FISCAL IMPACT OF PROPOSED LEGISLATION **Measure: SB 631 - A**

Seventy-Sixth Oregon Legislative Assembly – 2011 Regular Session
Legislative Fiscal Office

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Measure Description:
Directs Oregon Health Authority to establish and maintain a children's psychiatric access telephone line.

Government Unit(s) Affected:
Oregon Health Authority (OHA)

Expenditure Impact:
See Analysis

Local Government Mandate:
This bill does not affect local governments' service levels or shared revenues sufficient to trigger Section 15, Article XI of the Oregon Constitution.

Analysis:
SB 631A allows the Oregon Health Authority to establish and maintain a children's psychiatric access telephone line that provides assistance to primary care practitioners treating children from birth to 18 years of age. The bill specifies that the line must be accessible throughout the state; available Monday through Friday between the hours of 9 AM and 5 PM, provide face-to-face consultation for patients who have a high level of need; and provide face-to-face consultation by electronic means for patients in rural settings. The bill permits OHA to accept gifts, grants or contributions from any public or private source for the purpose of carrying out the provisions of the bill.

Although the bill permits, rather than obligates, OHA to establish and maintain this access line, the Legislative Office's protocol is to issue an explanatory fiscal impact statement providing an analysis of the expenditures, revenues, staffing, and organizational effects of implementing the provisions of the bill.

Oregon Health Authority (OHA)
OHA estimates the cost of establishing and maintaining this program to be $1.8 million for a full biennium, based on similar programs in the states of Washington and Massachusetts to increase primary care clinicians' access to child psychiatry consultation and to support referrals to mental health specialists. This pricing includes personal services for a staff consisting of child psychiatrists (3 FTEs), licensed social workers (2 FTEs), and administrative and data support assistants 1 (FTE), as well as the cost of housing and operating the access line. The calculations are based on the following assumptions: [1] a target population of 450,000 children; and [2] a multi-phase roll-out of the program, starting with services in Metro, Deschutes and Marion counties during the first year of operation, and services in Southern Oregon during the second year.

The pricing is assumed 100% General Fund, although this program may be eligible for federal Medicaid funds, and OHA may be able to secure other funding sources including partnerships and in-kind contributions. Although insufficient data exists to determine the funding source at this time, as a reference point, the following is an example of the financing plan and sustainability model from Massachusetts, which now finances the bulk of its program with state funds.

According to a March 2010 case study from the Commonwealth Fund (a private foundation that supports independent research on health care issues and makes grants to improve health care practice and

policy) the Massachusetts Child Psychiatry Access Project (MCPAP), launched in 2004, is funded by the state's Department of Mental Health through a contract with the Massachusetts Behavioral Health Partnership (MBHP), a managed care organization. Originally, MCPAP was envisioned as a service that would be supported by health insurers. However, because only approximately 16 percent of all MCPAP encounters are face-to-face visits for direct in-person assessments and therapy eligible for health plan reimbursements, it was deemed a program that could not be fully financed through claims, since much of the service would not be face-to-face, and some of the primary care practitioner support would not be client-specific. It was then promoted as a public health intervention that would benefit all insurers by improving quality of care and preventing the need for more intensive services. The financing model projected that insurers would share the operating costs of MCPAP on the basis of their share of covered lives in the participating practices. It was believed that the program likely met the criteria for administrative Medicaid, which would provide the state with a 50 percent federal match for the expenses due to MassHealth members. However, planners decided not to pursue this form of funding, because they were not sure that they could appropriately document the MassHealth share, and might therefore be at risk for recovery in an audit. As a result, the full $2.5 million first year operation cost of the pilot program was funded by the state, and other health plans were not asked to participate. As of July 2009, 365 primary care practices in Massachusetts have enrolled in this program. MBHP estimates that the enrolled practices cover at least 95 percent of the approximately 1.5 million children in the Commonwealth. At full implementation, the program budget is now at about $3.2 million a year. For the approximately 16 percent of face-to-face visits for direct in-person assessments and therapy, each MCPAP regional team host hospital is responsible for billing these services to the appropriate insurance plan. Overall, exclusively commercial plans cover about 58.3 percent of the billable encounter activities. MassHealth, together with its Medicaid-only managed care plans and a public plan for disabled children, is responsible for 32.7 percent of all encounters. Plans with both Medicaid and commercial enrollees account for 7.9 percent. Encounters without coverage account for 1.1 percent. This data was collected by MCPAP from the period starting July 1, 2008 and ending June 30, 2009.

The Oregon Health Authority reports that currently the Division of Medical Assistance Programs (DMAP) does not allow reimbursement for doctor to doctor consultations, and already reimburses providers under the Oregon Health Plan for face-to-face video conferencing consultations. Because HB 631A does not require OHA to pay for any additional types of consultations which could occur as a result of accessing this new service, OHA anticipates no fiscal impact on the Oregon Health Plan.