

WARMLINES AND THE FUTURE

By Paul Komarek

Person to person support for difficult emotions has always existed. It is part of human nature. The bundle of practices and technologies known as Warmlines emerged in the 1980s. It followed the development of suicide hotlines by about 25 years.

In 2022, a little over 60 years after the first suicide hotlines emerged, that crisis support technology will fully mature and go mainstream with the initiation of the 988 crisis service system throughout the United States.

The national 988 crisis service system is intended to integrate completely with emergency services in every local community in the country. This sort of integration became possible only after the mental health service system matured and consolidated. Until the mid-2010s, most mental health care was funded by meagre appropriations from state benefit systems, supplemented by a patchy network comprised of federal block grants and Medicaid service mandates. Parity legislation and the Affordable Care Act enabled most mental health care in America to move to an insurance-driven funding model. The current trend is for state Medicaid systems to become fully integrated healthcare systems. Managed care organizations (MCOs) are paid a flat rate per person served based on population characteristics, and they assume the full risk of healthcare costs for the people in their service population. This creates financial incentives to reduce spending for the most expensive services. It now makes financial sense for MCOs to fund lower-cost services that are proven to reduce utilization of expensive services like emergency rooms and inpatient care.

As insurance comes to dominate healthcare funding, including funding for mental health care, the public grants that Warmlines have traditionally relied on will tend to become scarcer. SAMHSA as a pass-through funder for behavioral health care can communicate program models and fund specific grants, but is becoming less of a player compared to the financial impact of Medicaid-driven mental health programming. States are also de-emphasizing their grants for mental health programs because Medicaid services are supported primarily by federal dollars.

What does this all mean for Warmlines?

1. Warmlines must adapt to compete for a place in the new mental health funding world that is insurance driven.
2. Adapting to be fundable by insurance does not necessarily mean changing the practice of delivering Warmlines services or changing the workforce that delivers Warmlines services.
3. Adapting to be fundable does mean acquiring the skills to demonstrate the value of a Warmlines to the population that the Warmlines serves. This is an exercise that combines healthcare economics, entrepreneurship, and salesmanship.
4. MCOs will want to know that a Warmlines service meets some sort of standard. The Warmlines community will need to create, apply, and communicate its own standards if it wishes to control this aspect of the conversation.
5. If Warmlines do not create their own way of fitting into the healthcare system's MCO-funded continuum of care, then entities that are better at billing insurance systems will create telephone support lines that serve the purpose of Warmlines. The resulting services will not share existing Warmlines values, methods, or workforce. They will be shadow versions of Warmlines.

Here is the bottom line. Warmlines must not be observers of what the new 988 system is turning into. To preserve the values and practices of existing Warmlines, today's Warmlines service providers must develop a path to the future that aligns with the new business models of mental health in America.

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