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 PIHP 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 separated from corporate operations
- Restricted oversight of HMO performance
- No accountability for cost shifting
- No objective, individual under-utilization review
- No commitment to long term—HMO will leave if budget is tight.

Community responsibility

- No HMO responsibility to address community needs (unlike CMH)
- Loss of representation of community interest—responsibility beyond individual recipients
- No community-wide collaboration—law enforcement, courts, schools, public health shelters, recreation, housing, transportation, food banks, employee assistance programs, more.
- Jail diversion and Kevin's Law (court ordered treatment) rely on CMH including non-Medicaid

Limited experience with key services

- No HMO experience with CLS oversight
- No experience in community based services including case mgt., ACT, clubhouses, drop-ins
- No HMO experience linking and coordinating ancillary services: housing, transportation, recreation, supported employment

Fragmented system—multiple HMOs

- The 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.]
- CMH system remains without meaningful capacity to serve non-Medicaid recipients
- Responsibility for spend-down unclear
- HMO service area limits recipient ability to travel or relocate across the state
- HMO competition is not consistent with the best interest of patients or community
- No county-wide responsibility for crisis resolution
- HMO competition is not consistent with the best interest of patients or community
- Fragmented coordination with criminal justice—increased criminal justice cost

Inadequate funding for services

- Privatization cannot cure inadequate funding
- Administration cost doubles with HMOs
- 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

- HMOs compete for low-cost recipients
- No early intervention incentive
- No long-term recovery incentive
- Treatment planning biased to minimize costs
- Criminalization as cost diversion.
- State hospital free to HMO (non-Medicaid cost).

Programs may close when underutilized (excessive cost per recipient)

- 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 coordination and collaboration
- Inconsistent accountability for performance
- Providers interacting with multiple systems add administrative cost and confusion

Quality care

- Restricted formulary limits doctors' discretion and access to best treatment
- No attention to basic needs that are outside scope of Medicaid
- No objective assessment of under-utilization that would enforce adequate services
- No enforcement of rights to services
- Difficult patients will fall through the cracks—hospitals currently refuse difficult recipients.
- Self determination and independent facilitation are not comprehended by HMOs

For a more detailed discussion see http://www.amioakland.org select "Advocacy"