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 mgmt., 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](http://www.amioakland.org) select “Advocacy”