# **Summary of the Perils of Mental Health System Privatization**

## Governance

* Privatization will require a substantial MDHHS staff increase for needs assessment, oversight, contract management and rights protection.
* State must have oversight offices in every CMH or HMO region to ensure contract compliance
* HMO financial stakeholder priority conflicts with public interest
* Private corporations are not open to public and advocate scrutiny—no FOIA and open meetings
* Rights enforcement must be independent of HMO corporate funding.
* Contracts limit oversight of HMO performance
* No accountability for cost shifting such as ER treatment and criminal justice involvement.
* No commitment to long term—HMO will leave if funding is limited.

## Community responsibility

* No responsibility to address community needs and interests (unlike CMH)
* No community collaboration and cooperation—law enforcement, courts, schools, public health shelters, recreation, housing, transportation, food banks, employee assistance programs, more.
* Unclear HMO role in jails and jail diversion and court ordered outpatient treatment

## Limited scope of services

* No HMO experience with direct care oversight
* No HMO experience linking and coordinating ancillary services: housing, transportation, recreation, supported employment
* No objective, individual under-utilization review
* CMH system remains without meaningful capacity to serve non-HMO recipients
* Responsibility for spend-down unclear

## Fragmented system—multiple HMOs

* No county-wide responsibility for crisis intervention and access to services.
* The remaining mental health system must still provide services for non-Medicaid recipients. [Mental Health Code, Section 810. An individual shall not be denied services because of the inability of responsible parties to pay for the services.]
* HMO service area limits ability to travel or relocate across HMO service areas.
* HMO funding and competition conflicts with the best interest of patients and community
* Providers must contract with and report to multiple HMOs
* Fragmented coordination with criminal justice—increased criminal justice cost

## Inadequate funding for services

* Privatization cannot cure inadequate funding
* Administration cost doubles with HMOs in addition to more duplication of administration
* Funding diverted from services to private company financial stakeholders
* No assessment or accountability for funding of unserved community need.
* No solution for recruiting and retention of quality personnel

## Incentives to avoid services

* Competition for low-cost recipients
* No early intervention incentive
* No long-term recovery incentive
* Treatment choices and planning biased to minimize costs
* Criminalization as cost diversion.
* Who pays for ER and state hospital care.

## Programs may close when underutilized

* ACT teams based on number of recipients
* Group homes inefficient with open beds
* Drop-ins, clubhouses not efficient if not shared across HMOs

## Diversity of standards and protocols

* Diversity of information systems barrier to care coordination and collaboration
* Inconsistent measures of performance for accountability
* Providers interacting with multiple systems add administrative cost and confusion

## Quality care

* Restricted and inconsistent formularies limit treatment discretion, access and continuity.
* No expectation of wage increases to hire and retain qualified personnel
* No attention to basic needs that are outside scope of Medicaid
* No objective assessment of under-utilization and unmet need to ensure adequate services
* No enforcement of rights to services since Medicaid is not an enforced entitlement
* Difficult patients will fall through the cracks—hospitals currently refuse difficult recipients.
* Self determination is not comprehended by HMOs and budget increases are needed