Chapter 1

Summary and Conclusions

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INTRODUCTION

On August 16, 1991, Oregon petitioned the Federal Government for permission to use Federal funds in a novel health care financing program. The proposed program is premised on two basic assumptions:

1. all uninsured poor people should have publicly funded health care coverage, and
2. coverage for this population can be made affordable to the taxpayers through a combination of two mechanisms: the explicit prioritization of health care services, and the delivery of covered services through managed care systems.

Oregon's plan to revamp its system of health care coverage was motivated by the steadily increasing costs of health care to the public treasury and the large number of Oregonians who have no health insurance. The State has estimated that between 400,000 and 450,000 Oregonians, or about 16 percent of the State's population, are uninsured (177).

To address this latter problem, the Oregon legislature passed the Oregon Basic Health Services Act in 1989, which established three mechanisms for increasing access to health insurance (box l-A). For individuals who could not qualify for private insurance due to a ''preexisting health condition, ' the State established a high-risk insurance pool with subsidized premiums. For individuals whose employers do not offer health insurance benefits, the State established a program that provides incentives for, and ultimately mandates, small businesses to provide such insurance to their employees. And for poor uninsured individuals, the Basic Health Services Act expanded the State Medicaid program to cover all residents with incomes up to 100 percent of the Federal poverty level (FPL).[1]

The last of these three measures has been the subject of particular controversy (25,28,47,55,70,94, 115,300,308). In part, the controversy stems from the need for the State to obtain permission from the Federal Government to implement its proposal as planned, since it wishes to receive Federal Medicaid matching funding for the program. The proposal is also controversial because of its explicit attention to determining how unfunded care should be denied, and because by design it encouraged public debate regarding the relative importance of different health care services (53,85,90,1 16,214,236,251).

Oregon's proposal is to make a sweeping change to its Medicaid program, the Federal/State funded, State-administered health care program for the poor. The proposed new program, if approved as it was submitted to the Federal Government, would continue for 5 years. The program was originally anticipated to begin by July 1, 1992, but the State now expects that implementation may be delayed because as of March 1992 the Federal Government had not yet decided whether to grant the waiver.

Under the proposed program, *the Medicaid-eligible population would be expanded to include all legal State residents*[2] *with incomes below the FPL. In* contrast, at present, most people in Oregon must fall into a federally specified need category (e.g., be eligible for the Aid to Families with Dependent Children (AFDC) program) to qualify for Medicaid. In addition, in most cases they must have incomes much lower than the FPL to qualify. Oregon residents who receive AFDC assistance, for example, generally must have incomes that are less than 50 percent of the FPL to be eligible for Medicaid.

According to the State of Oregon, the expansion in eligibility under the proposal would add approximately 120,600 people to the Medicaid rolls by the fifth year of the program. This number is predicted to be somewhat smaller (96,400) if the related employer-based health insurance mandate is in effect (table l-l) (177).

Certain groups currently covered by the Oregon Medicaid program would not initially be affected by the proposed changes in the program. The waiver proposal does not cover Medicaid eligibles who are elderly, disabled, in institutions, in foster care, or in the custody of the State, because these groups were exempt from Oregon Senate Bill (SB) 27, the bill

1 For 1992, the Federal poverty level is $11,570 per year for a family of three.

2 Undocumented aliens do not qualify as legal residents and would not be eligible for the program.

Box 1-A—The Oregon Basic Health Services Act

The Oregon Basic Health Services Act of 1989 consists of three separate bills to expand access to health insurance in the State. Each of the three bills targets a specific segment of the uninsured population.

The first bill, Senate Bill (SB) 27, expands the Oregon Medicaid program to include all legal residents with incomes up to the Federal poverty level. It also changes dramatically the method of defining benefits for the Medicaid population, greatly expands the use of prepaid managed care for this group, and makes other changes to the State Medicaid plan. To implement these changes and continue receiving Federal Medicaid matching funds, the State has proposed that its new plan be a Medicaid demonstration project, and it seeks Federal approval to carry out this project.

The second bill of the act, SB 534, establishes a State high-risk insurance pool. This pool sells subsidized health insurance to persons who are unable to purchase insurance on the market due to preexisting health conditions and anticipated future high health care costs. The premium charge for policies from this insurance pool is not to exceed 150 percent of the cost of an average private health insurance premium. Program costs not covered by the collection of premiums are financed through general State funds and through mandatory contributions by private insurers.

SB 935, the third bill of the act, addresses the problem of persons who are employed but have no employer-based health insurance. This law encourages, and ultimately requires, employers to provide health insurance to their employees that covers at least the level of services covered for the Medicaid population under SB 27. Businesses receive tax credits for providing insurance. They have the option of choosing private insurance plans or purchasing insurance from a State fund created for that purpose. The minimum benefits that must be covered are linked to the Medicaid benefits package. Employers who do not provide health insurance after 1994 will be required to make mandatory contributions to the fired, but that provision is repealed if at least 150,000 previously uninsured persons receive employer-based health insurance by January 1994.

Legislation passed in 1991 made some significant additions and changes to this three-part program. One particularly significant statute (SB 44) requires that the Medicaid-eligible elderly, disabled, and individuals in foster care or in the custody of the State be subject to the provisions of SB 27. These groups, originally exempt from the sweeping changes in the Medicaid program, are now intended to be included in 1993. Because the waiver proposal as submitted in August 1991 does not accommodate them, the State must submit an amendment to the waiver to do so if the waiver is approved in its current form.

The Health Insurance Reform Act (SB 1076), also passed in 1991, establishes some limits and safeguards on employer-based insurance. These limits would apply to the basic benefits package required under SB 935. The act establishes rate categories and limits rate increases in small group plans, provides for guaranteed issue and renewability of policies, and controls such factors as preexisting condition exclusions.

Finally, the Health Resources Commission Act of 1991 (SB 1077) "establishes a data and cost review commission designed to contain statewide health care costs as the above insurance expansions occur."

SOURCE: Office of Technology Assessment, 1992. Based on Oregon's SB 27, SB 44, SB 534, SB 935, SB 1076, SB 1077; and Oregon waiver application% August 1991.

authorizing the program changes. For the first year of the new program, these groups would continue to be eligible for all Medicaid benefits under the current rules and would continue to receive the same services as they would if the demonstration program were not in place. However, the State plans to file an amendment to the waiver permitting these groups to be covered under the new program beginning in October 1993 (177).[3]

Service deliver-y and payment would also change under the new plan. Most of the population receiving services under the demonstration program would be enrolled in some form of managed care reimbursed on a prepaid, per capita basis; the remainder would receive services on a case-managed, fee-for-service (FFS) basis. Payment to prepaid providers would no longer be linked to Medicaid FFS payment rates. Instead, payment rates to these providers would be

[3] The projected date for folding these groups into the program is apparently unchanged by the possibility that the program, if approved, would probably begin sometime after July 1992.

Table I-l—Demonstration Enrollment Projections[a]

Year of demonstration	Without employer mandate: Current eligibles	Without employer mandate: New eligibles	With employer mandate: Current eligibles	With employer mandate: New eligibles
Year 1 (FY1993)[b]	150,700	46,800'	150,700	46,800
Year 2 (FY 1994)	156,000	81,100	156,000	81,100
Year 3 (FY 1995)	160,600	105,400	160,600	105,400
Year 4 (FY 1996)	165,400	120,000	159,600	96,000
Year 5 (FY 1997)	170,300	120,600	164,400	96,400

[a]Enrollment is expressed as average monthly caseload. It is lower than the actual number of eligibles who have benefits for some period of time during the course of a year.
[b]The Oregon State fiscal year begins in July.
[c]Of these new eligibles, 2,700 are currently covered under a State-only General Assistance (GA) program that covers the medically unemployable (unemployed for more than 60 days due to a medical condition). Oregon's general assistance program only covers outpatient care.

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application*, submitted to the Health Care Financing Administration, Aug. 16, 1991.

based on the State's estimates of the average reasonable costs, across all providers, of rendering the given covered services.

Finally, *the covered services to which the Medicaid-eligible population is entitled would change.* For all Medicaid recipients subject to the program, the benefit package would be determined by a prioritized list of health services in which health conditions and their treatments are listed by importance from highest to lowest. The State legislature would then determine its budget for the program, and a line would be drawn where projected program costs equal the budgeted amount. All conditions and treatments at and above the line would then be covered; conditions and treatments below the line would not be covered. (Necessary diagnostic services are intended to be covered regardless of the condition and are not prioritized on the list.)

The prioritized list of services is limited to primary and acute health care services. Long-term care services would not be covered by the proposal and do not appear on the prioritized list; they would remain a separately covered set of Medicaid services. Mental health and chemical dependency services would initially be excluded from the prioritized list, but they are to be incorporated into the list in October 1993. Until that time, any of the group of Medicaid beneficiaries covered by the proposal, including newly eligible groups, would receive these services under current program rules.

Oregon has a 2-year budget cycle, and the State legislature would vote anew biennially on the threshold (i.e., the benefit package). An important provision of SB 27 is that if the Medicaid program should suffer a budget shortfall, the program may not cut people out of the program or reduce provider payments for covered services. Instead, the State must either allocate additional funds to the program or reduce covered services as necessary, with the lowest-ranked services being eliminated frost.

Thus, as the program is designed, the benefit package could either expand or contract every 2 years, depending on the budget. In addition, benefits could be reduced in the middle of the biennial cycle if funds prove inadequate to meet projected costs. The need for Federal approval may inhibit this intended flexibility. Oregon's waiver application states that it will seek an amendment to the waiver if in fact benefits would change "significantly" during the 5 years of the program. Exactly what the Federal Government would regard as ''significant' will not be known until (or unless) the waiver is approved.

Concern about the effects of Oregon's Medicaid proposal on program recipients, and the potential ramifications of the proposal for the ongoing national health care debate, prompted Congress to ask the Office of Technology Assessment to examine the proposal in detail.[4] The report was prepared in response to a request from Representative John Dingell, Chairman of the House Committee on Energy and Commerce, and Representative Henry Waxman, Chairman of the House Subcommittee on Health and the Environment. The request for the OTA study was endorsed by Senator Al Gore, Chairman of the Senate Subcommittee on Science, Technology, and Space, and by the Oregon delegation, including Senator Bob Packwood, Senator Mark Hatfield, Representative Les AuCoin, Representative Peter DeFazio, Representative Mike Ko-

'Unless indicated otherwise, details of the proposal discussed within this summary are based on Oregon's Office of Medical Assistance Programs' August 16, 1991 waiver application (177).

petski, Representative Ron Wyden, and Representative Robert F. (Bob) Smith.

The goals of this study are to describe and analyze the specifics of the proposed program and to discuss its most likely implications for the Federal Government, the State of Oregon, and Medicaid beneficiaries. The role of this report is not to critique the existing Medicaid program in detail. Rather, it is to examine the proposed program and especially its relevance to issues of particular interest to the Federal Government: the impact of the program on Medicaid beneficiaries, in whom the Federal Government (as a copayer) has a fiduciary interest; and the potential usefulness of Oregon's program if applied in other States and other contexts. The report is organized as follows.

- *Chapter 2* briefly describes the context in which the proposal was developed, particularly the dilemmas facing the Medicaid program and the barriers to providing health care coverage to the uninsured.
- *Chapter 3 examines the* method and assumptions used to derive the prioritized list of health services upon which the proposed packaged of covered services is based. It also describes some of the characteristics of the list. It addresses such questions as: What were the most important determinants of ranking on the final list? Do services for certain vulnerable groups (e.g., pregnant women) rank high or low? Is the list complete? Is it replicable by others?
- *Chapter 4 examines the* effects of the overall proposal on Oregon health care providers. Would particular kinds of providers be likely to be advantaged or disadvantaged under the program? Would providers be paid more or less? Would they participate in the program?
- *Chapter 5 analyzes the program's* effect on new and existing Medicaid program beneficiaries. Would each of these groups have better or worse access to health care services under the proposal? Who would gain eligibility for services under the program, and who would lose it? What benefits would existing Medicaid participants lose, and what would they gain?
- *Chapter 6* critiques the State's estimate of the costs of the proposed program? Are costs likely to have been over- or underestimated? If so, what are the implications for the Federal Government?
- *Chapter 7 examines* major legal issues that might arise if the proposal were implemented as planned. Does the proposal violate Federal constitutional principles? Is it likely to conflict with major existing Federal statutes enacted to ensure equal access to services?
- *Chapter 8* briefly outlines some basic evaluation issues regarding the proposed program. As a demonstration program, will it yield information valuable to other States and to the Federal Government?

The remainder of this chapter summarizes the findings of the report and draws overall conclusions regarding the technical merits of the proposal.

SUMMARY OF FINDINGS

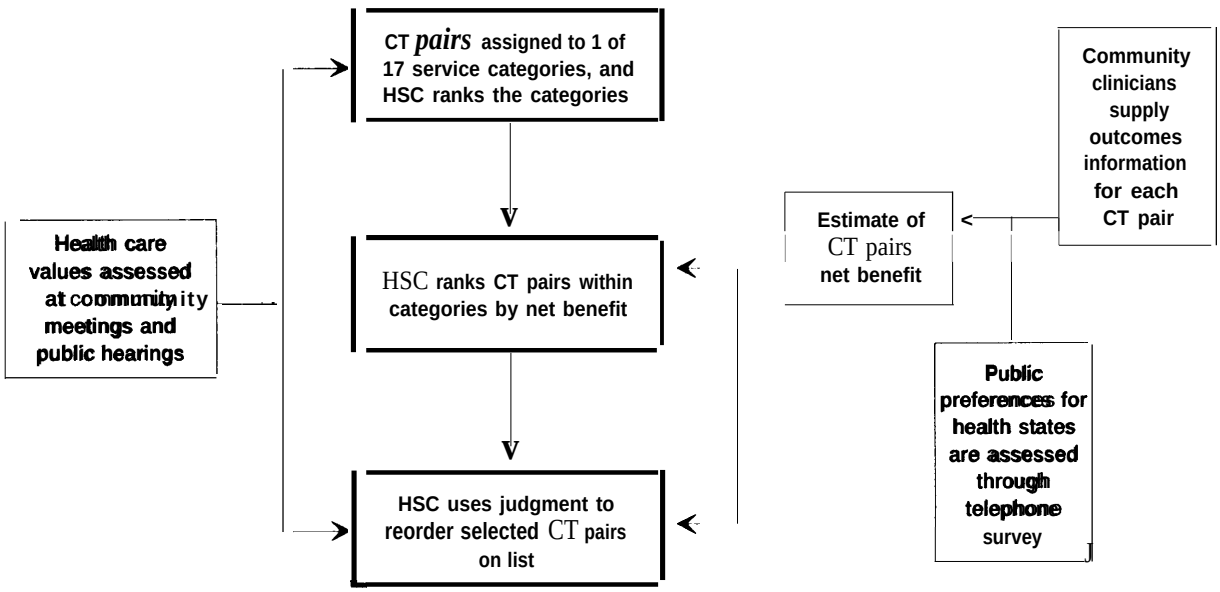
The Prioritized List

Developing the List

The use of a prioritized list of health care services as the basis on which to build a benefits package is unique to Oregon's Medicaid proposal. Other States (e.g., Maine) have established priorities within existing Medicaid services to determine which optional categories of services shall be eliminated first in the event that tight State budgets require cuts. Only Oregon, however, has combined a detailed, comprehensive list of primary and acute medical care services with a public prioritization process to build a package of benefits in an entirely new way. Rather than eliminating types of services (e.g., prescription drugs, durable medical equipment) from coverage if the budget requires cuts, as some States have done, Oregon's prioritized list would eliminate specific treatments for specific conditions.

The building blocks of the list are *condition-treatment (CT)* pairs. Each medical condition (e.g., appendicitis) is paired with one or more therapies used to treat it (e.g., appendectomy). Many ''treatments" are very broad (e.g., any medical therapy used to treat the condition). Even so, some conditions appear more than once on the list paired with different treatments; for example, medical therapy for a particular condition might be located fairly high on the list, while surgical therapy for the same condition is ranked lower. The total prioritized list includes 709 CT pairs, of which only the first 587 would be covered at the time the proposed demonstration project begins.

Figure 1-l-Oregon Health Services Commission's Prioritization Process



SOURCE: Office of Technology Assessment, 1991.

The list was compiled and prioritized by an n-member Health Services Commission (HSC), authorized in the Oregon Basic Health Services Act and appointed by the Governor for this purpose. The HSC's charge was to compile "a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the population to be served" (Senate Bill 27). Other than the accompanying charge to ''actively solicit public involvement, ' the HSC was given little guidance on how to proceed.

An interim working list, using a formula to indicate the relative cost-effectiveness of services, was released in May 1990 but was ultimately rejected by the HSC. The final list, transmitted to the State legislature in May 1991, abandoned the more rigid and quantitative cost-effectiveness approach in favor of a three-stage process (see figure l-l):

1. Each CT pair was assigned to one of 17 general service categories (e.g., maternity services, services for acute conditions for which treatment prevents death) (box l-B). The HSC then ranked the categories using a group consensus method intended to reflect community health care values as expressed at a series of public hearings and meetings.
2. Within each category, CT pairs were ranked according to their ''net benefit, " a number intended to indicate the average improvement in quality of life associated with treatment for the specified condition. To derive this "net benefit" term, the HSC used data from two sources: health care providers' assessments of treatment outcomes (furnished by provider groups in the State), and Oregonians' opinions about being in various states of health, as elicited through a telephone survey.
3. Finally, the HSC undertook a line-by-line review of the preliminary ranked list and used its judgment to move selected individual CT pairs up or down the list.

The final list was sent to an actuarial firm, which estimated the cost of providing services at various thresholds on the list. The State legislature then decided to fund an initial benefits package consisting of all services included in CT pairs 1 through 587.

Characteristics and Determinants of the List

In general, the prioritized list favors preventive services and services used primarily by women and children. Both maternity services and preventive services for children, for example, are categories of services that were ranked highly by the

Box 1-B--Categories of Services Used in the Prioritization Process and Examples of Condition-Treatment (CT) Pairs

Category	Description
"Essential" services	
1. Acute fatal	Treatment prevents death with full recovery. ***Example:*** *Appendectomy for appendicitis.*
2. Maternity care	Maternity and most newborn care. *Example: Obstetrical care for pregnancy.*
3. Acute fatal	Treatment prevents death without full recovery. *Example: Medical therapy* ***for acute bacterial meningitis.***
4. Preventive care for children	***Example: Immunizations.***
5. Chronic fatal	Treatment improves life span and quality of life. ***Example: Medical therapy for asthma.***
6. Reproductive services	Excludes maternity/infertility services. *Example: Contraceptive management.*
7. Comfort care	Palliative therapy for conditions in which death is imminent. ***Example: Hospice care.***
8. Preventive dental care	Adults and children. *Example: Cleaning and fluoride applications.*
9. Proven effective preventive care for adults	*Example: Mammograms.*
"Very important" services	
10. Acute nonfatal	Treatment causes return to previous health state. ***Example: Medical therapy for vaginitis.***
11. Chronic nonfatal	One-time treatment improves quality of life. ***Example: Hip replacement.***
12. Acute nonfatal	Treatment without return to previous health state. ***Example: Arthroscopic repair of internal knee derangement.***
13. Chronic nonfatal	Repetitive treatment improves quality of life. ***Example: Medical therapy for chronic sinusitis.***
Services that are "valuable to certain individuals"	
14. Acute nonfatal	Treatment expedites recovery of self-limiting conditions. ***Example: Medical therapy for diaper rash.***
15. ***Infertility*** services	***Example: In-vitro fertilization.***
16. ***Less*** effective preventive care for adults	***Example: Screening of non-pregnant adults for diabetes.***
17. Fatal or nonfatal	Treatment causes minimal or no improvement in quality of life. ***Example: Medical therapy for viral warts.***

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application,* submitted to the Health Care Financing Administration, Aug. 16, 1991.

HSC. CT pairs in which treatment usually prevents death or restores the individual to a previous state of health also rank relatively high. Treatment for chronic conditions tends to rank slightly lower than similarly described treatment (e.g., "treatment that prevents death without full recovery") for acute conditions.

Cost is not a major determinant of CT ranking. For example, although several types of organ transplants rank low on the list and are uncovered, many other equally costly transplant procedures are ranked fairly high. In fact, more than one-half of CT pairs associated with high costs (as estimated by the HSC) are located in the top one-half of the list, while one-third of the lowest-cost CT pairs fall below line 587.[5]

The process used to derive the list was intended to rely heavily on quantitative data regarding the outcomes of treatment and individuals' preferences for various health states. Collecting these data was time-consuming, and they were given considerable weight by the HSC, as evidenced by their use to initially rank CT pairs within categories. Despite this emphasis on quantitative measures of net benefit, however, the net benefit term associated with a given CT pair ultimately had surprisingly little effect on the final ranking of that CT pair on the prioritized list. Although the net benefit term remained relevant, in the end the strongest determinants of final rank were those that depended on the judgments of the Commissioners: the category rankings and the final line-by-line adjustment of the list.

The importance of the line-by-line review in determining final ranking is especially notable. The HSC's perception was that this review was relatively minor in overall effect; staff members estimated that about one-fourth of CT pairs were moved in some way during this process (35,244). OTA analyses showed, however, that many CT pairs moved substantially during the course of this final review. Compared with their pre-review rankings (based on category assignment and net benefit), over one-half (53 percent) of CT pairs moved at least 25 lines from their original positions, and 24 percent of all CT pairs moved up or down at least 100 lines on the list.[6]

Achievements of the Ranking Process and the List

Oregon has successfully defined a novel way of categorizing health care services. In doing so, it tested concepts such as the integration of outcomes estimation and public health preferences in a practical policy setting for the frost time.

The process of developing the prioritized list clearly involved both providers and consumers in Oregon in a public discussion of the relative value of different kinds of health care services. Whether or not the list is implemented in Oregon, it may prove to be a useful device in other States, and in the Federal arena, for stimulating a broader public discussion and enhancing political decisionmaking.

One useful outcome of the prioritization process is that by laying health coverage decisionmaking open to public input and debate, it highlighted some of the basic controversies underlying such decisionmaking. For example, there is no national consensus regarding whether average values regarding what health services are important are more relevant than the values of certain heavy users of health care (e.g., the disabled community). Oregon's process tended to emphasize the former (e.g., through the use of average public preferences from the health state preference survey), while the existing political process may often give more weight to the latter.

Finally, simply the process of trying to identify less important or effective services could affect the way providers make decisions. The process of developing the list-and, if implemented, the list itself-might stimulate providers to justify more clearly to themselves and their patients the effectiveness of a given treatment, and to question that treatment if they find justification difficult. These effects would probably be gradual and hard to identify explicitly. Nonetheless, in the long run they could be a valuable contribution of a comprehensive examination of the usefulness of health care services.

Problems of the Process and the List

In its critique of the list, OTA identified three types of problems with the method chosen to prioritize health care services. The frost-level problems are those associated with the immaturity of the

5 "High cost" as used here means services costing $40,000 or more; the "lowest-cost' CT pairs are those costing less than $1,000.

6 A total of 60 CT pairs changed initial coverage status as a result of this adjustment (30 moved above line 587, and 30 moved below).

list and incomplete definition of CT pairs. These problems are relatively easy to solve once they are identified (although they would make the list difficult for providers to use if it were implemented before they were addressed). In fact, the HSC is currently considering technical corrections to the list, some of which are relevant to the issues below. These problems include:

- *Missing codes.* Each condition is represented on the list by its ICD-9-CM code.[7] Many codes were intentionally left off the list, either because they refer to conditions to be incorporated into the list later (e.g., mental health conditions), or because they were nonspecific codes. Eliminating nonspecific codes would probably require many providers to change the way they code services, since the use of many of these codes is widespread when there is no definitive diagnosis. In addition, some codes for significant conditions were left off the list and must be added to make the list complete.
- *Duplicate and illogically placed codes.* Although there are a number of CT pairs in which code duplication is intentional (e.g., because the condition appears with different treatments at two places on the list), other code duplications are logically inexplicable and probably represent mistakes. Still other codes do not apparently belong in the CT pair to which they have been assigned.
- *Apparently illogical relative rankings of CT pairs. Since the* ranking process depended heavily on clinician, public, and HSC judgment, any individual clinician would undoubtedly have improvements to suggest, and the opinion of any one clinician cannot condemn the final ranking. Nonetheless, in a few cases the relative ranking of two CT pairs appears questionable on reasonably objective grounds. Some CT pairs in which medical therapy (usually tried first) is ranked lower than surgical therapy (a secondary line of therapy) for the same condition fall into this category.

A second type of problem relates to the limitations of the different inputs to the ranking process. Eliminating these problems would not necessarily have changed the ranking of CT pairs in the list, given the way the list was derived. Nor does the existence of these problems suggest that decision-making under the current program is superior to that under the prioritization process. However, these limitations do suggest that the reproducibility of the inputs to the process is open to question. In particular:

- Despite the considerable efforts of organizers, the community meetings held to inform the HSC about public values were not representative of community residents. Most (about two-thirds) of those in attendance were health care workers.
- The provider groups that furnished the HSC with health outcomes information had difficulty with the charge to present average outcomes, since patients in some CT pairs are very diverse. The groups were not uniform in their methods for deriving the information (e.g., use of the published literature, use of Oregon-specific data) or in the way they handled factors affecting outcomes (e.g., comorbidities).
- The outcomes information was intended to be representative of the opinions of practicing providers, since data from published clinical studies are not available to provide information on treatments for most CT pairs. Nonetheless, where published evidence does exist, it is sometimes at odds with the opinions of Oregon providers.
- Provider outcomes information was weighted according to public preferences. The survey used to evaluate people's preferences for being in various health states had a high proportion (over one-third) of inconsistent responses. Average scores on the survey were used to represent preferences, but individuals' scores for some preferences varied significantly by factors such as age, sex, and whether the respondent had experienced the health state in question. These differences raise questions regarding the application of average public preferences to resource allocation decisions.

A third set of problems relates to the use of CT pairs to define health care services and the use of the 17 categories as a contributing structure for ranking them. These problems are relatively intractable, because they cannot be solved without changing the very tools used to define the prioritized list.

71~.9-CM refers t. the *International Classification of Diseases*, 9th Revision, Clinical Modification coding system for diagnoses (45).

- The 17 categories include a mix of service-specific (e.g., maternity services) and condition/outcome-specific (e.g., acute condition, treatment prevents death) categories. The service-specific categories ranked high can include poor-outcome CT pairs that happen to include those services. The condition-specific categories, on the other hand, overlap to the point where they can be clinically meaningless, making CT pair assignment to a given category problematic. A recurrent condition, for example, might be legitimately categorized as either acute or chronic. Which category it is assigned to, however, could substantially affect its final rank.
- The use of CT pairs involves combining patients with heterogeneous conditions, comorbidities, and expected outcomes into the same group with the same ranking. The treatments included in a given pair are also often very broadly defined; the treatment in over one-half (51 percent) of CT pairs is defined as ''medical therapy' or ''medical and surgical therapy. '

To avoid the latter problem entirely, CT pairs would have to be defined so specifically as to make them unworkable for any practical program purpose. Intermediate levels of definition might ameliorate this problem and still yield a workable list. Nonetheless, accepting the level of heterogeneity implied by only 709 CT pairs (or even many more pairs) means accepting that some patients with excellent expected outcomes with treatment must forego therapy, while other patients with patently worse treatment-specific prognoses receive it. This may be very difficult for both patients and clinicians to accept.

Program Implications for Providers

Providers Under the Current Program

Oregon's Medicaid program currently operates under a Federal waiver that permits the State to make heavy use of prepaid managed care providers. About 68,000 AFDC enrollees in 10 counties, or about 31 percent of all Medicaid participants, are served by providers paid on a per capita basis. (Enrollment in prepaid plans is mandatory for these beneficiaries in nine counties and optional in a tenth.) Nearly 12,000 of these beneficiaries are enrolled with the Kaiser-Permanente health maintenance organization (HMO), which provides both inpatient and outpatient care (except dental care) to Medicaid enrollees on a prepaid basis. The remainder are served by 15 physician care organizations (PCOs), which are capitated for most outpatient, but no inpatient, services.[8]

The remainder of Oregon's current Medicaid population receives care that is reimbursed on an FFS basis (177). These participants include all Medicaid enrollees residing outside the 10-county managed care area, as well as non-AFDC enrollees within that area and some in-area AFDC enrollees that for various reasons (e.g., new eligibles who have not yet had time to enroll in a particular plan) are not receiving prepaid care. In addition, all PCO enrollees in the managed care counties receive their inpatient care and some outpatient services on an FFS basis.

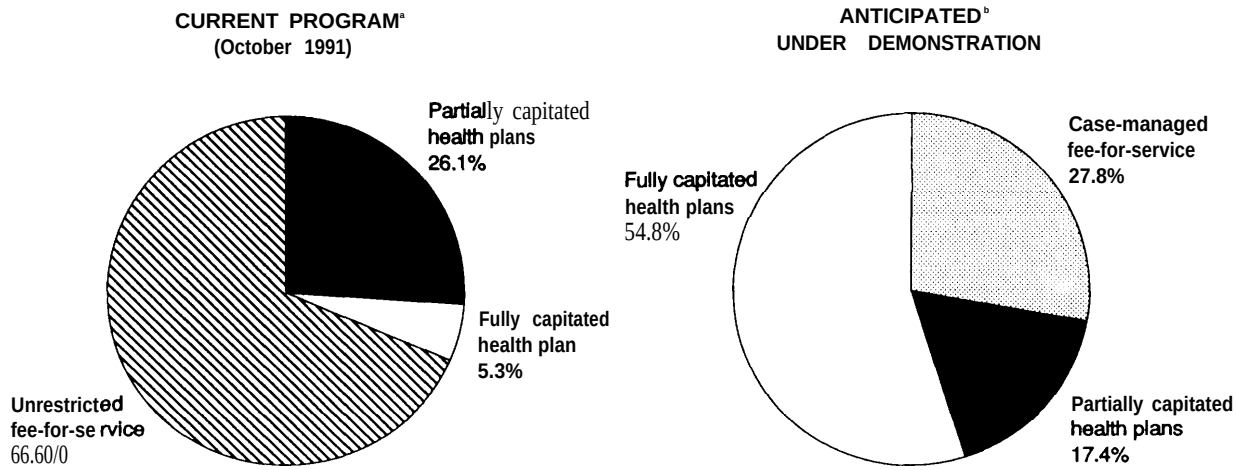
FFS hospital care for most Medicaid-covered inpatients is presently reimbursed according to diagnosis-related groups (DRGs) (similar to the way Medicare pays hospitals). Outpatient hospital services are paid on a percent-of-actual-costs basis (the current rate is 59 percent). Certain rural hospitals are exempt from these payment limits and receive 100 percent of costs for most services. Hospitals serving a disproportionate share of Medicaid patients receive an additional DRG-based payment.

Most primary care clinics are paid according to a fee schedule, but by Federal law federally qualified health centers (FQHCs) and federally certified rural health clinics (RHCs) are exempt from this rule and must receive their full incurred costs (Public Law 101-239; Public Law 95-210). Physician services are also paid according to a fee schedule; current Medicaid fees in Oregon are close to the average for this program across the Nation, but Medicaid physician fees generally are lower than fees paid by other insurers (e.g., Medicare) (203). Oregon's physician fees are frozen for the 1992-93 biennium.

Physicians are not required to accept Medicaid patients, and available evidence suggests that many do not. A 1988 survey of members of the Oregon Medical Association found that while 59 percent said they accepted any Medicaid patients who

[8] The U.S. General Accounting Office is studying the capabilities of Oregon's current Medicaid managed care system. This study will be completed in spring of 1992.

Figure 1-2—Distribution of Oregon Medicaid Enrollees by Type of Delivery System: Current and Proposed Programs



[a]Shows distribution of entire Medicaid enrollee population, including aged, blind, and disabled recipients. In the current system, only AFDC eligibles are enrolled in prepaid plans.
[b]Shows distribution of Medicaid eligibles subject to the demonstration. Excludes aged, blind, and disabled enrollees who may be included in demonstration during the second year. It has not been decided whether aged, blind, and disabled enrollees, once subject to the prioritized list, would be required to enroll in prepaid plans. This figure reflects the distribution *of* enrollees anticipated by the ninth month of the demonstration.

SOURCES: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application*, submitted to the Health Care Financing Administration, Aug. 16, 1991; B. Terhaar, Office of Medical Assistance Programs, Department of Human Resources, State of Oregon, Salem, OR, personal communication, Jan. 28, 1992.

sought their care, 33 percent said they restricted their Medicaid practice and the remaining 8 percent did not accept any Medicaid patients (195).

Changes Under the Proposed Demonstration

Oregon's proposed demonstration includes three major provisions intended to affect the way care is provided to Medicaid recipients (177). First, it would greatly expand the Medicaid population to be covered by mandatory prepaid managed care to all enrollees except those in an unspecified number of rural counties (i.e., those where adequate prepaid contracts cannot be negotiated) (see figure 1-2).[9] Providers would be fully capitated for all services (inpatient as well as outpatient) in at least the nine current mandatory managed care counties, and partially capitated (i.e., PCOs) in as many as possible of the remaining 27 counties in the State. All recipients not living in mandatory prepaid care counties would be enrolled with a primary care case manager, who would provide primary care services on an FFS basis and authorize all referrals. These delivery system changes would be phased in during the first 2 years of the demonstration program.

The second major change alters the way payment rates to prepaid providers are calculated-a change the State hopes will be an incentive to participate in the program. Rather than calculating per capita rates that are based on rates for services in the FFS sector, the State would base the new prepaid rates on an actuarial estimate of the average reasonable costs, across all providers, of providing the covered services.[10] (This estimate of average reasonable costs assumes some savings from managed care.) The extent to which the new method of calculating rates would result in higher payment than under the current system is unclear, since the payment amount, the packages of services to be delivered, and the covered population are all different.

The change in payment would apply only to prepaid care contractors; FFS providers would not

[9] The State predicts that about 15 percent of enrollees in the mandatory prepaid care counties would be enrolled with a primary care case manager for various reasons (e.g., because their need for care was so intensive that they exceeded the stop-loss cost threshold for the prepaid plan).

[10] Note that although this method is frequently—and accurately—referred to as "cost-based" payment, it is not based on the actual costs incurred by anyone provider. A particular provider's payments would thus not necessarily bear any relationship to that provider's costs of rendering the services.

receive fee increases.[11] As under the current system, subcontractors to prepaid plans (e.g., hospitals, clinics) would receive payments that reflect their negotiating strength. Rural hospitals, FQHCs, and RHCs located in the mandatory prepaid counties would lose their special reimbursement protections under the demonstration as proposed; these providers would no longer be paid their actual costs unless they could negotiate such payment with the primary contractors (or unless they were themselves primary contractors, and their actual costs were lower than the per capita rates). The greatest payment boon to many hospitals, clinics, and physicians under the demonstration is presumed to come from a reduction in the number of patients who cannot pay for the services they receive. To the extent that poor patients who previously received uncompensated care would be covered by Medicaid, total provider income could increase.

The third major change for providers would be the need to work within the prioritized list. It is not at all clear how the list would affect provider practice in the prepaid sector, since payment to these providers does not depend directly on the actual services rendered. Presumably, administrators in prepaid plans would simply make below-the-line services one set of a range of services and practices that physicians would be discouraged from providing. Some physicians in such plans might counter by redefining below-the-line conditions into ‘ ‘covered’ CT pairs where possible to justify providing these services, but the balance of behaviors can only be a matter of speculation. FFS providers, on the other hand, would have a clear incentive to ensure that all services provided could be classified into above-the-line CT pairs, Their financial success under the new program would depend heavily on their ability to become intimately familiar with the list. Because different providers have different incentives and capabilities for dealing with the prioritized list, Medicaid recipients’ access to specific benefits could vary depending on where they live and who they see for care.

Problems and Possibilities in the Proposed Delivery System

Managed care, and especially prepaid managed care, has been of intense interest to policymakers and insurers interested in gaining some control over health care costs. The number of people enrolled in HMOs nationally has grown from less than 2 million to almost 34 million over the past two decades (92). Over 1 million Medicare beneficiaries are enrolled in HMOs, and as of 1991 more than 1.6 million Medicaid beneficiaries were enrolled in risk-based prepaid health care plans (309). Another 1 million Medicaid participants were expected to be enrolled with primary care case managers by the end of 1991 (309).

Although Oregon is only one of many States that has experimented with using managed care to provide services to its Medicaid population, the little information that is available suggests that its program has avoided some of the pitfalls encountered by others (238). The State believes that its current Medicaid managed care program has reduced State spending (41). The U.S. General Accounting Office is currently evaluating Oregon’s existing Medicaid managed care program in depth to identify more precisely its problems and successes.

The great interest in managed care, coupled with the State’s past experience, implies that Oregon would be a logical choice for an experiment of comprehensive, statewide Medicaid managed care. (Arizona, the only other State in which all Medicaid care is delivered through managed care, has a very limited and unusual Medicaid program.) Still, there are a number of questions and potential problems that would deserve explicit attention (either at the planning or the evaluation stage) if the demonstration were to go into effect:

- *Implementation of the proposed managed care expansions—The* State maintains that managed care expansion is on schedule (26). If there should be any future delays or problems, however, the costs of the program and the effect of the prioritized list might be different than anticipated. For example, if the contract process with prepaid providers takes longer than expected, or if recruiting primary care case managers is difficult, traditional unrestricted FFS billing could be more widespread during the demonstration than anticipated.
- *Effects on ‘‘safety net’ providers—Managed care* is of concern to many of the public primary care clinics that currently serve large Medicaid and uninsured caseloads (37). FQHCs and

[11] Case managers would receive $3 per enrollee per month for the new case management services they would be required to provide.

RHCs would lose some key financial protections if they participate, and many of their actual-cost-reimbursed patients if they do not. Although they could expect to provide less uncompensated care, the financial benefits of this reduction to the clinics depend on whether it would be accompanied by a reduction in Federal subsidy funds and/or increases in Medicaid revenues. The State is encouraging public clinics to be capitated contractors themselves, but it is not clear that they have the expertise or the resources to assume the attendant financial risks. County health departments might similarly be unable to assume risk and be primary contractors due to lack of resources and the inability to meet other contractor requirements.

- *Ability to retain participating providers—The* State is counting heavily on the increased payment presumed possible through the new payment method to attract and retain participating Medicaid providers. The extent to which payments to prepaid providers would be-and would remain-high enough to keep providers in the program is an open question only answerable if the demonstration goes into effect. In the FFS sector, changes in initial and continued provider participation are similarly uncertain. The fact that fees would not change may mean that primary care provider participation would not increase. (Access to specialty care might increase, however, if case managers successfully negotiate referrals for their patients.)

Program Implications for Beneficiaries

Changes in Eligibility and Enrollment

If the waiver is approved, Oregon would be the first State in the Nation to guarantee federally cofunded Medicaid coverage to all legal residents with incomes below the FPL. The new income-only eligibility criteria for Medicaid would mean that projected enrollment in the program would increase by more than 20 percent in the frost year and 72 percent by the fifth year of the demonstration program. (The increase in the fifth year is projected to be 59 percent if the employer mandate is in place.)

Pregnant women and young children with family incomes up to 133 percent of the FPL are currently eligible for Medicaid, and they would remain eligible under Oregon's proposal. One aspect of the proposal intended to reduce program and applicant paperwork, however, might affect some of these currently eligible individuals. Under the demonstration, eligibility for non-AFDC applicants would be based solely on simple gross family income. In contrast, at present, near-poverty pregnant women and children under age 6 can exclude certain types of expenses (e.g., some work-related child care expenses) in order to meet income qualifications. Some applicants who thus would have been eligible under current rules might be ineligible under the new program.

The number of individuals who would be ineligible under the new rules is unknown. The State believes it to be very small (less than 1 percent of currently eligible pregnant women and young children) (253). On the other hand, one clinic estimates that over 9 percent of its patients who qualify because they are pregnant or are young children would be affected (see ch. 5) (1 14).

The demonstration would also eliminate the current 3-month retroactive eligibility for non-AFDC Medicaid enrollees and would guarantee 6-month periods of continuous Medicaid coverage for all new eligibles except those receiving AFDC. Average length of eligibility in the program would probably increase somewhat compared with the present. Non-AFDC beneficiaries would all remain eligible at least 6 months, and beneficiaries with AFDC-based eligibility could still be eligible for Medicaid under the demonstration even if their incomes increased somewhat.

Changes in Coverage and Access for the Newly Eligible Population

For the people who would be newly eligible under the waiver—those who cannot qualify for Medicaid benefits under current rules—the implications of the new eligibility and coverage rules are unambiguously good. These individuals would lose no coverage at all, since they have none now. They would gain coverage for all services included in CT pairs 1 through 587, as well as coverage for diagnostic services.

The implications of the demonstration program for access to health care services for this population are likewise unambiguous. If medical care coverage has any relevance for access at all, people in this group would have access to a broad spectrum of care

not previously within their reach. At the least, they would have the right to demand care that currently depends on either their ability to pay for it out-of-pocket, or on the good will and generosity of individual providers.

Changes in Coverage and Access for Current Beneficiaries

Changes in Benefits-For current Medicaid eligibles, the changes in coverage are more complex. Certain benefits that lie above line 588 would be clearly new for adults: many preventive health services, dental services, and several types of organ transplants (adults are currently covered only for cornea and kidney transplants). Hospice care for the terminally ill would also be a new benefit for both adults and children.[12]

"Lost" benefits for current eligibles would include all services below line 587 that are now covered. For many below-the-line CT pairs, the real coverage lost would be negligible. In some instances, for example, the pair is ''empty' '—i.e., those services are already never or rarely provided (e.g., aggressive therapy for anencephalic babies)[13] (215). In other cases, the service is significant but is not covered under current Oregon Medicaid rules (e.g., breast reconstruction after mastectomy [285]).

Other below-the-line CT pairs, however, are for conditions whose treatment is now covered by Medicaid (if it is determined to be "medically necessary' '). At least five of these CT pairs include some life-threatening diagnoses for which clinicians believe some patients might be effectively treated.[14] Other uncovered CT pairs include painful, disabling conditions for which treatment can sometimes bring relief (e.g., trigeminal nerve disorders), and conditions for which treatment is believed to be sometimes curative (e.g., focal surgery for certain types of epilepsy) (10,67,294,31 1). One uncovered CT pair, removal of viral warts, can sometimes be a preventive measure against sexually transmitted disease and certain gynecological and anal cancers (317).[15]

Implications for Access—For most persons currently eligible for Medicaid, access to care would probably be different under the demonstration, but it is not clear whether it would be better or worse for the population overall. On the one hand, if the managed care system is implemented as planned, all beneficiaries would be assured of a provider who has agreed to see them-something that may not always happen at present. In addition, adults in particular would have coverage for significant services not previously available. Even where services would ordinarily be uncovered, they might be provided in the FFS sector if they could be 'upcoded' to covered CT pairs, and they might be provided in either the FFS or the prepaid sector if the provider felt a professional responsibility to provide the care.

On the other hand, just as under the existing Medicaid program, coverage for services may not always mean receipt of those services. For example, if waiting time before getting an appointment for routine preventive services is long, some patients might not receive the services (or the followup treatment for detected conditions) before they became ineligible for Medicaid benefits. Long waiting times for appointments might also affect the ability of pregnant women to receive early prenatal care. In addition, the incentives of a prepaid, capitated payment system may mean that some managed care providers may be less willing to provide some covered services than their FFS counterparts.

The loss of previously covered benefits would certainly reduce access to these services. In some cases, the reduction may be desirable and even beneficial to the individual (e.g., if it reduces the provision of ineffective services). In other cases, however, it appears that some patients might lose access to useful and potentially effective services that are clearly utilized at present. Six of the most frequent diagnoses of Oregon Medicaid hospital

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12 Hyperbaric oxygen treatment and tissue expanders would also be new benefits under the proposed program.

13 In anencephalic babies, the brain is undeveloped and absent at birth.

14 The five potentially fatal diagnoses that are currently covered and can be effectively treated include impetigo herpetiformis, my asthenia gravis, Schmidt's syndrome, viral pneumonia, and bone marrow transplants for non-Hodgkin's lymphoma in children (3,17,21,38,44). (Transplants for non-Hodgkins lymphoma in adults and liver transplants for alcoholic cirrhosis are also low-ranked CT pairs in which treatment is sometimes lifesaving, but bone marrow and liver transplants are only covered for children under Oregon's current Medicaid program.) Myasthenia gravis may ultimately be reclassified into a CT pair higher on the prioritized list as a result of changes currently being considered by the Health Services Commission (23).

15 Genital viral wart removal is under consideration by the HSC, which may relabel a covered CT pair to clarify that it can include this service for men as well as women (23).

inpatients in 1989, for example, related to CT pairs that are below the line.[16]

Thus, current Medicaid beneficiaries would both gain and lose something under the proposed plan. It seems likely that both the gains and losses are less extreme for access than for benefits. Gaining a benefit does not always imply access (e.g., if waiting times were to inhibit access to covered preventive services), and losing a benefit is not accompanied by a complete loss of access, either (e.g., because charity care would still exist).

Three aspects of Oregon's proposal that Oregon's Medicaid program has not yet addressed in detail could have substantial implications for access to services:

- *CT/DRG incongruities.* It is not yet clear how hospital inpatients would receive coverage for diagnostic services related to uncovered conditions, because current hospital billing and payment practices do not separate diagnostic from treatment services. Under the proposed program, many hospitals would still be paid on an FFS basis (even within the prepaid care system), which means that reimbursement would be made on the basis of DRGs. But DRGs and CT pairs, on which coverage is based, are entirely unrelated to one another. There are many fewer DRGs, for example, and unlike CT pairs they include diagnostic as well as treatment services. The State intends to develop a mechanism to recognize inpatient diagnostic services specifically (212), but if it cannot do so promptly and adequately, beneficiaries' access to these services could be compromised.
- *Utilization review,* To a large extent, access to services under the proposed demonstration program would be determined not by the prioritized list itself but by the as yet unknown or unspecified policies and practices of the Oregon Medicaid administrators and by individual providers. The extent to which the Medicaid office would conduct CT-pair-level utilization review under the new program, for example, is still unclear. Even where review criteria exist, the State may not be able to detect some practices of interest. In particular, some treatments for CT pairs below the line (e.g., durable medical equipment, prescription drugs) cannot easily be linked administratively with the conditions for which they were prescribed, since the bills do not include diagnoses.
- *Guidelines and instructions for providers. The* codes on the prioritized list itself are not sufficient to enable a provider to reliably determin e where a patient's condition and treatment is most appropriately classified. For example, the only criteria for how to determine that a cancer patient is "terminally ill" (and therefore ineligible for treatment of the cancer) is that the patient has less than a 10 percent chance of surviving 5 years. Making this determin ation is up to the physician. Although it intends to do so, the State has not yet established detailed instructions or guidelines for providers using the list to determine which services are covered and under what circumstances.

Program Costs

Oregon **estimates that the costs** of the proposed demonstration (over and above the projected normal costs of the State's Medicaid program) would be about $25 million during the first year and about $238 million over the 5 years of the waiver (table 1-2). Of this, the State would spend about $95 million, while the Federal Government would be responsible for the remaining $143 million (177). (The State estimates that the Federal Government would save $34 million in the Medicare program as an indirect effect of the Medicaid waiver, for a net Federal cost over 5 years of $109.6 million.)

Costs specific to the demonstration project include the costs of increasing program enrollment and offering some new services, extra administrative costs, and other factors. Although the State predicts that the use of the prioritized list to reduce certain benefits and the use of managed care to control utilization would result in some offsetting savings, the demonstration is nonetheless expected to require a net increase in expenditures.

OTA finds that the State of Oregon and its actuarial contractors have used a reasonable approach for the difficult task of estimating the costs of the proposed demonstration program. Nonetheless, the State may have underestimated

16 These diagnoses include: asthma, unspecified; unspecified viral infection; intestinal infection due to other organism, not elsewhere classified; acute upper respiratory infection; displacement of lumbar intervertebral disc, without myelopathy; and viral pneumonia.

Table 1-2—Summary of Oregon's Demonstration Cost Estimate (in millions of dollars)

	Year 1 FY 1993	Year 5[a] FY 1997	5-year total
Projected cost of current program	$925.9	$1,546.7	$6,041.8
Total program cost under demonstration[b]	950.8	1,581.7	6,280.1
Incremental Medicaid cost due to demonstration	24.9	35.0	238.3[d]
State Medicaid share	10.1	14.5	95.0
Federal costs (Medicaid only)[c]	14.8	20.5	143.3
Change in Medicare due to employer mandate	0.0	(17.6)	(33.7)
Total change in Federal Medicaid/Medicare costs	14.8	2.9	109.6

NOTE: Oregon's cost estimates as presented here are based on the original anticipated startup date of July 1, 1992. Estimates may change because implementation has been delayed on a month-to-month basis pending HCFA approval of Oregon's waiver request.

[a]The employer mandate is to take full effect by the fourth year of the demonstration, resulting in a presumed drop in Medicaid (and Medicare) costs in years 4 and 5 of the demonstration due to beneficiary coverage through employers, rather than public programs.

[b]Total costs of Oregon Medicaid program, including services and populations not currently included under the demonstration.

[c]Incremental costs of the demonstration presented here do not include the costs of including mental health/chemical dependency services or the costs of services provided to elderly and disabled Medicaid beneficiaries. These services were not included in the original waiver application and their costs would be separately calculated at the time they would be included under the demonstration,

[d]Incremental Medicaid costs are assumed to increase through year 3, reaching $60 million that year, then decrease in years 4 and 5 due to the full implementation of the employer mandate.

[e]Does not include Federal research costs of demonstration evaluation.

SOURCE: Data from Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application,* submitted to the Health Care Financing Administration, Aug. 16, 1991.

program costs, since crucial assumptions would tend to raise costs or reduce savings if the estimates used prove incorrect.

Any delay in fully implementing the planned managed care system, for example, would reduce the expected program savings due to the use of managed care. Any inabilities of new managed care providers to actually meet savings expectations would have a similar effect. In addition, the administrative difficulties of determining below-the-line use of certain products and services (e.g., durable medical equipment, prescription drugs) means that if the use of these services is higher than accounted for in the cost estimate, overall patient care costs could be likewise somewhat higher than expected. Program costs could also be higher than expected if some ''technical fixes' to the program are necessary to avoid unintentional consequences of the initial list. For example, some effective services appear to be grouped in CT pairs with ineffective ones and ranked low; if this were "freed" by reassigning the codes for the effective services to higher ranked CT pairs, program costs would increase slightly.

Table 1-3-Examples of Condition-Treatment (CT) Pairs Excluded If Costs Were Underestimated by 5 Percent[a]

Baseline threshold: CT pair 587
Per capita monthly cost: $129.44

New threshold: CT pair 503
New per capita month/y cost: $122.98

Examples of CT pairs excluded

504	Hernia (unobstructed)	Repair
506	Muscular dystrophy	Medical therapy
514	Acute poliomyelitis	Medical therapy
515	Pituitary dwarfism	Medical therapy
525	Gallbladder anomalies	Medical and surgical treatment
531	Spontaneous and missed abortion	Medical and surgical treatment
533	Minor burns	Medical therapy
534	Allergic rhinitis and conjunctivitis	Medical therapy
544	Spine deformities	Repair and/or reconstruction
546	Disorders of bladder	Medical and surgical treatment
552	Foreign body in eye	Foreign body removal
554	Closed fracture of epiphysis of upper extremities	Reduction
555	Congenital dislocation of hip	Repair and/or reconstruction
569	Fractures of ribs and sternum	Medical therapy
572	Chronic sinusitis	Medical therapy
573	Lumbago	Medical therapy
586	Spondylosis and other chronic disorders of back	Medical and surgical treatment
567	Esophagitis	Medical therapy

[a]Assumes all cost savings to balance out the cost overrun would be achieved solely through reducing benefits.

SOURCE: Office of Technology Assessment. Calculated from information in Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application,* submitted to the Health Care Financing Administration, Aug. 16, 1991.

Although many factors that might increase costs would probably have fairly small effects, even small cost overruns could have significant implications for benefits. If all cost savings to balance out only a 5 percent cost overrun had to be achieved solely through reducing benefits, for example, more than 80 CT pairs would have to be eliminated from coverage (table 1-3).

Some costs external to the program, but relevant to Federal fiscal concerns, may also have been underestimated. In particular, the Congressional Budget Office (CBO) has predicted a loss of Federal tax revenues if the State implements the associated mandate requiring small businesses to provide health insurance. (This revenue loss was not accounted for in the cost analysis, although savings predicted from this mandate were included. The

Box 1-C--Medicaid Waivers Requested by the State of Oregon

To implement its proposed 5-year Medicaid demonstration program, the State of Oregon is requesting that the Federal Government waive 15 rules that it normally requires States to follow in order to qualify for Federal matching funds (33). Four of these waivers would be continuations of waivers already in effect in Oregon that enable the State to carry on its existing managed care demonstration program.[1] The other 11 waivers must be newly granted They are:

1. ***Amount, duration, and scope of services--Generally,*** all Medicaid recipients must have equivalent service coverage, with coverage unconnected to the patient's condition or other circumstances. In the demonstration, some services (i.e., those below the line) would be denied based on a patient's diagnosis. In addition, until the elderly and disabled populations are added to the program, covered services for these populations would differ from coverage for other recipients.
2. Uniformity--Federal rules require that a State's Medicaid plan apply uniformly throughout all geographic areas of a State. Under Oregon's demonstration, managed care plans and access to providers may vary between urban and rural regions and even within these regions.
3. ***Medically needy eligibility--States with*** medically needy programs must ordinarily make them available to at least children and pregnant women. Oregon proposes to eliminate the program for all populations enrolled in the demonstration program.
4. ***Income limitations--Federal rules*** prohibit Medicaid coverage for families with incomes greater than 1331/3 percent of the State's Aid to Families with Dependent Children (AFDC) standard and for disabled persons whose incomes exceed 300 percent of the Supplemental Security Income (SSI) income standard (unless they qualify as medically needy). Oregon's proposed coverage of all persons with incomes up to 100 percent of the Federal poverty level would include some persons who would not be eligible under the usual Federal rules.
5. ***Eligibility standards--Persons*** who are categorically eligible for cash assistance through AFDC, SSI, and other qualifying programs but who are not receiving this assistance are subject to resource as well as income standards to determine their financial eligibility for Medicaid. Oregon, however, proposes to eliminate the resource standard and permit individuals and families to qualify for Medicaid solely on their

[1] The four relevant waivers already in effect in Oregon that would need to continue under the proposed demonstration program waive Federal Medicaid rules regarding: 1) a patient's freedom to choose any qualified provider, 2) leek-b 3) sharing with providers any cost savings generated by decreased health service utilization, and 4) ease management.

State maintains that Federal revenue loss from this source would be negligible due to such factors as increased tax revenues from providers.) Also, if Oregon's passage of Ballot Measure 5[17] decreases the State funds available to the Medicaid program, as it is predicted to do, the State may be unable to furnish its full share of demonstration funding even if program costs have been correctly estimated.

Other Issues

Federal Legal Issues

Oregon has applied to the U.S. Health Care Financing Administration (HCFA) for permission to waive provisions of the Medicaid statute that conflict with its proposed demonstration project (box l-C). OTA assessed whether Oregon's proposal might be in conflict with provisions of other Federal statutes, which only Congress can waive, or might come in conflict with the U.S. Constitution, a barrier to its implementation that could be overcome only with a constitutional amendment.

With one possible exception, Oregon's Medicaid proposal appears not to conflict 'with the U.S. Constitution. This exception concerns provisions of the Oregon plan that would change the State's common law in such a way as to prohibit most legal recourse when a provider refuses to provide medically necessary care that is not covered by Medicaid. This could be interpreted by the courts as permitting a different level of legal protection against sub-

[17] Ballot Measure 5 is a statewide referendum passed in November 1990 which phases in a rollback of local property @x&i over 5 years and requires the State to replace billions of dollars lost by local counties for school funds from the State's general fund.

household income. The State would also change the rules regarding which household members' incomes are countable for eligibility purposes.

6. *Eligibility* procedures--States are generally required to have Medicaid eligibility procedures no more restrictive than under the State's AFDC plan. In addition, States are required to provide retroactive eligibility to certain categories of individuals (i.e., medical assistance applies retroactively for up to 3 months before the person actually applied for Medicaid). Under the demonstration, however, Oregon proposes to implement different eligibility rules and procedures for those persons receiving cash assistance (under AFDC, etc.) and those who are not. The latter group of persons would not qualify for retroactive eligibility, and their eligibility would be based only on gross income.
7. *Freedom of choice*—Under the demonstration, most recipients would not be able to change providers at will but would be ''locked in" to their chosen prepaid managed care provider, which could be changed only every 6 months.
8. *Cavitation contract requirements-The* Federal Government requires that prepaid health plans (PHPs) contracting to serve Medicaid patients meet specific requirements, including that the PHP's patient population beat least 25 percent non-Medicare and non-Medicaid patients. Oregon is requesting that the PHPs participating in the demonstration not be required to meet these standards. The State is also requesting waivers that would eliminate the need for the Health Care Financing Administration (HCFA) to approve large contracts with PHPs (i.e., those where payment may exceed $100,000).
9. *Upper payment limits for cavitation contract requirements*—Federal rules prohibit PHP payments that exceed estimated equivalent fee-for-service payments. Oregon requests a waiver of this requirement to enable incentive payments to certain PHI%.
10. *Payment to Federally QualifiedHealth Centers* (FQHCs)--State Medicaid programs must cover services provided in FQHCs, and they must provide facility-specific, cost-based reimbursement for these services. Under the demonstration program, however, some FQHCs might be part of PHPs and thus paid differently (and their services not uniformly available).
11. ***Early*** *and Periodic Screening, Diagnosis, and Treatment (EPSDT) service* mandate--States are usually required to pay for medical services when the need for that service is determined at an EPSDT visit (even if the State would not otherwise cover the service). This requirement must be waived if the demonstration is to proceed as planned, because some identified services might lie below the funded line (initially line 587 on the prioritized list).

Finally, in addition to the specific waiver requests, Oregon "requests that HCFA grant any other waiver that HCFA deems to be required in order to implement the demonstration" as it is described in the proposal document.

standard care-and possibly a different legal standard of care-for Medicaid beneficiaries than is permitted for the remainder of the State's population. Such a difference might possibly be interpreted as a violation of the Equal Protection Clause of the 14th Amendment of the U.S. Constitution (or of similar provisions of the Oregon State constitution).

Several Federal statutes are relevant to Oregon's proposal, including those requiring protections for human research subjects and those that prohibit discrimination on the basis of race, disability, or age. The proposal appears to fall within the exceptions allowed by the human research subject protection statute for social demonstration programs (although one advocate suggests that language in a 1992 appropriations bill suggests otherwise) (222).

The effects of the anti-discrimination statutes are not entirely clear-cut, but the proposal is probably not very vulnerable to a challenge on the basis of these statutes unless in its implementation the denial of benefits falls disproportionately on protected groups (e.g., because the services they use tend to appear below the cutoff point on the list). Based on OTA's analysis of the list, this type of disparate impact is unlikely to occur with the line drawn at 587. If the line were to move upward due to funding shortfalls, the potential for such a challenge would increase. Some advocates have argued that, in its implementation, the proposal may also be vulnerable to challenge on the basis of the Americans with Disabilities Act of 1990 (Public Law 101-336) (150). The lack of case law involving this statute, however, makes it impossible to predict how future courts would react.

The provision of SB 27 that exempts providers from liability if they refuse to provide uncovered but

medically necessary services to Medicaid beneficiaries[18] also conflicts with existing Federal statutes that require most hospitals to provide basic emergency care to anyone in need. Thus, it is possible that hospitals (and possibly emergency room physicians) could be prosecuted under Federal statute for not providing some services even if they were exempted from liability under State law.

Evaluation Issues

Oregon's demonstration proposal is ostensibly a health services research proposal. As such, a justification for funding the proposal would be to draw information useful to other States and to the Federal Government.

In this context, the program has some significant drawbacks. Many of the potential applications of the information gleaned from the project relate to its components rather than its overall effects (e.g., Does the use of a prioritized list to define benefits reduce costs without harming the existing Medicaid population?). An evaluation of the project, however, is unlikely to have the power to disassociate the independent effects of service prioritization from the effects of managed care expansion and broader insurance coverage for the poor.

In fact, a likely outcome is that no separate effect of the list on health status would be distinguishable at the current benefit threshold (even if one exists). If the threshold moves up the list to accommodate higher-than-expected program expenditures, the strongest detectable effect could well be a negative one for access, quality, and health status of current program beneficiaries. Given the limits of comparative data, it may not even be possible to detect the effect of the combination of these changes on many outcomes of interest.

There are two other potential experimental contexts in which the demonstration might be viewed. First, the proposal can be viewed as a simple experiment designed to answer a single question: Is it possible, using the mechanisms Oregon would implement, to provide acceptable health care coverage to the poor, uninsured population without significantly raising costs to the taxpayer and to the health care system? Evaluating this question in the aggregate requires much less detailed data than evaluating the components and intermediate effects of the program, and the answer would be of interest to many researchers and policymakers. The danger of this approach is that as a research demonstration, its results could only be appropriately extrapolated in the aggregate. Other States could apply the results only if they, too, were willing to implement the total package that Oregon proposes.

A second question is even further from the traditional bounds of health services research: Is health care coverage based on prioritization of health care services, with open public input, politically sustainable? If, for example, program costs were higher than expected, would the legislature actually be able to reduce benefits or increase revenues to fund it? Or would the plan evolve over time into simply another version of the current system, in which neither eliminating specific treatments nor raising taxes becomes politically feasible, and the State must resort once again to limiting eligibility and provider payment? If these questions could be answered, implementation of the proposal maybe of interest to some policymakers despite its potential drawbacks as a health services research project.

CONCLUSIONS

In designing its proposed Medicaid demonstration program and related changes to its health care system, the State of Oregon has achieved what few others have: a dramatic and comprehensive proposal to change the way health care is delivered that appears to be generally accepted by its residents and providers. The State has invested considerable resources into its unique Medicaid proposal. Many of the proposed changes have stimulated open public debate, and the lessons learned from the effort to develop a categorization of treatments and conditions are valuable ones. The State's explicit attempt to integrate and incorporate outcomes information and broad public input is especially notable.

The State believes that despite possible problems, the gains it anticipates from the proposal make the program worth trying. The immediate issue for the Federal Government, however, is not only whether the proposed changes should take place but whether Federal revenues should be used to fund them. Unlike the State, which is legitimately con-

18 Interestingly, this Provision has been codified in such a way as to imply that it might continue to apply to Medicaid providers even if the demonstration project does not go forward.

cerned primarily with the effects within Oregon, the Federal Government must consider the ways in which the information from the proposal might be useful to others. It must also consider the opportunity costs of funding Oregon's proposal relative to other possible uses for those funds.

Certain aspects of Oregon's proposal hold promise as a potential demonstration of ways that health care costs might be constrained or health care access improved. The proposal to include all Medicaid enrollees in some form of managed care, with an emphasis on various forms of prepaid care that grade the degree of financial risk to the size and experience of the provider, is intriguing. Many health care payers have looked to managed care to reduce costs without endangering health, and there would probably be considerable interest in the results of an experiment that tested comprehensive managed care for Medicaid beneficiaries. Oregon's past experience with managed care suggests that this State would be a reasonable location for such an experiment. The effect on provider participation of a changed method of payment likewise is of interest.

Expanding coverage to all poor persons is clearly a benefit of the proposal. This component of the proposal is both the most expensive and the most likely to yield positive results. Aside from the simple benefit to those involved, there are some solid reasons to test coverage expansion as an experiment; for example, such a study might shed additional light on the links between health insurance, health care access, and health status.

The move to simplify eligibility rules in conjunction with coverage expansion is also attractive, since it would be expected to increase program participation and reduce program expenditures relating to reviewing applications. However, the possibility that some pregnant women and young children might be ineligible for benefits under the new rules is a significant drawback of the demonstration as proposed, since it would almost certainly harm those affected. A simple remedy for this problem might be to increase the gross income eligibility level for pregnant women and children under age 6 applying to the program (e.g., to 150 or 185 percent of the Federal poverty level).

Despite the many positive aspects of these components of the program, OTA has some serious reservations about the overall demonstration project as proposed. The most troublesome aspects are the prioritized list and the lack of any minimum level below which benefits may not fall.

OTA has made no attempt to decide whether open ''rationing' of health care services is desirable, or unnecessary, or inevitable. However, OTA's analysis of Oregon's prioritization process and the resultant list of services suggests that if such a prioritization mechanism is adopted, classifying health care by general service categories and CT pairs in order to prioritize services is not an especially promising approach. The level of aggregation required by the CT pairs on Oregon's list means that treatments effective or ineffective for specific patients still cannot be adequately discriminated.

The prioritized list, while a potentially useful source of public opinion information to policymakers, would probably not be an effective internal cost-containment tool. The ranked list does enable overall program expenditures to be controlled by increasing or decreasing benefits. But the list itself does not necessarily encourage cost-efficient health care decisions to be made at the individual level. Diagnostic services, for example, are not prioritized; only existing review or management mechanisms (e.g., management practices of prepaid care providers) would limit their use. And despite the State's attempt to rank aggressive therapies for some diagnoses (e.g., cancer) low when patients are terminally ill, paradoxically the list does not preclude heroic procedures for these patients. A terminally ill patient would still be covered for last-minute life-saving therapies such as treatment for respiratory or cardiac arrest. This option would probably be desired by many patients, but it could not be expected to lower costs. In fact, assuming Oregon's estimates of the cost savings that could be expected from managed care are correct, managed care might have a much larger effect on internal cost control than the prioritized list.

A contribution of Oregon's extensive efforts is its demonstration that outcomes and cost-effectiveness data, while extremely valuable for certain purposes, are inadequate for use as the building-blocks of a ranking system of all services. More and better information on the outcomes of more health services would improve its usefulness, but it is unlikely that such information will ever be sufficiently comprehensive to enable all health care services to be objectively ranked. The value of such information lies in comparing the usefulness of

particular sets of services on the margin--e.g., for use in guidelines, quality-of-care screens, or deciding whether specific individual services should be covered and under what circumstances.

In fact, any comprehensive ranking system would, like Oregon's, need to rely on judgment- and value-based decisionmaking. Because such a list cannot be derived from scientific evidence on effectiveness, outcomes, and cost, and because the replicability of the public meeting and survey information is still open to question, Oregon's list would probably not be exactly reproducible in another State even if the identical process was undertaken. Agreement between two ranked lists might be similar at the bottom (since many people would agree that certain services are ineffective or futile), but differences might be much more substantial further up the list.

Oregon's intensive efforts to make public input a basis for detailed priority-setting demonstrate both the possibilities and the limitations of this process. The State successfully involved providers and consumers in a process to inform public decisionmaking regarding health care priorities. However, the validity of public input in any quantitative ranking is still subject to challenge. The use of public preference data to weight health outcomes has promise, but Oregon's experience suggests that this method is not sufficiently developed to use as the basis for a detailed ranking system ready for implementation.

The information from hearings and public meetings was clearly informative and useful in a ranking process that proved to be unavoidably subjective, but the meetings were not representative of the community despite the efforts of organizers. In fact, the level of effort Oregon undertook implies that proportional representation is probably not a standard possible to achieve under any system.

Any attempt to change the way benefits are defined will involve tradeoffs of gains and losses, and Oregon's proposal cannot be legitimately criticized on the grounds that there is a clear net loss to current beneficiaries. Current beneficiaries lose some current benefits, and a few would almost certainly be harmed in some way by this loss. But beneficiaries would also gain some new services under the demonstration, and they could still receive some uncovered services as charity care. At a benefit level set at line 587 on the prioritized list, the overall net effects of coverage changes on current Medicaid participants cannot be predicted with confidence.

If the benefit threshold changes and reduces the number of covered CT pairs, however, it would become more likely that the proposed program would result in net harm to the health of current beneficiaries. This finding is troubling because the related finding that demonstration costs may have been underestimated raises the likelihood that coverage would be cut during the course of the waiver. (Lower future funding itself would not necessarily mean that current beneficiaries would suffer net harm, because they might have lost some benefits under the current program as well. But lower future funding combined with relatively higher funding required to sustain the new proposal would increase the likelihood of net harm.)

In fact, the lack of a guaranteed minimum set of benefits below which coverage would not be allowed to fall is the most disturbing aspect of Oregon's proposal.[19] If program expenditures are higher than predicted, and if the passage of Ballot Measure 5 and internal budget priorities prohibit the State from making up the difference, the Federal Government would be faced with three possibilities. First, it could undertake to fund the difference out-of-pocket, covering Oregon's population at the expense of funding other health care experiments elsewhere in the Nation. Second, it could permit the benefit package to be cut, increasing the likelihood that Medicaid beneficiaries would be harmed by the demonstration. Third, it could withdraw or condition its continued approval and either modify the demonstration substantially or permit it to end, reducing the demonstration's usefulness for the purpose of research.

In summary:

1. Oregon's efforts to develop a proposal to make radical changes to its Medicaid program have yielded valuable information about the usefulness of outcomes data and public input in prioritizing services. The ranking process may also have value as a way to better inform policymakers and to enhance provider and

[19] In contrast, at present the Federal Government requires that States cover at least some mandatory benefits and populations in order to receive Federal funding.

patient awareness. Nonetheless, other States would not be well-advised at this time to rely on Oregon's particular CT-based prioritization method to categorize and rank services. The list itself cannot be applied in other settings with equivalent meaning. Also, the list discriminates poorly among effective services at the individual level, and it would probably not be ineffective internal cost-containment mechanism in FFS practice settings.

2. At a coverage level set at line 587, health care access under the proposed program would be improved for newly eligible participants and would not be clearly either better or worse for most current beneficiaries. Current beneficiaries would be more likely to be harmed if the number of covered CT pairs was reduced.
3. If implemented as proposed, the demonstration program may yield relatively little useful information about the different effects of service prioritization, comprehensive managed care, and comprehensive insurance coverage for the poor. A somewhat more modest experiment testing the effects of the managed care and coverage expansions alone would yield more specific information while providing most of the benefits of the current proposal. (The Oregon proposal in its entirety might still be valued as a political experiment, however.)
4. If the full demonstration is approved, some specific components deserve attention to ensure that the program is fully ready to implement. Examples include:
   - . The need for detailed instructions for providers on how to use the list;
   - . The need to reconcile hospital DRG-based billing, CT pairs, and covered diagnostic services;
   - . The need for more extensive baseline data for assessing program effects (particularly in the areas of utilization in the existing prepaid system, utilization and health status of the currently uninsured, and baseline health measures for specified subgroups of patients that could be significantly harmed if their treatments are not covered);
   - . The difficulties that public health clinics may face as they try to become part of the managed care system; and
   - • The possibility that some pregnant women and young children who would qualify for coverage under the current program would be ineligible under the proposed new eligibility rules.
5. Specifying a threshold below which coverage would not be allowed to drop and gaining greater confidence that Oregon could meet its financial responsibilities under the waiver would also improve the program's chances of success.