make a reasoned choice. There are three elements to informed consent: It must be voluntary, it must be competent, and it must be knowledgeable or informed.

**Informed consent must be voluntary.** Legal consent cannot be the product of deceit or duress. For example, a contract entered into under duress will not be enforced by the law. Similarly, a health care decision made under duress may invalidate the patient's consent. As the discussion below suggests, the question of "voluntariness" may take on new importance in some types of managed care settings.

**Informed consent must be competent.** There has been significant controversy regarding the question of competency and how it should be measured. Behavioral health care providers sometimes are accused of judging a client competent as long as the client adheres to treatment recommendations, while finding the client incompetent when the client declines treatment. Practitioners often express frustration with the law's insistence that individuals, even an individual who has just been civilly committed, are considered competent by the law for the purposes of making treatment decisions until specifically found to lack competence.

There is also not always consensus on what "competence" means. Roth and his colleagues, in a review, found five tests that have been suggested or employed:

1. *Expression of a choice.* Under this test, if the client expresses any choice about the treatment decision, he or she is judged competent. This test has found few adherents (and none among courts) because it ignores completely the client's underlying mental status and processes.
2. *The treatment decision is rational.* The client is considered competent if the decision he or she reaches is the decision that would be reached by a "reasonable" client. This test had significant support historically, but in recent years has lost favor because it makes the exercise of autonomy subject to a definition of reasonableness imposed by others.
3. *The process by which the decision was reached was unimpeded by mental or emotional illnesses or other factors, for example, substance abuse.* This test, in common use today, examines the underlying processes by which the client reached his or her decision. It tolerates choices that others might consider irrational, so long as the client's decisionmaking processes were not affected by illness or mental disorder and so long as the patient had "rational reasons" for the decision. This test is biased toward treatment adherence, because whether the patient had "rational reasons" for his or her decision may turn on the treatment provider's views on the wisdom of the patient's ultimate decision. The decision

- not to accept treatment may be viewed less favorably than the decision to accept it.
4. *The client had the ability to understand the choices he or she had and the consequences of the choice he or she made.* This test, in the view of Roth and his colleagues, is most consistent with the law of informed consent. It examines whether the patient had sufficient ability to comprehend those things deemed important by the law in making decisions about treatment. It does not concern itself with whether the patient then reaches a decision that is different from the decision that the treatment provider or another person might make.
  5. *The client had actual understanding.* This may be the most difficult test to assess, because it requires something more than assessing the client's intellect and cognitive abilities. It requires an assessment as to whether the patient truly understood information conveyed, choices to be made, etc. However, because it is difficult to measure what constitutes actual understanding, this test is rarely, if ever, applied in practice.

Competency is also a fluid concept, both substantively and temporally. As a general rule, an individual must be "more" competent the more intrusive or consequential the treatment proposed. For example, more competency is required to consent to electroconvulsive therapy than to take aspirin. Also, an individual may be competent one day, but incompetent the next, and then competent again the third, depending on the type of illness and its effects. Because of this, there has been a movement in the recent past to encourage client choice in anticipation of incompetency, for example, through living wills.

Finally, recent research done under the auspice of the MacArthur Foundation's Research Network on Mental Health and the Law has resulted in the development and testing of a number of new instruments for assessing competency to make treatment decisions (Grisso et al. 1995a, 1995b).

**Informed consent must be knowledgeable.** An individual must have adequate knowledge to give informed consent. As with competency, the definition of what constitutes "adequate knowledge" has changed as deference to the principle of autonomy has increased. As a general rule, a client must be informed of the treatment proposed, its risks and benefits, the risks and benefits of forgoing treatment, and the risks and benefits of alternative treatments. In the past, a treatment provider had broad discretion to withhold information if the provider believed that disclosure might make it unlikely for the client to undergo needed treatment. While many State laws continue to recognize some variation of this principle, most courts now ask whether a person in the patient's position would want the information. This perspective expands the amount of information made available, because courts generally assume a patient would want all information pertinent to the decision, even if a risk might be remote or the information might unduly heighten the patient's anxiety if revealed.

## **The Role of Substitute Decisionmaking**

If the client is unable to give consent, because of incompetency or age, then consent if not presumed must be given by another person.

### **Situations when consent is presumed**

Consent will be presumed in an emergency when the client is unable to give consent. For example, if a patient is presented to an emergency room unconscious after an automobile accident, treatment staff has the legal authority to assume that the patient would consent to the interventions necessary to address the emergency. However, consent is presumed only for the duration and extent of the emergency; in the course of providing emergency surgery, the physician cannot without some legal risk expand the scope of the surgery to address a problem unrelated to the emergency.

In other situations, consent may not be required if there is an immediate risk of harm to the patient or others. For example, on a psychiatric ward, medication to control behavior may be administered without patient consent if the individual's behavior creates an emergency situation on the ward threatening the safety of the patient, other patients, or staff.

### **Situations when substitute consent must be obtained**

If the client lacks capacity to give consent in a nonemergency, then consent must be obtained from another party. All States have processes for obtaining substitute consent. A common example is guardianship law. Many States now recognize "health care proxies" as well. This means that a competent individual may designate another individual as his or her "proxy" for making health care decisions if the individual becomes incapacitated. In other situations, courts may be the designated decision maker--for example, in States requiring a judicial order before a patient's decision to refuse psychotropic medications may be overturned.

Consent by and on behalf of children is a more difficult issue. Historically, children, like people with mental illness, were assumed categorically to be incapable of providing informed consent. However, research has shown that even young children in many situations may have decisionmaking capacity equivalent to that of adults, and the age at which children are assumed legally to be incapable of making decisions has dropped. Today, most States permit individuals 16 years of age to make at least some types of health care decisions without parental consent; however, some types of decisions, for example, to admit oneself to a psychiatric hospital, may require parental approval before or shortly after the admission. Because State laws vary on the question of parental consent, the treatment provider must know the laws of the particular State in which he or she practices.

Historically, informed consent dealt with clinical, not economic, information. However, as the discussion below suggests, the emergence of managed care is causing a rethinking of what types of information should be discussed with the client in obtaining informed consent.

## Section 3: The Impact of Managed Behavioral Health Care on Core Ethical Principles

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*Dr. Richard Furl, a psychologist, is negotiating a contract with Prevailing Winds, a health maintenance organization that has just signed a contract with Real Fine, a software maker employing 20,000 people. Prevailing Winds has agreed to provide all behavioral health care benefits to the employees of Real Fine for 90 cents per member per month. It wishes to enter a subcontract with Dr. Furl, in which it will pay him 70 cents per member per month to provide behavioral health services to the employees of Real Fine.*

*Dr. Furl has several questions regarding the proposed contract. First, he is uncertain whether he can provide the services he is contracting to provide for the money available. Second, he believes that he may be able to alleviate some of the financial risk he is about to incur by using civil commitment processes to transfer the responsibility for care to the State hospital, but he questions whether there is any risk in using such a strategy. Third, he is concerned about a contractual provision that would prohibit him from revealing to clients the fact that the number of sessions he can make available to them is limited informally by Prevailing Winds to five per client. He seeks your advice regarding whether he should sign the contract.*

Managed care may change the incentives available to caregivers because it often relies on techniques that check the exercise of professional judgment by treatment providers (for example, utilization review, prior authorization, and other gatekeeping requirements). In addition, the emergence of managed care has caused or reinforced a number of trends in the organization of health care services. These include a shift of practitioners from small private practices to working as employees or contractors to larger entities; the growing integration of the health care industry through mergers and acquisitions, as treatment providers seek to gain the economic leverage necessary to compete in a highly "corporatized" health care environment; continued competition on the issue of price among managed behavioral health care companies competing for contracts in both the publicly and privately financed sectors; and the importance of the contract as the vehicle governing relationships between payers and providers and between providers and clients.

These changes affect the treatment relationship in at least two fundamental ways. First, the relationship between treatment provider and client in many instances has become a

three-party relationship involving the treatment provider, the payer, and the client. In the past, a treatment provider provided treatment, and the client, either through his or her own resources or public or private insurance, was responsible for payment. The client, in turn, may have had a contractual relationship with an insurance company, but the payer typically had no direct relationship with the provider of treatment. However, in the Prevailing Winds vignette described above, Dr. Furl, if he signs the contract, will have contractual obligations to Prevailing Winds in addition to the ethical and legal obligations he has to the clients who come to him pursuant to that contract.

Second, the contract Dr. Furl has been asked to sign may create incentives to underutilize services. The contractual amount per member per month may be low compared to Dr. Furl's costs, and if he has underestimated the number of employees who will come to him for treatment he may be placed in financial jeopardy.

These changing relationships, and the potential conflict between ethical obligations and financial realities, also create legal vulnerability for the treatment provider in some circumstances. The next section of this monograph discusses the impact of managed behavioral health care on the fiduciary responsibility of treatment providers, and the law's response.

### **The fiduciary responsibility of treatment providers to individual patients and managed behavioral health care**

*Linda Major, a 15-year-old with a history of emotional problems and substance abuse, is admitted by her parents to Home Free, a for-profit, free-standing psychiatric hospital. Her physician finds her case quite complex, and orders a series of laboratory tests. The test results are due May 14. However, Ms. Major's insurance will provide benefits only until May 13. The hospital business office sends a note to her physician, advising him of this fact. The patient is discharged on May 13, and commits suicide 3 days later. Her parents sue the hospital, arguing that the hospital had a policy of discharging patients when their insurance expired, regardless of continuing clinical needs.*

In this vignette, Linda Major's family sues the hospital for negligence in her discharge, alleging that payment issues caused the hospital to ignore the patient's interests. A case alleging negligence or malpractice is one type of case that might be brought against a treatment provider in either a fee-for-service or managed care environment; this particular vignette deals with the consequences of a lack of reimbursement.

A second type of case that might be brought is a lawsuit for breach of contract, for example, against the payer (or in the case of a health maintenance organization, the payer-provider). This type of case would claim that benefits promised under the contract governing services had not been forthcoming.

There are comparatively few of either type of case in managed care settings. In large part, this is because of a Federal law (the Employee Retirement Income Security Act, or

ERISA) that makes the maintenance of such lawsuits difficult. However, those cases that have been resolved emphasize the preeminent value that the courts place on the fiduciary duties of treatment providers, duties rarely if ever diminished because of a lack of financial reimbursement.

In a lawsuit for negligence, the plaintiff has to prove four things. First, he or she must demonstrate that the defendant had a duty to the plaintiff. As a general rule, a duty exists when the patient-therapist relationship is established. The overarching duty of treatment providers is to practice according to prevailing professional norms. The plaintiff must then show a breach of the duty, that is, that the defendant's practice fell below the standard of the profession. It has sometimes been difficult in behavioral health to determine precisely what is the standard of care, because of the eclectic nature of behavioral health treatment, though with the emergence of practice guidelines some of this difficulty should be ameliorated in the future. The third and fourth elements are that the breach of the duty caused the plaintiff damages. Damages that may be recovered include but are not limited to medical bills resulting from the injury, lost wages, and pain and suffering.

The first case exploring liability questions in a managed care setting was *Wickline v. California* (239 Cal. Rptr. 810 (Cal.Ct.App.1986)). Lois Wickline had been hospitalized for an obstruction of the terminal aorta in her leg. The Medi-Cal program, which was paying for her care, authorized surgery and the 10 days of care requested by her physician. Near the end of the 10 days, her physician sought reimbursement for an additional 8 days of care but was given 4. Wickline was discharged within the 4 days, suffered additional complications, and eventually had to have her leg partially amputated.

She brought suit against the Medi-Cal program, arguing that its reimbursement decisions had caused her to be discharged prematurely. The court said that third-party payers "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 made on a patient's behalf for medical or hospital care are arbitrarily ignored or unreasonably disregarded or overridden" (p. 819). However, because the physician had not used the appeals process created by Medi-Cal to appeal adverse decisions, the court said it would not impose liability in this case on the payer (the court in a later case said that there was no legal duty to appeal on the part of the provider). More important, the court noted that while the physician may have been "intimidated" by the Medi-Cal program, "he was not paralyzed by [its] response nor rendered powerless to act appropriately...If, in his medical judgment, it was in his patient's best interest that she remain in the acute care hospital setting for an additional four days...[he] should have made some effort to keep Wickline there...Medi-Cal was not a party to that medical decision and therefore cannot be held to share in the harm resulting if such decision was negligently made"(p. 819). In short, while a payer could be found liable, primary responsibility for care decisions rested with the treating practitioner.

In a second case, *Wilson v. Blue Cross* (271 Cal. Rptr. 876 (Cal.Ct.App.1990)), the same court found again that in some cases a payer could be liable. This was a psychiatric case

involving the care of Mr. Wilson, hospitalized for depression, drug dependency, and anorexia. His physician believed he needed 3-4 weeks of hospitalization, but the payer authorized 10 days. After the physician determined from Mr. Wilson and his aunt that no additional sources of payment were available, Mr. Wilson was discharged after 10 days of care and killed himself approximately 3 weeks later. His estate brought suit against the payer, claiming that it had breached its insurance contract with Mr. Wilson. The court of appeals ruled that the case could go to trial, given "substantial evidence" that the payer's decision was a "substantial factor" in Mr. Wilson's death, because it may have resulted in his premature discharge.

While these cases suggest that it is possible legally for a payer to be held partially liable in some cases, it is clear that the treater retains ultimate responsibility for care *even in the face of a lack of reimbursement*. A recent case, *Muse v. Charter*, illustrates this point. In this case, similar to the Linda Major vignette above, a suicidal 16-year-old was hospitalized. His physician ordered blood work done, which was to be performed on July 13 with the results returned July 15. However, insurance expired July 14, and although the parents had signed a promissory note to make good on subsequent charges, the patient was discharged with instructions to receive care from a local mental health clinic. Approximately 2 weeks later, he killed himself. The court of appeals, in a decision later upheld by the North Carolina Supreme Court, upheld a jury verdict against the defendant, including a finding that the defendant had acted in reckless disregard of the rights of others. The court's ruling was based on the finding that the defendant "had a policy or practice which required physicians to discharge patients when their insurance expired and that this policy interfered with the exercise of medical judgment" (*Muse v. Charter Hospital*, 117 N.C.App. 468, 452 S.E.2d 589, 1995).

As the *Muse* case suggests, an individual presenting potentially serious clinical and risk issues cannot simply be discharged because insurance has expired. This is because the continuing fiduciary responsibility of the treater continues even though reimbursement may end. Another court, responding to provider challenges to a managed behavioral health care plan initiated by General Motors, used language that to date appears to characterize the views of most courts:

[T]he purpose of the [managed care plan] is to determine in advance whether the... plan will pay for the proposed treatment. *Whether or not the proposed treatment is approved, the physician retains the right and indeed the ethical and legal obligation to provide appropriate treatment to the patient...* Plaintiffs say, in effect, "irrespective of any obligation I have to my patients and to my profession, my judgement as to what is in the best interests of my patients will not be determined by the exercise of my medical judgment, but by how much I will be paid for my services." Plaintiffs are saying in effect, "Since I am weak in my resolve to afford proper treatment, [the] preauthorization program would induce me to breach my ethical and legal duties, and the court must protect me from my own weakness." In other words, protect me from my own misconduct.

This is strange stuff indeed from which to fashion a legal argument (Varol v. Blue Cross, 708 F.Supp.826, 831-833 (E.D.Mich.1989)).

These opinions do not mean that any person, once in treatment, has a lifetime guarantee of treatment. They do suggest that continuing, serious needs must be tended to, either by the treater or through adequate alternative care, regardless of the availability of reimbursement. These cases also reinforce the view, expressed below in the section on economic informed consent, that the impact of benefit design on treatment, as well as the conditions under which treatment may end (one condition might be a failure to pay for services) should be discussed with the client at the beginning of treatment, not when a clinical or reimbursement crisis emerges.

### **The fiduciary obligation of the provider to individuals other than the client**

Traditionally, health care professionals have not been asked to consider the overall allocation of health care resources in the context of individual treatment decisions. Rather, as discussed above, ethics and law have insisted that the health care professional focus on the needs of the individual client. While managed care has not changed that ethical or legal mandate, it may cause the clinician to confront more sharply a potential conflict between individual and group need.

Consider, for example, the case of an individual enrolled in a capitated managed care plan and being treated by a psychiatrist. Assume the individual does not wish to take medication, and is not particularly forthcoming during therapy. Assume also that the psychiatrist concludes, given the client's nonadherence to suggested treatment, that the client may require hospitalization. As a result, the psychiatrist may have to expend more resources than necessary clinically to provide treatment, resources that could otherwise be expended on other needs of individuals enrolled in the plan. In addition, given that the psychiatrist is providing treatment in a capitated setting, the need to hospitalize this patient may increase the financial risk to the psychiatrist. In short, managed care may make it very clear that health care resources are finite, and the reluctance of one enrollee to use the least costly treatment available may result in treatment that reduces the amount of resources available to other plan enrollees.

There are situations in which health care resources legitimately may be withheld. One example is in a case of "medical futility" where further intervention would be of no value. Cases of "medical futility" in this sense rarely if ever arise in the treatment of mental illness and substance abuse. However, there are situations where further intervention may be of very limited value, and may not perceptibly alter outcome. In such cases, is there an obligation to withhold resources to make them available to other people?

James Sabin (1994), a psychiatrist who has written frequently and well on the ethical challenges confronting behavioral health care providers in the era of managed care, suggests that treatment providers must look beyond the needs of the individual to societal interests. He points out that the Preamble to the American Medical Association and American Psychiatric Association's *Principles of Medical Ethics* states that "a physician

must recognize responsibility not only to patients but also to society." He argues that this creates a duty of "stewardship" regarding finite public resources, and that fee-for-service reimbursement previously enabled providers to ignore the responsibility to act as stewards. In his view, reconciliation of the conflicts between acting as fiduciary and as steward is the core emerging ethical question in managed care.

In addressing this issue in practical terms, Sabin urges the clinician to address openly and honestly with a client the costs of one alternative form of care versus another. His suggestion that caregiver and client engage in an ongoing dialogue is useful. It mirrors Jay Katz's view of informed consent as a conversation between treater and patient, in which the parties bring their respective strengths to the treatment relationship (the caregiver's professional knowledge, the client's self-knowledge) in order to reach the best possible outcome for the client. However, it should also be noted, as Sabin acknowledges, that most training of health care professionals focuses on the fiduciary responsibility to the individual client, not the notion of stewardship of a pool of finite resources. In addition, as the earlier discussion makes clear, the courts continue to insist on the primacy of the fiduciary duty to the individual; at this point, it is difficult to imagine a court endorsing a decision by a clinician to forgo a particular treatment for a client with significant needs based on concerns about the impact of the cost of that treatment on the prospective availability of resources for others enrolled in the same plan. In short, balancing the obligations of the fiduciary and the steward in a satisfactory way seems difficult in the current legal and ethical environment. It may be, as Sabin suggests, that "once we finally recognize and truly accept the need to integrate fiduciary and stewardship values and to work constructively with the inevitable tensions that arise, we will be able to get down to practical implementation of ethical approaches." However, attaining that outcome will require considerably more work by clinicians, managed care plan administrators, and others concerned with the overall allocation of health care resources.

### **The fiduciary obligation to the client and financial incentives in managed behavioral health care**

*Dr. Russ Fix, a clinical psychologist, works for New Life Health Maintenance Organization. Dr. Fix is paid a salary by New Life. In addition, New Life sets aside a reserve fund each year to pay for psychiatric hospitalization. At the end of the year, unexpended funds from the reserve are distributed to Dr. Fix and his colleagues as bonuses, with clinicians who hospitalized the fewest patients, adjusted for case mix, receiving the highest bonuses. Dr. Fix recently decided not to admit a patient who he believed might have been helped by hospitalization, choosing to continue the person in therapy even though her condition had deteriorated somewhat. Dr. Fix believes that his decision was not motivated by financial concerns, but he has doubts about his ability to maintain a separation between clinical conclusions and finances. He seeks advice from you as his colleague regarding ethical and legal issues that the reserve arrangements might create.*

Most managed care plans create incentives to direct clinical behavior. In many plans, the incentives are designed to minimize the use of more expensive services (in other plans, as discussed below, there may be so little money in the contract that providing any but the most minimal service becomes problematic). It is not unethical for a clinician to utilize the least expensive, clinically appropriate services available. However, an ethical issue does arise if financial incentives unduly contaminate clinical judgment.

In the vignette above, unexpended money from the reserve fund that pays for hospitalization is used as bonuses to the clinicians who must determine whether hospitalization is warranted. In a similar case involving a reserve fund set aside for specialty care, a court ruled that the estate of a person who had died from uterine cancer could proceed to trial against the HMO because it appeared that the financial incentives to the physician in that case created incentives to withhold care that was clinically indicated. This ruling suggests that clinicians who sign contracts with financial incentives tied to not using particular services need to satisfy themselves that the incentives do not cloud clinical judgment. As noted above, both legal and ethical principles dictate that clinicians attempt to wall off clinical judgment from their own financial interests.

The Federal Government recently attempted to address this problem in the context of physician reimbursement plans. The Department of Health and Human Services in early 1996 adopted regulations that place certain limitations on the incentives made available to physicians in prepaid health care organizations treating individuals enrolled in Medicare and Medicaid managed care plans. The regulation requires the plan to disclose to the Federal Government or State Medicaid agency provisions that create incentives for physicians to not use particular services. In addition, the rule prohibits plans from paying incentives to physicians to limit or reduce medically necessary services to a particular enrollee; requires plans that put physicians at "substantial risk" (defined in part as plans in which more than 25% of the potential payment to physicians is at risk for services it does not provide) to take steps to minimize their risk of financial loss, for example, through the purchase of stop-loss insurance; and to survey enrollees and disenrollees annually on enrollee satisfaction, access, and quality. In addition, a summary of incentive provisions must be made available upon request to enrollees.

While the Federal regulation does not cover all managed care plans, it does suggest growing Federal interest in the question of how financial incentives are structured, as well as a search for strategies that will protect consumers of health care from being denied care because of the incentives available to providers. One can predict continuing attention to this area in the future, both as an ethical and a legal issue.

## **Managed Behavioral Health Care and the Principle of Autonomy**

In the vignette presented above, Dr. Furl believes that he can relieve some of the financial pressure he may experience under the contract he is negotiating by initiating involuntary commitment proceedings for enrollees with serious mental disorders. Involuntary commitment in a managed care setting is one of several emerging issues involving autonomy, coercion, and managed behavioral health care.

## **The question of choice**

Individuals who are uninsured, or are enrolled in State Medicaid programs, usually have little choice where or from whom they receive health care. In unmanaged systems, emergency rooms are often the site of most primary care; in a managed Medicaid system, "freedom of choice" may mean that the individual must choose from three primary caregivers or be enrolled by default with one. Managed care plans also may limit patient choice and self-determination through limitations on benefits, or through decisions by a gatekeeper or utilization reviewer that the plan will not pay for treatment that the patient and treatment provider may believe is necessary.

Within these limitations, individuals retain the right to make informed treatment choices. Therefore, as noted below, there is an ethical obligation to inform enrollees and potential enrollees regarding the benefits and limitations on benefits available within a particular plan.

In addition, individuals with little choice regarding their specific providers continue to retain the right of autonomy in making decisions about their health care. This may be exercised in various ways, for example, simply by not going to the doctor even when it would benefit the person. Individuals may also disenroll from plans, though how often and under what conditions varies from State to State. However, while autonomy is a personal right, people with mental illnesses and substance abuse disorders continue to be subject to coercion, either through civil commitment or involuntary treatment orders, and the manner in which coercion is exercised in a managed care setting raises a number of issues.

## **Coercion as a shortcut in treatment**

It has become axiomatic that treatment may be limited in managed care plans. The limitations may be explicit, for example, through caps on treatment, or the limits may flow from the budget imposed in a prepaid, capitated plan. While limits exist in traditional indemnity plans, the limits in managed care may be reached sooner or be felt more acutely by a provider bearing financial risk. Treatment of an individual with a serious substance abuse problem or a serious mental illness may take considerable time; keeping that person out of the hospital may take a significant investment of clinical and other resources. If the managed care plan in which the person is enrolled is undercapitalized, or if limits on sessions are "hard" rather than "soft," the therapist may conclude that there simply is not enough time to provide long-term treatment. In such a situation, coercion conceivably could become a treatment strategy designed to substitute for the much longer treatment approach the therapist otherwise might take.

## **Coercion as a strategy to extend treatment**

In other circumstances, civil commitment may be used to extend treatment. There are at least two ways in which this might happen. First, if the managed care plan pays for involuntary treatment, a provider might be tempted to use commitment as a vehicle for

extending the treatment of an individual who might otherwise be denied additional care by the payer. Though ethically more questionable, this practice is similar to increasing the severity of the diagnosis as a way to capture reimbursement.

Second, civil commitment might be used to extend the stay of individuals *outside* the managed care plan if the provider has unused hospital capacity and if reimbursement for the committed individual is available. This strategy is similar to the use of civil commitment in the 1980s to hospitalize adolescents from families with mental health benefits in their insurance plans. In either situation, coercion is being used as a way to capture reimbursement, a practice that is clearly unethical.

### **Coercion as a strategy to avoid the cost of care**

Civil commitment also may be used as a cost-shift device, to "dump" patients who require significant levels of care or who present risk into the State hospital system or even into jail. Individuals with mental illness or substance abuse disorders may require a high level of investment not only to provide treatment but also, if the person is judged to present a risk to self or others, to monitor behavior, whether through case management, through more frequent clinic visits if the person is on out-patient status, or through longer lengths of stay if an in-patient. Depending on whether such care is compensated, the provider may be tempted to use civil commitment as a vehicle to shift the responsibility for care to another provider.

Involuntary commitment also may present a financial problem for providers who by State law must provide involuntary care (Petrila 1995). In many States, people who are committed involuntarily are treated first in a non-State hospital, and in some jurisdictions hospitals designated by the State to provide such care must accept the patient regardless of payment status. As more individuals with mental illnesses and substance abuse disorders are enrolled in managed care plans, there may be limitations imposed on the length of treatment that do not correspond to the duration of care the provider believes is appropriate. As a result, such providers may face increased "bad debt" in providing involuntary care. A similar situation may be faced by providers of emergency room care, who by Federal law must assess, stabilize, and then treat or transfer any individual presenting with a medical emergency. If the payer disagrees with the judgment that the condition was not an emergency, the provider again may experience a financial loss.

Finally, the fact that the person has been ordered into care directly conflicts with the principle of autonomy. If a person is civilly committed, or ordered by a court in another setting into treatment (for example, an individual may be ordered into drug treatment as part of the resolution of a criminal case), the provider will be asked to treat an individual who almost by definition does not want treatment. This situation may create issues for the treatment provider, faced on the one hand with a court order directing that treatment occur and on the other with a client who has entered treatment only because ordered to do so. While a discussion of techniques for resolving this conflict is beyond the scope of this monograph, it is worth noting that this conflict may become more frequent as managed

care principles are adopted in foster care, juvenile justice, and other systems in which courts play central roles as gatekeepers.

### **Coercion and individuals who decline treatment**

Individuals with mental illness and substance abuse disorders retain the right to decline treatment, absent an emergency or application of the State's rules permitting the ordering of treatment when it has been refused. In a managed care setting, or in any other setting, providers must understand State law governing the refusal of treatment.

In addition, because coercion abridges the exercise of autonomy, there are ethical considerations if providers resort to coercion before other efforts are made to gain treatment compliance. Individuals decline to take medication for a number of reasons, including its effects, a preference for one medication over another, and other reasons, like denial of the illness. It is important that the provider take steps to learn why the individual does not wish to take prescribed medication--such a dialogue may result in an agreement by the individual to accept an alternative treatment of similar efficacy.

### **Managed Behavioral Health Care and the Principle of Informed Consent**

*Paul Sloe is a patient of Rebecca Lant, a social worker with a large psychotherapy practice. Mr. Sloe is a Medicaid recipient enrolled in a State managed behavioral health care demonstration project. Dr. Lant treats enrollees under the demonstration project through a contract with Channelside, a national managed behavioral health company. While Dr. Lant averages 10-20 sessions with privately insured clients, she has determined to limit Medicaid recipients to an average of 6 sessions, because this is her first Medicaid contract and she is concerned about potential financial risk. She does not reveal this limitation to clients at the beginning of care, because she believes it would interfere with the development of a good therapeutic relationship.*

*After four sessions with Mr. Sloe, she believes that he would profit from several more sessions in treating the anxiety disorder that is keeping him from working. There is a provision in her contract that enables her to request more money to provide additional treatment to people whose illnesses are particularly severe. She believes Mr. Sloe is quite disabled, and is making progress, but his condition does not rise to the level of severity necessary to obtain additional reimbursement. Dr. Lant believes that her options are to adjust his diagnosis so that it meets the severity standard warranting additional reimbursement; end his treatment after two more sessions; or take him on as a charity case. She seeks guidance from a colleague. What advice should the colleague give?*

**The obligation to disclose role conflicts and "double agency"**

A clinician in either a managed care or a fee-for-service environment must disclose to the client any conflicts that might affect the provider's clinical judgment. For example, Principle 6 of the Ethical Principles of Psychologists (American Psychological Association 1992) requires that "when conflicts of interest arise between clients and psychologists' employing institutions, psychologists clarify the nature and direction of their loyalties and responsibilities and keep all parties informed of their commitments." Similarly, the Principles of Medical Ethics of the AMA, section 2, states that "a physician shall deal honestly with patients and colleagues." In the vignette, it would be incumbent upon Dr. Lant to disclose the fact that she has a contractual relationship with Channelside and that she has obligations under that contract that may affect her treatment of Mr. Sloe.

### **Economic informed consent**

As noted earlier, informed consent traditionally addressed clinical issues. However, with the advent of managed care, and reimbursement systems that place explicit limits on the types and duration of treatment, the idea of "economic informed consent" has emerged. This means that the treatment provider, as part of the informed consent process, attempts to ascertain whether the client is aware of limitations on services available to the client resulting from provisions in the client's insurance or managed care plan. Many managed care plans initially imposed contractual "gag rules" that prohibited clinicians from discussing the nonavailability of certain types of treatment or limitations on treatment. Such rules clearly place clinicians in an untenable ethical posture. State legislatures and courts have been eliminating those rules, however, and the Federal Government has barred such rules in plans funded by Medicare and Medicaid.

The National Association of Social Workers, in its most recent Code of Ethics (1996), has adopted at least a limited notion of economic informed consent. The code defines informed consent in the following way:

Social workers should use understandable language to inform clients of the purpose of the services, risks related to the services, **limits to services because of the requirements of a third-party payer, relevant costs,** reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions (NASW Code of Ethics, sec. 1.03(a) (1996) (emphasis added)).

This is an explicit recognition that financial information is sufficiently important to the client's exercise of autonomy that the principle of informed consent should be expanded to include it as a core element. The American Psychiatric Association's Ethics Committee has reached a similar conclusion. In responding to a question asking whether psychiatrists who had joined a preferred provider organization (PPO) were unethical, the Committee answered that psychiatrists participating in a managed care system "are not inherently unethical if":

1. Patients and prospective patients (or their employers) made an informed decision to participate in a managed care plan that included knowledge of
  - a. their other options;
  - b. benefit limits;
  - c. the pre- and current authorization process;
  - d. their right to appeal a utilization decision;
  - e. the limits as to whom they can see without having to make a greater financial investment; and
  - f. the potential invasion of their privacy by the review process.
2. No exaggerated claims of excellence are made.
3. Care provided is competent and meets patient needs within the benefit limits.
4. The utilization review process is not unduly invasive of the doctor-patient relationship.
5. Reviewers are not financially rewarded for denying care.

(Opinions of the Ethics Committee on the Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, section 6-K, 1995 Edition)

Two questions are worth asking at this point. First, why should the practitioner rather than the payer be obligated to discuss with the client benefit limitations? Second, what type of discussion should occur?

The answer to the first question can be found in the changing nature of the treatment relationship noted earlier in this monograph. In many managed care settings, the traditional dyadic relationships between treatment provider and client on the one hand and client and insurance company on the other simply do not exist. The vignette involving Dr. Lant illustrates this point: Dr. Lant is treating Mr. Sloe under the terms of a contract she has with the managed behavioral health care company that is managing the State Medicaid program's behavioral health benefit. Therefore, Dr. Lant has a contractual relationship with the payer; Mr. Sloe, the client, happens to be enrolled in the plan, but the limitations on his treatment result from Dr. Lant's belief that she must impose the limitations to stay solvent under her contract. While payers also have fiduciary responsibilities to provide information regarding benefits to enrollees, the notion of "economic informed consent" suggests a greater role for treaters in providing nonclinical information that affects treatment.

The type of discussion that should occur obviously will depend to a degree on the practitioner's style in discussing issues with potential clients. However, since limitations on benefits may shape the ensuing relationship to a significant degree, it seems clear that the discussion should begin at the beginning of the relationship. This arrangement gives the client the opportunity to decline to enter the relationship if he or she chooses because of the limits the therapist has outlined. In the vignette, Dr. Lant should discuss with Mr. Sloe the fact that she tends to limit Medicaid recipients to six sessions and why; that there are certain circumstances under which additional sessions might be reimbursed; and any

impact that the limitation on sessions has on the manner in which she conducts therapy. In addition, she should note, if it is true, that she would hold additional sessions with Mr. Sloe if he will pay for them. If her relationship with him is limited to the six sessions and both she and he believe additional treatment would be beneficial, she also should outline steps she would take, if any, to refer him to another therapist. [Note, given the earlier discussion on the therapist's fiduciary responsibility, that if at the end of six sessions Mr. Sloe presents a high degree of risk to himself or others, terminating treatment without a plan to address this risk creates the potential for legal liability for the therapist.]

Finally, it makes sense to discuss benefit limitations at the outset of the treatment relationship for both clinical and legal reasons. The issue of payment is important to the therapeutic relationship, and postponing discussion until the relationship has developed might erode any trust that has been established. From a legal risk management perspective, the treatment provider is much better off at the beginning of the relationship addressing the issue of payment and the terms under which the treatment relationship might end; in the legal cases discussing liability in the managed care era, payment issues appear not to have been raised until late in the relationship, when the termination of reimbursement became an issue.

The notion of "economic informed consent" is comparatively new, though many clinicians have always discussed with clients issues regarding payment. It is likely that additional discussion within professional groups, the courts, and legislatures will occur regarding how far such discussions with clients must go. For example, are physicians obligated to tell uninsured patients that certain medications are available only to individuals with insurance? Are therapists obligated to tell clients that another managed care plan provides a better therapy benefit? While answers to questions like this may not yet be clear, discussions of such questions will become the rule in the future.

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## Section 4: Ethics and the Behavioral Health Care Organization

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Businesses engaged in the delivery of health care services are not governed by the same ethical precepts as the practitioners who work on their behalf. While such businesses may share in liability, as a practical matter State law assumes that only licensed individuals may engage in the practice of medicine and other clinical specialties. The ethical principles of the professional associations discussed throughout this monograph apply to individuals licensed in those professions and engaging in practice, not to the businesses employing or contracting with them.

At the same time, behavioral health care entities can engage in practices that are unethical and in some cases illegal. Behavioral health care businesses also can enter into contractual arrangements that increase the likelihood that treating practitioners will face ethical conflict. In addition, if the individual heading the behavioral health care organization is a licensed practitioner, he or she continues to have ethical responsibilities flowing from that license that arguably carry over into his or her role as administrator.

This part of the monograph focuses on a number of ethical issues facing the behavioral health care organization, including contractual issues, ensuring that competent staff provide services, the use of financial incentives to attract business, fraud, and marketing and advertising.

### **Contractual issues**

*Autumn Leaves Behavioral Health Care Company bids on a managed behavioral health contract being issued by the State. Autumn Leaves, intent on winning the contract, enters a bid well below its competitors. After winning the contract, its chief financial officer meets with its clinical staff and informs them that the contract will lose the company money unless clinicians work closely with the financial office to monitor expenditures. Each clinician's performance will be posted weekly, and the amount of resources used by each clinician will be used in performance evaluations. The meeting concludes with the statement that "of course you are expected to use your clinical judgment in decisionmaking."*

*RENCO Behavioral Health, in contrast, will lose clients because of the award to Autumn Leaves--under terms of the contract, Autumn Leaves will now be providing care to individuals who have been treated, sometimes for years, by RENCO staff. Two therapists for RENCO have told clients that "this contract makes it almost impossible for you to get good care" and that "Autumn Leaves will leave you in the lurch." This has caused great anxiety among clients of RENCO, whose therapists have also declined to discuss clients with representatives of Autumn Leaves.*

Managed care contracts do not necessarily create ethical issues. However, if business strategies that have nothing to do with clinical values predominate, a contract may result that creates profound ethical conflict for treatment staff. In this particular vignette, Autumn Leaves has deliberately entered a low bid on a contract for strategic reasons. It then makes clear to its clinical staff that the clinical staff bears the burden of ensuring that the company does not lose money, and ties performance evaluations to resource utilization. As the above discussion made clear, clinicians are supposed to exercise professional judgment unclouded by personal financial concerns; a company that expects its clinicians to save it from questionable business decisions invites those clinicians to step into an ethical quagmire.

In such a situation, a clinician first must decide whether he or she can continue to work under such conditions. In addition, clinicians may have an ethical responsibility to make public circumstances that inevitably result in ethical conflicts. Finally, tying performance

evaluations to the impact of treatment decisions on resources may become illegal: Texas, for example, responding to the payment of incentives to employees based on creating admissions has outlawed performance standards based on the number of patient admissions resulting from an employee's efforts (chapter 164.005 Texas Codes).

Other contractual provisions can also create ethical dilemmas for treatment staff. For example, explicit limits on utilization of particular types of services may cause a clinician to have to reconsider proposing a treatment that in his or her professional judgment is the appropriate treatment. Contractual limits may also reduce the time available to a patient in a particular case, changing the conversation between clinician and patient in ways that may affect the substance of treatment.

Behavioral health care organizations devoted to retaining competitiveness in a difficult environment also may sign contracts that, because of the financial strain they place on the organization, reduce the possibility that the organization will provide charity or free care to at least some individuals. For-profit health care organizations generally are not required to provide charity care (in contrast to tax-exempt providers, which may have to provide some charity care to retain their tax-exempt status). However, the ethical principles of the various professional associations suggest a commitment to providing care to at least some who are unable to afford it. A behavioral health care organization that effectively contracts away its ability to do that may exacerbate the more general problem of inequitable access to health care.

Finally, a behavioral health care organization that loses clients to another provider because of a managed care contract has an ethical obligation to ensure that the transition in care causes as little harm as possible to the affected clients. Some managed care contracts do cause the disruption of long-standing clinical relationships; therapists must be particularly careful to not let their own anger and other emotions caused by the loss of clients (and business) contaminate the manner in which they end their relationship and transfer the responsibility for care to another organization. If a contract may cause this type of disruption in therapeutic relationships, management should take steps to ensure that the transition of care takes place as smoothly as possible.

### **Competent treatment staff must be utilized in providing care**

Cost-containment efforts may result in incentives to use less credentialed staff for treatment because they cost less. For example, a plan attempting to save money may be inclined to use master's-level rather than doctoral-level psychologists where possible, assuming that there are cost differences based on degree. In addition, a plan may advertise its contractual relationships with a number of well-known, highly competent providers. However, in practice, the plan may rely primarily on less-qualified, less-expensive providers of care, raising questions about the truthfulness of its advertising (a subject discussed in more detail below).

There is nothing intrinsically wrong with using the least expensive qualified staff available, just as there is nothing wrong with using the least expensive effective treatment

available. However, each profession has an ethical principle requiring members not to practice beyond the scope of their competence, a principle that the law has ratified as well. Therefore, if in implementing a managed care plan, staff are asked to perform functions that they are not qualified to do, both an ethical and legal issue is created.

This principle also may have ramifications for treatment providers deciding whether to join a managed care plan. If the plan relies on short-term treatment, for example, limiting the number of sessions available, it is incumbent upon the treatment provider to ensure that he or she has both the training and experience necessary to provide adequate treatment within the plan's limits.

### **The use of financial incentives to attract business**

*WeCare, a behavioral health care consortium specializing in the treatment of alcohol and substance abuse disorders, wishes to expand its client base. Faced with a highly competitive environment, WeCare decides to pay cash bonuses to physicians, psychologists, and social workers who refer clients to WeCare hospitals. It imposes only one condition on clinicians making referrals: They cannot reveal to the client that WeCare is paying the bonus in exchange for the referral. WeCare's business thrives, and its executives congratulate themselves on a successful business strategy.*

In this vignette, WeCare's strategy violates ethical principles on at least two counts. First, paying clinicians to direct clients to a particular business contaminates clinical judgment; a clinician receiving a cash bonus to direct a client to a particular provider will not be making a "neutral" decision regarding the client's needs. For example, the American Psychological Association requires that when a psychologist receives payment from another professional, other than in an employer-employee relationship, "the payment...is based on the services...provided and is not based on the referral itself" (APA Ethical Principles of Psychologists and Code of Conduct, Section 1.27). Second, if clinicians do not reveal the financial relationship with WeCare, the client will not receive all of the information necessary to make an informed decision.

In addition to violating ethical principles, the arrangements discussed in the vignette may violate the law in some States that have outlawed the paying of bonuses and other types of incentives for patient referrals. Such arrangements may also raise questions under Federal fraud and abuse laws, which attempt to ensure that clinical decisionmaking is not motivated by financial self-interest.

### **Fraud**

Estimates of the amount of money lost to private insurance fraud in the health care system run as high as 75 billion dollars per year (Garrett, Klonoski, and Baillie 1993). Fraud is committed both by providers and by patients. Provider fraud is highly varied. For example, providers may bill insurance companies for patients they have never seen. Free health screenings may be advertised; the insurer is then billed for the "free" screenings.

Capitation may eliminate incentives to engage in some types of fraudulent practices, because the provider organization now bears the financial risk. However, if a case rate is paid, where the organization is paid for each client using services rather than for each enrollee (regardless of use), there may be incentives to bill for services never provided by reporting the treatment of "cases" that never occurred. Similarly, in situations where the behavioral health care organization receives additional reimbursement for each individual enrolled, and where the company rather than the payer is responsible for enrollment, some organizations have enrolled individuals in who the provider had good reason to believe would never use the services. This practice increases the amount of money available to the provider with no additional risk, because the new enrollees are never going to use the services.

### **Ethical issues in advertising and marketing**

Health care organizations have a right to present truthful advertising. However, advertising and marketing can quickly become misleading, and, given the fears people have regarding mental illness and substance abuse, they can also easily become exploitative in the behavioral health care field.

For example, advertising may suggest that certain types of behaviors among adolescents (moodiness, alienation from parents) are indicators of possible mental disorders. While in individual cases that might be true, advertising may have the effect of exaggerating the importance of such behaviors and may imply that such behaviors are categorically equivalent to the existence of a mental disorder. In addition, advertising may suggest that the behavioral health care organization will provide a remedy for the "disorder." Such advertising raises ethical questions as much for what it does not reveal: that the behaviors described in the advertisement are often typical of adolescents, that only an individual assessment can reveal the existence of an underlying disorder, and that there may be little if any outcome data on the interventions the behavioral health care provider uses (which themselves are typically not described in marketing and advertising except in the most general terms).

There are also ethical issues to consider in the marketing of services to potential enrollees. Ethical and legal principles assume that individuals have a right to make informed decisions regarding health care choices. Brochures and other materials made available to individuals regarding a managed care plan should describe the chief characteristics of the plan accurately, and should also note significant benefit limitations. As noted earlier, describing the qualifications of providers should also be done so as not to mislead potential enrollees about the availability of those providers under the plan; marketing that emphasizes plan affiliations with providers or practitioners who are generally not available under the plan is misleading. The network relied on by the provider should also be described.

Behavioral health care organizations might also engage in efforts to discourage individuals from enrolling or using services, even when those individuals otherwise qualify for the plan. "Skimming" to avoid responsibility for individuals with significant

service needs is something that has become familiar to health care payers and providers. There is an ethical dimension to the practice when it results in the disenfranchisement of individuals who should be obtaining services through the plan.

## Section 5: Suggestions for Addressing Ethical Issues in Managed Behavioral Health Care

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The ethical issues described in this monograph can be addressed in a variety of ways. Some responses lie beyond the capacity of payers or providers. For example, an accessible, universal behavioral health care benefit would eliminate many of the incentives to cost-shift in the behavioral health care system. Recent Federal legislation that begins to address the parity issue moves in this direction; full coverage for behavioral health care benefits, and the elimination of incentives to cost-shift or undertreat are issues not yet resolved.

Other initiatives by the professional associations also may assist behavioral health care providers. The development of practice guidelines by the American Psychiatric Association contributes to standardizing at least the parameters of practice through a process accessible to and ultimately controlled by practitioners. Managed care companies already employ the equivalent of practice guidelines in determining how benefits will be allocated in their plans. The practice guideline project reinserts the practitioner in the debate over what constitutes appropriate practice in treating individuals with some types of diagnoses.

The State mental health agency and Medicaid agency can also act in their roles as payer and regulator to ensure that the managed care contract addresses the issue of payment for court-ordered services. These agencies can also take steps to try and minimize incentives to cost-shift to the State system from both commercially and publicly financed managed care plans. There are also a number of actions behavioral health care providers and practitioners can take to anticipate and address ethical issues arising from managed behavioral health care.

### **The Behavioral Health Care Organization**

The behavioral health care organization shapes the practice of its practitioners by the contracts it signs. If those contracts are underfunded, they can create significant ethical issues for practitioners and put clients at risk. Given the importance of these issues, the behavioral health care organization can adopt formal processes that provide an

opportunity to formulate and discuss ethical issues. These processes include creation of an ethics committee and adoption of a workable grievance process.

### **Creation of an ethics committee and adoption of a code of ethics**

In the last 20 years, ethics committees have become commonplace in hospitals. Their development was stimulated by the New Jersey Supreme Court's suggestion in the Quinlan case that a hospital "prognosis committee" consider the physician's request to withdraw life support; by a report in 1983 by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommending that institutional ethics committees be established to address ethical issues in patient care; and by a 1985 suggestion by the American Academy of Pediatrics and the American Hospital Association that hospitals caring for newborn infants establish review committees to address issues arising from the care of babies born with disabilities. Finally, in 1992, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a directive that all hospitals have in place a way of addressing ethical concerns. Given this history, many providers of behavioral health care will already have an ethics committee in place; behavioral health care organizations that do not will have examples to study if they wish to form one.

While ethics committees originated in health care in hospital settings, in the last few years, a number of health care and managed care organizations have adopted formal organizational codes of ethics. For example, the American Association of Health Plans, representing approximately 1,000 HMOs, PPOs, and similar organizations, has created a Philosophy of Care statement. This statement articulates a set of principles that are not binding on the Association's membership but do set forth general principles on patient access to affordable, quality care.

In addition, two large health care providers with holdings in the Midwest and the East have created a Shared Corporate Ethics Committee, which has issued Ethical Guidelines for Managed Care Contracting. The guidelines are based on three premises, titled Dignity of the Human Person, Dignity Can Only Be Protected and Realized in Community, and Special Responsibility for the Poor. The guidelines seek to ensure that members ground their contract negotiations in a set of ethical principles, and at least in part appear to be designed to ensure that the traditional mission of the members to provide care to the poor is not left out of negotiations.

In other settings, State officials have attempted to create ethical parameters for providers. For example, the attorney general of Massachusetts has issued voluntary ethical guidelines for hospitals and for health maintenance organizations. As these various activities suggest, health care organizations (as well as managed care organizations) increasingly have focused on incorporating ethical principles into organizational culture, rather than treating such issues as an afterthought or as unrelated to the business of providing health care. Adoption of a set of ethical principles as part of organizational policy can have the effect of legitimizing discussion within the organization about such issues.

While the composition of an ethics committee, as well as its functions, may vary from organization to organization, a number of issues appear to be worth considering in creating an ethics committee in a managed care setting.

First, an ethics committee designed to consider the types of issues raised in this monograph may have a somewhat different role than the traditional, hospital-based ethics committee, which often exists to consider questions of access to or withdrawal of clinical care for individuals at the end of life, or to determine whether experimental or costly technologies should be made available and if so under what circumstances. For example, an ethics committee designed to ensure that organizational values in conducting the business of managed behavioral health care are grounded in ethical principles may become involved in issues of contracting and advertising, issues that might not be considered by a traditional ethics committee.

Second, the composition of the ethics committee usually will reflect the different perspectives of the organization. For example, an ethics committee designed to reflect on clinical/ethical issues in a hospital setting might be drawn from the various medical staff departments, the pastoral service, and quality assurance and nursing, and might include a representative (for example an ethicist) from outside the hospital. In the managed care context, however, committee members might include not only clinical representatives, but representation from the business and personnel sides of the organization, as well as the counsel's office. Outside representatives might include a consumer or family member. A formal "ethicist" viewpoint might be available through a local university. There is no ideal composition; the point is to ensure that the different organizational perspectives are part of the ethics committee's discussion.

Third, the role of the ethics committee needs to be defined. Are its opinions advisory or binding? How do issues come to the committee? How often does it meet? Is one of its tasks to create an organizational code or principles of ethics? Does it provide training? Does it review contracts to identify ethical issues that the contract might create?

Fourth, where does the ethics committee fit organizationally? Does it report to the company CEO? the chief clinical officer? Or is it viewed organizationally as an appendage, a marketing tool with little visibility internally?

The behavioral health care industry is at an early stage in developing organizational vehicles for considering the ethical issues raised by managed behavioral health care. An ethics committee is one tool for beginning this task. The committee may be provider specific, or, as in the examples noted above, it may span a number of providers with similar organizational values and cultures. Regardless of the vehicle chosen, or its exact composition, development of an organizational strategy for considering the ethical questions raised by managed care contracting may prove useful to the behavioral health care organization in bridging the gap between business decisions and their impact on individual clinical transactions.

## **Grievance procedures**

Federal and State law require health maintenance organizations, managed care companies, and other entities to have a formal grievance procedure to address consumer complaints. Even if such a process is not required, adopting a grievance procedure is a tool that enables a behavioral health care organization to adhere to ethical standards.

A grievance process will have several elements. Those typically mandated by law for entities that must have a formal process include

1. The availability of formal and informal steps for resolving a grievance;
2. Designation of an individual who is responsible for overall administration of the grievance process;
3. Communication to clients regarding the grievance process, including phone numbers of company representatives and information on filing a grievance, with the communication available in the languages of the clients;
4. Posting of information regarding the grievance process, as well as forms for initiating a grievance, at each site where services are provided;
5. A process by which grievances are resolved, including an acknowledgment to the client that the grievance has been received, a fixed amount of time in which the grievance is to be resolved, and notification to the client of the outcome of the grievance;
6. Monitoring by the behavioral health care organization of the outcome of grievances, including changes in practice or policy resulting from the grievance; and
7. Training of staff in the grievance process and its importance to the organization.

In addition to an ethics committee and a good grievance process, the behavioral health care organization might examine such issues as its policies and procedures in the areas of informed consent, what steps the organization takes to ensure continuing care if it is clinically indicated after reimbursement ends, and the organization's stance on the use of coercion. As this monograph has suggested, these are core ethical and legal concerns in a managed care environment, and adopting organizational policies and procedures addressing them may anticipate the problems noted in the text.

## **The Treatment Provider**

The primary burden for ensuring that practice conforms to ethical principles, and for reconciling the tension between cost containment and client treatment needs, falls on the practitioner. This is not a new burden. Ensuring that practice was ethical has always been primarily the responsibility of the treatment provider, and as noted earlier in this monograph, ethical issues existed in a fee-for-service environment as well. In dealing with ethical concerns raised by managed behavioral health care, a number of commentators have made suggestions worth considering.

## **The ethical stance of the treatment provider**

The practitioner, like the behavioral health care organization, will be well served by considering his or her stance on ethical issues before they arise. Dr. James Sabin, whose work in this area was referred to earlier, suggests that practitioners base their work on four ethical principles, including

1. Acceptance by the practitioner of responsibility to the client and to society (the twin duties of fiduciary and steward discussed earlier);
2. Use of the most efficacious and economical treatment available;
3. Promotion of the greatest good for the greatest number of people; and
4. Judicious use of resources.

Others urge the treatment provider to assume the role of advocate for his or her client, particularly in advocating for the benefits the practitioner believes are in the client's interest (Morreim 1991). While advocacy can take many forms, two types of advocacy are noted here. First, the clinician may act as advocate with the managed behavioral health care company. In some circumstances, advocacy may mean pursuing formal appeals processes established by the managed care plan. In other circumstances, it may mean going beyond the appeals processes in attempting to persuade the plan's administrators to make available benefits the clinician believes are appropriate.

Second, the clinician can act in concert with his or her colleagues through professional associations to advocate for ethically based managed care plans. This is not to suggest that every position taken by a professional association in response to managed care necessarily is based on ethical principles or will lead to more ethical care. However, professional associations play a significant role in shaping the environment in which behavioral health care is organized and financed, and participation in professional associations may be a constructive way to act as advocate.

Acting as an advocate is not without risk. Clinicians fear retaliation if they advocate too aggressively with a managed care plan, and so may be inclined only to advocate for the most serious needs. Such a strategy obviously raises its own set of issues, as it forces the clinician to choose which among his or her clients is more "worthy" of advocacy. Concerned with this bind, States have begun adopting legislation prohibiting retaliation against a clinician based on client advocacy. While such legislation does not create absolute protection for clinicians, it does suggest a legislative preference for the role of advocate. Supporting such legislation may be one way in which professional associations can enable their members to play an advocate's role.

### **Issues to consider when entering a managed care contract**

In a managed care setting, terms of the contract are critical. Contracts define the relationship between payer and provider or practitioner, define the rights of enrollees, specify benefits, and establish rates. Contractual terms can establish the parameters of a well-functioning behavioral network; contractual terms can also lead practitioners into the most difficult ethical problems. Yet most behavioral health care professionals have had little if any formal training in contract law or contract negotiation. Today,

professional meetings increasingly include sessions on these topics, and practitioners might take advantage of such opportunities to better prepare themselves for negotiating contracts.

Haas and Cummings (1992) suggest several issues that a behavioral health care provider should consider before entering a managed care contract. These suggestions will assist the practitioner in thinking in advance about a number of the issues identified in this monograph:

1. The practitioner should identify who bears the financial risk in the contract, recognizing that the greater the financial risk borne by the treatment provider, the greater the temptation to skim in client selection, limit access and utilization, and "dump" clients onto other systems.
2. The practitioner should identify the ways in which the plan intrudes into the therapeutic relationship. Note that capitated contracts can create great flexibility as well as risk for the treatment provider; in an adequately funded plan, the provider may enjoy even more flexibility in meeting service needs than in a traditional fee-for-service program. Conversely, in an inadequately capitalized plan, or in a plan with significant utilization limits, the ability of the provider to meet client need may be significantly reduced.
3. Does the plan provide exceptions to the rules? Haas and Cummings suggest that if there is not some flexibility to the rules, providers will be tempted to engage in activities (for example, changing the diagnosis) designed to capture additional reimbursement but that violate ethical standards and may do harm to the client.
4. What alternatives exist if the client requires them or exceeds plan benefits? As the earlier discussion of the legal decisions suggests, some providers have abandoned their patients as benefits expire. The provider should consider in advance what alternatives are available if the client needs continued care but financial resources within the plan are exhausted.
5. Does the plan provide assistance to the provider or training to help the provider reach treatment goals? Haas and Cummings observe that many plans favor short-term therapies. If the provider is not trained in these approaches, will the plan help him or her in gaining the necessary competencies?
6. Does the plan create incentives to hospitalize clients? As noted earlier, some plans may create incentives to hospitalize clients or transfer them to other, more restrictive treatments for financial rather than clinical reasons. Such incentives are problematic clinically, ethically, and financially (in terms of the overall allocation of health care resources).
7. Does the provider have the opportunity to raise concerns about the plan and otherwise make suggestions to the managed care plan?
8. Does the plan inform enrollees about benefit limitations? As this monograph suggests, the emerging doctrine of "economic informed consent" places at least some of the burden for ensuring that the client understands the impact of benefit limitations upon the treatment provider. However, the provider may wish to review the materials used by the plan in advertising and marketing its services, as well as the materials used to inform enrollees of benefits and benefit limitations.

In addition to these issues, the practitioner should pay particular attention to the contractual definition of "medical necessity" (or "clinical necessity" if that phrase is used). This definition, applied to the benefits available in the plan, generally will control reimbursement decisions.

## Summary

Unless great care is exercised by payers, caregivers, and government, managed care systems can place undue pressure on both managed care organizations and providers to violate basic principles of medical ethics. While incentives in both fee-for-service and managed care behavioral health care systems can contribute to unethical behavior, managed care poses particularly challenging ethical issues due to the frequent tension between the goals of cost containment and obtaining services for people with mental disorders.

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Post Test: Managed Care Ethics  
Text: Ethical Issues for Behavioral Healthcare Practitioners  
and Organizations in a Managed Care Environment  
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### A. INTRODUCTION

1. The therapist in today's behavioral health care system often enjoys \_\_\_\_\_ discretion than in a fee-for-service system..

- A) more
- B) less
- C) the same
- D) A or C

2. The central ethical questions in a managed care environment flow from \_\_\_\_\_.

- A) a more explicit concern with cost.
- B) a changed therapist-client relationship.
- C) involvement of payers in individual treatment decisions.
- D) none of the above.

### B. ALLOCATON OF RESOURCES

3. There is \_\_\_\_\_ evidence that unlimited expenditures on health care

necessarily yield better health care outcomes, regardless of how "better health outcomes" is defined.

- A) no
- B) mounting scientific
- C) anecdotal
- D) B and C

4. To the degree that rationing of health care resources may exist, such rationing is based on:

- A) principles agreed upon by payers and professionals.
- B) the financial resources of clients.
- C) principles put forth by President Clinton in his health care proposal.
- D) no agreed upon criteria.

5. \_\_\_\_\_ is/are among the ethical issues complicating the task of creating a coherent ethical base for the behavioral health care system.

- A) Behavioral health care benefits have lagged behind general health care benefits in both privately funded and publicly funded systems.
- B) The availability of coercion and the conditions under which it may be properly used in the delivery of behavioral health care services to clients.
- C) A and B
- D) Neither A nor B

#### C. TREATMENT PROVIDER OBLIGATIONS

6. The first core ethical principle that governs the relationship between treatment provider and client is \_\_\_\_\_:

- A) do no harm.
- B) the practitioner is a fiduciary, whose primary obligation is to act in the client's best interest.
- C) the therapist's primary responsibility is to prevent harm being done to a client.
- D) B and C

7. The ethical and legal rule of autonomy holds that competent individuals as a general rule have control over health care decisions.

- A) TRUE
- B) FALSE

8. If the economic interests of the treatment provider are at odds with the interests of the client, a treatment provider:

- A) is obligated to provide those services agreed upon between the therapist and the client's payer.
- B) is not obligated to provide treatment the client cannot pay for.
- C) is obligated to provide the treatment he or she believes is best suited to the client's need under these circumstances.
- D) B and C

9. Which of the following are mandatory elements of informed consent?  
A) It must be voluntary.  
B) It must be competent.  
C) It must be knowledgeable.  
D) A, B, and C

10. The process by which the decision was reached was unimpeded by mental or emotional illness or other factors, for example, substance abuse

as a test for competence:

A) is in common use today.  
B) is biased towards treatment refusal.  
C) is rarely used today.  
D) applies only to those clients being treated involuntarily.

11. As a general rule, an individual must be:

A) less competent the more intrusive or invasive the treatment procedure.  
B) equally competent to consent to more or less intrusive or invasive treatments.  
C) more competent the more intrusive or invasive the treatment procedure.  
D) declared incompetent by a court before he/she can refuse invasive or intrusive treatment.

12. Under what circumstances is it ethically permissible to withhold information from a client about risks associated with a proposed treatment?

A) When such information would unduly raise a client's anxiety if revealed.  
B) When the risk is small.  
C) When the benefits clearly outweigh the risk to the treatment.  
D) Under no circumstances.

13. Consent will be assumed in an emergency when the client is unable to give consent.

A) TRUE  
B) FALSE

14. Substitute consent for treatment may be obtained when:

A) the individual involved is a child under 16.  
B) the individual has designated a "health care proxy" before becoming incapacitated.  
C) A and B  
D) Only when a person has been declared incompetent by the court to make decisions.

#### D. IMPACT ON CORE PRINCIPLES

15. If a provider signs a contract with a managed care company to provide services to their members, the provider incurs:

A) legal obligations.  
B) contractual obligations.  
C) A and B  
D) None of the above

16. Clinicians may be liable to what kind of legal action as contractors with managed care organizations?
- A) Negligence or malpractice if services are terminated or curtailed because of reimbursement and the client suffers an adverse outcome.
  - B) Breach of contract for failure to provide services guaranteed in the client's managed care contract
  - C) The same actions as apply to fee for service systems.
  - D) A and B
17. In Wickline v. California the court decided that third party payers:
- A) can be held legally accountable when medically inappropriate decisions result from defects in the design of implementation of cost-containment mechanisms.
  - B) cannot be held legally accountable when medically inappropriate decisions result from defects in the design of implementation of cost-containment mechanisms.
  - C) are responsible for poor medical decisions made by physicians intimidated by their reimbursement policies.
  - D) A and C
18. Who retains ultimate responsibility for care even in the face of a lack of reimbursement?
- A) The provider/treater.
  - B) The managed care company.
  - C) Both equally.
  - D) The client.
19. Recent opinions by courts regarding the responsibility of providers to continue care even if reimbursement is in question are a tacit guarantee for lifetime care to clients.
- A) TRUE
  - B) FALSE
20. Under what circumstances may health care resources legitimately be withheld?
- A) None
  - B) When the provision of services would put an economic burden on a client's family.
  - C) When further interventions would be of no value.
  - D) B and C
21. John Sabin suggests that treatment providers:
- A) must look beyond the needs of the individual to societal interests.
  - B) must not be coerced into looking beyond the individual's needs to societal needs.
  - C) have an obligation to act as stewards of health care resources.
  - D) A and C
22. It is unethical for a clinician to utilize the least expensive, clinically appropriate services available.
- A) TRUE

B) FALSE

23. Individuals with little choice regarding their providers, such as Medicaid recipients and other managed care clients

A) retain a limited right of autonomy in making decisions about their health care.

B) forego their right of autonomy in lieu of guaranteed benefits under the managed care system.

C) retain the right of autonomy in making decisions about their health care.

D) must choose treatment options from those offered by the managed care plan.

24. Individuals with mental illness and substance abuse disorders:

A) retain the same rights as others to decline treatment.

B) retain the right to decline treatment, absent an emergency or application of the state's rules permitting the ordering of treatment when it

has been refused.

C) do not have the right to refuse treatment that is not invasive or intrusive.

D) cannot be presumed competent to refuse treatment, although they retain the right to accept treatment.

25. The fact that a person has been ordered into care directly conflicts

with the ethical principle of:

A) Autonomy

B) Independence.

C) Coercion.

D) A and C

26. A clinician in either a managed care or a fee-for-service environment

must disclose to the client any conflicts that might affect the provider's

clinical judgment, only if the clinician thinks this is a realistic possibility.

A) TRUE

B) FALSE

27. \_\_\_\_\_ means that the treatment provider, as part of the informed consent process attempts to ascertain whether the client is aware of limitations on services available to the client resulting from provisions in the client's insurance or managed care plan.

A) Expanded informed consent

B) Pretreatment financial screening

C) Economic informed consent

D) Financial evaluation

28. Who among the following are ethically obligated to discuss with a managed care client benefit limitations?

A) The payer.

B) The client is responsible for knowing which benefit are in his/her plan.

- C) The state or federal entities regulating the managed care plan.
- D) The practitioner.

29. When should a discussion of the limitations of benefits and other economic issues occur between a client and a practitioner?

- A) At the beginning of the relationship.
- B) If economic issues begin to have an effect of the therapeutic alliance.
- C) If the client fails to make regular payments.
- D) At the last or next to last session.

#### E. ORGANIZATIONAL ETHICS

30. If the individual heading the behavioral health care organization is a

licensed practitioner,:

- A) he or she ceases to have ethical responsibilities flowing from that license that arguably carry over to his/her role as an administrator.
- B) he or she has ethical responsibilities flowing from his/her role as administrator.
- C) he or she continues to have ethical responsibilities flowing from that license that arguably carry over to his/her role as an administrator.
- D) ethical responsibilities do not apply to administrative positions.

31. What ethical responsibility does a behavioral health care organization

that loses clients to another provider because of a managed care contract retain?

- A) The organization must inform the clients about the reputation, good and bad, of the receiving organization.
- B) There are no specific ethical obligations imposed on an organization in these circumstances.
- C) Only those responsibilities imposed by state law.
- D) To ensure that the transition in care causes as little harm as possible to the affected clients.

32. It is ethical for a clinician to practice outside the scope of his/her

competence if:

- A) failure to do so would interfere with the delivery of optimum care to clients.
- B) a person with the required licensure is available for consultation and supervision.
- C) the clinician is complying with a contractual agreement he/she has with the organization.
- D) none of the above

33. Upon whom is it incumbent to ensure that a practitioner has both the

training and experience necessary to provide adequate treatment within a managed care plan's limits?

- A) The treatment provider.

- B) The managed care company.
- C) The behavioral health care organization.
- D) The client seeking treatment.

34. Clinicians who accept bonuses for referrals of clients:
- A) are engaging in acceptable business practices if the care delivered is equivalent to or better than the community standard of care.
  - B) cannot make a neutral decision about the appropriateness of the referral.
  - C) are violating ethical principles of informed consent.
  - D) B and C

#### F. ADDRESSING ISSUES

35. Formal processes for addressing ethical issues in a behavioral health care organization should include which of the following:
- A) an ethics committee.
  - B) a workable grievance process.
  - C) adoption of a code of ethics for all providers.
  - D) both A and B above

36. Which of the following principles are not included in the Ethical Guidelines for Managed Care Contracting formulated by the Shared Corporate Ethics Committee?
- A) Special Responsibility for the Seriously Impaired.
  - B) Titled Dignity of the Human Person.
  - C) Dignity Can Only Be Protected and Realized in the Community.
  - D) Special Responsibility for the Poor.

37. Ethics committees in managed care organizations should not include members of the business and personnel sides of the organization because of the conflict of interest they might have between the organization's interests and the clients.
- A) TRUE
  - B) FALSE

38. An appropriate outside member of a managed care organization ethics committee might be:
- A) an ethicist.
  - B) a consumer.
  - C) a family member of a consumer.
  - D) A, B and C

39. Federal and State law require \_\_\_\_\_ to have formal grievance procedures to address consumer complaints.
- A) health maintenance organizations
  - B) managed care companies
  - C) A and B
  - D) Neither A nor B

40. Which of the following elements are not legally required for entities that must have a formal grievance process?
- A) Training of staff in the grievance process and its importance to the organization.

- B) Posting of information regarding the grievance process.
- C) Designation of an individual who is responsible for overall administration of the grievance process.
- D) All are required.

41. On whom does the burden for ensuring that practice conforms to ethical principles, and for reconciling the tension between cost containment and client treatment needs, fall on?

- A) The managed care organization ethics committee.
- B) The chief clinical officer of the organization.
- C) The practitioner.
- D) all of the above equally.

42. In his work on ethics for behavioral health care practitioners, Dr. James Sabin concludes that practitioners should consider \_\_\_\_\_ in making ethical decisions about caring for clients?

- A) acceptance of responsibility to the client
- B) acceptance of responsibility to the client and to society
- C) use of the most efficacious treatment available without regard to cost
- D) promotion of the greatest good for the people at highest risk

43. How do the authors suggest clinicians can ethically act as advocates

for benefits which are in their clients best interest?

- A) By pursuing formal appeals processes established by the managed care plan.
- B) Going beyond the managed care appeals process to persuade the plan's administrators to make available benefits the clinician believes are appropriate.
- C) Act through professional organizations to advocate for ethically based managed care plans.
- D) A, B and C

44. Before entering a managed care contract, a behavioral health care provider:

- A) should consult a lawyer skilled in interpreting contracts to determine if the contract is to his/her benefit.
- B) should consult with his/her professional organization to determine if the contract conforms with the organizations ethical standards.
- C) should determine if the plan provides flexibility in the rules that prevent the practitioner from being tempted into unethical practices.
- D) A and B

45. The definition of \_\_\_\_\_ generally will control reimbursement decisions in a managed care system.

- A) available benefit
- B) medical necessity
- C) most efficacious treatment
- D) covered diagnosis

NOTE: Record your answers on the Course Completion Form - do not send in all exam pages!