Shifting Boundaries, Reducing Costs: Managed Behavioral Health Care and the Criminal Justice System

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Prepared for

The National GAINS Center
for People with Co-Occurring Disorders in the Justice System
Policy Research Associates, Inc.
262 Delaware Avenue
Delmar, NY 12054

Policy Workshop Retreat
St. Michael's Maryland
January 23-24, 1996

This concept paper presents a brief synopsis of recent trends in managed behavioral healthcare and its likely impacts on the criminal justice system. This overview and assessment is intended to develop a frame of reference for anticipating the "spill-over" effects or likely impacts that impending changes in the organization and financing of mental health and substance abuse services will have on the justice sytem. Much of the concern about managed care to date has focused on its "internal" workings within these two service systems to the neglect of its "external" or wider systemic impacts. This is a serious oversight. The argument advanced in this paper is that managed behavioral healthcare may have tremedous negative impacts on the criminal justice system. These will occur through the realignment of sector boundaries defining who is responsible for the care/custody of high risk or difficult to manage cases and from mounting pressures to shift costs of their processing to "someone else's budget", from one system to another. People with co-occuring disorders—those seen as "mad"/"bad" and/or "druggies"—will be most vulnerable to these types of intersystem dumping. Little in the way of empirical data now exists to substantiate these impacts because managed behavioral healthcare has not yet been widely implemented in the public mental health and substrance abuse systems. But, this is changing rapidly across the country. The goal in this paper is to define some key concepts, highlight precedents, and call attention to potential impacts. The hope is that these consideration will prompt policy recommendations and preventive measures to insure proper care for people with co-occurring disorders in the justice system.

What is Managed Behavioral Healthcare?

Managed care is an umbrella concept that subsumes a variety of mechanisms for monitoring and delivering health care and thus it has a variety of forms. At one

end of the continuum, managed care includes loosely-coupled preferred provider organizations (PPOs) which comprise individual physicians, physician groups, and hospitals who accept discounted fee-for-service payment in exchange for the promise of a large volume of patient referrals. At the other end are more tightly-coupled group and staff model health maintenance organizations (HMOs). Group model HMOs contract with physicians for the care of enrollees; physicians in staff model HMOs are salaried employees. In between these two extremes are point-of-service (POS) and independent practitioner association (IPA) plans which utilize physician gatekeepers to coordinate services required by patients. The practice of managed care may also be extended to include indemnity insurance using such mechanisms as utilization review and case management.

The key element shared by all of these managed care approaches is the prospective or concurrent review of care provided to individual patients, with the power to deny payment for care thought to be unnecessary or not-cost effective. Although advocates of managed care programs often maintain that their efforts will lead to improvements in the quality of care--through the elimination of unnecessary procedures or the substitution of less-restrictive for more-restrictive care--it is clear that the goal of reducing health care costs lies at the heart of managed care systems (Appelbaum; Institute of Medicine).

In the 1980s, as employment-based benefits for behavioral health care (mental health and substance abuse) expanded in the private insurance market, for-profit specialty psychiatric and chemical dependency inpatient facilities grew, and costs of employee health plans skyrocketed. In response, a new managed behavioral health care industry was created to administer health benefits and employee assistance plans for large corporations (Freeman and Trabin). Many independent companies and insurers began offering separate "carve-out" behavioral healthcare insurance products to employers. These programs entail (1)

management teams devoted exclusively to mental health and chemical dependency, (2) case management personnel who are specialty credentialed under the supervision of board-certified psychiatrists, (3) use of specifically developed mental health and chemical dependency level of care assignment, and case management criteria that address medical necessity; medical appropriateness; and levels of care determination, and (4) specialty behavioral group, staff model and PPO networks with a continuum of care; access to a full range of disciplines; and negotiated discounts. Other key features include continuous quality improvement programs, specialized behavioral information systems, outcome management systems, clinical practice guidelines, and provider network management systems. The market response to these vendors has been strong and positive, resulting in rapid growth of the managed behavioral healthcare carve-out industry (AMCRA Foundation).

Managed care is now the predominant mechanism used by private health insurers to coordinate and manage mental health and substance abuse services. A 1994 survey estimated that 108 million Americans have mental health and substance abuse services that are delivered through managed behavioral health care firms (Goplerud). This represents 58 percent of all persons with private health insurance and less than 20 percent of people covered by publicly funded health insurance such as Medicaid and Medicare. The growth market for managed care, then, is clearly in the public sector. Government officials and the public are concerned with escalating costs of Medicaid and Medicare which have been central issues in the ongoing Congressional debates about balancing the Federal budget by the year 2002.

States have been experimenting with various forms of managed care for Medicaid beneficiaries to gain control over rising costs and to assure improved access to primary care (Goplerud). These experiments have been conducted under two federal Social Security waiver authorities, Section 1915(b) and Section 1115.

Currently, 45 states have "freedom-of-choice" waivers that allow states to limit a beneficiary's choice of provider to HMOs and primary care case management systems, 14 of them include mental health or addiction treatment populations. More recently, states have shifted to 1115 waivers that afford more flexibility in waiving eligibility rules for non-Medicaid/uninsured individuals (e.g., the working poor). Should Congress enact inclusion of the Medicaid program in a federal block grant to the states, these waivers will be obviated. However, many states will use the block grant to accomplish the same ends.

States may structure their managed care programs in a variety of ways (Koyanagi). A fully-integrated approach links all mental health care and substance abuse services for adults and children under a single plan which includes physical health care. In a full carve-out, no mental health or substance abuse services are provided within the basic health care plan; both basic and intensive services are provided through a separate behavioral health care system. A partial carve-out is a hybrid of the first two options—basic mental health services are covered as part of the standard health plan, but adults and children with more disabling disorders who need more intensive services are carved out into a separate managed mental health care plan. Leaving out individuals with high costs is another option. In this approach, basic mental health services are included within the physical health benefit and run by a managed care entity, such as an HMO. Other mental health care is provided through the traditional fee-for-service and state grant-funded programs outside the waiver.

In addition, decisions must be made about who runs any mental health carve-out established by the state (Koyanagi). Most carve-outs are being planned or set up through contracts with private for-profit managed behavioral health care firms, as in Massachusetts and Tennessee. In some cases, such as in Minnesota,

HMOs subcontract for separate provision of mental health services. In a few cases, such as North Carolina and California, carve-outs are done through a reorganization of the public mental health system and nonprofit agencies to create a publicly-managed, managed care program.

The assumption implicit in managed care proposals is that a comprehensive array of services, coupled with the flexibility to provide such services on the basis of individual medical and psychological necessity, produces better outcomes and better cost controls than traditional fee-for-service financing (Hoge). To date, however, there is little rigorous evidence to support the relative effectiveness of the various managed care options in the public sector (Mechanic; Goplerud). Moreover, results in the private sector are not generalizable to the public sector. Public systems generally target people who are poor, who have severe and persistent mental illness and substance abuse disorders, and who often have other problems in living that complicate their care. For many public-sector patients, providers must also coordinate with housing, social services, primary health care, criminal justice, education and vocational services. The public-sector is the agent of last resort for the uninsured--now estimated at some 41 million persons--and other people with no alternate way of accessing services.

Private managed care companies have, as yet, little experience dealing with persons with disabling mental illness, or with the specialized services they need. While the attraction of private managed care companies is in cost-cutting and cost-avoidance, it is not at all clear that significant savings can be achieved in Medicaid mental health care for persons with severe and persistent mental illnesses. Most of the demonstrated savings to date have been in managed care arrangements for nondisabled adults and children, who generally require fewer services. A variety of joint ventures between private and public agencies are being developed to marry the

respective competencies of each system so that services can be provided in cost-effective ways.

Cost-Shifting Between Service Sectors: Will It Be Déjà Vu All Over Again?

There are many uncertainties about how things will play out in the mental health and substance abuse field under managed care arrangements in the next few years. Equally difficult to discern is how developments in the managed behavioral health care field will affect activities in adjacent sectors such as criminal justice, social welfare, schools, housing, and employment. It seems safe to say that the movement toward managed behavioral health care is predicated on a different set of values than those that have dominated services planning since the early 1960s. For much of the past thirty years community mental health programming has been carried out in the context of an expanding and relatively well-supported service system that emphasized increased access to underserved populations, comprehensive services, and efforts to decategorize and integrate services needed by disabled persons across human service sectors. Today, strategies are based on cost-control and limiting benefits and entitlements rather than leveraging and cross-subsidizing collaborative efforts with other agencies. The upshot of this pendulum swing is that provider incentives are now much more oriented to the bottom line. The emphasis is on meeting only stipulated contractual obligations, cost avoidance, and shifting costs to other providers and service sectors whenever possible.

There are two telling historical precedents that illustrate the magnitude and impact of cost shifting following fundamental changes in the way mental health care is organized and financed. The first occurred following passage of the State Care Acts beginning in the 1890s which monopolized control over public asylums for the insane and placed it in the hands of the state (Grob). Asylums were the first mental health carve-outs, but throughout most of the 19th century they operated under

local as well as state control. State monopoly was an effort to overcome the mismanagement, overcrowding, underfunding, understaffing, and consequent abuses that were all too common features of locally-operated institutions. Within a few years of the states assuming exclusive responsibility for care of the insane, the character of the institutions began to change with the influx of many elderly, chronic, and medically infirm cases. What happened is that local authorities soon realized their incentives had changed and that admission to a state asylum no longer represented a cost that had to be borne by local tax dollars, but rather a savings of funds otherwise required to support local persons in almshouses for dependent populations. Essentially, by defining senility as mental illness, local authorities were able to shift costs of local welfare institutions and jails to the state. Within a few decades local almshouses had disappeared, supplanted by ever-expanding state institutions that increasingly served as human warehouses for a miscellany of medical, psychiatric, and social problems.

In this first instance, localities were successful in shifting social welfare costs to state mental health authorities. In the second example, which occurred about 75 years later, states were able to pass many of these same costs along to the Federal government. This opportunity occurred with the passage of the Medicare and Medicaid amendments to the Social Security Act in the late 1960s. This legislation specifically prohibited payments to the states for the care of persons between the ages of 18 and 64 years of age while they resided in an "institution for mental disease" (IMD). However, financial incentives were created that led to the release of many thousands of long stay patients from state mental hospitals to nursing homes and other community settings. While these patients remained in state hospitals, they were a 100 percent cost to the state. Following enactment of the new entitlements, these same patients could be discharged to the community whereupon the costs of their care were largely supported by Federal Medicaid and Medicare dollars and their

subsistence by Supplemental Security Income (SSI) payments. These incentives were the engine that fueled rapid deinstitutionalization of state mental hospitals throughout the US. In the process, hundreds of thousands of long stay patients were transinstitutionalized to nursing homes, community care homes, and to the streets where the costs of their care were absorbed by local welfare systems, police, jails, and other criminal justice agencies.

Over the next two or three years, responsibility for mental health and substance abuse service delivery and billions of dollars allocated for those services will be placed under managed behavioral heath care systems. Though the future is difficult to predict at this stage of managed care development, it seems clear that the underlying logic of managed care will create incentives for cost-shifting on a massive scale once again. And it is in the nature and direction of these shifts that the some of the major impacts of managed behavioral health care on the criminal justice system will begin to appear. Left unchecked, these developments will seriously compromise many of the policy recommendations concerning services integration for mentally ill offenders and detainees that were developed during the preparation of the "Double Jeopardy" report.

Impacts on the Criminal Justice System

Traditionally, mental health and substance abuse services have been organized into distinct, fragmented, and antagonistic systems. One very positive aspect of the growth of managed behavioral healthcare in the public sector is its potential for coupling mental health and substance abuse services within a unified management system. In principle, this allows for a much more comprehensive and individualized approach to the treatment of persons who are dually diagnosed with mental illness and substance abuse disorders. Such cases make up such a large proportion of the detainee and inmate population in jails and prisons. The

promise here is that cost shifting (dumping) between these two sectors can be lessened and possibly result in more comprehensive care for mentally ill persons with co-morbid conditions. On the other hand, simply managing costs through poor implementation of managed care can occur by denying necessary care and excluding individuals with severe disorders and expensive needs. It results in poor outcomes for those who receive care, and for many others, increases the likelihood of homelessness or incarceration in the criminal or juvenile justice systems (Koyanagi).

To be sure, the impact of managed behavioral healthcare will not be uniform across various settings within the criminal justice system. Some components are more vulnerable to negative impacts, whereas others might be more insular. Here, some of the likely impacts will be highlighted in a schematic way for four major components of the criminal justice system: (1) policing, (2) jail detention, (3) imprisonment, and (4) probation/parole. A unifying feature of the policing and probation/parole components is that offenders are in the community and justice authorities have no special mandate to provide for their behavioral healthcare services. These services must be obtained from public and private sources in the community. Analogously, despite major differences in mission and support services, a unifying feature of jails and prisons is their constitutional obligation to provide healthcare while offenders are in custody. Managed care approaches are gaining increasing attention within correctional health care systems (McDonald), so in these settings there is the potential for an intensification of effects arising from both internal and external managed behavioral healthcare arrangements.

1. Policing

Police officers occupy a key interstitial position at the interface between the behavioral healthcare and criminal justice systems. It has long been recognized that

the police play a key role in the lives of persons with mental disabilities as "gatekeepers" to the mental health system. The psychiatric emergency room continues to receive a substantial number of referrals from the police. Despite some role expansion consistent with community policing, law enforcement officers often feel inadequately equipped or trained to deal with the crises of people with mental illness, and are often frustrated in the time-consuming attempt to provide them access to professional assistance. Some collaborative programs between police and mobile mental health crisis teams have been described in the literature, but these remain exceptions rather that the rule in most communities. As the portal of entry into the criminal justice system as well, the decisions and practices of police officers are crucial determinants of whether disturbed and disturbing individuals are diverted into one system or the other.

- In the extreme, the incentives for providers under managed behavioral healthcare are to undertreat, to substitute less intensive for more intensive services, and to avoid hospitalization. Case finding in the form of outreach and aggressive follow-up of clients may be de-emphasized. To the extent that managed behavioral healthcare in the community leads to cost-cutting and cost-avoidance, many of the efforts to create community support services for patients with disabling mental illness will be undermined. Within a thinner and porous psychosocial safety net in the community, police officers will encounter more crisis situations and fewer opportunities to divert individuals to community alternatives than arrest and incarceration.

- Managed care might lead to more police officer downtime associated with emergency evaluations, greater number of findings that apprehended persons are not commitable or eligible for services, and therefore, a greater likelihood of arrest and booking of mentally ill persons into jail as a way of coping with the rigidities of the public mental health system.

2. Jails

Arguably, jails are the setting in which managed behavioral healthcare will have its greatest impact. Jails have a very short length of stay on average, but mentally ill offenders tend to be detained for much longer periods that other persons. As a result, a significant number of mentally ill detainees accumulate in jails and local correctional facilities where behavioral healthcare screening, assessment, treatment, and discharge planning services are often minimal at best. Nonetheless, for medium and large-size jails, there is a sizable cost center associated with medical and behavioral care that is variously provided directly by correctional employees, under contract with private providers, or through public-sector community mental health agencies. Thus, the extent to which mental illness and substance abuse is a problem within the jail setting is a function of (1) the adequacy of the police and/or the community treatment system in diverting mentally ill persons to alternative settings and (2) the ability of the internal medical/behavioral program to interface with community agencies to assure adequate discharge planning and continuity of care. Both sets of functions may be negatively impacted as managed behavioral healthcare assumes responsibility for internal and external services.

- Jails may become the only available secure setting for the short-term management of disturbed and disturbing individuals for the growing number of persons in crisis who are seen as inappropriate for local hospitals and residential treatment settings or unable to be served in units that are already at maximum utilization.

- Cost shifting by public mental health providers will take the form of defining more cases as "bad" rather than "mad" and therefore increase the responsibility of police and the criminal justice system. This will lead to more detention of mentally ill offenders in jail; alternate secure treatment settings at the state or local level will become harder to access and subtle and not so subtle efforts will be made to further criminalize the mentally ill thereby transferring responsibly to the criminal justice system.

- Predictably, at the front-end of jail detention, there will be less receptivity by mental health providers operating under managed behavioral healthcare arrangements to agree to jail diversion, early release, or probation on condition of participation in community-based mental health treatment especially for cases that are seen as overly complex and costly.

- At the back-end of jail detention, it will become more difficult to arrange continuity of care with community agencies upon release for mentally ill/substance abusing offenders.

- With the growth of mentally ill/substance abusing detainees in the jail, behavioral healthcare costs will rise and thereby create pressures for the introduction of managed care principles within in-house jail medical and behavioral health services via contracting out or direct provision. This will tend to create incentives for underservice within the jails and for early release back to the community, exacerbating conditions already described above.

- Contract providers will be more oriented to in-jail behavioral management and less inclined to invest time and resources on community linkage.

3. Prisons

There has been explosive growth in the state prison system in the past decade and many more mentally ill offenders are now serving time in these facilities, but good data are lacking on the prevalence of these disorders and on current behavioral healthcare services for this population. Arguably, prisons will be less vulnerable than jails to immediate impacts from managed behavioral healthcare in the public mental health sector due to their long stay inmate population and internal service arrangements. Even so, some concerns can be identified.

- As community services and justice diversion efforts atrophy, one would expect that new admissions will be more symptomatic and in-need of care at the point of incarceration.

- With the continued growth of the US prison population the costs of behavioral health care will rise and be met with greater pressures for cost-savings and cost-cutting. As with jails, managed care practices will be increasingly applied to prison behavioral health services via contracting out or direct provision (McDonald).

- With the decline of community options for early release, more mentally ill inmates will be doing straight time and full sentences; this will contribute to the growing numbers of severely mentally ill inmates in state prisons.

- Incentives for contract providers will be to undertreat and to identify, diagnose, and treat only cases referred by correctional staff. With the tendency to underserve associated with managed care, one would expect that the access, intensity, and duration of services for mentally ill inmates would operate at minimal levels. Also, efforts to link offenders to community programs would be de-emphasized by prison healthcare staff.

- With the decline of community options for early release, more mentally ill inmates will be doing straight time and full sentences; this will contribute to the growing numbers of severely mentally ill inmates in state prisons. These tendencies are most likely to occur in settings where private managed care contractors are used to provide prison behavioral health services.

- As the above trends unfold, there will be growing pressures and conflicts between state departments of corrections and mental health over the care and treatment of mentally ill offenders within the prison system; each system will try to shift (dump) responsibility and costs to the other.

4. Probation and Parole (Community Supervision)

Much of the fall out from the above trends will surface in the community supervision arena. Pressures for cost-cutting and relieving facility overcrowding will predictably lead to many mentally ill offenders being released to less-costly community supervision arrangements. As noted earlier, probationers and parolees must access behavioral healthcare services from the community service system.

Therefore, these persons will be facing the double jeopardy of a community service system that has become more privatized and less receptive to take on difficult cases, especially of persons with incarceration histories. Under these circumstances, some of the following concerns are likely.

- The above trends will lead to a growth in the numbers of mentally ill persons under community supervision.

- Increasing responsibility for persons with disabling mental illnesses will strain the abilities of probation and parole officers to manage them. Officers might find it more difficult to link probationers and parolees to public mental health services, or these services, if available, will not be as intense or comprehensive as may be necessary. This will create pressures for more behavioral health training and management of probation and parole officers and more crisis management by law enforcement officers.

- There may well be differential trends between probation and parole; with a decline of jail diversion, there might be fewer mentally ill persons on probation, but more people coming out of prison with behavioral health needs and therefore more problems for parole officers.

Summary & Conclusions

Managed behavioral health care has pluses and minuses for mentally ill offenders in the criminal justice system. By fixing responsibility for mental health and substance abuse with the same provider, opportunities are created for more comprehensive and coordinated care especially for dually diagnosed persons who are so prevalent in jail and prison populations. However, the emphasis on cost-cutting and risk sharing in managed care leads to an even greater incentives to shift costs from intensive to less-intensive services and from one agency/service sector to another. These trends present major challenges to the mental health and criminal justice systems for meaningful integration of behavioral health care services so that

offenders with complex problems can be managed in a manner which attends to a wide range of needs that affect function, that avoids fragmentation in services, and that maintains continuity of care. The trends depicted in this paper are not inevitable or irreversible. Managed care companies are in business to fulfill a contract, so it is up to the state (and advocates) to establish the values they want reflected in the managed behavioral healthcare system and to insure that it is adequately funded (Petrilla; Appelbaum). Again, these assessments are intended to highlight precedents, to encourage discussion, and to target recommendations that can lead to truly cost-effective care.

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