Mental Health Services Dynamics and Dilemmas

This map was developed by the Multnomah County Task Force on Mental Health. It portrays the way public mental health services are delivered and the major factors that contribute to the problems faced by the different agencies and their customers.

**Draft v2**

Please send comments and suggestions to: reading@north.net.

**State Mental Health Agency** creates and contracts directly with these providers.

**Private Managed Care**

Regents and Family Care cover with state and County Behavioral Healthcare System (affiliates of Magellan Behavioral Health) operates the “care-out” for them.

**Public Managed Care**

CAAPCare (County Balloonal Health and Development, Division of Community and Family Services)

Some other providers (e.g. residential facilities) also receive Medicaid payments from the state.

Oregon State Executive Sector

**Federal Sector**

Mental Health Care Financing Administration (HCFA)

Medicaid is an entitlement program so HEWA doesn’t allow state to implement priority plan by rejecting requests to reduce the number of services to be covered.

**State Mental Health Agency (MIMDS)**

Requires “encompass” data system by payers.

Increased assets limits, residency requirements, and premium co-payments to reduce costs by making fewer people eligible.

**State Medicaid Agency (OMAP)**

Requires “encompass” data system by payers.

**Oregon State Legislature**

**Mental Health Task Force**

To cover a full range of mental disorders not previously covered in the health care priority list.

**Mental health advocates and providers**, thinking more money would be available for expanded services, pressed hard for inclusion in OHP.

**Increased Administrative Overhead Costs**

Capitation refers to payments based on the number of people who fall into the benefit categories of prepaid groups and those who are newly eligible.

**Non-Profit Community-Based Provider Agencies**

Lack of bilingual staff.

**The Medicaid Payment Sector**

Medicaid pays for about 78% of the $150 million (1998) total mental health services in the County including OMAP services.

However Medicaid managed care is only about 29% of total mental health costs. Remaining 71% is for extended care and fee-for-service.

**The state created mental health “care-outs” (1997). Care-outs are now entities of Medicaid, Medicaid Health Organizations (MHOs), that receive and distribute capitation payments to providers and report to data on the states.

**County Data System Sector**

Up to $15.5 million decrease (in transition to Oregon Health Plan).

There are more clients who appear to have more serious problems than expected when the rates were set (based on insurance information).

**Newerala Sector**

"Causes" or "links". The different colors for the arrows aid tracing of areas of mental health administration that could benefit from greater administrative integration.

**Commissioners’ Dilemma**

More clients eligible for more treatments.

More diverse customers than the rest of the state.

More seriously ill.

Less money to serve them.

Inadequate system administration.

Customer complaints accentuated.

Post and incomplete data.

Increased administrative costs.

**Multnomah County Sector**

Up to $15.5 million decrease in transition to Oregon Health Plan.

There are more clients who appear to have more serious problems than expected when the rates were set (based on insurance information).

**Other Departments**

Increased overhead costs lead to less money for actual delivery of services. These combined factors decrease ability to meet the increasing demand for services and adversely impact other County Departments.

**BHD**

BHD can’t control mental health system because state directly funds some services and because of fragmentation of alcohol and drug system.

This diverts county resources that could go to shore up deteriorating outpatient and case-management services.

**County contracts for 3 secure beds in Crisis Triage Center (Providence Hospital) to relieve pressure on acute care. But these beds are often full, so police have to find other hospitals. There are complaints by patient treatment failures.

**Cost Containment Failures**

Medical and surgical care can’t be contained as the Oregon Health Plan was intended to do.

It becomes more difficult to pay the 40 percent federal matching requirement for expanded coverage from limited state resources.

Increased assets limits, residency requirements, and premium co-payments to reduce costs by making fewer people eligible.

**Children Left Out**

6. Intensive treatment services for children (residentially) left out of managed care by Legislature, interrupting continuity of care.

**Oregon Health Plan**

(The rate not accounted)

Or decreased need for many are unmet.

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