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WILL MANAGED CARE ADVANCE THE GOALS OF COMMUNITY MENTAL HEALTH?

By
Michael B. Friedman, LMSW

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In the middle of the 20th century, when American mental health policy switched from institution-based to community-based, the primary goal was to enable people with severe, chronic mental illness to live freely and safely in the community with the same rights as other Americans. Considerable progress has been made. Mental institutions are gradually becoming a vestige of the past with plans in place to virtually eliminate them. Community-based services and supports have expanded considerably, helping hundreds of thousands of people to have better lives in the community than they would have had in institutions. The Americans with Disabilities Act and the Supreme Court's Olmstead Decision explicitly grant rights to people with mental disabilities that were not respected in the past.

But much remains to be done to achieve the original goal of community mental health policy. For many, many people, community mental health policy has at best not been useful and at worst may have exposed those in need of great support to dangers that have taken a terrible toll on them. These people have been left behind—not in mental institutions, perhaps, but living with families struggling with the burdens of caring for a disabled family member or living on their own but without safe, stable housing or living in other institutions such as shelters, adult homes, nursing homes, jails, or prisons. In addition, people with serious, long-term mental disorders are much more likely to abuse drugs or alcohol, to be victims of crime, to be in jails and prisons, to commit suicide, and to die long before their time than people without such disorders. They are also unlikely to be employed, and are, in general, not fully welcome in mainstream American society.

These lingering problems should define the primary agenda of American mental health policy in the early decades of the 21st Century. Safe and stable housing for all people with severe, prolonged and disabling mental disorders should be a primary goal. Good health and survival into old age should be a primary goal. Leading independent lives that they find personally satisfying and meaningful despite continuing mental illness should be a primary goal. And full integration into mainstream society should be a primary goal.

Rhetorically they are primary goals. Mental health policy is now supposed to be "person-centered" and "recovery-oriented." That's jargon, which no one outside our

field understands, for providing community-based services and supports that are relevant to each individual's needs and for helping individuals with serious, long-term mental illness to have satisfactory lives in the community.

But, in truth, mental health policy is now dominated by the expansion of Medicaid managed care to people with long-term psychiatric disabilities. This reflects decisions made by the top policy makers in the United States—especially by Governors determined to contain the cost of Medicaid. Despite its checkered history, they see managed care as a virtual panacea—as an instrument that can be used to improve care, improve health and mental health, and also contain costs—the "triple aim" as it is called.

For example, New York State created a Medicaid Redesign Team shortly after the election of Governor Andrew Cuomo, and it in turn created a Behavioral Health Workgroup. It "developed principles and recommendations for moving behavioral health services into managed care." Here are its "guiding principles:

- Coordinated care
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/consumer choice
- Protection of continuity of care
- Ensure adequate and comprehensive networks
- Tying payment to outcomes
- Track physical and behavioral health spending separately
- Reinvest savings to improve services for behavioral health populations
- Address the unique needs of children, families, and older adults."

"In an effort to ease the impact of transition, a two-phase transition was planned…." In phase 1, behavioral health organizations (BHOs) were put in place to manage access to inpatient treatment, to promote good discharge planning, and to shift away from a fee-for-service payment system. In phase 2, behavioral and physical health care will be managed by "risk bearing Qualified Mainstream Managed Care Plans and Health and Recovery Plans (HARPs)." (The quotes above are from NYS OMH's website, www.omh.ny.gov/omhweb/bho .)

To me it is striking that the guiding principles of behavioral managed care in New York State do not include the primary goals for community mental health that I mentioned before. Instead it is a list of ways of doing things that presumably will have beneficial outcomes. Coordinated care, integration of services, recovery orientation, etc. are all supposed to make life better for people with psychiatric disabilities.

Will they? Maybe they will. But it is equally likely, it seems to me, that putting in place highly complex systems of behavioral managed care will leave the humane reasons for creating them behind as a myriad of unanticipated problems of implementation crop up.

For example, the call for coordinated care is not new. It goes back at least to the end of the 1960s; but judging from the unending repetition of calls for coordination, not much progress has been made in achieving it. Why? Because it depends on busy (often overburdened) people with diverse goals and objectives communicating with each other, learning to see things from each others' points of view, making the compromises necessary to work together, and maintaining working relationships over time despite turnover of personnel and the personal quirks that make some people congenial and others hostile. Before I retired, I kept a sign over my desk that said, "Collaboration is an unnatural act committed by non-consenting adults." Still true, I'm afraid. The new solution? "Meaningful use" of electronic case records. Maybe, but I'm skeptical.

So, here's my pie-in-the-sky suggestion. Medicaid managed care arrangements should be judged by answers to these four questions:

1. Does this system result in more people with psychiatric disabilities having safe, stable housing?
2. Does this system promote better health and increase life expectancy?
3. Does this system result in more people developing lives that they find satisfying and meaningful?
4. Does this system promote integration into mainstream society?

If Medicaid managed care can make life better for people with serious, long-term mental illness, great. But if not, let's dump it before it makes life worse.

(Michael Friedman retired as Director of the Center for Mental Health Policy, Advocacy, and Education in 2010. He continues to write frequently on mental health policy issues. His writings are collected at www.michaelbfriedman.com. He can be reached at mbfriedman@aol.com.)