2001 DRAFTING REQUEST

Bill

Received: **10/04/2001**

Received By: **mlief**

Wanted: **As time permits**

Identical to LRB:

For: **Sheldon Wasserman (608) 266-7671**

By/Representing: **joe hoey**

This file may be shown to any legislator: **NO**

Drafter: **mlief**

May Contact:

Addl. Drafters:

Subject: **Public Assistance - med. assist.**

Extra Copies: **PG**

Submit via email: **YES**

Requester's email: **Rep.Wasserman@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Creating a health services commission and a prioritized list of diagnoses and treatments for MA

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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/P1			jfrantze 10/05/2001	_____ _____	lrb_docadmin 10/05/2001		State
/1	mlief	hhagen	pgreensl	_____	lrb_docadmin		State

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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/3	mlief 01/22/2002	hhagen 01/23/2002	kfollet 01/23/2002	_____ _____	lrb_docadmin 01/23/2002	lrb_docadmin 01/23/2002	

FE Sent For:
Att intro.

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LRB-3957

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Bill

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/1	mlief	hhagen	pgreensl	_____	lrb_docadmin		State

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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/2	mlief 01/08/2002	hhagen 01/08/2002	pgreensl 01/08/2002	_____ _____	lrb_docadmin 01/08/2002	lrb_docadmin 01/10/2002	

FE Sent For:

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/1	mlief	hhagen	pgreensl	_____	lrb_docadmin		State

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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/2	mlief 01/08/2002	hhagen 01/08/2002	pgreensl 01/08/2002	_____ _____	lrb_docadmin 01/08/2002		

FE Sent For:

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LRB-3957

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Received: **10/04/2001**

Received By: **mlief**

Wanted: **As time permits**

Identical to LRB:

For: **Sheldon Wasserman (608) 266-7671**

By/Representing: **joe hoey**

This file may be shown to any legislator: **NO**

Drafter: **mlief**

May Contact:

Addl. Drafters:

Subject: **Public Assistance - med. assist.**

Extra Copies: **PG**

Submit via email: **YES**

Requester's email: **Rep.Wasserman@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
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/1	mlief	hhagen 12 hmh 1/8/01	pgreensl 1/8 PS	_____	lrb_docadmin		

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FE Sent For:

<END>

LRB-3957

2001 DRAFTING REQUEST

Bill

Received: **10/04/2001**

Received By: **mlief**

Wanted: **As time permits**

Identical to LRB:

For: **Sheldon Wasserman (608) 266-7671**

By/Representing: **joe hoey**

This file may be shown to any legislator: **NO**

Drafter: **mlief**

May Contact:

Addl. Drafters:

Subject: **Public Assistance - med. assist.**

Extra Copies: **PG**

Submit via email: **YES**

Requester's email: **Rep.Wasserman@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

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Instructions:

See Attached

Drafting History:

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/P1		1, hmh 10/18/01	jfrantze 10/05/2001		lrb_docadmin 10/05/2001		

10/18 P8

FE Sent For:

<END>

LRB-3251

2001 DRAFTING REQUEST

Bill

Received: **05/04/2001**

Received By: **kenneda**

Wanted: **As time permits**

Identical to LRB:

For: **Sheldon Wasserman (608) 266-7671**

By/Representing: **Joe Hoey (aide)**

This file may be shown to any legislator: **NO**

Drafter: **mlief**

May Contact:

Addl. Drafters:

Subject: **Public Assistance - med. assist.**

Extra Copies: **PG**

Submit via email: **NO**

Pre Topic:

No specific pre topic given

Topic:

Creating a health services commission and a prioritized list of treatments and services for medical assistance

Instructions:

See Attached

Drafting History:

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/?	kenneda 05/14/2001	10/4/01	10/6	10/6			
	isagerro 08/03/2001						
	kenneda 09/04/2001						
	mlief						

FE Sent For:

<END>

Redraft - 3957

TC w/ Joe story

- One of physicians appointed by "State Medical Society"

11/22/04 - Add: - dentist appted by Wis Dental Assn
- pharmacist appted by governor

Gov must appt - OK to say "nominate"

To: Debora Kennedy

From: Joe Hoey

Date: 5/1/01

Re: Oregon Health Plan

Here is the brief synopsis of the Oregon Health plan that I told you about. On page 2 there is a list of 6 key features of the plan. Sheldon is interested in drafting a Wisconsin Health Plan that includes the first four of the listed features. He is also interested in establishing a Health Services Commission similar to the one discussed in the two paragraphs following the list of features. Give me a call if you have any questions.

The New England Journal of Medicine -- August 28, 1997 -- Vol. 337, No. 9
HEALTH POLICY REPORT

The Oregon Health Plan -- Lessons for the Nation (First of Two Parts)

Thomas Bodenheimer

In 1989, the state of Oregon embarked on a controversial experiment in the financing of health care. The state planned to add many uninsured people to the Medicaid program and to pay for this expansion by reducing the Medicaid benefit package -- more people would be covered, but for fewer services. The Oregon plan provides important lessons to a nation striving to expand health care coverage in an era of shrinking budgets.

At first, the Oregon plan made repeated headlines and provoked strong criticism. "The Oregon plan will target a new group for discrimination -- the seriously ill," wrote an Oregon physician in a letter to the editor of the Journal. (1) "It denies care only to the politically powerless poor," commented health analyst Emily Friedman. (2) "Oregon's decision to ration health care to its poorest women and children," charged Al Gore, "is a declaration of unconditional surrender just as the first battles are being fought over the future of our health care system." (3)

Why all the outrage? After all, Oregon was insuring more people, not fewer. Other states had axed thousands of families from Medicaid and reduced benefits, with little or no fuss. The difference was the method that Oregon chose to create its benefit package -- the prioritized list. In 1991, Oregon ranked more than 700 diagnoses and treatments in order of importance. The state legislature then drew a line at item 587; treatments below the line would not be covered. Oregon had openly embraced the "R word": rationing -- worse, rationing for the poor. Liberal Democrats in Congress, the Children's Defense Fund, the American Academy of Pediatrics, and others condemned the Oregon plan.

On February 1, 1994, the Oregon Health Plan, with its prioritized list, went into operation. How have Medicaid recipients fared during these first three years? Perhaps surprisingly, the plan has added more than 100,000 people to the Medicaid program, and it is politically popular. Serious complaints about the prioritized list are hard to find. Major problems exist, but they mirror the difficulties of the health care system throughout the nation.

History

The Oregon Health Plan began with the poignant story of a seven-year-old boy. In 1987, Coby Howard contracted acute lymphocytic leukemia and needed a bone marrow transplant. Earlier that year, the Oregon legislature had discontinued Medicaid coverage for organ transplantation. (4) Amid much publicity, Coby died.

John Kitzhaber, an emergency room physician in the town of Roseburg, Oregon, was also president of the Oregon senate. In the emergency department, he saw victims of Medicaid cuts with serious illnesses that could have been treated at earlier stages. In the state senate, he lived through the Coby Howard tragedy. Kitzhaber wanted to address the twin problems: lack of insurance among low-income people and denial of life-saving treatment despite coverage of less effective therapies for less serious conditions.

A legislature can reduce Medicaid expenditures by removing people from the program, lowering the rate of reimbursement to providers, or reducing the benefit package. Kitzhaber believed that removing people from the program was the worst of the options. He also believed that many physicians refused to see Medicaid patients because of low reimbursement rates and that the legislature should not reduce payments to providers. The remaining option in the case of a budget crisis was to reduce the benefit package. But how could the benefit package be reduced without letting more Coby Howards die? Perhaps a prioritized list could guarantee that benefit reductions would eliminate only the least effective treatments.

In 1989, Kitzhaber shepherded through the Oregon legislature a plan with several key features: (1) all persons with incomes below the federal poverty level would be eligible for Medicaid, (2) the Medicaid benefit package would consist of a prioritized list of diagnoses and treatments, (3) the legislature would draw a line on the list below which treatments would not be covered, (4) the legislature would not be allowed to reduce reimbursement rates to Medicaid providers, (5) Medicaid services would be provided through managed-care plans, and (6) employers would be required to insure their employees, with the prioritized list as the basic benefit package.

In 1989, the Oregon Health Services Commission was established to create the prioritized list. (5,6) The 11 commissioners were remarkably dedicated, attending many long meetings without pay over a three-year period. They sponsored community forums to gain public input into the process; two thirds of the attendees were health care providers, two thirds were college graduates, and only 5 percent were Medicaid recipients. (6) However, consumer organizations representing Medicaid patients were actively involved in the process, and the openness of the Health Services Commission was a breath of fresh air.

The commission established 17 categories of health problems -- for example, acute conditions that can be fatal and for which treatment provides full recovery, acute conditions that are treatable and unlikely to be fatal, chronic conditions that are unlikely to be fatal, maternity and newborn services, and preventive care of proven efficacy. All diagnoses and their treatments in the medical and surgical armamentarium were assigned to one of these categories, and the categories were ranked according to 13 criteria, including life expectancy, quality of life, the cost effectiveness of a treatment, and whether it would benefit many people. Treatments that prevent death and lead to full recovery were ranked first, maternity care was ranked second, and treatments that prevent death without full recovery were ranked third. Treatments that result in minimal or no improvement in the quality of life were ranked last. The diagnosis and treatment items were then prioritized within the categories on the basis of outcomes data, a scale for the quality of well-being, and a consideration of the reasonableness of the rankings. (7)

In 1991, the Oregon plan was submitted to the Bush administration for federal approval. The following year, the plan was rejected on the somewhat questionable grounds that the list undervalued the quality of life of people with disabilities. Some Oregonians suspected that the plan was denied because George Bush, about to wage a presidential campaign against Bill Clinton, was afraid to be labeled the "rationing president."

The Health Services Commission produced another version of the list. Each diagnosis and treatment pair was analyzed with regard to the probability of death or disability with and without treatment. (7) For example, bacterial meningitis has a high probability of causing death without treatment and a lower probability with treatment, whereas metastatic pancreatic cancer is certain to cause death with or without treatment. Each diagnosis and treatment pair was assigned a number based on this analysis, and a new list was formed. Even with this entirely different method, 85 percent of the items on the list were ranked almost the same as they had been in the earlier version.

In March 1993, the plan was approved by the Clinton administration. On February 1, 1994, five years after its initial passage in the state legislature, the Oregon Health Plan went into operation. Later that year, John Kitzhaber was elected governor of Oregon.

The Accomplishments of the Oregon Health Plan

The Oregon Health Plan received one of the earliest federal waivers granted under Section 1115 of the Social Security Act. Such waivers suspend many of the federal requirements that normally apply to state Medicaid programs (e.g., regulations governing eligibility and services, safeguarding the freedom to choose a health care provider, and stipulating how providers are reimbursed), thereby allowing states to increase the number of Medicaid beneficiaries and to institute mandatory managed care. (8,9)

All Oregonians with incomes under the federal poverty level ($13,000 for a family of three) are now eligible for Medicaid. Previously, only 57 percent of people with incomes under the poverty level were eligible. In addition to the 100,000 people newly enrolled in Medicaid through the Oregon Health Plan, 65,000 people are eligible but not enrolled. Some have chosen not to enroll, some are deterred by the complex enrollment process, and some cannot afford the sliding-scale premiums, ranging from $0 to $28 per month. However, any of these 65,000 persons who become sick can enroll and receive coverage on the same day -- a benefit that no private insurance company provides.

According to the Census Bureau, between 1991 and 1995, the proportion of uninsured Oregonians dropped from 14 percent to 12 percent of the state's 3.2 million population. (10) (State data suggest a greater reduction, from 18 percent to 11 percent. (11)) During the same period, the proportion of uninsured persons in the U.S. population rose from 14 percent to 15 percent. (10)

Several states besides Oregon have provided health insurance to people who were previously uninsured. Minnesota insured an additional 100,000 people through MinnesotaCare. Tennessee added 400,000 people to its Medicaid program, now called TennCare. Massachusetts, New York, and Arizona recently passed legislation to expand coverage, particularly for children. But in most states, because of the decrease in the

numbers of Americans with employer-sponsored insurance, the uninsured population is growing. (12) In 1995, 15 percent of the residents of New York, 21 percent of those in California, and 24 percent of those in Texas had no health insurance. (10)

Oregon's success in increasing its Medicaid population by 39 percent has had a price tag, but not a steep one. The state's Medicaid expenditures in 1996 were 36 percent higher than those in 1993. (11) Nationally, Medicaid has undergone an inflation of 30 percent during the same period, whereas coverage has expanded by 11 percent. (13)

Managed Care under the Oregon Health Plan

Eighty-seven percent of persons enrolled in the Oregon Health Plan are in 1 of the 13 capitated Medicaid managed-care plans with which the state contracts. These are all not-for-profit plans; three for-profit plans dropped out (PacifiCare, Qual-Med, and a local health maintenance organization [HMO]). By far the largest Medicaid managed-care plan is HMO Oregon (owned by Blue Cross and Blue Shield of Oregon), with 34 percent of Medicaid managed-care enrollees. (14)

Medicaid managed care has been growing rapidly throughout the United States. In 1996, one third of all Medicaid recipients were enrolled in managed-care plans in 48 states, representing a 33 percent increase in the number for 1995. The federal government is likely to eliminate the waiver process and allow states more flexibility to require that Medicaid beneficiaries enroll in managed-care plans.

Oregon was able to move its Medicaid population into managed care rapidly because managed care has been a major component of Oregon's health system for decades. Kaiser Permanente arrived in the 1940s and started to enroll Medicaid patients in 1976. During the decade before the institution of the Oregon Health Plan, the state enrolled 90,000 Medicaid recipients in HMO-style health plans. Thus, by 1993, when the federal waiver was approved that allowed the state to require that Medicaid recipients enroll in managed-care plans, Medicaid managed care was already well established.

In any Medicaid managed-care plan, one measurement stands out as critically important: the size of the capitation payment from the state to the plan. Kitzhaber recognized the need to make capitation payments reasonably high for two reasons: with adequate payment, physicians, hospitals, and managed-care plans are more likely to support funding for the Medicaid program; and reasonable rates attract physicians to the program, which means greater access to care for beneficiaries. Kitzhaber insisted that capitation payments cover the costs of care, whereas some other states provide payments that are lower than the costs of care.

Although it is difficult to compare capitation payments from state to state (since the mix of services covered by the payments varies), estimates can be made. In 1995, Oregon's capitation rate for nondisabled persons under the age of 65 years was about $130 per member per month. This payment represented a 30 percent increase over the fee-for-service Medicaid payments physicians received before the Oregon plan was introduced. In Tennessee's TennCare program, in contrast, 1995 capitation rates for a similar population were closer to $100 per member per month, representing a 40 percent decrease in pre-TennCare payments. (15,16) California's comparable capitation rate is even lower, about

$80 per member per month. New York's rates were considerably higher but have been ratcheted down in the past few years. Studies have shown that the willingness of physicians to provide care for Medicaid patients is related to the level of Medicaid reimbursement. (17)

Are Oregon's doctors, hospitals, and health plans satisfied with the capitation rates? Of course not. Are they extremely dissatisfied? Not really. Physicians still earn one third less for services provided to Medicaid patients than for those provided to patients covered by commercial plans or Medicare. Some physicians are limiting the number of Medicaid patients they see, giving rise to complaints -- especially in rural areas -- that Oregon Health Plan membership cards are simply hunting licenses that enable the poor to join the hunt for a physician who will give them an appointment. The state counters that in 1996, 88 percent of surveyed Medicaid enrollees were satisfied with their access to health care, as compared with 70 percent in 1994.

The Prioritized List

In 1990 and 1991, Oregon's prioritized list was a controversial topic of conversation among health care professionals, policy analysts, bioethicists, and politicians. Today, complaints about the list are unusual.

What does the list look like? Table 1 shows three parts of the 1995 list: the top five lines, the bottom five lines, and those near the current line (578) below which services may be denied. (18) A number of diagnoses listed below line 578 -- for example, hepatorenal syndrome -- can be managed by choosing a treatment listed above the line, such as comfort care (line 260). Pulmonary sarcoidosis, which is near the bottom of the list, can be treated with corticosteroids (line 158, medical treatment for respiratory failure). Expensive therapies that are medically effective, such as renal transplantation for end-stage renal disease and liver transplantation for biliary atresia and other life-threatening hepatic disorders, are ranked high on the list. Contraception is also ranked high, at line 51. Low birth weight (less than 2500 g) is at line 67. Preventive services for children are at line 143, and preventive services with proven effectiveness for adults are at line 181. Medical therapy for human immunodeficiency virus disease and AIDS is at line 168.

Five factors have stilled the argument that the list represents rationing of medical care. First, on balance, the Oregon Health Plan has expanded health care benefits more than it has reduced them. In particular, all enrollees are now covered for dental care and organ transplantation, benefits previously denied to Medicaid recipients.

Second, the line below which services may be denied has been set quite low on the list of diagnoses and treatments and has remained low. Most of the treatments listed below the line have little effectiveness. "Line movement" (movement of the line upward so that fewer treatments are covered) has been minimal, in part because the Health Care Financing Administration (HCFA) must approve any line movement passed by the state legislature. In 1996, the legislature moved the line from 606 to 581. In 1997, the legislature attempted to move the line from 581 to 574, but HCFA approved a move only from 581 to 578. If the line were moved much further up, protests could be expected from health plans, physicians, and patients. That situation is unlikely, however, since HCFA has indicated that it will not favor further movement of the line in the near future.

Third, since the items on the list represent diagnosis and treatment pairs, a diagnosis is required before a treatment can be denied. For simple maladies listed below the line, such as acute bronchitis, treatment is given at the diagnostic visit and is covered. Complex diagnostic workups are also covered.

Fourth, physicians occasionally "game" the system, choosing a diagnosis above the line even though the patient has an illness that falls below the line.

Finally, and most important, the state Medicaid program requires adherence to the list only for the 13 percent of patients whose physicians are paid on a fee-for-service basis by the state. In these cases, International Classification of Diseases, 9th Revision (ICD-9) codes and Current Procedural Terminology, 4th revision (CPT-4) codes for treatments listed below the line are not reimbursed. But for the 87 percent of Medicaid enrollees in capitated health plans, the state has shifted the financial risk to the plans and provides no additional funds if treatments listed below the line are given. The state has calculated that items below the line account for about 10 percent of all medical expenditures and has therefore subtracted 10 percent from capitation payments to the health plans. In this way, the state saves money as a result of the list. Yet the medical directors of health plans may, and often do, authorize care for diagnoses listed below the line. Recently, the utilization review committee of the CareOregon health plan approved high-dose chemotherapy and bone marrow transplantation for a nine-year-old child with medulloblastoma, a $75,000 treatment of unproven efficacy that is listed below the line.

Oregon's prioritized list serves as the Medicaid benefit package, indicating which services are covered and which are not. The list parts company with most health insurance and HMO benefit packages, which cover services that are "medically necessary" but leave the interpretation of medical necessity to medical directors within the insurance company or HMO. In contrast, Oregon's program clearly defines services that are deemed medically necessary, and if fiscal constraints require a reduction in benefits, this reduction is accomplished by taking away less appropriate treatments before denying more appropriate ones.

A similar approach to the design of benefit packages has been proposed by two health policy experts. Robert Brook suggests that substantial resources be devoted -- through outcomes research -- to the development of detailed guidelines that all health insurance plans can use to determine medical necessity, so that all appropriate care, and no inappropriate care, is covered. (19) David Eddy, arguing that "almost anything would improve on the hopelessly vague terms 'medically necessary' and 'appropriate,'" wants more precise benefit language but rejects the level of detail in Oregon's list. (20)

Although many particulars of Oregon's list are open to criticism, (5) it does incorporate a large dose of common sense. As one Oregon physician explained, "Most things at the top are important, and most things at the bottom are not so important." Oregon's list represents a new approach to the design of a benefit package, introducing a health policy issue that merits further discussion and debate.

10/2/01 Tc w/Joe Hoeg -

Preliminary draft

① Committee appointed by governor - same membership as OR health commission
Job: come up w/ prioritized list

Report to leg council by Sept 1, 2003

② Leg council, in consult. w/committee, come up w/ proposed leg to implement list
- reimbursement rate may not be reduced
- all persons w/ incomes below fed poverty level elig by MA

1989, Adult

SECTION 31. The Juvenile Services Commission as constituted on the effective date of this Act shall perform its function. However, the Governor may appoint the members to the Oregon Youth Services Commission under ORS 417.475 as amended by section 4 of this Act and those newly appointed members shall constitute the Oregon Youth Services Commission for purposes of implementing this Act and shall appoint an executive director pursuant to ORS 417.485. The rules of the Juvenile Services Commission shall continue in effect until amended or repealed by the Oregon Youth Services Commission.

SECTION 32. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1989.

Approved by the Governor July 26, 1989

Filed in the office of Secretary of State July 27, 1989

CHAPTER 836

AN ACT SB 27

Relating to health services; creating new provisions; amending ORS 414.025, 414.036, 414.042 and 414.065; appropriating money; limiting expenditures; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 414.036 is amended to read:

414.036. (1) The Legislative Assembly finds that:

(a) Hundreds of thousands of Oregonians have no health insurance or other coverage and lack the income and resources needed to obtain health care;

(b) The number of [*medically needy*] persons **without access to health services** increases dramatically during periods of high unemployment;

(c) Without health coverage, [*the medically needy*] **persons who** lack access to health [*care and*] **services may** receive treatment, [*if at all,*] **but** through costly, inefficient, acute care; [*and*]

(d) The unpaid cost of health [*care*] **services** for [*the medically needy*] **such persons** is shifted to paying patients, driving up the cost of hospitalization and health insurance for all Oregonians; **and** [*.*]

(e) The state's medical assistance program is increasingly unable to fund the health care needs of low-income citizens.

(2) In order to provide access to health [*care*] **services** for those [*most*] in need, to contain rising health [*care*] **services** costs through appropriate incentives to providers, payers and consumers, **to reduce or eliminate cost shifting** and to promote the stability of the health [*care*] **services** delivery system and the health and well-being of all Oregonians, it is the policy of the State of Oregon to provide medical assistance to those in need [*and eligible*] **whose family income is below the federal poverty level and who are eligible** for [*benefits*] **services** under the [*program*] **programs** authorized by this chapter.

SECTION 2. As used in this Act, "health services" means at least so much of each of the following as are approved and funded by the Legislative Assembly:

(1) Provider services and supplies;

(2) Outpatient services;

(3) Inpatient hospital services; and

(4) Health promotion and disease prevention services.

SECTION 3. The following services are available to persons eligible for services under this Act but such services are not subject to subsection (1) of section 4a of this Act:

(1) Nursing facilities and home- and community-based waivered services funded through the Senior Services Division;

(2) Medical assistance for the aged, the blind and the disabled or medical care provided to children under ORS 418.001 to 418.034 and 418.187 to 418.970;

(3) Institutional, home- and community-based waivered services or Community Mental Health Program care for the mentally retarded or developmentally disabled, for the chronically mentally ill or emotionally disturbed and for the treatment of alcohol- and drug-dependent persons; and

(4) Services to children who are wards of the Children's Services Division by order of the juvenile court and services to children and families for health care or mental health care through the division.

SECTION 4. (1) The Health Services Commission is established, consisting of 11 members appointed by the Governor and confirmed by the Senate. Five members shall be physicians licensed to practice medicine in this state who have clinical expertise in the general areas of obstetrics, perinatal, pediatrics, adult medicine, geriatrics or public health. One of the physicians shall be a Doctor of Osteopathy. Other members shall include a public health nurse, a social services worker and four consumers of health care. In making the appointments, the Governor shall consult with professional and other interested organizations.

(2) Members of the Health Services Commission shall serve for a term of four years, at the pleasure of the Governor.

(3) Members shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties.

(4) The commission may establish such subcommittees of its members and other medical, economic or health services advisers as it determines to be necessary to assist the commission in the performance of its duties.

SECTION 4a. (1) The Health Services Commission shall consult with the Joint Legislative Committee on Health Care and conduct public hearings prior to making the report described in subsection (3) of this section. The commission shall solicit testimony and information from advocates for seniors; handicapped persons; mental health services consumers; low-income Oregonians; and providers of health care, including but not limited to physicians licensed to practice medicine, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

(2) In conjunction with the Joint Legislative Committee on Health Care, the commission shall actively solicit public involvement in a community meeting process to build a consensus on the values to be used to guide health resource allocation decisions.

(3) The commission shall report to the Governor a list of health services ranked by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. The recommendation shall be accompanied by a report of an independent actuary retained for the commission to determine rates necessary to cover the costs of the services.

(4) The commission shall make its report by July 1 of the year preceding each regular session of the Legislative Assembly and shall submit a copy of its report to the Joint Legislative Committee on Health Care.

(5) The Joint Legislative Committee on Health Care shall determine whether or not to recommend funding of the Health Services Commission's report to the Legislative Assembly and shall advise the Governor of its recommendations. After considering the recommendations of the Joint Legislative Committee on Health Care, the Legislative Assembly shall fund the report to the extent that funds are available to do so.

SECTION 5. For the purpose of this Act, and for the 1989 1991 biennium only:

(1) The Health Services Commission shall make its report to the Governor and to the Joint Legislative Committee on Health Care no later than March 1, 1990.

(2) The committee shall make its recommendations to the Emergency Board.

(3) After consideration of the recommendations of the committee, the Emergency Board shall fund the report to the extent that funds are available to do so.

(4) The Joint Legislative Committee on Health Care and the Emergency Board are not authorized to alter the report of the Health Services Commission.

SECTION 6. Upon meeting the requirements of section 9 of this Act:

(1) Pursuant to rules adopted by the Adult and Family Services Division, the division shall execute prepaid managed care health services contracts for the health services funded pursuant to section 9 of this Act. The contract must require that all services are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. Such contracts are not subject to ORS 279.011 to 279.063. It is the intent of this Act that the state move toward utilizing full service managed care health service providers for providing health services under this Act. The division shall solicit qualified providers or plans to be reimbursed at rates which cover the costs of providing the covered services. Such contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private entities. The division shall not discriminate against any contractors which offer services within their providers' lawful scopes of practice.

(2) The initial contract period shall begin on or after July 1, 1990.

(3) Except for special circumstances recognized in rules of the division, all subsequent contracts shall be for one-year periods starting on July 1, 1991.

(4) In the event that there is an insufficient number of qualified entities to provide for prepaid managed health services contracts in certain areas of the state, the division may institute a fee-for-service case management system where possible or may continue a fee-for-service payment system for those areas that pay for the same services provided under the health services contracts for persons eligible for health services under this Act. In addition, the division may make other special arrangements as necessary to increase the interest of providers in participation in the state's managed care system, including but not limited to the provision of stop loss insurance for providers wishing to limit the amount of risk they wish to underwrite.

(5) As provided in subsections (1) and (4) of this section, the aggregate expenditures by the Adult and Family Services Division for health services provided pursuant to this Act shall not exceed the total dollars appropriated for health services under this Act.

(6) Actions taken by providers, potential providers, contractors and bidders in specific accordance with this Act in forming consortiums or in otherwise entering into contracts to provide health care services shall be performed pursuant to state super-

vision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and shall not be considered to be the transaction of insurance for purposes of the Insurance Code.

(7) Health care providers contracting to provide services under this Act shall advise a patient of any service, treatment or test that is medically necessary but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

SECTION 7. The commission shall establish a Subcommittee on Mental Health Care and Chemical Dependency to assist the commission in determining priorities for mental health care and chemical dependency that shall be reported to the Sixty-sixth Legislative Assembly. The subcommittee shall include mental health and chemical dependency professionals who provide inpatient and outpatient mental health and chemical dependency care.

SECTION 8. (1) If insufficient resources are available during a contract period:

(a) The population of eligible persons determined by law shall not be reduced.

(b) The reimbursement rate for providers and plans established under the contractual agreement shall not be reduced.

(2) In the circumstances described in subsection (1) of this section, reimbursement shall be adjusted by reducing the health services for the eligible population by eliminating services in the order of priority recommended by the Health Services Commission, starting with the least important and progressing toward the most important.

(3) The division shall obtain the approval of the Legislative Assembly or Emergency Board, if the Legislative Assembly is not in session, before instituting the reductions. In addition, providers contracting to provide health services under this Act must be notified at least two weeks prior to any legislative consideration of such reductions. Any reductions made under this section shall take effect no sooner than 60 days following final legislative action approving the reductions.

SECTION 9. The prerequisites for implementation of this Act are:

(1) The Adult and Family Services Division shall obtain the necessary agreement from the Federal Government; and

(2) The Emergency Board must vote affirmatively to authorize the release of the appropriation for the second year of the 1989-1991 biennium.

SECTION 10. Any health care provider or plan contracting to provide services to the eligible population under this Act shall not be subject to criminal prosecution, civil liability or professional disciplinary action for failing to provide a service which the Legislative Assembly has not funded or has eliminated from its funding pursuant to section 8 of this Act.

SECTION 11. Notwithstanding the term of office specified by section 4 of this Act, of the members first appointed to the commission:

(1) Two shall serve for terms ending July 1, 1990.

(2) Three shall serve for terms ending July 1, 1991.

(3) Three shall serve for terms ending July 1, 1992.

(4) Three shall serve for terms ending July 1, 1993.

SECTION 12. (1) In addition to and not in lieu of any other appropriation, there is appropriated to the Emergency Board for the fiscal year beginning July 1, 1990, out of the General Fund, the sum of $62,182,348, which may be expended for purposes of this Act if the agreement described in section 9 of this Act is given. The Emergency Board shall authorize expenditures of any or all of the amount appropriated by this section upon recommendation of the Joint Legislative Committee on Health Care.

(2) The amount of the appropriation in subsection (1) of this section is in lieu of the same amount in the appropriation of the Adult and Family Services Division for medical assistance in the second year of the biennium ending June 30, 1991.

(3) If all of the moneys referred to in subsection (1) of this section are not allocated by the Emergency Board prior to July 1, 1990, such moneys on that date become available for purposes of ORS 414.025 to 414.325 and 414.610 to 414.670.

(4) Nothing in this section prohibits the Emergency Board from authorizing expenditures of amounts greater than appropriations under this section for the purpose of this Act.

SECTION 13. In addition to and not in lieu of any other appropriation, there is appropriated to the Adult and Family Services Division, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $523,567 for purposes of meeting the administrative expenses incurred by the division under this Act.

SECTION 14. In addition to and not in lieu of any other appropriation, there is appropriated to the Office of the Director of the Department of Human Resources, out of the General Fund, for the biennium beginning July 1, 1989, the sum of $173,780 for purposes of contracting with the Executive Department for administrative expenses of the Health Services Commission.

SECTION 15. Notwithstanding any other law, the amount of $347,560 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, excluding federal funds, collected or received by the Executive Department for purposes of meeting the

administrative expenses of the Health Services Commission.

SECTION 16. Notwithstanding any other law, the amount of $698,299 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal funds collected or received by the Adult and Family Services Division for the purposes of meeting the administrative expenses incurred by the division under this Act.

SECTION 17. Notwithstanding any other law, the amount of $173,780 is established for the biennium beginning July 1, 1989, as the maximum limit for the payment of expenses from federal funds collected or received by the Office of the Director of the Department of Human Resources, for purposes of contracting with the Executive Department for administrative expenses of the Health Services Commission.

SECTION 18. Nothing in this Act is intended to limit the authority of the Legislative Assembly to authorize services for persons whose income exceeds 100 percent of the federal poverty level for whom federal medical assistance matching funds are available if state funds are available therefor.

SECTION 19. ORS 414.025 is amended to read:

414.025. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

(1) "Category of aid" means old-age assistance, aid to the blind, aid to the disabled, aid to dependent children or Supplemental Security Income payment of the Federal Government.

(2) "Categorically needy" means, insofar as funds are available for the category, a person who is a resident of this state and who:

(a) Is receiving a category of aid.

(b) Would be eligible for, but is not receiving a category of aid.

(c) Is in a medical facility and, if the person left such facility, would be eligible for a category of aid.

(d) Is under the age of 21 years and would be a dependent child under the program for aid to dependent children except for age and regular attendance in school or in a course of vocational or technical training.

(e) Is a caretaker relative named in ORS 418.035 (1)(c) who cares for a dependent child who would be a dependent child under the program for aid to dependent children except for age and regular attendance in school or in a course of vocational or technical training; or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

(f) Is under the age of 21 years, is in a foster family home or licensed child-caring agency or institution under a purchase of care agreement and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(g) Is a spouse of an individual receiving a category of aid and who is living with the recipient of a category of aid, whose needs and income are taken into account in determining the cash needs of the recipient of a category of aid, and who is determined by the Adult and Family Services Division to be essential to the well-being of the recipient of a category of aid.

(h) Is a caretaker relative named in ORS 418.035 (1)(c) who cares for a dependent child receiving aid to dependent children, or a child who would be eligible to receive aid to dependent children except for duration of residence requirement; or is the spouse of such caretaker relative and fulfills the requirements of ORS 418.035 (2).

(i) Is under the age of 21 years, is in a youth care center and is one for whom a public agency of this state is assuming financial responsibility, in whole or in part.

(j) Is under the age of 21 years and is in an intermediate care facility which includes institutions for the mentally retarded; or is under the age of 22 years and is in a psychiatric hospital.

(k) Is under the age of 21 years and is in an independent living situation with all or part of the maintenance cost paid by Children's Services Division.

(L) Is a member of a family which received aid to dependent children in at least three of the six months immediately preceding the month in which such family became ineligible for such assistance because of increased hours of or increased income from employment. As long as the member of the family is employed, such families will continue to be eligible for medical assistance for a period of four calendar months beginning with the month in which such family became ineligible for assistance because of increased hours of employment or increased earnings.

(m) Was receiving Title XIX benefits in the month of December 1973, and for that reason met all conditions of eligibility including financial eligibility for aid to the disabled or blind by criteria for blindness or disability and financial criteria established by the State of Oregon in effect on or before December 1973, had been determined to meet, and for subsequent months met all eligibility requirements.

(n) Is an essential spouse of an individual described in paragraph (m) of this subsection.

(o) Is an adopted person under 21 years of age for whom a public agency is assuming financial responsibility in whole or in part.

(p) Is an individual or is a member of a group who is required by federal law to be included in the state's medical assistance program in order for that program to qualify for federal funds.

(q) Is an individual or member of a group who, subject to the rules of the division and within available funds, may optionally be included in the state's medical assistance program under federal law and regulations concerning the availability of federal funds for the expenses of that individual or group.

(r) Is a pregnant woman who would be eligible for aid to families with dependent children including such aid based on the unemployment of a parent, whether or not the woman is eligible for cash assistance.

(s) Would be eligible for aid to families with dependent children pursuant to 42 U.S.C. 607 based upon the unemployment of a parent, whether or not the state provides cash assistance.

(t) Except as otherwise provided in this section and to the extent of available funds, is a pregnant woman or child for whom federal financial participation is available under Title XIX of the federal Social Security Act.

(u) Is not otherwise categorically needy and is not eligible for care under Title XVIII of the federal Social Security Act, but whose family income is less than the federal poverty level.

(3) "Essential spouse" means the husband or wife of a recipient of a category of aid who is needy, is living with the recipient and provides a service that otherwise would have to be provided by some other means.

(4) "Income" means income as defined in ORS 413.005 (3).

(5) "Medical assistance" means so much of the following medical and remedial care and services as may be prescribed by the Adult and Family Services Division according to the standards established pursuant to ORS 414.065, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases;

(e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(m) Other diagnostic, screening, preventive and rehabilitative services,

(n) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(o) Any other medical care, and any other type of remedial care recognized under state law;

(p) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental defects, and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered thereby; and

(q) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases.

(6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. **"Medical assistance" includes "health services" as defined in section 2 of this 1989 Act.** "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) "Medically needy" means a person who is a resident of this state and who is considered eligible under federal law for medically needy assistance.

(8) "Resources" means resources as defined in ORS 413.005 (4).

SECTION 20. ORS 414.042 is amended to read:

414.042. (1) The need for and the amount of medical assistance to be made available **for each eligible group of recipients of medical assistance** shall be determined, in accordance with the rules of the Adult and Family Services Division, taking into account:

(a) The requirements and needs of the person, the spouse and other dependents;

(b) The income, resources and maintenance available to the person;

(c) The responsibility of the spouse, and, with respect to a person who is blind, or is permanently and totally disabled, or is under the age of 21 years, the responsibility of the parents; [*and*]

(d) The conditions existing in each case; **and** [.]

(e) Except for eligible groups of aged, blind and disabled, or children under ORS 418.001 to 418.034 and 418.187 to 418.970, the report of the Health Services Commission as funded by the Legislative Assembly.

(2) Such amounts of income and resources may be disregarded as the division may prescribe by rules, except that the division may not require any needy person over 65 years of age, as a condition of entering or remaining in a hospital, nursing home or other congregate care facility, to sell any real property normally used as such person's home. Any rule or regulation of the division inconsistent with this section is to that extent invalid. The amounts to be disregarded shall be within the limits required or permitted by federal law, rules or orders applicable thereto.

(3) In the determination of the amount of medical assistance available to a medically needy person, all income and resources available to the person in excess of the amounts prescribed in ORS 414.038, within limits prescribed by the division, shall be ap-

plied first to costs of needed medical and remedial care and services not available under the medical assistance program and then to the costs of benefits under the medical assistance program.

SECTION 21. ORS 414.065 is amended to read:

414.065. (1) With respect to medical and remedial care and services to be provided in medical assistance during any period, and within the limits of funds available therefor, the Adult and Family Services Division shall determine, subject to such revisions as it may make from time to time **and with respect to the "health services" defined in section 2 of this 1989 Act, subject to legislative funding in response to the report of the Health Services Commission:**

(a) The types and extent of medical and remedial care and services to be provided **to each eligible group of recipients of medical assistance.**

(b) Standards to be observed in the provision of medical and remedial care and services.

(c) The number of days of medical and remedial care and services toward the cost of which public assistance funds will be expended in the care of any person.

(d) Reasonable fees, charges and daily rates to which public assistance funds will be applied toward meeting the costs of providing medical and remedial care and services to an applicant or recipient.

(e) Reasonable fees for professional medical and dental services which may be based on usual and customary fees in the locality for similar services.

(2) The types and extent of medical and remedial care and services and the amounts to be paid in meeting the costs thereof, as determined and fixed by the division and within the limits of funds available therefor, shall be the total available for medical assistance and payments for such medical assistance shall be the total amounts from public assistance funds available to providers of medical and remedial care and services in meeting the costs thereof.

(3) Except for payments under a cost-sharing plan, payments made by the division for medical assistance shall constitute payment in full for all medical and remedial care and services for which such payments of medical assistance were made.

(4) Medical benefits, standards and limits established pursuant to paragraphs (a), (b) and (c) of subsection (1) of this section for the eligible medically needy may be less but shall not exceed medical benefits, standards and limits established for the eligible categorically needy, except that, in the case of a research and demonstration project entered into under ORS 411.135, medical benefits, standards and limits for the eligible medically needy may exceed those established for specific eligible groups of the categorically needy.

(5) Notwithstanding the provisions of this section, the division shall cause Type A hospitals, as defined in ORS 442.470, identified by the Office of Rural Health as rural hospitals to be reimbursed fully for the cost of covered services based on the Medicare determination of reasonable cost as derived from the Hospital and Hospital Health Care Complex Cost Report, referred to as the Medicare Report, provided by the hospital to a person entitled to receive medical assistance.

SECTION 22. This Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this Act takes effect July 1, 1989.

Approved by the Governor July 26, 1989
Filed in the office of Secretary of State July 27, 1989

CHAPTER 837

AN ACT SB 3

Relating to wetlands; creating new provisions; amending ORS 197.015, 215.213, 215.283, 541.605, 541.615, 541.625, 541.626, 541.645, 541.650, 541.670 and 541.695 and section 2, chapter 313, Oregon Laws 1989 (Enrolled Senate Bill 5548); repealing ORS 197.767 and 541.640; and limiting expenditures.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2, 3, 6, 7, 10 to 14, 20 and 32 of this Act are added to and made a part of ORS 541.605 to 541.695.

SECTION 2. The Legislative Assembly finds that:

(1) Wetlands provide a natural means of flood and storm damage protection through the absorption and storage of water during high runoff periods, thereby reducing flood crests and preventing loss of life and property;

(2) Wetlands provide essential breeding, spawning, rearing, feeding, nesting and wintering habitats for a major portion of this state's fish and wildlife;

(3) Wetlands provide essential habitat for waterfowl using the Pacific Flyway and for the rearing of salmon and other anadromous and resident fish;

(4) Wetlands act as accumulation areas for sediments which retain nutrients and other pollutants that may prevent entry of the pollutants into other waterways;

(5) Wetlands provide a valuable public service of maintaining clean water by retaining nutrients, metals and toxic materials from the water to protect water quality;

(6) Wetlands provide significant opportunities for environmental and ecological research, public recreation and education and provide scenic diversity and aesthetic value as open space and areas of visual enjoyment;

(7) Much of this state's original wetlands have been diked, drained, filled, dredged, ditched or otherwise altered;

(8) There is continuing development pressure on wetlands in Oregon;

CHAPTER TWO:

PRIORITIZATION OF HEALTH SERVICES

The Prioritized List of Health Services

The Health Services Commission was established to:

> *"[R]eport to the Governor and Legislature a list of health services, including health care services of the aged, blind and disabled...and including those mental health and chemical dependency services...ranked by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served....The recommendation shall include practice guidelines reviewed and adopted by the Commission...."*[1] *(emphasis added)*

The Commission is composed of eleven members. There are five physicians, including one Doctor of Osteopathy, four consumer representatives, a public health nurse, and a social worker.[2] The Commission relies heavily on the input from its subcommittees and ad hoc task forces.[3] A Commissioner chairs each subcommittee or task force and composition varies depending on the purpose of that body. If appropriate, membership from outside of the Commission will generally include representatives of specialty-specific providers, consumers, and advocacy groups within the area of interest.

The current Prioritized List of Health Services contains 743 medical condition/treatment pairs. Each condition/treatment pair that makes up a line item on the List is composed of diagnostic and treatment codes to define the services being represented. The conditions on the List are represented by the coding nomenclature of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Medical treatments are listed using codes from the American Medical Association's Current Procedural Terminology, Fourth Edition (CPT-4), and selected OMAP unique codes. Dental procedures are listed using codes from the American Dental Association's Current Dental Terminology (CDT-2).

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[1] Oregon Revised Statutes (ORS) 414.720(3).
[2] A list of the Commission membership can be found in Appendix B.
[3] Chapter 4 will outline the activities of the Commission's subcommittees and task forces.

The Commission maintains the Prioritized List by making changes in one of two ways:

1. The **Biennial Review** of the Prioritized List of Health Services, which is completed prior to each legislative session according to the Commission's established methodology.
2. **Interim Modifications** to the Prioritized List that consist of:
   a. **Technical Changes** due to errors, omissions, and changes in ICD-9-CM, or CPT-4, or CDT-2 codes; and,
   b. **Advancements in Medical Technology** that necessitate changes to the List prior to the next Biennial Review.

Prioritization Methodology

In 1998 the Commission completed its third biennial review of the List since implementation of the Medicaid Demonstration in February 1994. The review process followed the methodology dated April 19, 1993, which was approved by the U.S. Department of Health and Human Services. The final ranking of each of the condition/treatment pairs is determined either by 1) the treatment's effectiveness in the prevention of death and/or its average lifetime cost; or, 2) the application of a set of subjective criteria to the service being prioritized.

In creating the Prioritized List, an initial sort was performed following these steps:

a) The condition/treatment pairs were ranked according to the likelihood that treatment would prevent death;
b) Those remaining condition/treatment pairs whose treatments have an equivalent ability to prevent death or whose conditions have no risk of mortality were rank ordered by the average lifetime cost of treatment, from the least expensive to the most expensive; and,

c) Any condition/treatment pairs not separable by both of these measurements were sorted alphabetically by diagnosis.

The Commission then reviewed the initial sort of the condition/ treatment pairs line-by-line to determine whether the data resulted in an appropriate relative ranking of the line item. If the Commission felt that the initial placement of the line did not properly reflect its importance as a health service, the subjective criteria listed in Table 2 were used to move the condition/treatment pair up or down the list. These criteria were developed using the values expressed at the public hearings and community meetings held throughout the State. In order to alter the placement of a line using the subjective criteria, the list was divided into 30 groups of approximatcly 25 lines each. If it was determined a line did not belong in its initial group, the Commission used one or more subjective criteria to justify the movement into a different group of 25 lines.

The Commission performed a final sort using steps a) through c) within each new group of lines and then reviewed the entire list to ensure that the basic principles of prevention and early intervention were preserved. For example, regular prenatal care was placed higher on the list than the treatment of low birthweight babies since the provision of these services lead to fewer premature deliveries.

Biennial Review

Since the implementation of the initial Prioritized List in February 1994, the Health Services Commission has seen its role change to one of focusing on the maintenance of an already existing list. The Health Services Commission conducts a complete review of the Prioritized List every two years. The ongoing review of the List is a dynamic process that is responsive to changes in medical diagnoses, treatments, outcomes, and social values.

The most recent biennial review of the List began in the Fall of 1997. First, provider groups representing a cross-section of disciplines were surveyed as to changes in treatment outcomes related to mortality and

Table 2.
Subjective Criteria

A. General Preventive Services: This judgment determines the placement of three lines: children, adult, and dental preventive services.

B. Comfort Care: This judgment determines the placement of one line.

C. Maternity Care: This judgment considers the placement of services required from conception through the first 28 days of life. Examples are pregnancy care and neonatal services.

D. Family Planning Services: This judgment determines the placement of services for preventing pregnancy or planning families. There were four lines involved and this is a high priority for the Federal government.

E. Prevent a Condition Before Treatment: This judgment considers the importance of interceding early in the process before the condition develops. An example is placing the treatment for dysplasia of the cervix before the treatment of cervical cancer.

F. Medical Ineffectiveness: This judgment considers the fact that the specified treatment for the condition does not achieve its objective in the majority of the cases. An example is the dental services that provide only marginal improvement.

G. Prevent Additional Complications: This judgment considers the importance of interceding in order to stabilize or to prevent deterioration of a condition. An example is the treatment of glaucoma.

H. Prevent Future Costs: This judgment considers the importance of interceding early before resources must be spent in crisis. An example is the treatment of insulin dependent diabetes.

I. Cosmetic Services: This judgment reflects the fact that cosmetic services are not a covered benefit for Medicaid in Oregon.

J. Self-limiting Conditions: This judgment considers the fact that these conditions will run their course without, or in spite of, medical intervention. An example is the treatment of acute upper respiratory infections.

K. Congruent Conditions: This judgment considers the fact that the organ system and/or etiology of the conditions are similar to that of another condition/treatment pair elsewhere on the List or that the outcomes of the condition/treatment pairs are congruent.

L. Public Health Risk: This judgment reflected the fact that prevention of communicable diseases is a high priority for the state and federal government. An example is the treatment of syphilis.

cost of treatment within their area of expertise. Information about any recent advancements in medical technology was also solicited. In addition to those rankings requiring review based on medical advancements or changes in data as supplied by the provider community, requests for consideration came from consumers, advocacy groups, other state agencies, and Health Services Commission members. In addition, recommendations for placements of a number of ICD-9-CM and CPT-4 codes that did not appear on the Prioritized List were given by a workgroup composed of staff from the Office of Medical Assistance Programs and the Commission.

The Health Outcomes Subcommittee, composed of the physician members of the Commission, reviewed the evidence submitted to justify changes to the List. The Subcommittee met five times between February and June of 1998 to formulate their recommendations to the full Commission regarding biennial changes to the List. Commission action then resulted in the movement of individual codes on the List or the addition, deletion, merger, or splitting of entire lines.

Tables 3 through 6 reflect the significant changes in line placement or line composition between the May 1, 1998, and April 12, 1999, prioritized health services lists. The Commission adopted four new lines that have a low placement, with three of them representing conditions with no effective treatment or no treatment necessary (see Table 3). The Commission also moved twelve lines such as uncomplicated hernias in adults, which went from line 645 to line 552 (see Table 4). The Commission clarified and refined the List by merging ten sets of lines, as in the case of Breast Reconstruction being merged into line 229 with the treatment of cancer of the breast (see Table 5). Six other lines were found to be inappropriately grouped and were therefore divided into two separate lines. For example, symptomatic urticaria was removed from line 629 and placed on its own line at 571 (see Table 6). A complete listing of all biennial review changes by code can be found in Appendix C.

Table 3.
New Lines
4/12/99 Position and Line Descriptor Listed

Line 642:	Disorders of Sleep without Sleep Apnea/Medical Therapy
Line 729:	Infectious Diseases with No Effective Treatments or No Treatment Necessary/Evaluation
Line 733:	Musculoskeletal Conditions with No Effective Treatments or No Treatment Necessary/Evaluation
Line 737:	Gastrointestinal Conditions with No Effective Treatments or No Treatment Necessary/Evaluation

Table 4.
Lines Moved From Previous Ranking
4/12/99 Position and Line Descriptor Listed
(5/1/98 Position in Parentheses)

Line 7:	Torsion of Ovary/Oophorectomy, Ovarian Cystectomy (from line 439)
Line 8:	Torsion of Testis/Orchiectomy, Repair (from line 440)
Line 10:	Injury to Internal Organs/Medical and Surgical Treatment (from line 449)
Line 145:	Disorders of Spine with Neurologic Impairment /Medical and Surgical Treatment (from line 324)
Line 318:	Sarcoidosis/Medical Therapy (from line 729)
Line 327:	Brachial Plexus Lesions/Medical Therapy (from line 142)
Line 398:	Wound of Eye Globe/Corneal Laceration Repair (from line 419)
Line 406:	Purulent Endopthalmitis/Vitrectomy (from line 424)
Line 417:	After Cataract/Discission, Lens Capsule (from line 396)
Line 421:	Chronic Inflammatory Disorder of Orbit/Medical Therapy (from line 502)
Line 552:	Uncomplicated Hernia/Repair (from line 645)
Line 734:	Intracranial Conditions with No Effective Treatments or No Treatment Necessary/Evaluation (from line 618)

Table 5.
Merged Lines Previously Found on Separate Lines
4/12/99 Position and Line Descriptor Listed
(5/1/98 Line Position and Descriptor in Parentheses)

Line 207:	Herpes Simplex and Herpes Zoster with Neurological & Ophthalmological Complications/Medical Therapy (from line 391 Herpes Zoster & Herpes Simplex w/Ophthalmic Complications/Medical Therapy)
Line 229:	Cancer of Breast, Treatable/Medical and Surgical Treatment, which Includes Chemotherapy, Radiation Therapy, and Breast Reconstruction (from line 602, Absence of Breast after Mastectomy as Treatment for Neoplasm/Breast Reconstruction)
Line 267:	Acute and Subacute Ischemic Heart Disease, Myocardial Infarction/Medical and Surgical Treatment (from line 278, Angina Pectoris, Other Forms of Chronic Ischemic Heart Disease/Medical and Surgical Treatment, and line 279, Acute Myocardial Infarction/Medical Therapy)

Table 5. (Cont'd)
Merged Lines Previously Found on Separate Lines
4/12/99 Position and Line Descriptor Listed
(5/1/98 Line Position and Descriptor in Parentheses)

Line 298: Regional Enteritis, Idiopathic Proctocolitis, Ulceration of Intestine/Medical and Surgical Treatment
(from line 310 Ulceration of Intestine/Colectomy, Enterostomy)

Line 358: Breast Cysts and Other Disorders of the Breast/Medical and Surgical Treatment
(from line 332, Premalignant Lesions and Carcinoma-in-Situ/Destruction, Excision, Medical, and line 354, Cellulitis, Non-Orbital, Abscess of the Nails/Medical and Surgical Therapy)

Line 370: Cholelithiasis, Cholecystitis, Common Biliary Duct Stone/Medical and Surgical Therapy
(from line 134 Calculus of Bile Duct with Other Cholecystitis/Medical Therapy)

Line 377: Conduct Disorder, Age 18 or Under (See Guideline Note)/ Medical & Psychotherapy
(from line 579, Conduct Disorder, Severe/Medical/Psychotherapy)

Line 413: Primary and Open Angle Glaucoma/Trabeculectomy, Cyclocryotherapy, Laser Trabeculoplasty
(from line 395, Primary and Other Open Angle Glaucoma/ Cyclocryotherapy, and line 400, Primary and Other Open Angle Glaucoma/ Iridectomy, Laser Surgery)

Line 440: Noninflammatory Disorders and Benign Neoplasms of Ovary, Fallopian Tubes and Uterus, Ovarian Cysts/ Medical and Surgical Therapy
(from line 442, Hyperestrongenism/ Medical Therapy, Hysterectomy)

Line 514: Episcleritis and Acute Conjunctivitis/Medical Therapy
(from line 405 Episcleritis/Medical Therapy)

Line 672: Gender Identification Disorder, Paraphilias and Other Psychosexual Disorders/Medical & Psychotherapy
(from line 688 Transsexualism/Medical Therapy)

Table 6.
Previously Existing Lines Divided Into Two Separate Lines
4/12/99 Line Position and Descriptor
(5/1/98 Line Position and Descriptor in Parentheses)

Line 56: Birth of Infant/Newborn Care
(from line 52, Pregnancy/Maternity Care)

Line 161: Pneumonia Due to Respiratory Syncytial Virus in Persons Under Age 3/Medical Therapy
(from line 157, Asthma/Pneumonia Due to Respiratory Syncytial Virus in Person Under Age 3/Medical Therapy)

Line 217: Idiopathic or Viral Myocarditis and Pericarditis/Medical and Surgical Treatment
(from line 112, Myocarditis, Pericarditis and Endocarditis/Medical and Surgical Treatment)

Line 426: Entropion/Repair
(from line 582, Entropion and Trichiasis of Eyelid, Ectropion, Benign Neoplasm of Eyelid/Ectropion and Entropion Repair)

Line 571: Symptomatic Urticaria/Medical Therapy
(from line 629, Urticaria/Medical Therapy)

Line 578: Sexual Dysfunction/Medical and Surgical Treatment
(from line 578, Sexual Dysfunction/Medical & Psychotherapy)

On June 26, 1998, the Commission announced the completion of the biennial review process.[4] The revised Prioritized List of Health Services appearing in Appendix F was then forwarded to the independent actuarial firm of PricewaterhouseCoopers. The actuarial analysis of the average per-member-per-month costs of providing various levels of services for the different Medicaid eligibility groups appears in Appendix E. Upon the approval of this report, the 70th Oregon Legislative Assembly will set a funding level for the April 12, 1999, Prioritized List of Health Services. This will establish the benefit package for the Medicaid Demonstration for the 1999-2001 biennium.

Interim Modifications

The Commission was aware from the outset that this unique process for determining health benefit coverage would need further refinement as feedback was received after implementation. Anticipating the Prioritized List would have to evolve in order to be successful, the Commission asked for the authority to make adjustments to the List during the interim period. This request was granted in 1991 in the following statute:

> *"The commission may alter the list during the interim only under the following conditions:*
>
> *a) technical changes due to errors and omission; or,*
>
> *b) changes due to advancements in medical technology or new data regarding health outcomes.*
>
> *If a service is deleted or added and no new funding is required, the Commission shall report to the Speaker of the House of Representative and the President of the Senate. However, if a service to be added requires increased funding to avoid discontinuing another service, the Commission must report to the Emergency Board for funding."*[5] *(emphasis added)*

[4] Press Release issued June 30, 1998.
[5] ORS 414.720(5)a, (5)b and (6)

Technical Changes

Each year the medical codes used to represent the diagnoses and procedures on the Prioritized List are revised by the National groups responsible for their maintenance. Revisions to the 7,000+ CPT-4 procedure codes occur in January, and revisions to the 13,000+ ICD-9-CM diagnosis codes become effective in October at the beginning of the federal fiscal year. As a result, the Commission must make technical changes to the Prioritized List at least twice a year. Technical changes are also made to the List when omissions or errors are identified.

During the previous two years, physician aid-in-dying became a legal medical service in the State of Oregon, creating a need to consider placement of the service on the Prioritized List. See Chapter Three for a complete discussion of the addition of a practice guideline to the line representing comfort care for the terminally ill. This guideline was approved as a technical change to the List. An example of a technical change made because of error is the movement of the treatment of male organic impotence from line 542 to line 578 of the May 1, 1998, Prioritized List of Health Services. Due to the heightened media attention surrounding the FDA approval of Viagra as a treatment for male impotence, the Commission found the specific ICD-9-CM code for that condition was mistakenly included along with medically non-related conditions on line 542, Balanoposthitis and Other Disorders of the Penis. Effective October 1, 1998, the Commission moved both the codes for the medical and surgical treatment of male organic impotence to line 578, Sexual Dysfunction, which appropriately included the code for male impotence of nonorganic origin.

The health care plans under contract with OMAP asked that interim modifications to the List be made as few times during the contract year as possible in order to reduce administrative costs. During the 1997-99 biennium the Commission gave notice of six sets of interim modifications to the Prioritized List. This was a significant improvement when compared to the thirteen sets of changes implemented during the previous biennium. Appendix D reflects the

interim modifications made by the Commission since the May 5, 1997, report.

While yearly updates to the coding systems can be handled easily as technical changes, the conversion of ICD-9-CM to ICD-10-CM (a new categorical disease classification that radically differs from ICD-9-CM) planned during the year 2001 will necessitate a complete revision of every line item of the Prioritized List during the next biennium. ICD-10-PCS, a new procedural coding system that will either coexist with or supercede CPT-4 codes, is in the final stages of development and may need to be incorporated into the treatment specifications on the List.

Advancements in Medical Technology

The Commission periodically receives requests to modify the placement or content of condition/treatment pairs to reflect significant advancements in medical technology. These requests come from medical providers and commercial developers of emerging technologies. The Commission staff assembles needed background information and arranges to have experts testify before the Health Outcomes Subcommittee as it prepares a recommendation for the full Commission. During the last biennium, interferon alfa 2b was acknowledged as a significant advancement in treatment for chronic hepatitis B and C. Chapter Three contains a complete discussion of the Commission's 1998 decision to re-prioritized this condition/ treatment pair. In the event an added service is projected by an independent actuary to have a significant fiscal impact on the Medicaid Demonstration during the remainder of the biennium, the Health Services Commission is required to appear before the Legislative Emergency Board for additional funding. To date, no interim modifications have been found to have a significant fiscal impact on the Medicaid Demonstration.

GO TO PREVIOUS SECTION	RETURN TO TABLE OF CONTENTS	GO TO NEXT SECTION