Chapter 5

Implications for Beneficiaries

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INTRODUCTION

This chapter examines Oregon's proposed waiver from the perspective of those who would participate in the new program. The aim of this analysis is not a defense or evaluation of the status quo. The focus here is on how the demonstration might affect *current* and, to a lesser extent, *new* Medicaid participants compared with the existing program.

The first part of the chapter analyzes in detail the effects of the State's proposed new eligibility rules and describes how the makeup of Oregon's Medicaid population would change under the demonstration. The second part examines key elements of access to care, focusing on the prioritized list, its effect on benefits, and particularly, the implications of withdrawing funding for 'below-the-line' condition-treatment (CT') pairs. It also presents available data that help assess how often current Oregon Medicaid participants might experience an uncovered condition. The final part of the chapter reviews the overall implications for beneficiaries of expanding eligibility, establishing Medicaid benefits based on the prioritized list of health services, and reforming the delivery system.

HOW THE OREGON MEDICAID POPULATION WOULD CHANGE

Oregon proposes to extend Medicaid eligibility to all of its poor population. This reform is significant not only because it broadly expands participation in the Oregon Medicaid program (by more than 20 percent in the first year alone), but also because it eliminates the historic categorical approach to Medicaid eligibility. Oregon's demonstration, if approved, would be the first to use Federal matching funds to make Medicaid available to all *the poor* regardless of age, marital status, family relationship, or pregnancy. Oregon's proposal seeks to cover not only people in traditional assistance categories (e.g., poor single women with children) but other groups as well, including single men, childless couples, and two-parent families whose incomes are within the Federal poverty level (FPL).

This section will review the details of current Oregon Medicaid eligibility requirements, compare them with eligibility rules under the proposed waiver, and assess the implications of the new waiver rules for current Medicaid participants.

Current Eligibility Requirements

Eligibility for the current Oregon Medicaid program is determined by federally defined mandatory and optional categories of the poor as well as State-determined income standards for participation. Recent congressional mandates to expand coverage of pregnant women and children have weakened the link between Medicaid and the Aid to Families with Dependent Children (AFDC) cash welfare program (see ch. 2). Still, the rules of access to Medicaid, throughout the country, remain focused on children, pregnant women, and recipients of either AFDC or Supplemental Security Income (SSI) cash assistance. Single men and childless couples, regardless of how poor or how medically vulnerable, are denied access to Medicaid unless they are also elderly or disabled.

Mandatory Groups

The Federal Government mandates coverage of certain groups and allows coverage of a number of optional categories. The federally mandated coverage groups include (see table 5-1) (301):

- AFDC participants-single-parent families who receive AFDC cash assistance or who have been terminated from AFDC cash assistance because of increased earnings or hours of employment within the last 12 months; [1]
- Unemployed-parent families-families whose principal breadwinner is recently unemployed and who meet AFDC income and asset requirements;
- Poverty level medical (PLM) women and children[2]—pregnant women and children up to

[1] AFDC is a Federal-State program that provides cash assistance to needy children and/or their caretaker relatives when there is deprivation of a child due to the absence, incapacity, or unemployment of a parent.

[2] "Poverty level medical" (PLM) is the term used by the Oregon Medicaid program to describe this group of pregnant women and young children, which was mandated Medicaid coverage under the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-239).

Table 5-1--Mandatory and Optional Eligibility Groups Covered by the Oregon Medicaid Program, 1991

Federally mandated groups	Optional groups covered by Oregon	Optional groups not covered by Oregon
Families and children	*Families and children*	*Families and children*
• Single-parent families receiving Aid to Families with Dependent Children (AFDC) cash assistance.	. Medically needy: pregnant women and children under age 18.	• Children between 18 and 21 years old in AFDC families.
• Families terminated from AFDC cash assistance because of increased earnings or hours of employment (limited to 12 months).	*Other groups*	• Pregnant women and children up to age 1 between 133 percent and 185 percent FPL.
• Unemployed parent families who meet the State AFDC income requirements.	• Individuals in nursing facilities who would be eligible for SSI if they lived at home.	• Children aged 9 to 21 of two-parent families whose income is below AFDC standards but who do not otherwise qualify for AFDC.
• Children for whom adoption assistance or foster care maintenance payments are made.	• individuals in nursing facilities who are eligible for Medicaid because income Is less than 300 percent of SSI.	• Medically needy children between the ages of 18 and 21.
• Pregnant women and children up to age 6 whose family income is less than 133 percent of the Federal poverty level (FPL).	• Individuals receiving home and community-based services under a waiver (Oregon covers Aged and Disabled under Senior and Disabled Services Division and Mental Health and Developmental Disabilities Services Division waivers).	• Medically needy adults who are not pregnant, aged, blind, or disabled.
• All children born after September 30, 1983 whose family income is less than 100 percent of the FPL.	• Aged, blind, or disabled individuals receiving only optional State supplements (Oregon covers individuals receiving Oregon Supplemental Income Program payments).	*Other groups*
Other groups	• Medically needy elderly (65 or older), blind, or disabled.	. Aged, blind, or disabled individuals under 100 percent of the FPL who are not otherwise eligible for Medicaid.
• Aged, blind, or disabled individuals receiving Supplemental Security Income (SSI) or other more restrictive criteria established by the State under the 209(b) option.	• Medically unemployable adults who receive general assistance (not eligible for Federal funding).	. Disabled children underage 19 who are cared for at home in lieu of institutional care but whose family income is above the eligibility limits of SSI.
• Certain severely disabled individuals terminated from SSI because of earnings from employment.		
• Medicare recipients with family incomes under 100 percent of the FPL (coverage limited to payment of Medicare premiums, coinsurance, and deductibles).		
• Working disabled individuals under 200 percent of the FPL (coverage limited to payment of Medicare Part A hospital insurance premiums).		

SOURCE: Oregon Department of Human Resources. Office of Medical Assistance Programs. Salem. OR. "Medicaid and the State of Oregon Medical Assistance Programs," (OMAP3061), January, 1991 and M. Waid, "Addendum: A Brief Summary of the Medicaid Program," *Health Care Financing Review* 1990 Annual Supplement, Baltimore, MD, December, 1990.

age 6 whose family income is less than 133 percent of the FPL and all children up to age 19, born after September 30, 1983, whose family income is less than 100 percent of the FPL;
- Foster care children--children for whom adoption assistance or foster care maintenance payments are made under Title IV-E of the Social Security Act; and
- Certain aged, blind, and disabled individuals.

Optional Groups

Of the eligibility options *allowed* under Federal Medicaid rules, Oregon covers medically needy pregnant women and children under age 18 and certain groups of the elderly, blind, and disabled (see table 5-1) (168).[3] States have the option to offer Medicaid to the medically needy when their family income and resources lie above the AFDC need standards if they also meet the categorical requirements of the program (e.g., an absent parent or disability).[4] Each State has the right to set its own medically needy eligibility standards as long as they do not exceed 133.33 percent of the maximum AFDC assistance thresholds for similarly sized families. Through a spend-down provision, individuals with incomes above the medically needy standard also may become eligible if their medical expenses are high enough to reduce their countable income below the medically needy maximum.

Oregon also provides a "general assistance" program of limited health care benefits (without Federal funding) to medically unemployable adults who would not be disabled long enough to qualify for Social Security benefits (168).[5]

Although Federal Medicaid options permit coverage, the current Oregon program does *not* cover AFDC children between 18 and 21 years of age; pregnant women and infants under age 1 with family incomes between 133 and 185 percent of the FPL; children aged 9 to 21 of two-parent families whose incomes meet income eligibility standards but who are categorically ineligible (often referred to as "Ribicoff children'');[6] and the medically needy, ages 18 and older, other than those described above (168).

Oregon Income Standards for Medicaid Eligibility

In 1991, the FPL was *$928* per month for a family of three.[7] Figure 5-1 shows the monthly income levels required to obtain Medicaid in Oregon. Income criteria vary widely with the applicant's demographic characteristics and can even differ among individuals within the same family. Pregnant women, infants, and young children (under age 6) are eligible if their family incomes are under 133 percent of the FPL. Children from age 6 to 8 must live in families with incomes under 100 percent of the FPL to be eligible for benefits.[8] Children 9 to 17 years old who meet AFDC categorical requirements are limited by the medically needy monthly income standard of $613 for a family of three (66 percent of the FPL).[9] Young people overage 18 and nonelderly adults (unless pregnant) must meet AFDC categorical requirements and are subject to the most sbin-

[3] In July 1991, budgetary constraints led the Oregon State legislature to eliminate coverage of nonpregnant medically needy AFDC adults and curtail medically needy coverage of the aged, blind, and disabled. Benefits for the latter groups now include only: 1) prescription drugs provided in a pharmacy, and 2) mental health and alcohol/drug treatment services provided by community mental health and alcohol/drug programs (171). Although 36 States had medically needy programs in 1990, it is not known how many were as restrictive as Oregon's (4). Medicaid regulations require that States which cover the medically needy must at least provide a minimum level of services, including prenatal and delivery services for pregnant women, ambulatory services for children under 18, and home health services to those individuals entitled to skilled nursing facility services. State plans that include services in mental health institutions, or in intermediate care facilities for the mentally retarded, must offer a broader range of services to the medically needy.

4$ 'Categorically needy'' refers to those who are Medicaid-eligible because they belong to certain categories of poor people, such as those who are a member of a family with dependent children where one parent is absent, incapacitated, or unemployed.

[5] The general assistance recipients are not entitled to Medicaid-funded hospital care but are eligible for outpatient and prescription drug benefits.

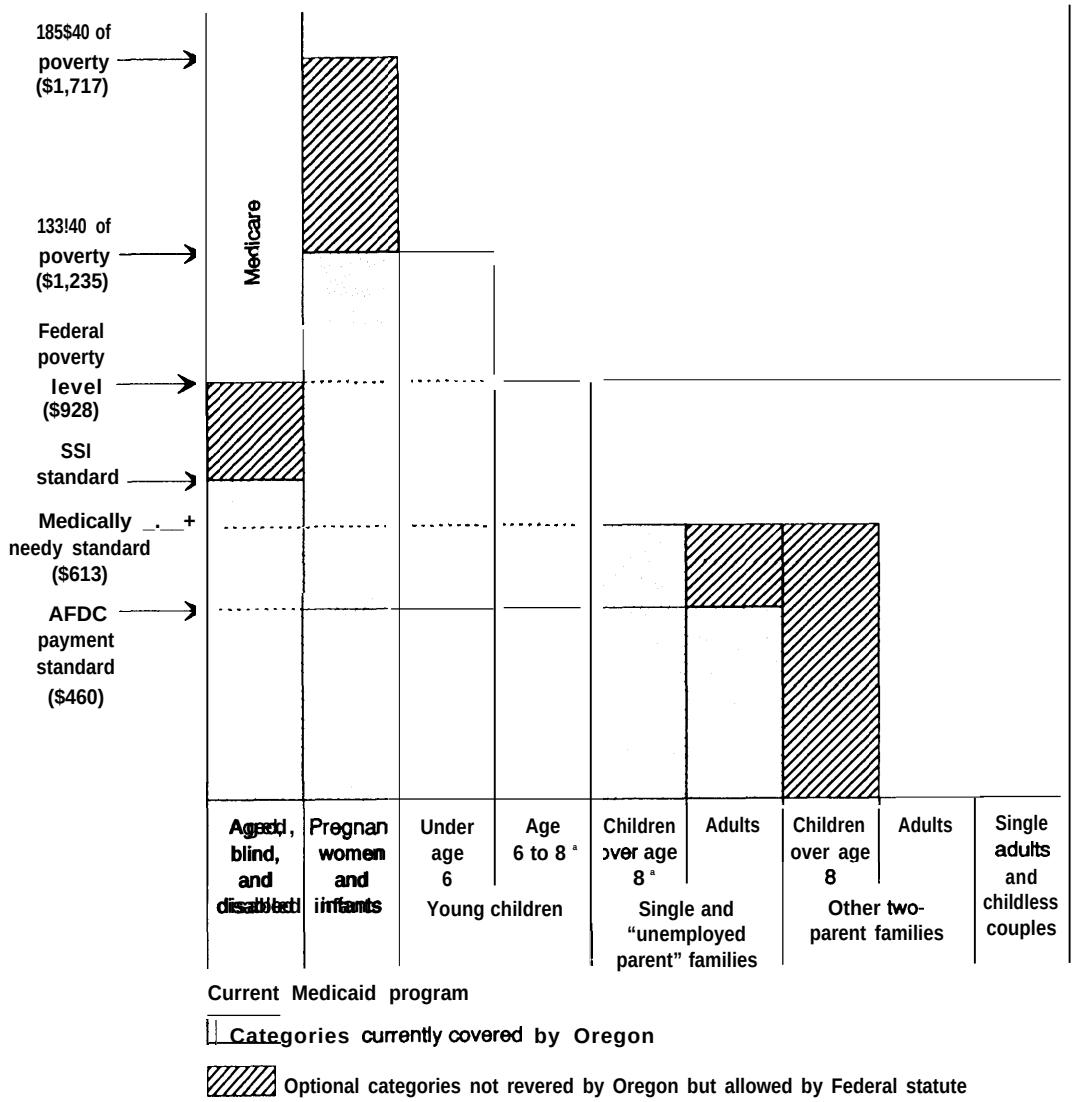
6 ''Ribicoff children'' are named for former Senator Abraham Ribicoff, the sponsor of legislation authorizing coverage for this group.

[7] The 1991 FPL is used here because it was the poverty guideline that was in place at the time Oregon submitted the waiver application. The 1992 FPLis$11,570, or $964 per month, for a family of three in the contiguous 48 States (57 FR 5456). The Federal Government has established separate poverty levels for both Alaska and Hawaii ($14,460 and $13,310, respectively) because of their unique economic conditions.

[8] The Omnibus Budget Reconciliation Act of 1990 (Public Law 101-508) mandated that State Medicaid programs cover all children under age 19 who were born after September 30, 1983 and whose family income is less than 100 percent of the FPL. By the year 2002, coverage of all children under age 19 will be universal (270). At present, only 6- to 8-year-olds are affected.

[9] Children and pregnant women can also qualify for medically needy coverage by ''spending down' to the required net income level if they also meet a mandatory asset test. Oregon's asset limits for the medically needy are $2,000 for the first household *member, $3,000* for two, and $50 for each additional household member (252).

Figure 5-l-Current Medicaid Eligibility in Oregon (Monthly Income Levels for a Family of Three in 1991)



KEY: SSI = Supplemental Security Income; AFDC - Aid to Families with Dependent Children

NOTE: This is a simplified presentation of eligibility. Income thresholds are net of allowable deductions including childcare expenses, work related expenses, and certain work incentive disregards. Medically needy groups can "spend down" to eligibility by incurring medical expenses. Assets also enter into eligibility. Not all eligibility groups are shown. Oregon&es, for example, cover some older children in intact families, such as those in foster care and institutions. Elderly, blind, and disabled with incomes under poverty can obtain Medicaid and Medicare copayments and deductibles.

a All Children under age 19 and born after September 30, 1983 must be covered if family income is below poverty; ages shown are as of October 1991.

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.

gent income criteria of all: the AFDC monthly income standard of $460 for a family of three (less than 50 percent of the FPL). Recent entrants into the workforce are allowed certain financial work incentives (see below).

Counting Income and Resources—But how are income and resources defined? State and Federal rules on how to count income and resources for AFDC and Medicaid eligibility are complex and appear to be understood in great detail by few (59). The above description of Oregon's income criteria is by necessity simplistic and masks a few critical details. For example, does the Medicaid applicant have a household member who works, and for how long has that person worked? Does the applicant have any assets? Does the individual own a car or a

home? Are there deductible child-care expenses? All of these questions and others determine what is called ''countable' income. The net result is that in some cases, families with gross incomes *greater* than the reported income eligibility standards can gain access to Medicaid. In fact, in 16 States, families with a recently employed worker and incomes *greater than the* FPL are eligible for Medicaid benefits (270).[10]

To be eligible for AFDC payments and automatically eligible for Medicaid, a family must pass both a gross income test and a ''countable' income test. Gross monthly income cannot exceed 185 percent of the State's AFDC need standard (see table 5-2). Families with no other income than their AFDC cash assistance payment must have countable income that is less than the State's AFDC need standard. For others, countable income must be less than the State's need standard after allowing for child-care costs up to $160 per child and a standard allowance of $75 per month. In addition, during the frost year on a job, AFDC recipients are allowed a work-incentive bonus based on the length of employment (i.e., the bonus varies depending on whether the working family member has been employed less than 4 months, between 5 and 12 months, or more than 12 months) (266).[11,12]

The same rules governing income counting apply to PLM women and young children, except that these mandatory coverage groups are subject to higher net income thresholds (i.e., 100 or 133 percent of the FPL).

Oregon vs. OtherStates—in 1991, only 17 States had higher AFDC income standards than Oregon's (270). Very few State AFDC need standards approach the FPL and many fall short of 50 percent of the Federal poverty guideline (see table 5-2) (148,270). In many cases, States have failed to adjust the AFDC income standards for inflation and, consequently, the average income threshold as a percentage of poverty has been eroded substantially, from 71 percent in 1975 to 45 percent in January 1991 (146,148).[13] AFDC monthly eligibility thresholds in 1991 for a family of three ranged from a low of $124 in Alabama to a high of $694 in California (270).[14,15]

As of July 1991, 28 States had higher income eligibility limits for pregnant women and infants than Oregon did (i.e., between 140 and 185 percent of the FPL) (148).[16] A 1989 survey of State Medicaid programs found that 34 States covered "Ribicoff children," many through age 21 (138).[17] Oregon does not cover these children (see above).

Rules Under the Waiver[18]

All legal residents of Oregon, with family incomes less than the Federal poverty guideline, would be eligible for Medicaid under the proposed

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10 The 16 States are Alaska, California, Connecticut, Hawaii, Kentucky, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, New York, Rhode Island, Utah, Vermont, Washington, and Wisconsin.

11 During the first 4 months of a job, the bonus is equal to the first $30 of earned income plus one-third of additional earnings after the child-care and standard deductions are taken. For the remaining 8 months, the bonus is $30. There is no work incentive bonus after 12 months, but a $75 standard deduction is allowed.

12 Despite these work incentives, longitudinal Medicaid data show that few people who leave the AFDC welfare program get the transitional Medicaid benefits they are entitled to receive (59).

13 While the Consumer Price Index rose an estimated 245 percent from July 1970 to January 1991, the AFDC income eligibility standard increased only 134 percent (270).

14 These income standards pertain to eligibility levels for the first 4 months of AFDC participation and assume work expenses of $90 per month and no child-care expenses. Eligibility levels after the first 4 months of coverage are considerably more stringent. The percentage presented in the text are based on the 1990 poverty level of $10,560 for a family of three.

15 The eligibility thresholds in Alaska is even higher (i.e., $891), but this is not comparable to the thresholds in the contiguous 48 States.

16 The 28 are Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New Mexico, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Vermont, Washington, West Virginia, and Wisconsin.

17 The 34 are Alaska, Arkansas, California, Connecticut District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Care@ Tennessee, Texas, Utah, Vermont, Virginia, and Wisconsin. The majority of these States cover Ribicoff children through age 21.

18 This description of eligibility rules is drawn from Oregon's waiver application unless otherwise noted.

Table 5-2-Monthly Income Standards for Medicaid Benefits for a Family of Three as a Percentage of the Federal Poverty Level, January 1991° [b]

State	AFDC[c] need standard	AFDC effective first 4 months	Eligibility Level after 12 months	Medically needy standard
Alabama	13.4%	35%	25%	NA
Alaska	76.8	168	113	NA
Arizona	31.6	64	44	NA
Arkansas	22.0	49	34	30%
California	74.8	134	90	101
Colorado	45.4	87	59	NA
Connecticut	62.6	131	89	83
Delaware	36.4	72	49	NA
District of Columbia	46.1	88	60	59
Florida	31.7	65	44	32
Georgia	45.7	87	59	40
Hawaii	59.2	123	83	72
Idaho	33.9	69	47	NA
Illinois	39.5	77	53	53
Indiana	31.0	64	44	NA
Iowa	45.9	87	59	61
Kansas	41.3	85	57	50
Kentucky	56.7	105	71	33
Louisiana	20.5	47	32	28
Maine	70.2	126	85	66
Maryland	43.7	84	57	50
Massachusetts	62.4	107	72	84
Michigan	63.1	105	71	55
Minnesota	57.3	106	72	76
Mississippi	39.6	77	53	NA
Missouri	31.5	64	44	NA
Montana	39.9	78	53	48
Nebraska	39.2	77	52	53
Nevada	35.5	71	48	NA
New Hampshire	55.6	103	70	66
New Jersey	45.7	87	59	61
New Mexico	33.4	67	46	NA
New York	62.2	114	77	78
North Carolina	29.8	61	42	40
North Dakota	43.2	83	57	47
Ohio	36.0	72	49	NA
Oklahoma	50.7	73	50	50
Oregon	47.8	91	62	66
Pennsylvania	45.4	87	59	50
Rhode Island	59.7	110	74	80
South Carolina	47.4	90	61	31
South Dakota	41.5	80	55	NA
Tennessee	44.4	85	58	27
Texas	19.8	46	32	28
Utah	57.8	107	72	58
Vermont	73.1	131	89	97
Virginia	31.3	75	51	39
Washington	57.2	106	72	70
West Virginia	26.8	57	39	30
Wisconsin	55.8	103	70	74
Wyoming	38.8	76	52	NA
Average	45.1	83	58	56

NOTE: NA = Not applicable: the State does not have a medically needy program.
[a] These calculations assume work expenses of $90 per month and no child-care expenses. The calculations are also based on a 1990 poverty level of $10,419 ($868 per month) for a family of three, and a 1991 minimum wage salary of $7,904 ($659 per month).
[b] Income level at which Medicaid eligibility ends.
[c] AFDC = Aid to Families with Dependent Children.

SOURCE: U.S. Congress, House of Representatives, Committeeon Ways and Means, *Overview of Entitlement Programs:1991 (Green Book) Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means,* (Washington, DC: U.S. Government Printing Office, May 7, 1991) and National Governors' Association, MCH update, OBRA-86/87/89 *Summary Status: Medicaid Coverage Options Pregnant Women and Children, Washington, DC, July 1991.*

waiver (see figure 5-2).[19 20] In addition, pregnant women and children up to age 6 with gross family incomes below 133 percent of the FPL would continue to be Medicaid-eligible.[21]

The waiver eligibility categories would be: 1) AFDC, 2) PLM pregnant women and children with family incomes between 100 and 133 percent of the FPL, 3) new eligibles, and 4) general assistance recipients.

Simplified Rules

Oregon's waiver application outlines streamlined eligibility rules for all demonstration participants except those who receive AFDC cash assistance. Under Oregon's proposed rules, income calculations for non-AFDC demonstration participants would differ in a number of important ways:

- Gross vs. net income--Medicaid applicants would be subject to a gross income test instead of the current net income assessment. Standard deductions and work incentives, such as essential work and child-care expenses, would not be considered in counting income.
- Retroactive eligibility-Federal requirements to provide retroactive benefits up to 3 months prior to the date of application for Medicaid benefits would be waived.
- Whose income counts?—Federal rules limiting ''countable income' to that of the applicant, or a parent or spouse, would be waived to allow consideration of the incomes of other household members. Under the waiver, the definition of a family unit would be expanded to include unmarried cohabiting couples who have at least one joint child under age 19 or an unborn child.
- Assets test—The resources (or assets) of demonstration applicants would not be considered.[22]
- Medically needy—Medicaid applicants with medical expenses would no longer be able to "spend down" to become eligible under the medically needy program. In fact, the current medically needy program for pregnant women and children under age 18 would be eliminated altogether under the waiver.

These changes are expected to greatly simplify Medicaid eligibility primarily because they reduce the considerable amount of personal documentation now required. Under existing rules, proof of up to 4 months income and detailed expenses as well as evidence of family assets may be necessary to determine eligibility. It is well established that the Medicaid eligibility procedural requirements are often a significant barrier to coverage. In 1986, nationwide, 62 percent of rejected Medicaid applications were due to 'failure to comply with procedural requirements" (246).

Yet Oregon's proposed simplified procedures would not apply to a large proportion of demonstration participants. AFDC recipients, who are projected to make up 63 percent of demonstration enrollment in the first year of the waiver and as much as half the population in the final demonstration year, would continue to be subject to current AFDC rules so that they could receive cash benefits (see below for other enrollment data). Thus, although waiver rules would significant.ly improve Medicaid eligibility processing in Oregon, the program's remaining link with AFDC *means* a continued need for detailed personal income, expense, and other demographic information.

Implications for Current Medicaid Participants

In addition to the great majority of poor, uninsured Oregonians who would gain access to Medicaid benefits under the waiver, almost all *current* Medicaid recipients would be able to participate in the demonstration. However, the simplified eligibil-

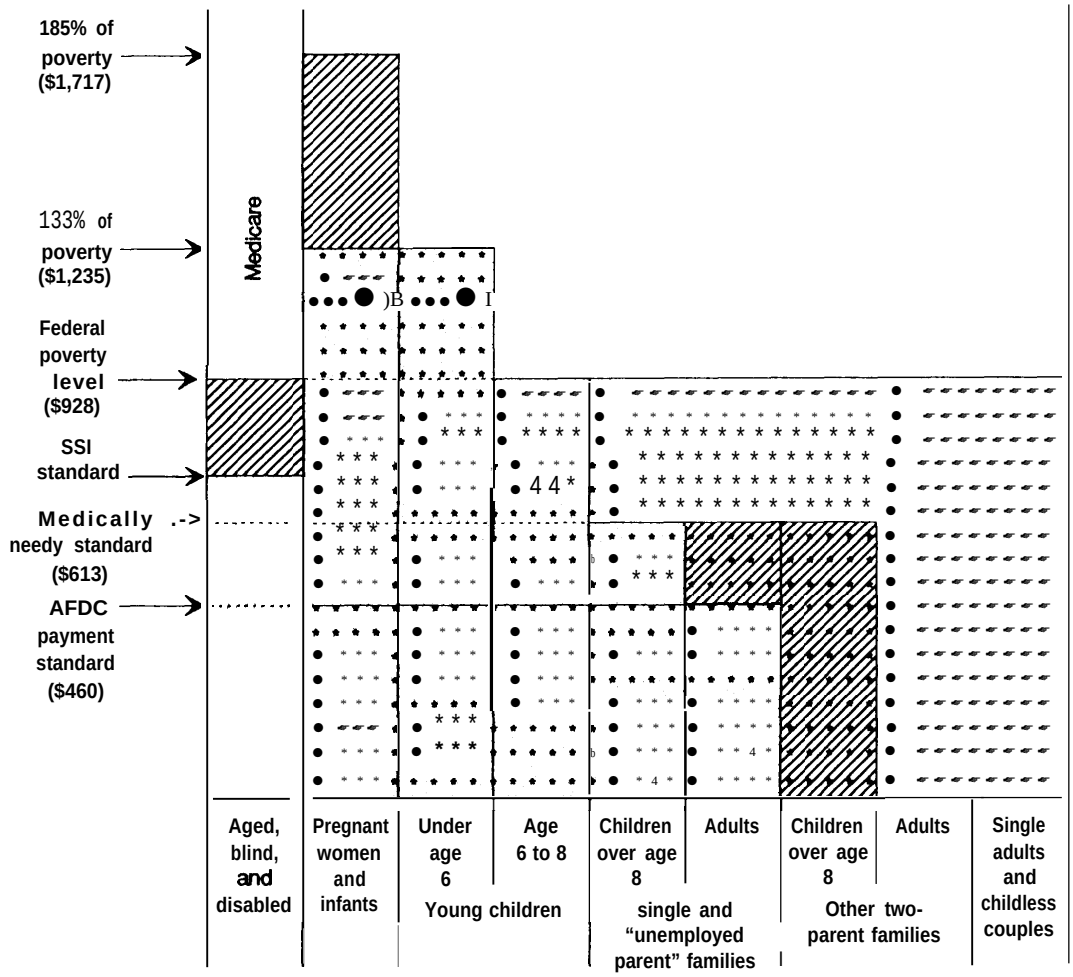
19 Because many migrant and seasonal workers are undocumented aliens, they are currently ineligible for Medicaid benefits and also would not be able to participate in the demonstration. The waiver rules maintain the current policy that Medicaid applicants be citizens or legal aliens who can demonstrate that they intend to reside in Oregon (173). There would be no required length of residency for migrant workers during the demonstration (as is current policy) (252). There were approximately 128,564 migrant and seasonal farmworkers in Oregon in 1989 (296); it is not known what proportion were undocumented aliens,

20 The aged, blind, disabled, and foster care children would be exempt from the demonstration until October 1993 (assuming the Health Care Financing Administration's approval to phase in this population). Their eligibility would continue to be determined under current rules until that time and they would continue to qualify for Medicaid and receive services under existing rules (177).

21 Pregnant women with incomes between 100 and 133 percent of the FPL would have coverage until 60 days postpartum (as is current practice).

22 The Omnibus Budget Reconciliation Act of 1986 gave States the option to omit the assets test when determining Medicaid eligibility for PLM women and children. All but five States, including Oregon, have done so. The five States that have not are California, Illinois, Iowa, North Dakota, and Texas (148).

Figure 5-2-Proposed Demonstration Eligibility (Monthly Income Levels for a Family of Three In 1991)



KEY: SSI - Supplemental Security Income; AFDC = Aid to Families with Dependent Children.
NOTE: This is a-simplified representation of eligibility. See text for further explanation.
a All children under age 19 and born after September 30, 1983 must be covered if family income is below poverty; ages shown are as Of October 1991.

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.

ity rules do eliminate some individuals who could have Medicaid benefits *without the* new requirements. The most vulnerable groups appear to be PLM women and children.

PLM Women and Children-For PLM eligibles, countable income *sources* would be the same as for the AFDC program, although none of the income *deductions* used in calculating AFDC eligibility, such as essential work and child-care expenses, would be allowed.

There is some uncertainty surrounding the estimates of the number of individuals who would be affected by this change in rules. The State estimates that only 215 *currently* eligible individuals (less than 1 percent) would not meet the income standards of the demonstration each year based on a recent l-day survey of all its eligibility offices (253). On the other hand, one county health provider of Medicaid services, the Clackamas County Public Health Division, has tracked PLM applications over a 12-day period and reports that more than 9 percent of its currently qualified PLM candidates would not be eligible for Medicaid under the simplified waiver rules (114).23 Most of the Clackamas County cases would be disqualified because they would be unable to use the $90 monthly earned income disregard.

Whether the Clackamas County experience would be typical for *all* PLM applicants during the demonstration is not known. Clackamas County has an active Medicaid eligibility outreach program on the site of its health clinic. In contrast, at present, most other PLM applicants must go to a county welfare office to obtain Medicaid benefits. Oregon plans for eligibility processing during the demonstration mirror Clackamas County's program in that they include a special outreach effort to avoid any welfare-related stigma of Medicaid benefits (177). The Oregon Medicaid Program plans to enroll Medicaid participants in community settings other than welfare offices, such as schools, churches, and elsewhere. If the State is successful at reaching out to a community that has no present relationship with the welfare system, the outcome of eligibility processing under the waiver may be similar to Clackamas County's current experience.

Given that the Clackamas County survey period was significantly longer than the State's survey (12 days vs. 1 day) and that the State intends to implement extensive outreach during the demonstration, it is likely that the actual denial rate of currently eligible PLM women and children would be greater than the State's current estimate of less than 1 percent.

Retroactive Benefits-Although AFDC recipients would continue to be able to receive retroactive benefits for 3 months, coverage for new eligibles would commence on the date of request.[24] The number of people who would be affected and the scope of the related debt has not been well established. The State has estimated that only 154 PLM participants received retroactive coverage in 1991 (253). Continuing retroactive coverage would entail a significant burden of paperwork and could markedly increase the cost of bringing uninsured individuals into the Medicaid program. There are some who are concerned, however, that eliminating retroactive coverage may lead providers to delay treating patients until they can present a valid Medicaid card (221).

Medically Needy--The State has not estimated how many medically needy recipients would lose coverage under the waiver.[25] Because Oregon's medically needy standard is only 66 percent of the FPL, many of the current medically needy who use the spend-down provision to become eligible are likely to have incomes under the waiver's 100 percent FPL income limit.

Asset Test—While an asset test would not be used for new eligibles, this should have little effect on current Medicaid participants. PLMs are already exempt from asset test requirements and AFDC recipients would continue, under the waiver, to be subject to the current asset test.

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23 The Clackamas County PLM denial rate includes 10 of 109 individuals who applied for Medicaid coverage during the period January 2-17, 1992 and were determined to be eligible. Of this group, eight were pregnant women and two were children under age 6. Some of these individuals applied for coverage as part of a family unit.

24 As required by Federal statute, there would be a 45-day maximum limit between the application date and final determination of eligibility [Title 42, part 435, sec.91 1].

25 The State did examine 1 month's eligibility files and found31 individuals who became eligible for the medically needy program by spending down from family incomes above the FPL (252). Oregon reports, however, that it is unable to use this experience to develop an estimate for a 1 year period because some people may be spending down for several consecutive months. The medically needy are required to apply for coverage on a monthly basis.

Continuity of Coverage—A long-held criticism of the Medicaid program has been that the constant turnover of participants hurts continuity of care, increases administrative expense, and discourages provider participation. Because eligibility hinges on personal characteristics that are often transient, such as pregnancy, marital status, and the size of medical bills compared with income, Medicaid participants become eligible and then ineligible with disruptive frequency (102). Yet, it is not clear from Federal statutory eligibility criteria whether Medicaid is intended to principally serve as a permanent source of assistance or as a safety net for those experiencing temporary hardships (239).

Oregon studies have shown that continuous Medicaid coverage is relatively brief for many program participants. A 1989 survey of Oregon AFDC recipients found that more than 45 percent had continuous coverage ranging from only 1 to 11 months. A 1990 report revealed that, despite ***guaranteed*** continuous coverage of pregnant women up to 60 days postpartum, the average length of uninterrupted Medicaid coverage for PLM pregnant women and children was only 6 months (159). It appears that many PLM women enroll in the Medicaid program late in their pregnancy.

National statistics indicate similar findings. One study, using the National Longitudinal Survey, reported that half of all AFDC recipients are continuously covered for 1 year or less and only 18 percent remain on AFDC for more than 5 years (154). An analysis of the Survey of Income and Program Participation showed that other groups of Medicaid participants, such as pregnant women and young children, are even more likely to have short-term coverage (239).

Short and colleagues argue that the Oregon approach of using poverty as a criterion for eligibility, instead of more narrowly defined categorical criteria, would open the Medicaid program to many more people on a short-term basis. This is because periods of poverty are often short-term and associated with intermittent participation in the labor force (15,154). Persistent turnover of Oregon's Medicaid population could be particularly troublesome to managed care providers who would be more subject to the administrative and clinical problems associated with the interruption of care when eligibility is terminated (239). On the other hand, Oregon's apparently successful managed care experience indicates that the State may be able to help new Medicaid managed care providers deal with these difficulties (238).

Table 5-3 shows the projected average length of eligibility for demonstration participants during the course of a l-year period. Oregon's waiver rules guarantee 6-month periods of continuous coverage (for all but AFDC participants) and may decrease the turnover of the Medicaid population. While AFDC eligibles would continue to be subject to current rules, those who lose AFDC benefits should be able to transfer to demonstration-only eligibility without a break in Medicaid coverage (252). PLM women and children, with family incomes below 100 percent of the FPL should also be able to transfer to demonstration-only eligibility. The State expects demonstration-only eligibles to have continuous Medicaid benefits longer than any other eligibility groups.

Enrollment 2627

The Oregon Medicaid population is projected to increase dramatically and its makeup would change considerably under the proposed waiver. In the first year of the demonstration (i.e., fiscal year (FY) 1993), the change in eligibility rules is forecast to increase the average monthly number of Medicaid enrollees by more than 20 percent, from 214,364 to 258,464 (see table 5-4). By the fifth and final year of the waiver, Oregon forecasts a total average enrollment of 368,700, including 120,600 beneficiaries who would not be eligible under current rules (see figure 5-3).[28] 29

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26 Enrollment data presented in this section are drawn from two sources: 1) the Oregon waiver application and 2) unpublished data provided to the Office of Technology Assessment by the Oregon Medical Assistance Programs (OMAP) office. The reader should note that OMAP data include enrollment figures for two eligibility groups, the medically needy participants in the Oregon Supplemental Income Program and Qualified Medicare Beneficiaries, that are not included in the waiver statistics. Both groups are relatively small and would not be part of the demonstration until the phase-in of the disabled and elderly populations.

27 Enrollment data are presented on a fiscal year basis. Oregon's fiscal year runs from July 1 through June 30.

28 Unless indicated otherwise, this review of enrollment data focuses on average monthly data rather than counts of the total number of unduplicated Medicaid beneficiaries. Because many beneficiaries have Medicaid benefits fora short period of time, annual unduplicated counts are significantly higher than monthly averages. Unduplicated counts show the considerable volume of individuals flowing through the Medicaid program, but they are less useful than average data for describing the program's caseload.

Table 5-3-Oregon Medicaid Program: Estimated Average Length of Eligibility, Before and After the Proposed Demonstration in a l-Year Period

Eligibility category	Average length of eligibility (in months)[a]	
	Before the demonstration	After the demonstration
AFDC	6.5[c]	6.5
PLM children	3.4	4.8
PLM adults	3.9	3.9
General assistance	4.3	4.3
Demonstration only		
Newly eligible families	NA	10.5
Newly eligible singles	NA	9.9
Newly eligible childless couples	NA	9.9

KEY: NA = not applicable; AFDC = Aid to Families with Dependent Children; PLM = poverty level medical.
a Eligibility is described in terms of person-months. individuals can appear in more than one eligibility category.
b "Before the demonstration" data are based on actual FY 1989 experience.
c Shows adjustment for 1989 welfare reform rules that was expected to result in increased length of eligibility for the AFDC program.

SOURCE: Coopers & Lybrand, *Oregon Medicaid Basic Health Services Program: Calculation of Per Capita Cost Report,* (San Francisco, CA: Coopers & Lybrand, May 1, 1991) and Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *Oregon Health Plan: Offerers Conferences Questions and Answers,* (Salem, OR: OMAP, Feb. 18, 1992).

This section will describe and compare the current and projected program enrollment.

Current Enrollment

The average monthly Medicaid enrollment in FY 1991 was 185,709 (see table 5-4). Close to 71 percent of the participants were poor women and children who enrolled either as PLM or AFDC program participants. About 7,600 (4.3 percent) of the AFDC eligibility group became eligible through the medically needy program, which has since been significantly scaled back to include only pregnant women and children under age 18 (252).[30] The elderly, blind, disabled, and foster care children made up the remainder of the population in 1991.

Race and Ethnicity of the Current Medicaid Population-Data on race/ethnicity are shown in table 5-5. Minorities make up a small proportion of Oregon Medicaid participants, reflecting their distribution in the statewide population (see ch. 2). Oregon Medicaid participants are predominately white (84.3 percent), The largest minority groups among Medicaid participants are blacks (6.2 percent) and American Indians/Alaskan Natives (5.2 percent).

The Poor Without Access to Medicaid—Al- though more than 282,000 Oregonians were eligible for Medicaid some time during FY 1991, many of Oregon's poor were uninsured.[31] In FY 1990, more than 101,000 Oregonians whose family incomes were below the FPL, or about 29 percent of the State's poor population, had neither Medicaid, Medicare, nor private health insurance coverage (184). They are the target population of the proposed demonstration project. The proportion of Oregon's poor without health insurance is lower than that of the Nation overall; 35.7 percent of the U.S. population living in poverty were uninsured in 1989 (265).

Impact of the Waiver on Enrollment

The average monthly number of Medicaid participants in the demonstration is projected to be 197,500 in FY 1993 (see table 5-4). More than 302,000 poor Oregonians would take part in the demonstration for some period during its frost year.

Oregon's demonstration enrollment projections assume that, although there are more than 101,000 uninsured poor Oregonians, only about 40 percent of the target population of new eligibles would actually enroll in the first year. On average, about 72 percent

29 The State expects total Medicaid enrollment to be 338,500 in the last year of the waiver if its mandate to employers to provide health insurance is fully implemented.

30 Although the medically needy must meet the categorical requirements of the AFDC program (e.g., an absent parent) to be eligible for Medicaid benefits, they are not eligible for AFDC cash assistance because their family incomes are too high. See the earlier discussion regarding eligibility rules.

31 Note that although 282,844 Oregon residents received Medicaid benefits in FY 1991, many were eligible for only a brief period during the year.

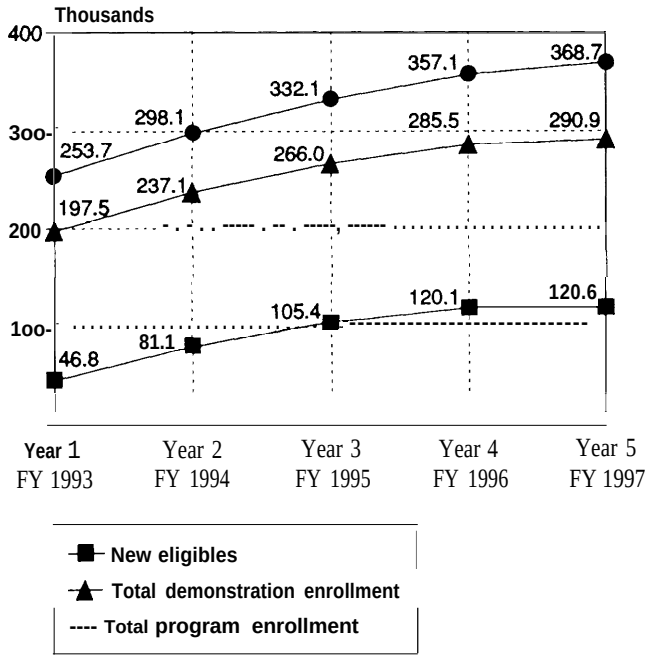
Table 5-4--Oregon Medicaid Enrollment for FY 1991 and Projected for FY 1993, With and Without the Demonstration, by Eligibility Group

	FY 1991 enrollment		Projected FY 1993 withoutS627			Projected FY 1993 withS627		
	Average eligibles per month	Percent of total	ed Average eligibles per month	Percent of total	undu eli	ed Average eligibles per month	Percent of total	undu eli
Medicaid eligibles (SB) 27[a]								
Old age assistance .	18,877	10.2Y0	28,019	22,161	10.3%	28,019	22,161	8.6%
Aid to blind/aid to di:	22,037	11.9	35,249	26,465	12.3	35,249	26,465	10.2
Foster care	7,409	4.0	10,526	7,620	3.6	10,526	7,620	2.9
Medically needy OS	2,931	1.6	5,738	3,934	1.8	5,738	3,934	1.5
Qualified Medicare I	550	0.3	1,504	784	0,4	1,504	784	0.3
Total non-SB 27	51,804	27.9	81,036	60,964	28.4	81,036	60,964	23.6
Current eligibles in								
AFDC[c]	115,113	62.0%	189,085	124,900	58.3%	189,085	124,900	48.3%
Poverty level medic:	5,312	2.9	14,905	6,100	2.8	14,905	6,100	2.4
Poverty level medic:	10,880	5.9	40,389	19,700	9.2	40,389	19,700	7.6
Total	131,305	70.7	244,380	150,700	70.3	244,380	150,700	58.3
New Medicaid eligibles								
Categorical..... NA	NA	—	NA	NA	—	8,114	7,100	2.7%
Noncategorical ..... NA	NA	—	NA	NA	—	44,848	37,000	14.3
General assistance..... 4,506	2,600	1.4	4,679	2,700	1.3	4,679	2,700	1.0
Total new eligibles 4,506	2,600	1.4	4,679	2,700	1.3	57,642	46,800	18.1
Total demonstration enrollment. .... NA	NA	—	NA	NA	—	302,022	197,500	76.4
Total Medicaid enrollment 282,844	185,709	100.0%	325,416	214,364	100.0%	383,058	258,464	100.0%

KEY: NA = Not applicable; OSIP = Oregon Supplemental Income Program; AFDC = Aid to Families with Dependent Children; FY = fiscal year.
NOTE: Percentages may not add to exactly 100.0 due to rounding error.
[a] The State intends t. ask the Health Care Financing Administration (HCFA) for an amendment to the waiver to incorporate these eligibility groups into the demonstration in October 1993.
[b] These eligibility groups were omitted from Oregon's waiver application.
[c] About 4.3 percent or 7.604 recipients, qualified for AFDC through the medically needy program (252).
[d] Oregon considers the general assistance population t. be a "new" eligibility group under the waiver because it is not eligible for Federal matching payments under current rules.

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, unpublished enrollment data, 1991.

Figure %3-Oregon Medicaid Demonstration Enrollment Projections[a]



Medicaid demonstration enrollment,

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.

of people potentially eligible for the Oregon Medicaid program have enrolled in the past. The waiver projections assume the same overall participation rate of current eligibles once the demonstration is phased in.

Oregon expects that in the waiver's first year more than three-quarters of the demonstration population would be individuals and families who could qualify for Medicaid benefits under current rules, principally through the AFDC program. Later on, current eligibles would make up a smaller proportion of the demonstration, approximately 59 percent.[32]

New Eligibiles--New eligibles, who would not qualify for Medicaid under current rules, are forecast to total 46,800 in FY 1993. By the final year of the waiver, 59 percent of potentially new eligibles are expected to enroll in the demonstration, a total of 120,600.[33] Most of the new eligibles are "noncategorical' ' and would not meet the current demographic restrictions of the Medicaid program. They are principally single adults, childless couples, and two-parent families.

Table 5-5-Race and Ethnicity of the Oregon Medicaid Population, FY 1990

Race/ethnicity	Total	Percent
Total number of eligibles	227,198	100.0%
White, not of Hispanic origin	191,546	84.3
Black, not of Hispanic origin	13,977	6.2
American Indian or Alaskan Native	11,921	5.2
Asian or Pacific Islander	3,972	1.7
Hispanic	5,084	2.2
Unknown	698	0.3

NOTE: Percentages may not add to exactly 100.0 due to rounding error.

SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, HCFA 2082 data from the *Statistical Report on Medical Care: Eligibles, Recipients, Payments and Services,* Section D (2). Eligibles for Medical Care by Age, Race/Ethniaty, and Sex (Baltimore, MD: Dee. 24, 1990).

Table 5-6 illustrates how the newly eligible population differs from current Medicaid participants. The new eligibles are primarily a group that has been ignored by congressional efforts to expand Medicaid eligibility. More than half of new eligibles are expected to be male and 63 percent would be adults over the age of 24 years. In contrast, males make up only 41 percent of the current eligibles who would participate in the waiver and adults over 24 years make up less than 21 percent. (In addition, most of the currently eligible males are children.) Although children under age 18 would make up 17 percent of the new eligibles, they are already scheduled to be phased in (slowly) to the Medicaid population.

Where Does the Oregon Demonstration Population Live?—Figure 5-4 shows Oregon's expected distribution of Medicaid eligibles by county in the first year of the proposed waiver. FY 1991 data indicate that 65 percent of Oregon's Medicaid participants live in the State's eight metropolitan counties (182).[34] The remaining Medicaid population is dispersed among 25 nonmetropolitan counties.

32 If the employer mandate is implemented, current eligibles would make up a projected 63 percent of total demonstration enrollment.

33 If the employer mandate is fully implemented, new eligibles are expected to total 96,400 in the last year of the waiver.

34 A metropolitan county is defined by the U.S. Office of Management and Budget as one that includes either: 1) a city of at least 50,000 residents, or 2) an urbanized area with at least 50,000 people tbat is itself part of a group of counties with at least 100,000 total residents.

Table 5-6-Projected Oregon Medicaid Enrollment by Age and Sex, Under the Proposed Demonstration, FY 1993

	Total Medicaid population				Current eligibles/group subject to the waiver				Current eligibles/group not subject to the waiver			
Age	Males	Females	Total	Percent of total	Males	Females	Total	Percent of total	Males	Females	Total	Percent of total
&.	34,221	32,899	67,121	26.5%	32,108	30,849	62,957	41.870	1,600	1,537	3,137	1 .2%
6-14	21,823	21,285	43,108	17.0	16,925	16,458	33,383	22.2	2,566	2,495	5,062	2.6
15-18	3,749	8,013	11,764	4.6	2,329	5,842	8,171	5.4	498	1,249	1,748	1.0
19-24	9,248	17,248	26,496	10.4	3,598	11,393	14,990	9.9	556	1,761	2,317	4.8
25-34	11,103	26,286	37,390	14.7	4,441	16,909	21,350	14.2	1,234	4,699	5,934	12.2
35-54	11,341	22,034	33,375	13.2	2,292	7,337	9,629	6.4	2,557	8,188	10,745	22.1
55-64	5,876	6,625	12,499	4.9	79	140	219	.1	1,915	3,404	5,318	10.9
65 and over	5,808	16,184	21,992	8.7	0	0	0	0.0	5,804	16,181	21,985	45.2
Total	103,169	150,575	253,745	100.0	61,771	88,929	150,700	100.0	16,731	39,515	56,246	100.0

	New eligibles				General assistance			
Age	Males	Females	Total	Percent of total	Males	Females	Total	Percent of total
4	513	513	1,027	2.3%	0	0	0	0.0%
6-14	2,332	2,332	4,663	10.6	0	0	0	0.0
15-18	922	922	1,845	4.2	0	0	0	0.0
19-24	4,936	3,969	8,905	20.2	158	125	284	10.5
25-34	5,091	4,410	9,501	21.5	337	268	605	22.4
35-54	5,733	5,907	11,640	26.4	759	602	1,361	50.4
55-64	3,635	2,885	6,519	14.8	247	196	443	16.4
65 and over	0	0	0	0.0	4	3	7	0.3
Total	23.162	20.937	44.100	100.0	1.505	1.195	2.700	100.0

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, unpublished enrollment data, 1991.

ACCESS TO CARE UNDER THE DEMONSTRATION

Access has been defined as "those dimensions which describe the potential and actual entry of a given population group to the health care delivery system' (2). Would Oregon's demonstration enable its participants to gain greater access to health care services than they have at present? Two key components to this answer are the number of people covered and the health services for which they are covered. As noted in the previous sections on eligibility and enrollment, the numbers clearly show that this proposal makes significant inroads into resolving the dilemma of insuring the uninsured poor. The role of benefits is examined below after a brief review of why Oregon's proposal may be so valuable to the State's uninsured poor. To examine the potential implications of the waiver's change in benefits for *current* Medicaid eligibles, an analysis of common diagnoses that would *not* be covered under the waiver is also provided.

The Newly Insured [35]

Although much of this chapter focuses on current Medicaid beneficiaries, it is important to review the significance of Oregon's initiative for the uninsured poor. While there are limited data regarding differences in health outcomes between uninsured and insured persons, a growing body of research documents that people without health insurance are less likely to seek medical care and, if they do, are often more seriously ill than the insured (88, 124,263,303). People without health care coverage are also likely to be treated less aggressively than the insured (88,319). The eventual effects can be unnecessary deaths, more serious illness, and possible higher overall costs of health care.

A recent study of more than half a million hospital admissions found that uninsured people had a 44 to 124 percent higher risk of in-hospital mortality than did insured people (89). In addition, uninsured patients were sometimes treated less aggressively and had shorter lengths of stay in the hospital. Other studies have examined differences in how aggressively insured versus uninsured patients with AIDS, lung cancer, and cardiovascular disease were treated (86,87,319).

The uninsured population's access to primary care is also poor relative to others. Recent findings from the National Medical Expenditure Survey (NMES) indicate that public insurance, such as Medicaid, improves access to care; at each income level, the nonelderly with public insurance were about 20 percent more likely to use health services than the uninsured nonelderly (124).[36] This disparity was found even among those who reported that they were only in fair or poor health.

Having a usual source of care is an important factor in predicting the use of health services (2). NMES findings show that only 65 percent of the uninsured population had a usual source of medical care in 1987, compared with 87 percent of those with any Medicaid or similar public coverage (297). In addition, the benefits of free care have been shown to be particularly important for low-income people who have specific conditions with well-established treatments (e.g., hypertension) (24). NMES data further indicate that Medicaid coverage made a significant difference in the use of preventive care by preschool children. For low-income preschoolers who would be uninsured without Medicaid coverage, a full year of Medicaid benefits was found to increase the probability of having any well-child visits by 17 percentage points (240).

It is apparent that, despite the restriction of coverage to medically necessary treatments above line 588, low-income uninsured Oregonians stand to gain considerably under the proposed demonstration.

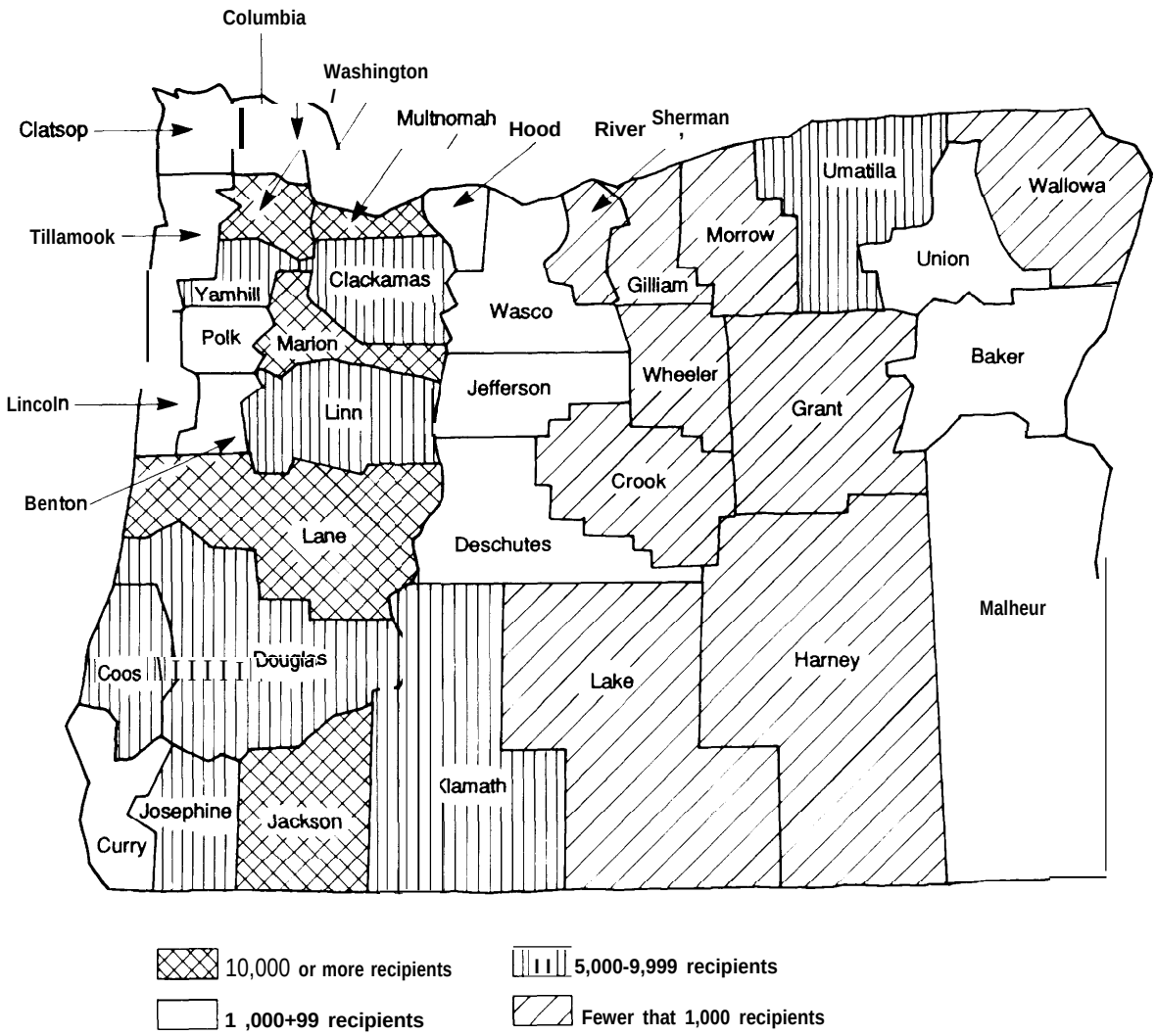
How Oregon Medicaid Benefits Would Change Under the Waiver

One of the most controversial aspects of the Oregon waiver proposal is its change in the scope of health benefits for Medicaid participants. Under the waiver, benefits would not be based on traditional health service categories, such as hospital care, physician services, prescription drugs, etc. Instead,

35 The Office of Technology Assessment is currently conducting a study examining the relationships between technology, health insurance, and the health care system. An interim document examining the literature on the relationship between health insurance status and health outcome will be published in summer 1992. The full report is scheduled for publication in spring 1993.

36 The National Medical Expenditure Survey was conducted in 1987 and provides nationally representative estimates of health care use for the U.S. civilian noninstitutionalized population (124).

Figure 5-4-Projected Concentration of Medicaid Eligibles in Oregon, FY 1992 (under the demonstration)



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.

coverage would be defined in new terms: the CT pairs formulated by the Oregon Health Services Commission (HSC).[37] The HSC's list of 709 CT pairs is intended to include all primary and acute medical care.[38] The waiver proposal restricts covered health services to those falling above line 588 of the list, as well as diagnostic, ancillary, and some mental health and chemical dependency services.[39]

Unlike any existing private or public health insurance benefit package, Oregon's Medicaid proposal does not contain a core set of basic health benefits, nor does it guarantee any essential benefits during the course of the 5-year demonstration. At the outset, coverage would be clearly defined by the first 587 CT pairs. Medical and surgical treatments that fall below line 587 would not be covered. But if at

37 See ch. 3 for an analysis of the list and the methodology used to develop it.

38 Mental health and chemical dependency services would be incorporated into the list by October 1993. Until that time, they would be provided under current rules. It is not yet known how the addition of these services would affect coverage of benefits related to physical health.

39 Some health services would continue to be subject to prior authorization.

any time during the course of the waiver there are not enough funds to cover the related costs, benefits would be cut, in descending order of priority, until the necessary savings have been achieved.[40] There is no statutorily established line on the list beyond which coverage could not be dropped.

Under current rules, budget shortfalls can and have led to unexpected cuts in *optional* benefits and *optional* eligibility groups (254). However, mandatory Medicaid benefits (see below) as well as mandatory eligibility groups are *protected* from budget shortfalls.

This section describes current Federal and Oregon Medicaid benefit rules, compares them with coverage given implementation of the list, and assesses the implications of the change in benefits for current Medicaid participants.

Current Oregon Medicaid Benefits

Federal Medicaid rules permit each State to define its own benefit package within broad guidelines. All States are required to offer a core package of mandatory services that includes basic hospital, ambulatory, long-term care, and ancillary services (see chapter 2 for a complete list). States must also pay for coinsurance for Medicare participants with family incomes under 100 percent of the FPL.

Although Medicaid law authorizes Federal matching funds for necessary medical services, it does *not* require coverage of all medically necessary services. Federal law defines a service as medically necessary:

> . . . if it is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and if there is no other equally effective (although more conservative or less costly) course of treatment available or suitable for the recipient requesting the service (36).

States are required to provide services that are sufficient in amount, duration, and scope to reasonably achieve their purpose (266). Although Medicaid programs may place limits on services, they may not arbitrarily deny or reduce coverage of a required service solely because of the diagnosis, type of illness, or condition.

Oregon currently covers a wide range of optional Medicaid benefits, such as prescription drugs, physical and occupational therapy, certain organ transplants, and services of other licensed practitioners (such as chiropractors, psychologists, and podiatrists) (168). (See chapter 2 for a complete list.) Although Federal statute allows it, Oregon does not cover adult dental services, hospice services, screening services for adults, or Christian Science nurse services (168,301).

Oregon's ability to finance optional benefits is currently in question due to Ballot Measure 5, a statewide referendum passed in November 1990. Measure 5 calls for a rollback of local property taxes earmarked for schools and requires the State's general fired to replace any revenue lost by public schools due to these limits (250). Significant budget reductions in nonschool State services will be required. As a consequence, in July 1991, the State eliminated coverage of all medically needy groups except pregnant women and children, eliminated coverage of adult emergency dental care, and curtailed benefits for the medically needy aged, blind, and disabled (259). State officials are currently evaluating how to further reduce the Medicaid budget and are considering a number of potential cutbacks, including dropping every optional adult service, cutting provider reimbursement, and adding a client copayment requirement (200).

Coverage Under the Waiver

New Benefits

The list introduces several important new benefits for adult Medicaid participants, including preventive health services, dental care, numerous organ transplants, and comfort and hospice care for the terminally ill (see table 5-7).[41] Because Medicaid coverage of children is already quite extensive, the waiver would add little to their benefit package. In fact, all of the new demonstration benefits, except

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40 See ch. 6 for an analysis of program expenditures and cost issues.

41 Current Medicaid participants who are enrolled in the Kaiser Permanente medical care program already receive preventive health services and hospice care (100).

42 Most of the new demonstration benefits are also currently available to 18- to 20-year-olds if provided within the Context of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. See below for more information on EPSDT.

Table 5-7—Proposed New Benefits Under the Oregon Medicaid Demonstration

Type of service	Condition-treatment pair(s)	Affected population
Preventive services	167	Adults
Comfort and hospice care	164	Terminally ill
Organ transplants, including heart, liver, bone marrow, and pancreas/kidney[a,b,c]	209,214,249,294,307,31 1,365,366-368,523-4	Adults
Dental care	165,166,398,479,548-50	Adults
Tissue expanders	49,115,136,205,258,171 ,215	Adults
Hyperbaric oxygen pressurization	77,133	Adults

NOTE: Akt to Families with Dependent Children and poverty level medical children under age 18 are already eligible for all the above services except comfort/hospice care.

a Although heart/lung and liver/kidney transplants are currently covered for children, it is not clear whether they would be covered under the waiver. The heart/lung transplant CPT-4 code does not appear on the list. There is no CPT-4 code for liver/kidney transplants.

b Transplant recipients must meet strict medical eligibility criteria. Under current policy all transplants, except those provided on an emergency basis, require prior approval and must be provided in a transplant center that provides quality care (OMAP, 1990). Emergency transplants are subject to post-transplant review to confirm that the patient and the transplant center met State-set eligibility and medical criteria at the time of the transplant. This policy is likely to continue under the waiver.

C Liver transplants would not be available to beneficiaries with alcoholic cirrhosis. Bone marrow transplants would not be covered for non-Hodgkins lymphoma.

SOURCE: Oregon Health Services Commission, Salem, OR, *Prioritization of Health Services: A Report to the Governor and Legislature,* 1991.

comfort and hospice care, are currently available to children under age 18.[42]

Preventive Services for Adults—The list incorporates the guidelines of the U.S. Preventive Services Task Force in CT pair 167 (see table 5-8).[43] It is clear that this represents a significant expansion in coverage for adults. Although State Medicaid programs have the option to cover adult screening services, Oregon has not covered them except for selected procedures (i.e., immunizations, Pap smears, and mammograms).

Because many adults would be eligible for Medicaid benefits for less than a year, it is not clear how much they could gain from this expansion in coverage. Quick access to appointments and actual receipt of preventive services would be essential if there is to be any clinical benefits from early disease detection. If transfer out of Medicaid equates with transfer into an employer-sponsored health plan, there may be more potential for following up any condition that was identified during a Medicaid-funded screening exam.

Adult Dental Care-Coverage of dental care also makes an important addition to Oregon's Medicaid benefits. In July 1991, due to fiscal constraints, the Oregon State legislature discontinued finding for adult dental care (254).[44] Up until that time, adults were able to receive emergency dental services, and available data indicate that those services were widely utilized (42). In fact, the data show that, despite Oregon's intent to restrict dental coverage to emergency care only, a significant volume of dental care was funded by the Oregon Medicaid program until the dental benefit was eliminated (42).

Organ Transplants for Adults—Under current policy, children are eligible for a wide range of organ and tissue transplants, including bone marrow, cornea, heart, heart/lung, kidney, liver, liver/kidney, and pancreas/kidney transplants (168). Adult transplant coverage is restricted to kidney and cornea transplants. The waiver would provide additional funding for bone marrow, heart, pancreas/kidney, and liver transplants for adults.[45,46] Given the success of organ transplants in treating many indi-

42 Most of the new demonstration benefits are also currently available to 18- to 20-year-olds if provided within the context of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. See below for more information on EPSDT.

43 The U.S. Preventive Services Task Force was a 20-member, nonfederal panel charged in 1984 by the Assistant Secretary for Health with reviewing the scientific evidence in support of clinical preventive services and developing age-and sex-specific recommendations for their delivery (123) The guide was presented to the U.S. Department of Health and Human Services in 1989.

44 Dental services are funded in all but four State Medicaid programs (287).

45 Transplant recipients must meet strict medical eligibility criteria. Undercurrent rides, all transplants, except those provided on an emergency basis, require prior approval and must be performed in a transplant center that provides quality care (165). Emergency transplants are subject to post-transplant review to confirm that the patient and transplant center met OMAP eligibility and medical criteria at the time of the transplant (212). This policy is likely to continue under the waiver.

46 Bone marrow transplants would not be covered for children or adults with non-Hodgkins lymphoma. The HSC is currently considering whether to recommend to the State legislature that the list be modified to cover bone marrow transplants for non-Hodgkins lymphoma (244). If the commission moves to take such action, the modification would be subject to the final approval of the State legislature (or its Emergency Board).

Table 5-8--Oregon Medicaid Coverage of Adult Preventive Services: Demonstration vs. Current Benefits

Adult preventive services benefits under the demonstration [a]	Current Oregon Medicaid coverage for adults during preventive visits [b]
Screening:	
History	No
Physical exam	No
Brief mental status exam	No
Lab/diagnostic procedures [c]	
Nonfasting total blood cholesterol	No
Mammogram [d]	Yes
Papsmear [e]	Yes
For high-risk groups[f]	
Fasting plasma glucose	No
Rubella antibodies [g]	*No*
VDRL/RPR	No
Urinalysis for bacteriuria	No
Chlamydial testing	No
Gonorrhea culture	*No*
Counseling/testing for HIV infection	No
Hearing	No
Tuberculin skin test	No
Electrocardiogram	No
Fecal occult blood/colonoscopy [h]	No
Fecal occult blood/sigmoidoscopy [h]	No
Bone mineral content	No
Counseling:	
Diet/exercise	No
Substance use	No
For high-risk groups[f]	
Sharing/using unsterilized needles	No
Sexual practice	No
Injury prevention	No
For high-risk groups[f]	
Back conditioning exercises	No
Fails in the elderly	No
Prevention of childhood injury	No
Dental health	No
Other primary preventive measures	
For high-risk groups [f]	
Skin protection from ultraviolet light	No
Discussion of hemoglobin testing	No
Discussion of aspirin therapy	No
Discussion of estrogen replacement therapy	No
Immunizations:	
Tetanus-diphtheria booster	Yes
For high-risk groups[f]	
Hepatitis-B vaccine	Yes
Measles-mumps-rubella vaccine	Yes
Pneu mococcal vaccine	Yes
Influenza vaccine	Yes

KEY: VDRL/RPR = Venereal Disease Research Laboratory/Rapid Plasma Reagin; HIV = human immunodeficiency virus.
[a] The frequency of the individual preventive services is left to clinical discretion unless otherwise noted in other footnotes.
[b] Shows coverage for adults for services provided in the context of a preventive medicine visit. All of the services listed are covered when provided for diagnostic rather than screening purposes. Note also that children currently have comprehensive preventive services coverage under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit.
[c] All laboratory and diagnostic procedures are *not* covered as part of routine health exam for adults, with the exception of pap smears and mammograms.
[d] Every 1 to 2 years for women beginning at age 50 or age 35 for those at increased risk.
[e] Every 1 to 3 years.
[f] Criteria for high-risk groups are detailed in "Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force" (see ref. 123).
[g] Suggested only for adults, ages 19 to 39.
[h] Suggested only for adults, ages 40 to 64.

SOURCE: Office of Technology Assessment, 1992.

viduals, this is an important expansion in coverage (31,32,64,210,218,262).

Liver transplants for alcoholic cirrhosis (CT pair 690) would not be covered despite success rates similar to as those for nonalcoholic liver failure (CT pair 366) (294,299).[47] It is important to note that, after considering available outcomes data, the Health Care Financing Administration (HCFA) approved Medicare payment for liver transplants for alcoholic cirrhosis in 1991 (294; 56 FR 15006). It is especially troublesome that the well-established and effective medical therapy (e.g., prescription medications, special diet) for alcoholic cirrhosis (31 1) is missing from the list altogether.

While current policy covers heart/lung and liver/kidney transplants for children, it is not clear whether these transplants would be covered under the waiver. Neither joint transplant type appears separately on the list.

Comfort and Hospice Care—The list indicates that the demonstration would allow Medicaid funding of hospice care in Oregon for the first time. Because the details of the hospice program are currently under development, the scope of the benefit is not yet known. Covered comfort care services presumably would include at least pain medication and pain management devices, in-home and day care services, and medical equipment and supplies (e.g., beds, wheelchairs, bedside commodes, etc.).

Hyperbaric Oxygen Pressurization--This costly treatment is currently covered only for children. It can be lifesaving for individuals seriously exposed to carbon monoxide fumes (e.g., in a house free) (45). It is also an important treatment for some anaerobic infections (e.g., gangrene), decompression sickness, and other conditions.

Tissue Expanders—Tissue expanders, also referred to as temporary inflatable devices, are widely used in reconstructive surgery and are currently covered for Oregon Medicaid children. The principal advantage of this technology is that it allows the use of adjacent tissue in restoring a congenital or acquired deformity (201). Tissue expanders are used throughout the body in all age groups, particularly in breast reconstruction, head and neck reconstruction, and correction of defects in the scalp and extremities (133).

Coverage of Diagnostic and Ancillary Services

The State intends that every Medicaid participant receive all "services and tests required to identify, *within reason, the* patient's condition to be treated' (emphasis added) (193). While this policy pertains to all patients, even those who are ultimately diagnosed with a below-the-line condition, it is not clear what limits would be placed on diagnostic procedures.

There is reason to be concerned about access to some diagnostic procedures provided in a hospital setting. Although OMAP intends to do so, it has not yet developed a mechanism for paying for inpatient diagnostic care for CT pairs below line 587 (212). This is a critical matter, because Oregon hospital reimbursement is based on diagnosis-related groups (DRGs) and does not allow diagnostic or any other type of inpatient service to be "carved out" for payment purposes. Without a change in current hospital billing and payment rules, patients with an uncovered condition might not receive (or the hospital might not be paid for) related inpatient diagnostic services. A significant proportion of demonstration participants may be affected since, for many, inpatient care would be provided on a subcontracted or fee-for-service (FFS) basis.

There is a similar incongruity between practical billing matters and the coverage of some ancillary services. In this case, the effect may be to ***enable*** **access** to uncovered services. Ancillary services, such as physical therapy, prescription drugs, and medical supplies and equipment, are not included on the list, but they would be fully covered if associated with a covered CT pair and found to be medically necessary based on Oregon's usual Medicaid rules. (See table 5-9 for a list of covered ancillary services.) However, it is not clear whether the State would be able to fully restrict the coverage of certain ancillary services to those associated with CT pairs 1 through 587. Pharmacies, for example, may not have the means to easily identify which CT pair relates to a

[47] The HSC is currently considering whether to recommend to the State legislature that the list be modified to cover liver transplants for alcoholic cirrhosis (244). If the commission moves to take such action, the modification would be subject to the final approval of the State legislature (or its Emergency Board).

prescription presented by a Medicaid patient participating in the demonstration.[%]

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The EPSDT program was broadened considerably and has been described as the most expansive preventive services program for children in the country (267). The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) amendments dramatically expanded Medicaid coverage of children and adolescents by essentially eliminating any State Medicaid limitations on diagnosis or treatment for any health condition identified during the course of an EPSDT screen as long as the services are within the limits of Federal Medicaid guidelines and are deemed medically necessary (271 ,272).

Coverage of children's preventive services would not change under the proposed demonstration, but the Federal mandate to treat all conditions identified during the course of an EPSDT screening visit would be restricted to CT pairs 1 through 587. It is difficult to say whether this threatens an important gain for children's health under the Medicaid program. There are no reliable data describing access to EPSDT services among Oregon's Medicaid children. Nor is it known to what extent these children are screened by an EPSDT provider and then actually receive followup treatment. Some common medically necessary pediatric services would not be covered under the waiver, but most are acute conditions that are not the focus of EPSDT screens (see utilization data below).

Uncovered Conditions[49]50

A CT pair's low rank on the prioritized list is intended to reflect lower relative importance but not necessarily complete ineffectiveness. Consequently, it should not be surprising that some below-the-line CT pairs include conditions with effective therapies. Nevertheless, most uncovered CT pairs do *not* have significant clinical implications (see table 5-10).

Table 5-9-Oregon Medicaid Coverage of Ancillary Services Under the Proposed Demonstration

- **Anesthesia services**
- **Case management services, i.e., services that are designed to obtain health care services necessary to maintain an optimal level of physical and emotional development and health. Examples of case management services include: maternity case management that involves management of non medical services which address social, economic, and nutritional factors; and targeted case management for at-risk/vulnerable children, individuals with catastrophic illness or injury such as AIDS or cancer, Individuals with developmental disorders, and individuals with chronic mental illness.**
- **Home health services, i.e., skilled nursing; home health aide services; speech, occupational, or physical therapy; and equipment and supplies provided through a certified home health agency.**
- **Laboratory services**
- **Medical supplies and equipment prescribed by a practitioner (e.g., prosthetic devices, wheelchairs, respirators, ventilators, apnea monitors, diabetic testing strips, ostomy supplies, oxygen and related equipment, and ophthalmic materials).**
- **Nutritional counseling (e.g., diabetic counseling, counseling for improved pregnancy outcomes).**
- **Personal care services (e.g., health care aide services)**
- **Physical, occupational, speech, language, hearing, and vision therapy**
- **Prescription drugs (to include outpatient, inpatient, intravenous, and enteral therapy and limited over-the-counter drugs)**
- **Private duty nursing services**
- **Radiology and Imaging services**
- **Transportation, meals, lodging, and day care necessary for recipients to access revered services**

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.

In fact, some below-the-line CT pairs clearly reflect treatments that are generally considered ineffective or would make little difference to exclude from coverage given current clinical practice. This is particularly true of three neonatal-related CT pairs: intraventricular and subarachnoid hemorrhage of fetus or neonate (CT pair 687), extremely premature (under 23 weeks gestation) and low-birthweight (under 500 grams) infants (CT pair 708), and

48 OMAP and Coopers & Lybrand (which performed many of the financial analyses for the State) have recognized the difficulty in determining how pharmacy claims would be handled relative to the prioritized list. They increased the demonstration's projected list-related costs by 5 percent to account for this problem (see ch. 6).

49 This analysis is based on the latest available version of Oregon's list of prioritized health services. It is OTA'S understanding that the Oregon Health Services Commission is preparing to vote on a number of changes to the list. The relevant list changes are noted in footnotes below.

50 In addition to the references noted in the text, much of the analysis related to uncovered conditions is W on contract work prepared for OTA by D. Asch, J. Patton, A. Giardino, and M.A. Schuster (see refs. 14,80,235).

Table 5-10-Examples of Below-the-Line Condition-Treatment (CT) Pairs With Limited Anticipated impact on Beneficiaries' Health

CT pair	Description	Comments	Reference[a]
606	Hepatorenal syndrome--medical therapy	Treatment is usually ineffective	(Punukoilu, 1990) (208)
610	Cancer of liver and intrahepatic bile ducts--liver transplant	Treatment is usually ineffective	(Trans. Proceedings, 1991) (299)
639	Herpes simplex without complications--medical therapy	Treatment is often ineffective	(Hurst 1988; Edwards, 1991) (56,99)
646	Lymphedema--medical therapy, other operation on lymph channel	Treatment is usually ineffective	(Hurst, 1988) (99)
649	Diaper or napkin rash-medical therapy	Treatment advice can be offered during the diagnostic visit; complications can be treated using other CT pairs	
671	Preventive services for adults with questionable or no proven effectiveness--medical therapy	Services are not effective; benefit is not covered under the current program	(USPSTF, 1989) (123)
681	Gallstones without cholecystitis--medical therapy, cholecystectomy	Inappropriate treatment	(Hurst, 1988) (99)
687	Intraventricular hemorrhage and subarachnoid hemorrhage of fetus or neonate-medical therapy	"Empty" CT pair [b]	(Ehrenhaft, 1991) (57)
695	Acute upper respiratory infection and common cold-medical therapy	Self-limited condition; advice regarding relief of symptoms can be provided during the diagnostic visit	(Hurst, 1988) (99)
708	Extremely low birth weight (under 500 gm) and under 23 week gestation-life support	"Empty" CT pair [b]	(Ehrenhaft, 1991) (57)
709	Anencephalous and similar anomalies and reduction deformities of the brain-life support	"Empty" CT pair [b]	(Ehrenhaft, 1991) (57)

a See references 56, 57, 99, 123, 20S, and 299 for full citations.
b The term "empty" is used h-et. describe CT pairs that are not likely to occur. See the accompanying text for further explanation of the related CT pairs.

SOURCE: Office of Technology Assessment, 1992.

anencephalous and similar anomalies and reduction deformities of the brain (CT pair 709).[51]

Extreme prematurity and very low birth weight are very rare; only an estimated five infants (regardless of insurance status) who have both characteristics are born in Oregon each year (57). Similarly, very few anencephalic infants (13 in 1989) are delivered annually in Oregon. Extremely premature and underweight infants and anencephalic infants are not viable, and medical treatment, other than comfort care, is typically not provided. Most physicians agree that a very short gestation with delivery at less than 23 weeks makes any birth virtually nonviable (215). Although the exact time at which the fetus becomes viable is not known, before 23 weeks of gestation the skin is gelatinous and the kidneys and several other organs are not developed sufficiently to sustain life (57,58,215). In fact, these infants are usually not admitted to Oregon's neonatal intensive care units. As a result, their low priority on the list should have little, if any, effect on provided services or cost of care.

Intraventricular hemorrhages are fairly common among very premature and low-birth-weight infants. Each year, these hemorrhages affect an estimated 110 low-birth-weight (under 1500 grams) infants cared for in Oregon's neonatal intensive care units (NICUs) (215). Of these, about 45 infants might suffer severe life-threatening hemorrhages that are often accompanied by stroke, seizures, and shock. If extensive brain damage occurs, there is little medicine can offer to improve the diagnosis. Since there is no therapy for the intraventricular hemorrhage per se, the neonatologist's principal goal is to stabilize

51 It is important to note that if the waiver is approved, the State intends to eventually request an amendment to include the disabled population. Now, under current waiver rules, *all* infants with birth weights of less than 1,200 grams would be exempt from the demonstration. This is a result of Social Security Administration (SSA) regulations that define as disabled any infants of this size, at least until their first birthday (CFR 416.924b). Infants who are at least 4 weeks premature and weigh at least 1,200 grams but less than 2,000 grams are similarly considered disabled by SSA regulations.

the infant. Typically, the infant would be maintained on life support equipment while his or her condition is watched. Infants' treatment in the NICU continues after a hemorrhage much the same as before the hemorrhage occurred. Most importantly, all the comorbidities that these extremely premature infants experience are covered by CT pairs much higher on the list (e.g., CT pair 22). Consequently, the demonstration is not likely to have any impact on the care or cost of treating these infants.

There are also a number of clinically valuable below-the-line CT pairs that are not *now* covered by the Medicaid program. For these, implementation of the waiver would make no difference at all. Examples include bone marrow transplants for *adults* with non-Hodgkin's lymphoma (CT pair 691),52 liver transplant for alcoholic cirrhosis of the liver (CT pair 690), breast reconstruction for mastectomy patients (CT pair 600), and infertility services (CT pairs 598, 602, 603, and 696) (113,274,285,299).

But, at least 25 of the below-the-line CT pairs represent medical conditions that are currently covered and in the absence of treatment have serious clinical consequences .53 Ten include conditions that have no above-the-line alternative treatments; 15 involve diagnoses in CT pairs that could possibly be upcoded by a physician to a covered CT pair (see tables 5-11 and 5-12). Five below-the-line CT pairs include currently covered life-threatening diagnoses for which there are effective treatments for at least a subset of those who are affected; these include impetigo herpetiformis (CT pair 591),[54] myasthenia gravis (CT pair 593),[55] Schmidt's syndrome (CT pair 640), viral pneumonia (CT pair 669), and bone marrow transplant for *children* with non-Hodgkin's lymphoma (CT' pair 691) (113,131,233,294,311). Treatment for some uncovered conditions, such as trigeminal nerve disorders (CT pair 592) and chronic pancreatitis (CT pair 703), can mean relief of disabling pain for some of the affected patients (10,31 1). Treatment of other uncovered conditions can be completely curative for some of those affected, for example CT pair 615—focal surgery for generalized convulsive or partial epilepsy (67298,311). While there is no effective treatment for CT pair 609, amyotrophic lateral sclerosis (ALS), patients with this disease live longer and better lives when the complications of the disease are managed (311).56

One below-the-line CT pair (678), removal of viral warts, can be an important preventive measure against cervical and anal cancer (317).57 But treatment of condyloma acuminatum, a type of viral wart, would not be covered unless located on the cervix (CT pair 171), even though it commonly affects males and in women can be found on the vaginal wall or external genitalia as well as the cervix. Condyloma acuminatum often results from the human papillomavirus (HPV), a common sexually transmitted disease that is associated with cervical and anal cancer (317). I-WV has been found to be common among certain groups of adolescents (271,272).

There are some excluded CT pairs that although cosmetic can have important psychologic and social implications. For example, some dermatologic diseases included in CT pair 675 can cause significant psychologic and social disability and can be fully or partially responsive to therapy (206).

Common *Medical Conditions Among Oregon Medicaid Beneficiaries*

How often would serious treatable below-the-line conditions actually occur among those in the demonstration population? Although the State has not projected the frequency of uncovered conditions under the demonstration, this may be answered in

52 It should be noted that children would lose coverage for bone marrow transplants for non-Hodgkin's lymphoma.

53 Given available data, it is not possible to estimate the number of individuals who might be affected by these uncovered CT pairs. However, see the below section, "Common Medical Conditions Among Oregon Medicaid Beneficiaries," for an analysis of recent Oregon Medicaid beneficiaries' most frequent below-the-line diagnoses.

54 Impetigo herpetiformis is a rare condition that can affect pregnant women. Whether a physician would interpret it as a covered condition because the patient is pregnant would depend on the level of detail and direction included in the provider guidelines that are ultimately developed by the Oregon Medicaid program.

55 The HSC is scheduled to vote on whether to move treatment of myasthenia gravis (CT pair 593) above the line to between CT pairs 159 and 160.

56 It is not clear which manifestations of ALS are intended to be included in CT pair 609. Many of the most common conditions related to ALS, including respiratory failure, bacterial pneumonia, bed sores, and phlebitis, are in above-the-line CT pairs. Whether a physician would feel free to treat these complications may depend on the level of detail and direction included in the provider guidelines that are ultimately developed by the Oregon Medicaid program.

57 The HSC is scheduled to vote on relabeling CT pair 171 (dysplasia of cervix and cervical carcinoma *in situ*) to include all genital warts, including condyloma acuminatum.

Table 5-11—Examples of Uncovered Condition-Treatment (CT) Pairs With Clinical Significance and No Possible Alternatives for Coverage[a,b]

CT pair	Description	Affected population	Comments[c]
592	Trigeminal nerve disorder--medical and surgical treatment	Adults	Some patients experience painful and frequent attacks that do not respond to medication and require transection of the nerve for relief, while other patients will have an occasional attack that is effectively treated with medications (31 1).
593	Myasthenia gravis--medical therapy, thymectomy[d]	Children and adults	Medical therapy (i.e., prescription medications and plasmapheresis) and thymectomy are often effective for this potentially fatal disorder (31 1).
600	Absence of breast after mastectomy as treatment for neoplast--breast reconstruction	Women	This cosmetic procedure may be of great psychological importance for some patients (285). Treatment is not now covered under Medicaid.
615	Generalized convulsive or partial epilepsy without mention of impairment of Consciousness--focal surgery	Children and adults	Focal surgery is considered to be of value for some patients and can be curative (67,298,311). Appropriate indications for surgical therapy are not included on the prioritized list (e.g., a partial or generalized seizure disorder that is unresponsive to conventional medical therapy).
640	Testicular and polyglandular dysfunction-medical therapy	Adults	This CT pair includes the ICD-9-CM code for Schmidt's syndrome, which is fatal without treatment and for which the treatment (i.e., hormone replacement) is inexpensive and completely effective (311).
660	Internal infections and other bacterial food poisoning-medical therapy	Children and adults	Most infections included here are self-limited gastrointestinal illnesses which do not require treatment (311). However, all infections can sometimes require therapy for dehydration and some patients with certain infections need to be treated. Some high-risk patients with nontyphi salmonella infections (e.g., very young infants, patients with hemoglobinopathy), for example, should be treated with antibiotics (125,314). Failure to treat in such cases would require not following the recommendations of the American Academy of Pediatrics. One infection, pasteurella multocida, appears to have been misplaced into this line item. It is not related to food poisoning and requires antibiotics (318).
675	Vitiligo, congenital pigmentary anomalies of skin--medical therapy	Children and adults	Conditions included in this line item are generally cosmetic dermatologic diseases. Some can cause significant psychologic and social disability, and some are responsive (fully or partially) to therapy (206). Skin tags, for example, are usually trivial, but they can be in locations where they become irritated and a source of discomfort or potential infection (229). Removal is simple and inexpensive. Some patients with urticaria pigmentosa suffer flushing attacks that can lead to shock (311). Antihistamines and other drugs can control the illness.
678	Viral warts--medical therapy, cryosurgery[f]	Children and adults	Some untreated viral warts can be painful and disfiguring. Condyloma accuminatum (a type of viral wart) is especially important because it is a very common sexually transmitted disease that is correlated with cervical and anal cancer (317). Viral warts are only covered if located on the cervix (CT pair 171). They also commonly occur on the vaginal wall, external genitalia, and among males (317).
690	Alcoholic cirrhosis of liver-liver transplant[g]	Adults	Liver transplants for alcoholic cirrhosis of the liver have similar success rates as liver transplants for nonalcoholic liver failure (299). Absent from the list is a CT pair for medical therapy for alcoholic cirrhosis. Such therapy, including prescription medications and special diet, is well-established and effective (311).
691	Non-Hodgkin's lymphoma--bone marrow transplant (5-6 loci match)[h]	Adults	Bone marrow transplant is the best remaining therapy for patients that fail to respond to conventional chemotherapy (more than one-half fail to respond) (113). About one-third of these patients are able to sustain a prolonged disease-free period with bone marrow transplantation. .

NOTE: The above are examples of CT pairs that OTA considers to be of particular clinical significance. Individual clinicians might select others as well.

a The Oregon Health Services Commission is scheduled to vote on a number of changes to the prioritized list. The potential changes affecting this table are detailed in the footnotes below.

b In addition t. the references noted in the above comments, much of this table is also based on contract work prepared for OTA (see refs. 14,80, 235).

c Numbers in parentheses are references. See reference list at the end of this report.

d The HSC is scheduled to vote on moving this CT pair above the line.

e The HSC is scheduled to vote on adding a new above-the-line CT pair for disorders of fluid, electrolyte, and acid base balance (ICD-9-CM code 276). This would allow therapy fOr the dehydration sometimes experienced by patients in this CT pair.

f The HSC is scheduled to vote on relabeling this CT pair to include only *non*-genital warts and also CT pair 171 (dyplasia of cervix and cervical carcinoma *in situ*) to include all genital warts including condyloma accuminatum.

9 The HSC is currently considering whether to recommend to the State legislature that the list be modified to cover liver transplants for alcoholic cirrhosis (ref. 244). If the Commission moves to take such action, the modification would be subject to the final approval of the State legislature (or its Emergency Board).

h The HSC is currently considering whether to recommend to the State legislature that the list be modified to cover bone marrow transplants for non-Hodgkins lymphoma (ref. 244). If the Commission moves to take such action, the modification would be subject to the final approval of the State legislature (or its Emergency Board).

SOURCE: Office of Technology Assessment, 1992.

Table 5-12-Examples of Uncovered Condition-Treatment (CT) Pairs With Clinical Significance and Possible Alternatives for Coverage[a,b]

CT pair	Description	Affected population	Comments[c]
591	Impetigo herpetiformis and subcorneal pustular dermatosis--medical therapy	Pregnant women, adults	Impetigo herpetiformis is a rare condition that can affect pregnant women (and more rarely) other adults (131). It can be fatal, but recent literature suggests that there maybe treatment options available. Whether a physician would interpret it as a covered condition when the patient is pregnant would depend on the level of detail and direction included in the provider guidelines that are ultimately developed by the Oregon Medicaid program. Subcorneal pustular dermatosis is a rare disease that may occur in association with immunologic disorders (51). It is a recurrent problem that may respond, at least temporarily, to drug treatment. Such uncommon and diagnostically difficult conditions could possible be treated by using a covered CT pair (e.g., CT pair 224) that includes bullous dermatoses.
609	Amyotrophic lateral sclerosis (ALS)--medical therapy	Adults	While there is no effective treatment for the direct effects of ALS, patients with this disease live longer and better lives when the complications of the disease are managed (31 1). It appears that respirator support of ALS patients may be covered in CT pair 69 (respiratory failure) or CT pair 112 (adult respiratory distress syndrome). Other common conditions among ALS patients (e.g., pneumonia bedsores, and phlebitis) are in above-the-line CT pairs.
619	Congenital anomalies of the ear without impairment of hearing- otoplasty, repair and amputation	Children	Severe malformations of the outer ear occur rarely but can result in very disfiguring malformations (e.g., an extra ear) (27). Coverage for surgery for an ear malformation associated with other defects (e.g., cleft palate) might be possible.
635	Disorders of function of stomach and other functional digestive disorder--medical therapy	Adults	This CT pair includes postsurgical peptic ulcer patients who develop complications. Without treatment, these patients may have abdominal pain, difficulty eating, poor nutritional status, and possibly shorter life expectancies than if treatment was available (31 1). Treatment generally involves medications and dietary counseling (some patients require additional surgery) (233). Some patients could possibly be covered for treatment under CT pair 152 (ulcers, gastritis, and duodenitis).
643	Chronic bronchitis--medical therapy	Children and adults	Chronic bronchitis is a common disease that lies on a continuum with other lung diseases including emphysema (CT pair 306) and asthma (CT pair 151). Treatment reduces symptoms (cough and shortness of breath) and exacerbations of the illness. Without treatment, many more patients would be expected to have serious acute exacerbations (9). It would be easy for physicians to facilitate coverage of patients with chronic bronchitis by using alternative diagnostic codes in related higher ranked CT pairs.
656	Candidiasis--medical therapy	Children and adults	Treatment for candidiasis is imperative in patients such as those with HIV infection or others who are undergoing chemotherapy for cancer (46,205). Immunocompromised patients would be covered in CT pair 255. However, it is not dear what evidence of immunocompromised status would be required to ensure coverage. This issue is especially important for HIV-positive patients whose HIV status has not been confirmed.
663 670	Acute tonsillitis-medical therapy and acute pharyngitis and laryngitis and other diseases of vocal cords-medical therapy[d]	Children and adults	These CT pairs include many minor or self-limited conditions but also include abscesses and cellulitis, which require treatment to prevent serious systemic infections (311). In addition, it is unclear whether the common clinical practice of prescribing antibiotics for patients presenting with sore throat while awaiting diagnostic results of throat culture (for possible strep infection) could be continued.
667	Aseptic meningitis-medical therapy	Children and adults	Most viral infections included in this CT pair are self-limited and require no treatment (16). They can, however, cause pain or discomfort warranting use of non-steroidal anti-inflammatory drugs or mild narcotics (e.g., codeine). In rare cases, these infections can cause serious destabilization that can require intravenous fluids and cardiopulmonary support (99). Until a definitive diagnosis is made, patients are often provisionally treated for bacterial meningitis for several days while awaiting culture results. It is unclear whether such treatment would be covered.

(continued on next page)

Table 5-12—Examples of Uncovered Condition-Treatment (CT) Pairs With Clinical Significance and Possible Alternatives for Coverage[a,b]--Continued

CT pair	Description	Affected population	Comments[c]
668	Infectious mononucleosis--medical therapy[d]	Adolescents and young adults	Infectious mononucleosis is generally a self-limited disease that requires no specific therapy (1 6). When a patient's throat is so sore that fluid intake is inadequate, however, intravenous fluids and hospitalization may be required. Whether such supportive measures to prevent dehydration and malnutrition would be covered is unclear. Treatments for some, but not all of the complications associated with infectious mononucleosis, might be covered by using above-the-line CT pairs. These complications include respiratory distress, thrombocytopenia, hemolytic anemia, and necrologic complications.
669	Other nonfatal viral infections-medical therapy[d]	Children and adults	One condition included in this CT pair, viral pneumonia can be life-threatening especially for children who were born prematurely or children with congenital heart disease (1 6). There is no specific treatment for viral pneumonia but some children need hospitalization for intravenous fluids, oxygen, or even assisted ventilation (16). Newborns and children with congenital heart problems may possibly be treated by using an above-the-line CT pair.
688	Cancer of various sites with distant metasteses where treatment will not result in a 10 percent 5-year survival--medical and surgical treatment	Children and adults	In practice, it is difficult to determine when a patient is at this stage of cancer. Many patients would probably be treated for secondary illnesses that appear above the line (e.g., bacterial pneumonia).
693	Congenital cystic lung, severe--lung resection	Infants	Mild to moderate forms of this condition appearinCTpair212. It is clinically difficult to distinguish the degrees of severity of the cystic lung, however, and clinicians would have wide latitude in determining whether to treat a patient (27).
702	End-stage HIV disease-medical therapy	Children and adults	It is unclear why end-stage HIV disease, but not end stages of other diseases (e.g., heart failure), has been listed separately toward the bottom of the list. In practice, it is difficult to determine when a patient is in the end stage of HIV disease. There are numerous opportunities for finding coverage to treat patients, including: CT pair 156 (HIV disease), CT pair 255 (opportunistic infections in immunocompromised hosts), CT pair 238 (pneumocystis carinii pneumonia), and CT pair 257 (cancer of skin, treatable [excluding malignant melanoma]).
703	Chronic pancreatitis--surgical treatment (703)	Adults	The Predominant manifestation of chronic pancreatitis is pain (31 1). Medicaltherapy, which is covered in CTpair317, is often ineffective for patients with severe pain (307). A common cause of pancreatic pain is pseudocyst, which is covered in CT pair 370. This CT pair includes a smaller subset of patients with chronic pain who would benefit from removal of all or part of their pancreas (10).

NOTE: The above are examples of CT pairs that OTA considers to be of particular clinical significance. Individual clinicians might select others as well.

a The Oregon Health Services Commission is scheduled to vote on a number of technical changes to the prioritized list. The potential changes affecting this table are detailed in the footnotes below.

b In addition t. the references noted in the above comments, much of this table is also based on contract work prepared for the OTA (s8s refs. 14,60, 235).

c Numbers i„ parentheses are references (see reference list at the end Of this report).

d The HSC is scheduled t. vote on adding a new above-the-line CT pair for disorders of fluid, electrolyte, and acid base balance (ICD-9-CM code 276). This would allow therapy for the dehydration sometimes experienced by patients in this CT pair.

SOURCE: Office of Technology Assessment, 1992.

part by examining the most common diagnoses among current Oregon Medicaid beneficiaries. To pursue this question, OTA asked the Oregon Medicaid program's actuarial consultant, Coopers & Lybrand, to provide frequency rankings of the most common principal diagnoses among current Oregon Medicaid beneficiaries who would be subject to the waiver. These data are described below and are based on actual Oregon Medicaid claims paid in FY 1989.[58]

Data Limitations

There are clear obstacles to identifying current utilization of services. In recent years, more than half of the Oregon AFDC population (approximately 51,500 AFDC recipients in FY 1989) have been enrolled in mandatory health maintenance organization (HMO) or physician care organization (PCO) prepaid health plans (169). Since historical utilization data is typically drawn from FFS care claims processing data, limited information is available to describe how this population uses health services.[59] No utilization data are currently available for the HMO enrollees, and only inpatient utilization records can be analyzed for PCO members. This analysis examines the use of services by PLM women and children, AFDC recipients who receive FFS care, and general assistance adults.[60] While all these Medicaid participants would be subject to the rules of the waiver, using this FFS database to project the dynamics of a managed care system is obviously problematic.

Common Principal Diagnoses Related to Inpatient Hospital Services

The most common inpatient principal diagnoses in FY 1989 are ranked in tables 5-13 and 5-14.[61][62] Given that current Medicaid eligibility rules favor pregnant women and young mothers, it is not surprising to find that more than 72 percent of hospital stays among current participants (who would be subject to the waiver) were for newborns or pregnancy-related conditions.

A significant number of discharges (i.e., 181 for all ages and 150 for children) among the most frequent conditions were primarily for diagnostic and observational services and would be covered under the waiver.[63] These include stays for abdominal pain, convulsions, lack of expected normal physiological development, pyrexia of unknown origin (i.e., fever), and miscellaneous respiratory abnormalities.

Also relatively common were hospitalizations related to diagnoses that are currently missing from the CT pair list; these include 124 hospital stays for volume depletion (e.g., dehydration and blood loss) and nonspecific urinary tract infections.[64] [65] These conditions are not included in the list because of their lack of specificity. Nonetheless, they are very frequently coded conditions, and it is not clear how they would be handled during the demonstration.

Inpatient Care Below Line 587-Six of the most frequent principal diagnoses (or diagnostic categories) would not be reimbursable, given current coding practices, because they relate to CT pairs below line 587 (see table 5-13). An estimated 407 discharges relate to these low priority conditions; the vast majority were pediatric cases. More than 40 percent of these below-the-line hospital stays were

58 Oregon's fiscal year extends from July through June.

59 The U.S. General Accounting Office is currently conducting an in-depth review of access to managed care services by Oregon's Medicaid recipients.

60 Coverage for hospital inpatient care for general assistance recipients was eliminated in April 1989.

61 Frequency of diagnoses was tallied by counting the related number of hospital discharges. Newborn, pregnancy-related, and some other diagnostic codes were aggregated into larger diagnostic groups to allow analysis of a wider range of diagnoses. See tables 5-13 and 5-14 for further details.

62 An important caveat is necessary before examining these data: the total discharges reported here represent the number of cases assigned to the specific *International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes* appearing in tables 5-13 and 5-14. They do nor show the total number of cases that would fall into each CT pair because most CT pairs include more than one diagnostic code. Nor do they reflect any utilization by HMO enrollees. Thus the data probably *underestimate* the number of related discharges that would not be covered during the demonstration. See ch. 3 for a more detailed description of CT pairs and the prioritized list.

63 Diagnostic services are covered under a hypothetical CT pair O that doesn't actually appear on the list. "CT pair O" is a designation used to allow reimbursement of diagnostic services for inconclusive diagnoses (98).

64 The HSC is scheduled to vote on adding a new above-the-line CT pair between CT pairs 154 and 155 for disorders of fluid, electrolyte, and acid base balance (ICD-9-CM 276) that would allow therapy for dehydration.

65 Another common diagnosis, brief depressive reaction (ICD-9-CM 309.0), was also missing because mental health conditions have not yet been incorporated into the list.

Table 5-1 3-inpatient Hospital Utilization by Oregon Medicaid Recipients Subject to the Proposed Demonstration: Most Common Principal Diagnoses, FY 1989[a]

Rank by frequency	CT pair(s)	ICD-9-CM diagnosis code	Description of principal diagnosis	Estimated number of discharges	Percent of total
1	21	—[c]	Single liveborn	8,611	32.54
2	21	—[d]	Pregnancy, childbirth, specified complications	7,651	28.91
3	21	650	Pregnancy, childbirth, normal delivery	1,698	6.42
4	21	—[e]	Complications of pregnancy, without delivery	869	3.28
5	16	574.00,.10	Calculus of gallbladder with cholecysitis	189	0.71
5	1	486	Pneumonia, organism unspecified	189	0.71
6	21	V31.0	Twin birth	172	0.65
7	643	493.90,.91	Asthma, unspecified	164	0.62
8	19,106	774.6,770.8	Conditions of the perinatal period	152	0.57
9	1	466.0,.1	Acute bronchitis and bronchiolitis	147	0.56
10	10	633.1	Tubal pregnancy	109	0.41
11	107	558.9	Other and unspecified noninfectious gastroenteritis and colitis	102	0.39
12	0	780.3,.6	General symptoms (convulsions, pyrexia)	95	0.36
13	5	540.9	Acute appendicitis	94	0,36
14	0	789.0	Abdominal pain	86	0.33
15	—[f]	276.5	Volume depletion	83	0.31
16	13,537	614.3,9	Pelvic disease	74	0.28
17	14	590.10	Acute pyelonephritis, without lesion of renal medulary necrosis	70	0.26
18		309.0	Brief depressive reaction	56	0.21
18	669	079.9	Unspecified viral infection	56	0.21
19	660	008.8	Intestinal infection due to other organism, not elsewhere classified	52	0.20
20	695	465.9	Acute upper respiratory infection	48	0.18
21	588	722.10	Displacement of lumbar intervertebral disc, without myelopathy	47	0.18
22	—[f]	599.0	Urinary tract infection, site unspecified	41	0.15
23	669	480.1	Pneumonia, viral	40	0.15
Total				20,895	78.95

KEY: CT = condition-treatment; ICD-9-CM = International Classification of Diseases, 9th Edition, Clinical Modification; FY = fiscal year.
NOTE: "CT O" is used to designate inconclusive diagnoses to allow reimbursement for diagnostic services.
a Excludes Kaiser Permanence Medicaid enrollees.
b Only 87 percent of claims were available for analysis; total discharges were estimated to reflect 100 percent.
c Includes codes: V30.0, V30.00, V30.01, V30.1.
d Includes codes: 641.21,642.31,642.41, 642.51,642,91, 644.21 ,645.01,646,61,647.61 ,64.21, 648.81, 648.91 ,651.01,652.21,652.81 ,653.41,654.21, 656.01,656.11,656.31, 656.41,656.01,656.11, 658.21,660.01,660.11, 660.31,660.41,661.01, 661.10, 661.21,661.31,662.21, 663.11,663.21,663.31, 664.01, 664.11,664.21, 664.31,665.41, 665.51, 666.12,669.51, 669.81,670.04.
e Includes codes: 642.43, 643.03, 643.13, 644.03, 644.13, 646.63, 648.83, 648.93.
f These m&s are missing from the list.

SOURCE: Coopers & Lybrand, San Francisco, CA, unpublished data drawn from paid Oregon Medicaid claims, 1991.

for nonspecific asthma diagnoses that under the demonstration would be coded into CT pair 643. More specific asthma codes appear in the much higher priority asthma CT pair 151. Presumably, under the demonstration, providers could assign such hospital stays to covered CT pairs by providing more specific codes in the patient's medical record. (It is important to point out that the frequent use of nonspecific codes for asthma and other common diagnoses is not unique to Oregon physicians (232).)

Low-priority viral infections led to 107 discharges, which would be coded into CT pair 669 (see table 5-14). Various viral pneumonias accounted for 61 pediatric hospitalizations that would not be reimbursable under the waiver. Most children with viral pneumonia recover uneventfully, although the course of the illness maybe prolonged, especially in infants (16). There is no specific treatment for viral pneumonia, but some children need hospitalization for intravenous fluids, oxygen, or even assisted ventilation (16). In many cases, patients are given antibiotics if bacterial pneumonia is suspected. During the demonstration, it is not clear whether children with these diagnoses would receive medically necessary treatment. Estimated hospital payments for these diagnoses totaled $123,811 in FY 1989 (see tables 5-15 and 5-16).

Fifty-two discharges were for nonclassified intestinal infections (i.e., ICD-9-CM code 008.8) which relate to CT pair 660. Forty-three of these were for children under age 18. There appears to be no opportunity to upcode such diagnoses to more

Table 5-14-inpatient Hospital Utilization by Oregon Medicaid Recipients Subject to the Proposed Demonstration: Most Common Principal Diagnoses for Children Under Age 18, FY 1989[a]

Rank by frequency	CT pair(s)	ICD-9-CM diagnosis code	Description of principal diagnosis	Estimated number of discharges[b c]	Percent of total
1	21	—[d]	Single liveborn	8,568	67.59
2	21	—[e]	Pregnancy, childbirth, specified complications	592	4.67
3	19,21,22,64,106	—[f]	Conditions of the perinatal period	247[g]	1.95
4	21	V31.0	Twin birth	168	1.33
5	21	650	Pregnancy, childbirth, normal delivery	159	1.25
6	1	486	Pneumonia, organism unspecified	151	1.19
7	1	466.0,.1	Acute bronchitis and bronchiolitis	128	1.01
8	643	493.90,.91	Asthma unspecified	117	0.92
9	0	780.3,780.6,786.09	General symptoms (other respiratory problems, convulsions, pyrexia)	114[g]	0.90
10	107	558.9	Other and unspecified noninfectious gastroenteritis and colitis	74	0.58
11	21		Complications of pregnancy, without delivery	74	0.58
12	—[h]	276.5	Volume depletion	67	0.53
13	669[i]	480.1,.9	Pneumonia, viral	61[g]	0.48
14	5	540.0,.9	Acute appendicitis	61	0.48
15	669	079.9	Unspecified viral Infection	46[g]	0.36
16	695	465.9	Acute upper respiratory infection, unspecified site	46[g]	0.36
17	660	008.8	Intestinal infection due to other organism, not elsewhere classified	#19	0.34
18	146	750.5	Congenital hypertrophic pyloris stenosis	*40*	0.32
19	0	783.4	Lack of expected normal physiological development	*36*	0.28
20	151	493.00,493.01	Extrinsic asthma	*32*	0.25
21	8	464.4	Croup	*31*	0.25
22	—[j]	599.00	Urinary tract infection, site unspecified	*30*	0.24
23	9	376.01	Orbital cellulitis	24[g]	0.19
24	1	485	Bronchopneumonia, organism unspecified	22	0.17
25	—[j]	V58.I	Maintenance chemotherapy	22	0.17
Total				10,974	87.09

KEY: CT = condition-treatment; ICD-9-CM = International Classification of Diseases, 9th Edition, Clinical Modification; FY - fiscal year.
NOTE: "CT O" is used to designate inconclusive diagnoses to allow reimbursement for diagnostic services.
a Excludes Kaiser Permanence Medicaid enrollees.
b Because age data wer, missing from some claims, discharge totals for some ICD-9-CM codes may differ from those in table 5-13.
C Only 87 percent of claims were available for analysis; total discharges were estimated to reflect 100 percent.
d Includes codes: V30.0, V30.00, V30.01, V30.1.
e Includes codes: 642.41,64,4.21,64501, 647.61, 84&21, 652.21,653.41,654.21, 6=.31, 658.11,6~.11, 660.31 , 661.11,661.21, 661.31,662.21, 883.11, 663.31, 664.01,664.11, 664.21,664.31,665.51, 666.12,669.51, 670.04.
f Includes codes: 765.1, 768.5, 769, 770.1, 770.6, 770.8, 771.8, 774.2, 774.6.
9 Discharge totals maybe greater than those in table 5-13 because additional ICD-9-CM diagnoses occurred in the under age 18 population.
h Includes codes: 644.03,644.13, 646.63.
i These codes are missing from the list.
j Maintenance chemotherapy is considered an ancillary service and would be covered for all treatable cancers under the waiver.
SOURCE: Coopers & Lybrand, San Francisco, CA, unpublished data drawn from paid Oregon Medicaid claims, 1991.

specific codes that might appear above the line. Most of these infections are self-limited gastrointestinal illnesses that do not require treatment (311).[66] However, all such infections can sometimes require therapy for dehydration and some patients with certain infections need to be treated. Some high-risk patients with nontyphi salmonella infections (e.g., very young infants, patients with malignancy or hemoglobinopathy), for example, should be treated with antibiotics (125,314). Failure to treat in such cases would require not following the recommendations of the American Academy of Pediatrics (3).

Forty-eight hospital stays were for acute upper respiratory infections; all but two were for children. These discharges are in CT pair 695. It is not clear whether more specific coding would reassign these cases to higher priority CT pairs.

CT pair 588, the first below the line, includes 47 adult discharges for displacement of lumbar intervertebral disc without myelopathy. It is not

[66] Self-limited refers to conditions that tend to be limited in duration or course even if untreated.

Table 5-15--Inpatient Hospital Utilization by Oregon Medicaid Recipients Subject to the Proposed Demonstration: Most Costly Principal Diagnoses, FY 1989 [b]

Rank by cost	CT pair(s)	ICD-9-CM diagnosis code	Description of principal diagnosis	Estimated number of discharges [b]	Total paid ($thousands) [c]	Percent of total costs
1	21	—[d]	Single liveborn	8,611	$7,714,830	26.00
2	21	—[e]	Pregnancy, childbirth, specified complications	7,385	6,847,130	23.07
3	21	650	Pregnancy, childbirth, normal delivery	1,698	1,188,689	4.01
4	16	574.00,.01,.10	Calculus of gallbladder with cholecystitis	200	561,105	1.89
5	21	V31.0, V32.O	Twin birth	179	505,685	1.70
6	21	—[f]	Complications of pregnancy, without delivery	634	438,476	1.48
7	19,22,106	—[g]	Conditions of the perinatal period	203	387,722	1.31
8	1	486	Pneumonia, organism unspecified	189	299,254	1.01
9	5	540.0,.9	Acute appendicitis	118	245,585	0.83
10	643	493.90,.91	Asthma unspecified	164	199,523	0.67
11	10	633.1	Tubal pregnancy	109	175,506	0.59
12	1	466.0,.1	Acute bronchitis and bronchiolitis	141	166,350	0.56
13	69	518.81	Respiratory failure	6	145,833	0.49
14	588	722.10	Displacement of lumbar intervertebral disc without myelopathy	47	113,875	0.38
15	0	789.0	Abdominal pain	86	110,534	0.37
16	—[h]	276.5	Volume depletion	83	108,338	0.37
17	250	745.5	Congenital ostium secundum type atrial septal defect	9	104,652	0.35
18	107	558.9	Other and unspecified noninfectious gastroenteritis and colitis	102	95,499	0.32
19	64	998.5	Postoperative infection	36	94,605	0.32
20	14	590.10	Acute pyelonephritis, without lesion of renal medullary necrosis	70	94,343	0.32
21	669	480.1	Pneumonia viral	40	93,925	0.32
22	—[h]	572.8	Other sequelae of chronic liver disease	1	82,959	0.28
23	448	626.2	Excessive or frequent menstruation	31	72,044	0.24
24	—[h]	309.0	Brief depressive reaction	56	69,716	0.23
25	0	780.3	General symptoms (convulsions)	63	67,938	0.23
Total				20,261	$19,984,196	67.34

KEY: KEY: CT = condition-treatment; ICD-9-CM = International Classification of Diseases. 9th Edition, Clinical Modification; FY = fiscal year.

NOTE: "CT O" is used to designate inconclusive diagnoses to allow reimbursement for diagnostic services.

a Excludes Kaiser Permanence Medicaid enrobes.

b Most costly diagnosis based on total claims paid by Medicaid.

c Only 87 percent of claims were available for analysis; total discharges Were estimated to reflect 100 percent.

d Includes codes: V30.0, V30.00, V30.01, V30.1.

e Includes codes: 641.11, 641 .21,642 .31,642.41,642.51, 642.91,644,21,64501, 647.61,84.21,64381,651 .01,652 .21,653.41,654.21, 656.11,656.31,656.41, 656.51,658.11,658.21, 660.01, 660.11,660.31, 660.41,661.01, 661.11,661.21,661.31, 662.21,663.11,663.31, 664.01,664.11, 664.21, 664.31,665.51,666.12, 669.51, 670.04.

f Includes codes: 644.03,646.63, 648.93.

g Includes codes: 765.1, 769,770.1, 770.8,774.6.

h These codes are missing from the list.

SOURCE: Coopers & Lybrand, San Francisco, CA, unpublished data drawn from paid Oregon Medicaid claims, 1991.

Table 5-16--Inpatient Hospital Utilization by Oregon Medicaid Recipients Subject to the Proposed Demonstration: Most Costly Principal Diagnoses for Children Under Age 18, FY 1989 [b]

Rank by cost	CT pair(s)	ICD-9-CM diagnosis code	Description of principal diagnosis	Estimated number of discharges [c,d]	Estimated total paid ($thousands) [c,d]	Percent of total rests
1	21	—[e]	Single liveborn	8,568	$7,602,903	53.56
2	19,21,22,64,106,361,708	—[f]	Conditions of the perinatal period	254	546,594	3.85
3	21	—[g]	Twin birth	174	496,490	3.50
4	21	—[h]	Pregnancy, childbirth, specified complications	494	425,371	3.00
5	1	486	Pneumonia organism unspecified	151	222,561	1.57
6	210,211,250,256	745.10,.19,.2,.4,.5	Congenital anomalies of cardiac septal closure	30	203,707	1.43
7	151,643	493.90,.91,.01	Asthma, unspecified	136	145,810	1.03
8	69	518.81	Other diseases of the lung, respiratory failure	3	133,964	0.94
9	1	466.0,.1	Acute bronchitis and bronchiolitis	128	132,708	0.93
10	5	540.0,.9	Acute appendicitis	61	124,671	0.88
11	669	480.1,.9	Pneumonia viral	61	123,811	0.87
12	21	650	Pregnancy, childbirth, normal delivery	159	105,506	0.74
13	0	780.3,.6	General symptoms (convulsions, pyrexia)	83	88,453	0.62
14	—[i]	276.5	Volume depletion	67	86,426	0.61
15	—[i]	572.8	Other sequelae of chronic liver disease	1	82,959	0.58
16	146	750.5	Congenital hypertrophic pyloric stenosis	40	67,866	0.48
17	248	277.01	Cystic fibrosis	1	64,325	0.45
18	107	558.9	Other and unspecified noninfectious gastroentiritis and colitis	74	61,246	0.43
19	381	821.01	Fracture of other and unspecified parts of femur	21	51,436	0.36
20	—[i]	756.6	Congenital anomalies of diaphragm	2	50,107	0.35
21	0	783.4	Lack of expected normal physiological development	36	45,567	0.32
22	669	079.9	Unspecified viral infections	46	44,657	0.31
23	695	465.9	Acute upper respiratory infection, unspecified site	46	40,425	0.28
24	660	008.8	Intestinal infection due to other organism, not elsewhere classified	43	35,594	0.25
25	—[i]	759.8	Other specified congenital anomalies	1	35,297	0.25
Total				10,680	$11,018,454	77.59

KEY: KEY: CT - condition-treatment; ICD-9-CM - International Classification of Diseases, 9th Edition, Clinical Modification; FY - fiscal year.
NOTE: "CT O" is *used* to designate inconclusive diagnoses to allow reimbursement for diagnostic services.
a Excludes Kaiser Permanence Medicaid enrollees.
b Most costly diagnosis based on total claims paid by Medicaid.
c Only 87 percent of claims were available for analysis; total discharges were estimated to reflect 100 percent.
d Because age data were missing from some claims, discharge and dollar totals for some ICD-9-CM cedes may differ from those in table 5-15.
e Includes codes: V30.0, V30.00, V30.01, V30.1.
f Includes co&s: 765.1,765.18, 768.5, 769, 770.1,770.6,770.8, 771.2,771.8, 774.2,774.6.
9 Includes codes: V31 .0, V32.0.
h Includes codes: 642.41,644.21,645.01, 652.21,653.41,654.21, 656.31, 660.11,660.31,663.31, 664.01,664.11, 664.21, 664.31,669.51.
i These codes are missing from the list.

SOURCE: Coopers & Lybrand, San Francisco, CA, unpublished data drawn from paid Oregon Medicaid claims, 1991.

known what proportion of these patients received medical or surgical treatment. While neither would be covered by the waiver, treatment for this condition is often ineffective (44).

Common Principal Diagnoses Related to Physician Services

Tables 5-17 and 5-18 show a frequency ranking of the most common principal diagnoses related to FFS physician visits in FY 1989.[67] These data include all FFS physician visits, by Oregon Medicaid participants who would be subject to the waiver, regardless of site (e.g., doctor's office or hospital). Almost 12 percent of visits were for routine infant exams, child health checks, or immunizations; another 8 percent were for maternity-related or newborn care. Coverage for all such care would not change during the demonstration.

A few of the most common diagnoses related to physician services are missing from the prioritized list. Three are nonspecific codes (i.e., vaginitis/vulvovaginitis, urinary tract infection, and unspecified fetal growth retardation) that may be used less often under the demonstration as providers become more sophisticated in their coding practices. A third, impetigo, accounted for 912 pediatric physician visits in FY 1989. Impetigo is a self-limited and contagious condition common among children that if treated can prevent spread to other children (16).

Physician Services Below Line 587—Under current coding practices, a number of the most common principal diagnoses fall into CT pairs below line 587. Although *treatment* for these conditions is not reimbursable under the waiver, the visit or visits to establish the diagnosis would be fully covered. The proportion of these visits that are diagnostic is not known. It is likely that many of the reported visits for self-limited conditions, such as acute respiratory infections and acute pharyngitis, are essentially diagnostic encounters that typically do not require followup treatment. Denying payment for any related treatment for these diagnoses is not likely to change the volume of related physician visits or have any significant clinical consequences. For those cases that become more serious, such as a cold that develops into acute bronchitis, a return visit to the physician and treatment would be covered.

Not surprisingly, acute pharyngitis (i.e., sore throat), tonsillitis, and colds and respiratory infections (CT pairs 670, 663, and 695 respectively) are particularly common especially among children. The vast majority of the 23,283 related FFS physician visits in FY 1989 were pediatric. Under the waiver, symptomatic care (e.g., acetaminophen, gargle, etc.) could be recommended and would not require prescription medication. In rare instances, when a patient's throat is so sore that fluid intake is inadequate, intravenous fluids and hospitalization may be required. Current waiver rules do not make clear whether such supportive measures to prevent dehydration and malnutrition would be reimbursable. Dehydration (ICD-9-CM code 276.5) is missing from the list altogether.

In addition, it is uncertain whether the common clinical practice of prescribing antibiotics for patients with sore throat while awaiting results of throat culture (for possible strep infection) could be continued. Whether a change in this practice would compromise the ultimate health outcome continues to be debated in the clinical literature.

Conjunctivitis (CT pair 627) and oral candidiasis were fairly common pediatric conditions in FY 1989; together they accounted for 1,848 physician visits among patients under age 18. Oral candidiasis (commonly referred to as "thrush" in infants) would be included in CT pair 658 unless it was found to be related to an immunosuppressive condition such as HIV infection (CT pair 255). Yet, despite the immediate need for treatment for HIV-infected patients (46,205), it is not clear whether waiver rules would allow payment for treating affected patients whose HIV status is suspected to be positive but is not yet confirmed.

A number of nonspecific below-the-line diagnoses would probably be coded differently under the waiver. For example, nonspecific codes for asthma and bronchitis (CT pair 643) are frequently used by Oregon physicians serving Medicaid patients. Almost 2,900 FFS physician visits in FY 1989 were for

[67] The total visits reported here represent the number of physician encounters assigned to the specific KID-9-CM codes appearing in these tables. They do not show the total number of cases that would fall into each CT pair because most CT pairs include more than one diagnostic code. Nor do they reflect any utilization by HMO or PCO enrollees. Thus the data probably *understimate* the number of related physician visits that would not be *covered during* the demonstration.

Table 5-17-Utilization by Oregon Medicaid Recipients Subject to the Proposed Demonstration: Most Common Principal Diagnoses, FY 1989[a]

Rank by frequency	CT pair(s)	ICD-9-CM diagnosis code	Description of principal diagnosis	Estimated number of Visits[b]	Estimated percent of total[b]
1	143'	*V20.2*	Routine infant or child health check	36,412	9.77
2	354	*382,.9*	Suppurative and unspecified otitis media	20,166	5.41
3	695	*465,.9*	Acute upper respiratory infections; multiple or unspecified site	12,192	3.27
4	21	*V30.O*	Single liveborn	8,818	2.37
5	354	*381,.0,.01,.1,.4*	Nonsupportive otitls media and Eustachian tube disorder	8,110	2.18
6	143,167	V06.1 ,.3[c]	Immunizations; diphtheria-tetanus-pertussis (DTP)	7,921	2.13
7	21	V22,.1	Supervision of pregnancy	7,691	2.06
8	670	462	Acute pharyngitis	6,818	1.83
9	22,708[c]	765.1	Other preterm infants	6,531	1.75
10	21	V22.2	Pregnant state; incidental	5,639	1.51
11	643	490	Bronchitis, not specified as acute or chronic	5,031	1.35
12	0	789,0	Abdominal pain	4,842	1.30
13	1	466,.0,	Acute bronchitis and bronchiolitis	4,308	1.16
14	107	558.9	Other and unspecified noninfectious gastroenteritis and colitls	3,699	0.99
15	391[c]	692.9	Dermatitis; unspecified cause	3,609	0.97
16		599.0	Urinary tract infection; site not specified	2,912	0.78
17	643	493.9	Asthma unspecified	2,891	0.78
18	669[c]	079.9	Unspecified viral infection	2,812	0.75
19	163	V25.4,.9	Contraceptive management	2,749	0.74
20	1	486	Pneumonia, organism unspecified	2,403	0.65
21	695	460	Acute nasopharyngitis	2,279	0.61
22	21	650	Pregnancy, childbirth; normal delivery	2,232	0.60
23	0	784.0	Headache	2,192	0.59
24	171,678	078.1	Viral warts	2,123	0.57
25	482,572'	473.9	Unspecified sinusitis	2,039	0.55
26	663	463	Acute tonsillitis	1,994	0.54
27	—[d]	616.10	Vaginitis and vulvovaginitis, unspecified	1,965	0.53
28	534[c]	477.9	Allergic rhinitis; unspecified cause	1,887	0.51
29	19	774.6	Conditions In the perinatal period	1,613	0.43
30	167	V72.9	Unspecified examination	1,527	0.41
31	0	780.3	General symptoms (convulsions)	1,475	0.40
32	537	625.9	Unspecified symptoms associated with female genital organs	1,458	0.39
33	362	779.3	Feeding problems in newborn	1,379	0,37
34	292	770.7	Chronic respiratory disease arising In the perinatal period	1,368	0.37
35	1	487.1	Influenza, with other respiratory manifestations	1,361	0.37
36	171	662.1	Dysplasia of cervix	1,349	0.36
37	0	782.1	Rash and other nonspecified skin eruption	1,342	0.36
38	167	V72.3	Gynecological examination	1,312	0.35
Total				186.449	49.69

KEY: CT = condition-treatment; ICD-9-CM= International Classification of Diseases, 9th Edition, Clinical Modification; FY = fiscal year.
a Excludes Medicaid recipients enrolled in health maintenance and physician care Organizations.
b Only 77 percent of claims were available for analysis; total visits were estimated to reflect 100 percent.
c Most closely associated CT pair(s).
d Missing from the list.

SOURCE: Coopers & Lybrand, San Francisco, CA, unpublished data drawn from paid Oregon Medicaid claims, 1991.

nonspecific asthma. Specific asthma codes are ranked high in CT pair 151.

Nonspecific bronchitis accounted for more than 5,000 FFS physician visits in FY 1989. How many of these cases were actually acute or chronic is not known. Actual *acute* bronchitis cases would be coded in CT pair 1. Although *chronic* bronchitis remains in CT pair 643, such cases could often be redefined and coded into related higher ranked CT pairs (e.g., emphysema (CT pair 306) and asthma (CT pair 151) (14). If not, failure to treat chronic bronchitis could have serious clinical consequences. Untreated patients may experience various symptoms, including coughing and shortness of breath, and are likely to have frequent and more prolonged acute episodes of illness (9). Without treatment, many more chronic bronchitis patients would be expected to require hospitalization for acute exacerbations of symptoms.

There are no above-the-line alternative codes for the common nonspecific viral infections (ICD-9-CM code 079.9 in CT pair 669) that accounted for

2,812 physician visits in FY 1989 (2,395 among children). The low priority assigned to most nonfatal viral infections is appropriate, however, since related diagnostic costs would be covered, effective treatments are not available, and the conditions are self-limited (31 1). Viral pneumonia is an important exception; in some cases it can be life-threatening without treatment (230,3 11).

SUMMARY OF IMPLICATIONS FOR THE DEMONSTRATION'S PARTICIPANTS

Eligibility

Expanding Medicaid coverage to include all poor Oregonians who currently lack health coverage is a tremendous breakthrough for this population in terms of access and perhaps health outcome as well. The available literature make clear that having health insurance, including Medicaid coverage, can have a substantial effect on whether one receives health services.

Streamlining Medicaid eligibility processing would also be a considerable accomplishment of the proposed waiver, but the new rules disqualify some pregnant women and young children. This is a needless side effect of the waiver proposal and could be remedied by lifting the eligibility threshold for this group.

Benefits and the Prioritized List

The implications of the proposed changes in Medicaid benefits clearly depend on the individual beneficiary. Current eligibles would both gain and lose some clinically important services; their bottom line is essentially a personal one based on individual health needs. Can we say that overall the health of Oregon's poor would improve or diminish with the proposed changes in Medicaid benefits? Certainly the newly insured would be in a better position to gain access to care. But the potential effect of the prioritized list on Oregon's *current* Medicaid population is very difficult to project. Given that Medicaid benefits are typically short-term and that any evaluation effort is likely to be based on limited baseline data, it may never be possible to clearly identify how this aspect of the demonstration affected its participants' access to services or, ultimately, their health.

Some of the financial barriers to early prenatal care could be eliminated by the demonstration. The new eligibility rules enable poor women to have Medicaid benefits *before they* become pregnant. An effective prenatal outreach program would be key to realizing the potential of the demonstration to actually reduce infant mortality and the number of low-birth-weight babies among the State's poor.

Expanding Medicaid coverage to include all poor children would be an important achievement that accelerates Congress's recent efforts to bring them into the Medicaid program. It creates the potential to improve children's access to routine pediatric care, to increase immunization rates, and expedite early intervention for potentially serious and chronic conditions. Whether these goals are achieved must be monitored.

Providing benefits for adult preventive services would also markedly improve Oregon's Medicaid program. Would it *noticeably* enhance the health status of the Oregon poor? In the short term, the answer is likely to be negative, unless participants are aggressively encouraged to obtain preventive care and have the long-term coverage necessary to take advantage of any clinical benefits from early disease detection.

Making organ transplants available to adults may certainly save some lives, but the number of participants who would be affected would be small. Providing dental care is sure to enhance many adult beneficiaries' health although the consequences of going without dental treatment are less dire than forgoing treatment for some below-the-line conditions (e.g., Schmidt's syndrome in CT pair 640).

It is not surprising to find that some below-the-line CT pairs include conditions with effective therapies, since low rank on the prioritized list is intended to reflect lower relative importance but not necessarily complete ineffectiveness. Nonetheless, most uncovered CT pairs do not have significant clinical implications and clearly reflect treatment that is generally considered ineffective or would make little difference to exclude from coverage.

Yet there is some evidence that some individuals could be harmed by the demonstration. Recent utilization data show that some below-the-line conditions would occur among the waiver population rather frequently and may have serious consequences. If, for example, infants with viral

Table 5-18—Utilization of Physician Services by Oregon Medicaid Recipients Subject to the Proposed Demonstration: Most Common Principal Diagnoses for Children Under Age 18, FY 1989[a]

Rank by frequency	CT pair(s)	ICD-9-CM diagnosis code	Description of principal diagnosis	Estimated number of visits[b,c]	Estimated percent of total
1	143	V20.2	Routine infant or child health check	36,243	15.32
2	354	382,.00,.9	Suppurative and unspecified otitis media	20,261[d]	8.56
3	695	465,.9	Acute upper respiratory infection; multiple or unspecified site	10,548	4.46
4	21	V30,.0	Single liveborn	8,822	3.73
5	354	381,.0,.00,.01,.1,.4	Nonsuppurative otitis media and Eustachian tube disorder	8,70@	3.68
6	143,167	V06.1,.3	Immunizations; diphtheria-tetanus-pertussis (DTP)	7,862	3.32
7	22,708	765.1	Other preterm infants	6,468	2.73
8	670	462	Acute pharyngitis	5,091	2.15
9	19,22,106,292	—[e]	Conditions of the perinatal period	4,925	2.08
10	643	490	Bronchitis, not specified as acute or chronic	3,206	1.36
11	107	558.9	Other and unspecified noninfectious gastroenteritis and colitis	2,971	1.26
12	1	466,.0,	Acute bronchitis and bronchiolitis	2,801	1.18
13	391	692.9	Dermatitis; unspecified cause	2,770	1.17
14	151,643	493,.9	Asthma unspecified	2,690	1.14
15	669	079.9	Unspecified viral infection	2,395	1.01
16	695	460	Acute nasopharyngitis	2,108	0.89
17	0	780.3,.6	General symptoms (convulsions, pyrexia)	1,982	0.84
18	1	486	Pneumonia, organism unspecified	1,874	0.79
19	663	463	Acute tonsillitis	1,645	0.70
20	0	789.0	Abdominal pain	1,579	0.67
21	482,572	473.9	Unspecified sinusitis	1,448	0.61
22	362	779.3	Feeding problems in newborn	1,375	0.58
23	—[f]	599.0	Urinary tract infection; site not specified	1,216	0.51
24	171,678	078.1	Viral warts	1,108	0.47
25	0	782.1	Rash and other nonspecific skin eruption	1,081	0.46
26	649	691.0	Diaper or napkin rash	1,058	0.45
27	534	477.9	Allergic rhinitis, cause unspecified	1,049	0.44
28	627	372.30	Conjunctivitis, unspecified	1,016	0.43
29	0	783.4	Lack of expected normal physiological development	994	0.42
30	1	487.1	Influenza with other respiratory manifestations	992	0.39
31	—[f]	684	Impetigo	912	0.39
32	255,658	112.0	Candidiasis of mouth	832	0.35
33	—[f]	764.9	Fetal growth retardation, unspecified	814	0.34
34	434	132.0	Pediculus capitis	777	0.33
Total				149,621	63.23

KEY: CT = condition-treatment; ICD-9-CM = International Classification of Diseases, 9th Edition, Clinical Modification; FY = fiscal year.
NOTE: "CT O" is used to designate inconclusive diagnoses to allow reimbursement for diagnostic services.
a Excludes Medicaid beneficiaries enrolled in an HMO or PCO.
b Only 77 percent of claims were available for analysis; total visits were estimated to reflect 100 percent.
c Because age data were missing from some claims, visit totals for some ICD-9-CM codes may differ from those in table 5-17.
d Visit totals maybe greater than those in table 5-17 because additional diagnoses occurred in the under age 18 population.
e Includes codes: 770.7,770.8,769,774.6.
f These codes are missing from the list.

SOURCE: Coopers & Lybrand, San Francisco, CA, unpublished data drawn from paid Oregon Medicaid claims, 1991.

pneumonia are denied care during the demonstration, the result could be tragic. Would hospitals deny the admission or provide the care without compensation?

Other below-the-line CT pairs are less common, but at least five include currently covered life-saving treatments for conditions that have no above-the-line alternative.[68] If effective therapies are available, providers might treat patients with an uncovered potentially fatal disorder, but the lack of a guarantee is worrisome for these individuals. In the FFS sector, providers may "upcode" uncovered CT pairs if *covered* alternatives exist; prepaid providers may absorb the costs of uncovered treatments if they find it cost-effective to do so.

It is especially troublesome that the demonstration's participants would not be guaranteed a minimum package of basic benefits. If a budget

68 These CT pairs include impetigo herpetiformis, myasthenia gravis, Schmidt's syndrome, viral pneumonia and bone marrow transplants for children with non-Hodgkin's lymphoma. (Bone marrow transplants for non-Hodgkin's lymphoma are not currently covered for adults.)

shortfall eliminates coverage for some treatments above CT pair 588, the chances grow that individuals could be harmed from the demonstration. This concern is heightened by OTA's conclusion that the waiver's costs may be underestimated (see ch. 6).

The Role of the Delivery System

How the delivery system is organized is key to whether demonstration participants would receive the benefits to which they would be entitled. Changes in access to primary care would depend, above all else, on provider participation in the demonstration. Oregon's proposal would affect Medicaid beneficiaries' access to almost all health services. In addition to restricting covered services to those falling above CT pair 588, it would lock in most participants to one or a group of health care providers. It is these providers who would play a critical role in each participant's access to basic primary care as well as the most specialized tertiary level services.

Participants' **usual** source of care is certain to differ with implementation of the demonstration, as the uninsured population is brought into the system and many more current eligibles are assigned a managed care provider. Having a specific provider has been associated with greater use of preventive and other health services (2,111231). The response of Oregon Medicaid providers to the new system will be critical. Proponents of Medicaid managed care suggest that it can increase provider participation and improve access to more efficient and effective services (149). Critics of Medicaid managed care argue that it creates strong incentives for underservice. In the case of Oregon, however, the U.S. General Accounting Office has reported that the State has, in its current system, "instituted financial safeguards to prevent financial incentives that would lead to inappropriate reduction in service delivery and quality" (238). As managed care providers are at financial risk for enrollees' use of health services, they should be motivated to encourage preventive care and early access to primary care. But if the rather short-term nature of Medicaid enrollment dissuades Oregon providers from considering the long-term as well as short-term needs of participants, the program may fall short of its goals.

Access to hospital services would change for many of the demonstration participants. The vast majority of Oregon's Medicaid participants currently receive FFS inpatient care. Ultimately, 55 percent of the waiver population maybe enrolled in fully capitated health plans (FCHP) that cover hospital as well as physician services. The State anticipates that, compared with FFS care, expanded FCHP enrollment would yield a 25 percent managed care-related savings in Medicaid expenditures for hospital care, presumably as a result of improved access to primary care and fewer unnecessary hospitalizations (177) (see ch. 6). Hospital stays for below-the-line CT pairs should also decline. Any increase in access to hospital care (e.g., for adult organ transplants) related to implementation of the list should be small for current beneficiaries, although there should be substantial improvement in access to inpatient care for those newly covered under the demonstration.

A Critical Evaluation Is Essential 69

Would Oregon Medicaid participants get the care they need? Would they have to bear an excessive burden in waiting time to get an appointment or travel time to get care? Would there be a sufficient number of Medicaid providers of all necessary types? Unfortunately, there is very little information to rely on to help project the course of the demonstration. It is not yet known how many providers will participate in the Oregon health plan. Nor can we estimate the extent to which participating FCHPs, FFS physicians, hospitals, and others would be willing to provide uncovered services that they deem to be clinically important. These unanswered questions underline the importance of a comprehensive evaluation of Oregon's demonstration should the waiver be granted.

69 See ch. 8 for a discussion of evaluation issues.