

# FORUM

OPINION & COMMENTARY

## Marking progress Oregon-style

*Oregon Benchmarks is being eyed nationally as process that works*

By NEAL R. PEIRCE

Oregon, a perennial innovator among the states, has come up with an inventive way to measure how well it's doing.

The approach, borrowed from the corporate world, is called Oregon Benchmarks. And in contrast to many ballyhooed government reforms and management fads (Remember "sunset laws" and "zero-based budgeting"?), it may be here to stay.

Why?

First, it's a way to track, over periods of years, just where a state or city stands — and where it would like to be headed — on critical indicators about health, crime, education, the economy.

Second, it breaks with familiar government practice by measuring outcomes, not inputs.

The question, for example, is not whether environmental regulations are in place, but whether the air and water are getting cleaner. Not how many dollars are spent on teachers and schools, but whether kids are learning and to what standards.

Third, it's a system of goals developed through broad popular participation and then ratified and given the force of law by action of the Legislature and governor.

Finally, it's designed to last through successions of political leaders.

Oregon Benchmarks began in 1988 with "Oregon Shines," a strategic planning exer-

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PEIRCE

ise started by then-Gov. Neil Goldschmidt. Hundreds of Oregonians — from business, labor, education, environmental groups, state and local government, the health care system and grass-roots organizations — developed the official set of benchmarks for the state.

Then, 18 state legislative committees reviewed and approved the proposed benchmarks. In 1991, the Legislature enacted Oregon Benchmarks into law. The lawmakers also created an Oregon Progress Board to make sure the process stays alive and on target. Every two years, the board has to report publicly on progress toward each benchmark goal. It's headed by the governor and designed to be bipartisan.

Goldschmidt and his successor, Barbara Roberts, are Democrats, but Roberts actually appointed David Frohnmayer — the Republican she'd defeated for governor in 1990 — to sit on the Progress Board. "I needed him there to show the board is really bipartisan. And he has a good head," Roberts told me.

Benchmarks are necessary, Roberts argues, because "a lot of government programs, written with the best intentions, don't reach the goals they were written for in the first place. You have to be willing to measure yourself. This focuses you on results."

Altogether, Oregon has 272 benchmarks. For practicality they've been divided into two classes — priority standards related to acute questions (health care access, drugs, reducing teen-age pregnancy, for example) and "core" benchmarks (for more long-term, fundamental issues such as the base of the state's economy and basic literacy of the population).

All are, however, based on measurable outcomes. Teen pregnancy goals are quantified in the pregnancy rate per 1,000 females aged 10-17 for each of the target years — 1995, 2000 and 2010. Social harmony is measured by hate crimes per 100,000 Oregonians per year. Urban mobility is measured by the percentage of Oregonians who commute to and from work by some means other than a single occupancy vehicle.

Oregon Benchmarks got everyone's attention in 1993 when Roberts, faced with a seemingly cataclysmic 17 percent budget shortfall because of a voter initiative, actually cut all state agencies' budgets even deeper — 20 percent. Then she offered a 3 percent rebate to agencies able to shape their programs to achieve benchmark goals. The Legislature ratified almost all of Roberts' benchmark-targeted budget measures.

Over time, as actual performance of the state is compared to the benchmarks, problem areas will stand out and one can expect lawmakers and the governor to come under heavy pressure to recast programs to meet the goals that they — and the citizenry — have so clearly and publicly ratified.

Oregon Benchmarks is being emulated. Minnesota has a similar Milestones program, for example, and there are other versions developing in Maine, Hawaii, Florida, Texas and Ohio.

And now the approach is going local, too. Oregon has pioneering versions in rural Baker and Deschutes counties. Multnomah County Executive Beverly Stein and Portland Mayor Vera Katz have inaugurated a joint Multnomah-Portland benchmarking process that incorporates the most relevant state benchmarks and then adds ones that local citizens want.

Local benchmarks may be critical to long-term success, says Duncan Wyse, director of the Oregon Progress Board. Why? Because "more and more we're seeing the action — how to improve education, reduce drug use or teen-age pregnancy, for example — is in communities, not in federal or state programs."

The tough question, of course, is whether benchmarks will end up making a real difference in the conditions of life in a state. Do they have a chance against the negative tides of family dissolution, lawlessness, flawed public education?

Just as goals, clearly not. But to the degree they oblige states and localities to measure what they do by hard numbers, by standards everyone's agreed on, they could provide welcome realism and perhaps even a prospect for more effective government.



TALKING POINTS ON OREGON WAIVER

- ◆ The State of Oregon has been granted a waiver to modify its Medicaid coverage. The waiver allows Oregon to expand health care coverage to residents who do not now have insurance.
- ◆ The Oregon plan is an attempt by one state to provide security to more Oregon residents, control soaring medical costs and grapple with the health care crisis.
- ◆ The federal government should cooperate with states so that they have the flexibility to craft health care proposals which meet the needs of their citizens.
- ◆ But what works for Oregon's Medicaid program is not necessarily a national model for health care reform.
- ◆ In fact, Oregon officials acknowledge that their Medicaid plan may have to be modified to make it consistent with our national health care plan which will be presented in the next few months.
- ◆ What we envision for the nation is a comprehensive reform plan that:
  - Controls the rapid upward spiralling of health care costs.
  - Provides security and peace of mind so that you don't have to worry about being denied coverage when you're sick or losing your insurance when you change jobs.
  - Provides a comprehensive package of benefits.
  - Simplifies the system and reduces paperwork.
  - Maintains the highest quality medical care in the world and your choice of doctors while letting you choose your own health care plan.

## Q. AND A. ON OREGON WAIVER DECISION

1. Why did the administration approve this waiver if it is inconsistent with your vision of health care reform?
  - A. We share their goals -- providing security and controlling costs. This waiver is being granted to give one state the flexibility to design a Medicaid program that meets the needs of its citizens. Their plan may have to be modified when a national plan is presented.
2. How can you approve a plan that rations care?
  - A. What Oregon officials did was to develop a plan that expands medical care to cover more of its citizens. One hundred and twenty thousand more people will receive coverage under this Medicaid plan.
3. Does this plan now comply with the provisions of the Americans with Disability Act? What changes were made?
  - A. Yes. Oregon officials changed the plan to ensure full compliance with the ADA. They changed the process by which medical services were ranked to remove the "quality of life" criteria and indicated their willingness to accommodate any additional concerns.
4. Were the changes made as a direct result of pressure from the disabled community?
  - A. No. The ADA is the law of the land. The Department of Health and Human Services, Oregon officials and the disabled community have a common interest in ensuring that the terms and the spirit of the law are met. We consulted with the disabled community and legislative leaders on Capitol Hill to ensure full compliance with the ADA.
5. Whose decision is this? Is this waiver being granted just because President Clinton promised to do it during the campaign?
  - A. As Secretary of Health and Human Services, it is my decision, made after consultation with the President. The waiver is being granted to give the State of Oregon the flexibility it needs to provide security to more Oregonians until a comprehensive national plan is put into place.
6. Despite your assertions, many will see this as a signal of what's likely to be included in the Clinton Health Care Proposal. How would you respond?

- A. **This decision carries no implications for the Administration's national health reform proposal.** We are glad to support a Medicaid plan that works for Oregon. Our health care task force is working on a comprehensive health plan for the nation. We envision fundamental health care reform that provides security and choice for health care consumers.
8. What about the people who were going to lose coverage if this waiver was granted? What happens to them?
- A. No one now eligible for Medicaid will lose their coverage because of this waiver. The disabled and the chemically dependent will continue to receive all the services for which they are currently eligible.
9. Oregon has drawn a line and decided that all the services that fall beneath the line should not be covered. What is to stop them from moving the line up at some later point if they discover the cost of this universal coverage is too high?
- A. The list of services covered cannot be altered without prior approval from the Department of Health and Human Services. We have also made clear to Oregon officials that the burden is theirs to bear if this plan does not yield the cost savings they envision. [This is the case for all Medicaid waivers.]
10. Some groups including the disabled still feel that this plan rations health care and hurts one group while helping another. How do you respond?
- A. The Oregon plan **broadens Medicaid coverage** to provide security for many residents who are currently without medical insurance. **No one will lose coverage under the plan.**
11. In granting the waiver, aren't you endorsing the Oregon approach?
- A. No. We endorse the goals of providing comprehensive coverage and controlling costs for the citizens of Oregon.

**What we are endorsing through this waiver is state flexibility.** Oregon worked hard to develop their plan. We are granting them the flexibility to design a plan that meets the individual needs of their state.

THE WHITE HOUSE

WASHINGTON

March 17, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco *CHR*

SUBJECT: Oregon Waiver

I. SUMMARY

Attached is a memorandum from Secretary Shalala on the Oregon Medicaid Demonstration Waiver. This is to be a Secretarial decision and she is prepared to sign it; she has promised a decision to Governor Roberts by Friday, March 19.

II. DISCUSSION

In addition to the main memo with Tabs A, B, and C are two memos which are (1) a Q and A about the project and (2) a political memo (this is the only copy) which outlines statements by you and the Vice-President.

I have asked the Vice-President's office and the Secretary's office to arrange for a briefing of the Vice-President today or tomorrow.

The only outstanding question for you now is whether or not you want a briefing/discussion with the Secretary and appropriate HHS staff members along with the Vice-President and members of your staff.

\_\_\_\_\_ Inform the Secretary to proceed

\_\_\_\_\_ I want a formal briefing/full discussion before the Secretary proceeds



MAR 16 1993

## MEMORANDUM FOR THE PRESIDENT

SUBJECT: Oregon Medicaid Reform Demonstration Waiver

### I. ACTION-FORCING EVENT

Oregon's legislature, currently in session, meets only every two years. I have promised the State a final decision on its Medicaid Reform demonstration proposal by March 19.

### II. BACKGROUND/ANALYSIS

The Oregon Health Plan is a comprehensive, legislatively-approved package of reforms intended to provide universal health insurance coverage to all State citizens, and to introduce cost control. One component is the Oregon Medicaid Reform Demonstration Plan which would cover all Oregonians below the Federal poverty line for defined treatment interventions connected to a specified set of medical conditions. Both the expansion of eligibility and the limitation of coverage to specified condition-treatment pairings would require Federal waivers.

Under Section 1115 of the Social Security Act, I am granted very broad waiver authority for any demonstration which, "in the judgment of the Secretary is likely to assist in promoting the objectives" of the Social Security Act. No other guidelines are listed in the authorizing legislation, and previously this Department has mainly sought assurances that any proposed demonstration was legal and budget neutral to the Federal government.

The proposal itself has many strengths. These include: universal protection, promotion of access and cost containment through managed care, and a thoughtful, open and inclusive development process. Moreover, approving the proposal would signal the Federal Government's trust and respect for state experimentation and initiative. It is a bold experiment. We at HHS believe the proposal is evaluable and could yield useful information on various questions regarding delivery and access to health care.

Plan Methodology -- A number of major concerns ought to be considered, most of which involve the overall methodology of the Plan and its perceived "rationing" of health care services.

The Oregon Health Services Commission (five physicians, two registered nurses, one medical social worker, four consumer advocates), supported by groups of medical specialists, used evidence on cost and effectiveness as well as subjective judgements in developing and ranking a series of condition-treatment pairs. The total list prioritizes 688 condition-treatment pairs. The Oregon legislature has decided that it is currently able to fund coverage of the top 568. The present list of uncovered services (e.g.,

number 586, surgical treatment of benign neoplasms of the digestive system; number 594, reconstructive breast surgery following cancer surgery; number 587, acute and chronic disorders of the back without spinal cord injury) does not appear to raise highly disturbing ethical or medical issues, largely because the Commission used its subjective judgement to move any procedures which would raise serious concerns above the cut-off point.

ADA Legal Issues --Two broad issues arise with regard to the methodology. The first is legal. In particular, does the plan violate the Americans with Disabilities Act (ADA)? The former HHS Secretary decided in August 1992 he could not approve the Oregon Medicaid demonstration pending resolution of legal issues related to the ADA.

Oregon sought to address those ADA concerns in its resubmission. Nonetheless, one legitimate, but in our view resolvable concern, raised as early as last October, remained: whether the methods used for ranking non-lethal condition-treatment pairs violate the ADA by appearing to favor outcomes in which the patient is freed of all symptoms. After face-to-face discussions on this issue in Oregon late last week, our General Counsel and the Civil Rights Division of the Justice Department believe the ADA issues have been successfully resolved. In essence, Oregon has agreed to re-rank the condition-treatment pairs without regard to symptomatic-asymptomatic considerations. (See Tab A on legal issues.) We do not believe that this re-ranking by the Commission will significantly alter the list of covered services.

Appropriateness of the "Rationing" System -- The larger issue concerns the validity of rationing at all, especially prior to wringing all possible inefficiencies out of the current system. To opponents of the plan, it provides additional coverage for one group of poor persons, in part, by reducing benefits to another. It is also said to signal that the poor deserve less medical care than others. Certain groups such as the elderly and disabled are excluded initially from the demonstration, so they are not being rationed. This initial exclusion raises questions of equity. (Oregon says it expects to add these groups within a couple of years; when the State's proposal for including these groups becomes available, it will be carefully assessed by this Department.) Finally, opponents raise legitimate questions about the scientific basis for the rankings in the first place.

Supporters counter that all states' Medicaid programs "ration" health care, usually through obscure, budget-based executive branch decisions to limit benefits' amount, scope and duration, or to exclude optional services. Oregon proposes, instead, an alternative rationing scheme which attempts to exclude the least important services through an open and accessible process, rather than using arbitrary service limitations.

The list of excluded services does not appear to present serious problems as the standards are currently drawn. Opponents often complain less about the current list of exclusions, and more about the possibility that as budget pressures grow, Oregon will begin to exclude far more serious conditions. Partly in response to these concerns, we

The President -- 3

have negotiated very strict conditions with Oregon. Should the waiver be granted, any change in the rankings or the list of covered condition-treatment pairs will require HHS approval. We have made clear we would be skeptical about major new exclusions. Most opponents have been unaware of this new condition, and in several cases, including Representative Waxman, learning of it has reduced -- but certainly does not eliminate -- concerns about the plan.

Budgetary Issues -- There are other concerns as well. We are skeptical that Oregon can do all the things it promises at the budgetary cost they project. We have built in extremely strong Federal financial protection into the waiver, and Oregon has accepted these conditions. Thus the Federal financial exposure is minimal. If the costs are higher than expected, Oregon will have to pay them. But budget pressures could push Oregon to seek either additional expanded Federal financial support or a significant change in the list of excluded services in the future.

Connection to Health Reform -- Finally, important questions remain about the connections between Oregon's plan and health reform. While the overall goals of the two efforts are quite similar, Oregon's plan seems likely to be different from the proposal you will eventually develop in several important ways. If health reform is passed, major parts of the plan would have to be reformulated (and, in concept, Oregon has agreed to make changes which may be necessary). Some worry that accepting the Oregon waiver will be interpreted as a signal of where national health reform is headed and, if we are to argue that such an interpretation is incorrect, the question then becomes why are we approving an approach which cannot be synchronized with the overall health reform plan. (A summary of key issues is at Tab B.)

### III. OPTIONS

Negotiations with Oregon have progressed to the stage where the basic decision now is either accept or reject the waiver. We must decide whether to approve the proposal, subject to terms and conditions which include (a) requirements of prior approval by HHS of changes in the prioritization list and (b) limitation on the degree of Federal financial exposure. (A draft list of special terms and conditions is at Tab C.)



Donna E. Shalala

#### Attachments:

- Tab A -- Legal Issues
- Tab B -- Key Issues
- Tab C -- Special Terms and Conditions

TAB A

Analysis of ADA Concerns with Oregon's Revised  
Methodology for Prioritizing Health Care Services

BACKGROUND

On August 3, 1992 former Secretary Sullivan informed Governor Barbara Roberts of Oregon that the State's Medicaid Demonstration proposal could not be approved until a number of identified concerns arising under the Americans With Disabilities Act (ADA) were resolved. Department officials worked with Oregon over the next few months and on November 13, 1992, Oregon submitted a revision to its methodology for prioritizing health care services under its demonstration.

Oregon's Revised Methodology. Oregon's revised methodology is based on the Health Services Commission's attempt to rank services according to their medical effectiveness. The Commission measured effectiveness first by the ability of a treatment to prevent death as a result of a condition. When two or more treatments were tied on this basis, the Commission looked to the degree to which a person is likely to be asymptomatic after treatment. Remaining ties were broken by ranking treatments according to their cost, with lower cost treatments being ranked higher.

The Commission then reviewed a computer-generated ranking of health services, based on the above methodology, and made "hand" adjustments to the list to reflect the following social values that Oregonians had expressed at public meetings and hearings:

Highly valued services were--

- Healthy mothers and healthy babies
- Comfort care
- Family planning services
- General preventive services
- Prevention ranked before treatment for the disease
- Treatment for contagious diseases

The following services were considered less important--

- Treatments for conditions that get better on their own
- Cosmetic services
- Infertility services
- experimental services

Problems with the Revised Methodology. While the revised methodology is fully responsive to the concerns that were

originally raised, the Department of Justice<sup>1</sup> and a number of disability advocacy organizations have criticized the new proposal as also being inconsistent with the ADA, but for new reasons arising out of the revised methodology. The specific concerns raised by the Department of Justice are the following:

After the initial ranking of treatments according to ability to prevent death, the treatments that are equally effective in that regard are ranked according to their ability to return an individual to an asymptomatic state. As between two treatments that are equally effective in preventing death, a treatment that is more likely to return an individual in his or her previous health state will be ranked higher than one that may result in residual symptoms. Since Oregon defines symptoms with reference to conditions such as "functional impairment" as well as residual medical conditions, individuals whose medical conditions may leave them disabled even after treatment will rank lower on this scale.

Because of the substantial hand movements made by the Commission, this factor may not ultimately have much actual impact on placement of a particular condition on the list. However, sanctioning its use in this demonstration could be found to violate the ADA in that treatment for an individual may be given lower priority "by reason of disability."

We have proposed that Oregon should rerank the condition/treatment pairs without using this factor. It should be fairly easy for the Commission to generate a new list without using that factor and then to apply the hand adjustments according to the factors that were previously used. The Congressional Office of Technology Assessment has indicated that because of the extensive hand movements, the ranking methodology used by Oregon ultimately had only a small effect on the final rankings. Therefore, this revision should not have a substantial effect on the prioritized list.<sup>2</sup>

While it is not clear that a court would invalidate the waiver under the ADA because of this factor, there is certainly some risk of that outcome should litigation ensue. We understand that the mainstream disability advocacy organizations are not anxious to file suit against an Oregon waiver and that they definitely would not sue if this change is made. For that reason we have strenuously urged Oregon to make these changes.

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<sup>1</sup> See attached letter from the Assistant Attorney General, Office of Legal Counsel to the Acting General Counsel, Department of Health and Human Services dated January 19, 1993.

<sup>2</sup>Office of Technology Assessment Health Program Staff Memorandum, Re: Brief Analysis of Medicaid Waiver Resubmission, December 23, 1992, pp. 1, 4.

Oregon has agreed to make the changes we suggested, including adding a new criterion to the list of factors used to make hand adjustments that would reflect medical effectiveness. This criterion could not, however, reflect functional limitations but must be based only on medical factors. Oregon and we recognize that this is only an interim step and that we will work with the State to help them to develop a revised methodology that does not implicate the ADA.

The other legal issues involving the waiver were much more easily resolved. In particular--

- o The Department of Justice criticized the ranking system because it used "value laden" judgments about the importance of certain health states. In particular, infertility services were given a low priority by the Commission in its hand movements.<sup>3</sup> Because infertility is undoubtedly a disability under the broad definition in the ADA, the Department of Justice questioned whether it is permissible under the ADA to devalue that service simply because it is considered less important than other services.

Oregon will resolve this problem either by excluding infertility services altogether from the Medicaid program (which it is permitted to do) or by applying content neutral criteria (such as cost or medical effectiveness) in determining what priority should be accorded these services.

- o The Department of Justice observed that some of the considerations applied by the Commission in making hand adjustments are described at such a level of generality that it is not possible to conclude on the present record that factors impermissible under the ADA had no effect on the ranking process.

The Department of Justice did not have the benefit of considerable additional information, including computer runs, analyses of movements on the list, minutes of

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<sup>3</sup> None of the other criteria applied by the Commission is as condition-specific as its treatment of infertility. The other criteria, discussed above, relate to health and societal values that are content neutral, i.e., they do not measure the value of a treatment with reference to a condition that may be a disability. Therefore, we believe that if the problems the Department of Justice identified with relation to infertility can be resolved, the issue of "value laden" criteria will be resolved as well.

**TAB B**  
**THE OREGON WAIVER REQUEST**  
Key Issues

The Oregon Health Plan is a comprehensive, legislatively approved package of reforms intended to provide universal health insurance coverage and cost control to all State citizens. This will be accomplished through an expansion of Medicaid eligibility to all poor citizens, private insurance reform, risk pooling, and phased-in employer mandates ("pay or play"). One component, implementation of which would require Federal waivers, is the Oregon Medicaid Reform demonstration plan.

This memo discusses key issues regarding the plan. We have organized the discussion of the key issues around six questions:

1. What are the strengths of Oregon's proposal?
2. Does the proposal violate the Americans with Disabilities Act?
3. Does the Oregon proposal constitute unacceptable rationing of care?
4. Can Oregon really provide the coverage it proposes within the budget it promises?
5. Is it evaluable?
6. What is the relationship between the Oregon proposal and national health care reform?

**I. What are the strengths of Oregon's proposal?**

Universal Access

Under the Medicaid waiver, all Oregonians below the poverty level would be covered by Medicaid. Thus, over 5 years some 90,000 single adults, childless couples, and families with children with incomes above the current eligibility levels would be brought into Medicaid eligibility, an increase of 36%. An especially attractive feature of this arrangement is a substantially simplified eligibility determination process.

In addition to the expansion of Medicaid, State statutes mandate that by a set future date, all employers must "play or pay" -- that is, help finance health insurance coverage for their employees or pay into a state insurance pool.

The State has also legislated a "risk pool" to enroll persons considered medically uninsurable.

Promotion of Access and Cost Containment Through Managed Care

The State proposes to move virtually all Medicaid beneficiaries into one or another model of managed care. Some -- mainly those in urban areas -- will go into fully-capitated health plans from fee-for-service. Others will go into "Physician Care Organizations," a partial capitation model through which the State now contracts for

ambulatory care services for 65,000 Medicaid beneficiaries. Residents of sparsely-populated areas will be enrolled in managed fee-for-service systems.

#### Thoughtful, Open, Inclusive Development Process

Whatever other shortcomings the proposal might have, the openness and inclusiveness with which the reform proposal was developed represents a "best practices" process. In addition to the legislative hearings and deliberations, a Health Services Commission was established, staffed, and supported by the work of expert physician panels. As specified by law, the Commission: held 12 public hearings and 47 two-hour community meetings at which over 1500 people testified; met with health care providers; conducted a telephone survey of 1,001 Oregonians to ask them what value they attach to different health states; and obtained expert reaction to the proposed methodology.

#### Signal About the Federal Government's Respect for and Trust in States

The elements of the proposal described above are clearly compatible with a number of the basic principles underlying the Administration's approach to health reform -- universal coverage, case management of health services, cost containment, and a broadly-participatory design process that involves the people affected. Approval would recognize this effort on Oregon's part and would signal confidence in the creativity and responsibility of the states as partners in the health reform process.

## **II. Does the proposal violate the Americans with Disabilities Act?**

In August of 1992, the Justice Department determined that one aspect of the priority ranking process was "based in substantial part on the premise that the value of the life of a person with a disability is less than the value of a life of a person without a disability," hence violative of the then-recently passed Americans with Disabilities Act (ADA). It was on this basis that former Secretary Sullivan declined to approve the original proposal.

Oregon re-submitted its proposal on November 13, 1992, including a number of changes designed to address ADA-related matters. However, on January 19, 1992, the Justice Department again informed the Department of Health and Human Services (HHS) that the Oregon priority ranking process was deficient because the ranking favored condition-treatment pairs which return patients to an asymptomatic state over those which leave patients with remaining symptoms. That is, a condition-treatment pair where the patient had symptoms which were completely cured or relieved by the treatment was ranked higher than a condition-treatment pair where the symptoms were not fully cured or relieved (as might be the case with someone who was left disabled). This ranking process was construed as a bias against those with disabilities and contrary to requirements of the ADA.

Since that time, the Department has had extensive discussions with officials of the Oregon State government regarding further modifications of their prioritization process. These discussions culminated in face-to-face discussions on this issue in Oregon late last week between key HHS and State personnel, following which our General Counsel and the Civil Rights Division of the Justice Department believe the ADA issues have been successfully resolved. (See Tab A on legal issues.)

### **III. Does the Oregon Proposal Constitute Unacceptable Rationing of Care?**

#### "Rationing" as a Strategy for Limiting Costs

For most opponents, the decision to explicitly exclude certain condition-treatment pairs is at the heart of their worries about the proposal. The concerns are as much philosophical and symbolic as substantive. Is it fair and appropriate to "ration" care to low-income families while care is not necessarily "rationed" to other Oregonians in the same fashion? Or to put the matter even more bluntly, is it appropriate to increase coverage for some poor persons by reducing the protection granted to others? Many fear that accepting the Oregon plan legitimizes a strategy with a very slippery slope which will ultimately lead to second class medical coverage and care for the poor, both in Oregon and, if adopted more broadly, elsewhere. They worry that budget pressures will cause Oregon to reduce sharply the number of covered condition-treatment pairs. And most importantly they argue it sends the worst kinds of signals about the rights of poor persons to medical coverage.

When one moves beyond the signals and symbols, the substance gets more ambiguous for three reasons. First, everyone agrees that Medicaid services are now rationed in more hidden ways (like low reimbursements which limit provider participation, and limitations on the amounts of mandatory services that are covered).

Second the amount of actual rationing via application of the current cut-off point in the prioritization list appears to be modest. Indeed, the Department's view is that the costs associated with the list of uncovered services are so modest that the State's expectations that it will achieve significant savings by their exclusion are unrealistic. Nonetheless, there is a substantial argument that the removal of system inefficiencies ought precede even minor benefit reductions.

Covered services will include expanded benefits for adult preventive care, dental care, and hospice services. The enumerated list of State-covered Medicaid condition-treatment will serve as the basic employee benefit package when mandated employer coverage is phased in. Excluded services include procedures such as surgical treatment of benign neoplasms of the digestive system (no. 586), reconstructive breast surgery following cancer surgery (no. 594), and acute and chronic disorders of the back without spinal cord injury (no. 587).

Third the State has already agreed to conditions whereby it could not modify the list in any way nor reduce the covered treatments without prior approval from HHS. Most opponents are unaware of this condition--something to which HHS and Oregon agreed to some time ago. Indeed, a number of the most vociferous opponents, including Representative Waxman and Sarah Rosenbaum, seem much more comfortable with the plan so long as this proviso is included and applied rigorously.

#### Initial Exclusion of Aged and Disabled

Initially the aged and disabled, and mental health and substance abuse services are not included in the demonstration. These groups and services are covered under the old Medicaid rules. This exclusion cuts two ways. On the one hand, it blunts criticism with respect to rationing for the aged and disabled. On the other hand, it raises the argument that services are being reduced for women and children while protecting other, more politically powerful groups. At some point in the future, the State anticipates bringing these groups and services into the demonstration. HHS approval of the State's specific implementation plans for these populations groups and services will be required.

#### The Oregon Ranking Process and its Scientific Validity

The Oregon Health Services Commission (five physicians, two registered nurses, one medical social worker, four consumer advocates), supported by groups of medical specialists, used evidence on cost and effectiveness as well as subjective judgements in ranking procedures.

Unfortunately the data and evidence for such rankings is often weak -- in part because the needed studies do not exist. The Office of Technology Assessment (OTA) recently released a report critical of Oregon's procedures, especially the Commission's re-ranking of some 25 percent of condition-treatment pairs based on members' subjective tests of "reasonableness." OTA and others point out that a procedure often is cost-effective for one person with a particular condition and wasteful for another, so a single ranking with blanket inclusions and exclusions often may lack patient-specific clinical appropriateness. Many critics question the whole notion of ranking procedures on the basis of some "average patient," and argue that the data are far too limited to rank things adequately even if one thought it appropriate to do so.

### **IV. Can Oregon Really Provide the Coverage it Proposes Within the Budget it Promises?**

#### The Costs/Savings From the Program

The State originally estimated additional federal costs of \$140 million; Oregon now estimates that the demonstration will save \$3 million in Federal costs over 5 years. Against a base program cost of more than \$5 billion over the period, either of these estimates, whether for costs or savings, is imprecise but comparatively insignificant.

Oregon's goal is to save money by reducing the number of covered Medicaid services and by using managed care. They intend to use the savings to cover the low-income population. However, as noted previously, excluding these services may not save much money. In addition, under this plan, Medicaid payments to providers are required by State statute to be set and maintained at a level sufficient to cover providers' costs; this will substantially enhance payments to providers and significantly raise costs with managed care incentives alone working to wring out inefficiencies from the system.

Thus, the possibility of significant out-year savings is largely dependent upon two factors: (a) savings from broad enrollment in managed care which, while potentially quite substantial, are, to date, modest; and (b) movement of Medicaid beneficiaries out of Medicaid and onto employer-sponsored coverage under Oregon's "play-or-pay" mandate. In both cases, any net savings are at least several years away and costs are expected to increase in the short run.

#### Budget Implications Now and for the Future

In response to concerns about the potential costs of the program, the Department has developed procedures that sharply limit Federal expenditures under the demonstration. OMB and HHS both believe that the Federal government is well protected by these procedures. The State is left to fund any excess costs under the current conditions of the waiver.

Nonetheless, there seems likely to be pressure on the Federal government to either contribute more money or to allow Oregon to significantly alter the list of covered services if the budget is understated as we believe. Oregon is experiencing a taxpayer "revolt," raising questions regarding the State's ability to support its share of the costs throughout the life of the demonstration. If Oregon is unable to pay for the services it has promised, HHS will again be confronted with difficult choices between increased Federal spending and further rationing with continuing political fallout.

#### **V. Is the Demonstration Evaluable?**

You have committed yourself to granting waivers only if they are truly evaluable, a view HHS strongly shares. In our view, important lessons can be learned from the experiment.

Massive state-wide demonstrations always pose some difficult evaluation questions for there is no way to create a reliable control group. Moreover, it is extremely difficult to judge the impacts of alternative service delivery mechanism and coverage arrangements on health outcomes. Nonetheless, the Oregon plan does offer the best opportunity yet to learn about the impact of comprehensive managed care and capitation plans, pay or play strategies for the uninsured, and the impact of alternative coverage rules. Oregon

### **Monitoring Budget Neutrality for the Oregon Reform Demonstration**

Oregon will be at risk for the per capita costs provided in the proposal for both current and new eligibles, but not at risk for the number of current eligibles. By providing Federal Financial participation (FFP) for all current eligibles, Oregon will not be at risk for changing economic conditions. However, by placing Oregon at risk for the per capita costs provided in the proposal for both current and new eligibles, HCFA assures that the demonstration expenditures will reflect Oregon's estimates of savings from managed care and the priority list. Oregon will be at partial risk for the number of new eligibles by using the State's estimate of the ratio of new eligibles to old eligibles to limit the number of new eligibles for which FFP will be provided.

#### LIMITS ON FEDERAL EXPENDITURES

- o Eligibility Groups Subject to the Limit - The Oregon per capita cost estimate for the current eligible population (as defined in term and condition number 6, above) and newly eligible populations will be the basis for establishing the limits on FFP. The costs of populations not included in the demonstration, such as the Supplemental Security Income (SSI) eligibles, will not be included in the limits.
- o Limit on Demonstration Expenditures - The annual limits are defined as follows:
  - a. Current Eligibles: Actual number of current eligibles times the Oregon estimate of per capita cost for current eligibles; and
  - b. New Eligibles: Actual number of current eligibles times the Oregon ratio of new eligibles to current eligibles times the Oregon estimate of per capita cost for new eligibles.

## MONITORING SYSTEM

The form HCFA 64, Quarterly Medicaid Statement of Expenditure for the Medical Assistance Program, will be used for monitoring Oregon expenditures under the demonstration.

Oregon will continue to submit a HCFA 64 for the entire Medicaid program and additional HCFA 64s for the AFDC population. The additional HCFA 64s will provide eligibility counts and expenditure data on:

- o All current AFDC (including PLM children and adults) and new eligibles;
- o All current AFDC eligibles (including PLM children and adults); and
- o All new eligibles.

These HCFA 64s will be used to monitor Oregon expenditures. FFP will be provided to the State for its actual expenditures, but limited to the caps.

## HEALTH CARE FINANCING ADMINISTRATION SPECIAL TERMS AND CONDITIONS

**NUMBER:** 11-P-90160/0-01  
**TITLE:** Oregon Reform Demonstration  
**AWARDEE:** Oregon Department of Human Resources

1. Oregon will, within 60 days of this approval, rerank the condition/treatment pairs without relying on data which it collected with respect to whether treatment returned an individual to an asymptomatic state. Oregon may, at its discretion, add the criterion of "medical effectiveness" to those criteria which served as the bases for the Health Services Commission to adjust the placement of condition/treatment pairs. The medical effectiveness criterion may not take into account changes in individuals' functional limitations as a result of treatment. Pursuant to term and condition 5 below, the revised priority list must be submitted and approved by the Health Care Financing Administration (HCFA).

Oregon may conduct additional analyses of medical effectiveness and may revise its methodology for determining the placement of condition/treatment pairs to include data regarding medical effectiveness. Such a revised methodology shall be submitted to HCFA for comment before its use and any revised priority list of condition/treatment pairs must be approved by HCFA.

2. Oregon will revise the list of criteria used by the Health Services Commission to make hand adjustments to the list to exclude the factor relating to infertility services. If Oregon decides to cover infertility services under the demonstration (which it is not required to do), it will rank infertility services along with other services using content neutral factors that do not take disability into account.
3. Oregon will adopt policies that will ensure that before denying treatment for an unfunded condition for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual has a funded condition or a condition comparable to a funded condition that would entitle the individual to treatment under the program. Oregon will provide through a telephone information line and/or through the applicable appeals process for expeditious resolution of questions raised by providers and beneficiaries in this regard.

4. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The State must perform periodic review, including validation studies, in order to ensure compliance. The State shall have provisions in its contract with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The State shall develop a workplan showing how collection of plan encounter data will be implemented and monitored; the workplan shall also identify State resources that will be assigned to this effort. The workplan shall describe how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis. If the State fails to provide accurate and complete encounter data for any managed-care plan, it will be responsible for providing (at 100 percent State cost) to the designated HCFA evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.
5. Any revision to the October 30, 1992 priority list of 688 condition/treatment pairs, including the cut-off line for covered services, shall be submitted to HCFA for review and approval.
6. The State shall provide quarterly expenditure reports (HCFA-64s) that provide expenditures on both the currently eligible and the newly eligible populations under the demonstration. HCFA will provide Federal Financial Participation only for annual expenditures that do not exceed pre-defined limits on the number of demonstration eligibles and costs incurred, following the attached budget guidelines. (NOTE: For reporting and budget neutrality purposes, currently eligible shall be defined as the AFDC populations, women who are pregnant (plus 60 days postpartum eligibility) with incomes to 133% of the Federal Poverty Level (FPL), children under age six with incomes to 133% of FPL, and children born after September 30, 1983 with incomes to 100% of FPL.)
7. The State shall submit a tentative timeline and detailed proposal on how mental health and chemical dependency service and the elderly and disabled will be incorporated into the demonstration. The tentative timeline should be submitted by October 1, 1993. The detailed proposal will be submitted as a later waiver amendment.
8. Prior to the start date of the demonstration, the State must submit evidence that health plan and physician capacity is adequate to serve the expected enrollment. This will include an discussion on how individuals who currently rely on FQHCs and RHCs will continue to have access to health care through the managed care delivery system.

9. The State must also fully meet the usual Medicaid disclosure requirements for contracting providers prior to the start date of the demonstration.
10. For those plans that do not meet section 1903(m) requirements, prior to award of contract to these plans, the State shall submit for HCFA approval a description of their delivery system, their financial viability, and their quality assurance system.
11. The State will submit to ORD and to the HCFA Regional Office copies of all financial audits of participating health plans and quality assessment reviews of these plans.
12. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The first quarterly report will be due September 1, 1993. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, access, financial results, benefit package, and other operational issues. The report should also include proposals for addressing any problems identified in the quarterly report. Utilization of health services should be reported on a quarterly and cumulative basis.
13. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties by April 1, 1994. Within 30 days of receipt of comments from ORD, a final annual report will be submitted.
14. Within 30 days of the date of award, the State shall submit revised waiver cost estimates reflecting the start date of the demonstration. As a minimum, these tables should include revised estimates of per capita cost and number of eligibles for each year of the demonstration. These estimates must be consistent with the December 1992 revisions to the State's waiver cost estimate.
15. During the last 6 months of the demonstration, no enrollment of individuals who would not be eligible under current law will be permitted.
16. Oregon must implement procedures so that hospitals will be able to distinguish individuals who are eligible under current law from individuals who are only eligible because of the demonstration. The proposed procedure must be submitted to HCFA for approval within 60 days of the date of approval.
17. Oregon will implement modifications to the demonstration by submitting revisions to the original proposal. The State shall not submit amendments to the approved State plan relating to the new eligibles.

18. The State's new eligibility rules under the demonstration will not adversely affect Medicaid eligibility of persons who:
  - (a) have been determined to be eligible for Medicaid prior to the start date of the demonstration; and
  - (b) remain eligible as of the day immediately prior to the start date of the demonstration;

but only to the extent that these persons continue to meet the Medicaid eligibility criteria in effect on the day immediately prior to the start date of the demonstration.
19. A draft final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.
20. The HCFA project officer or designee will be available for technical consultation at the convenience of the awardee within 5 working days of telephone calls and within 10 working days on progress reports and other written documents submitted.
21. HCFA may suspend or terminate any grant in whole, or in part, at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the grant. HCFA will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date.
22. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The HCFA project officer shall not direct the interpretation of the data used in preparing these documents and reports.
23. The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

24. The HCFA project officer shall be notified prior to formal presentation of any report or statistical or analytical material based on information obtained through this grant. Formal presentation includes papers, articles, professional publications, speeches, and testimony. In the course of this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate it to the HCFA project officer before formal dissemination to the general public.

The final report of the project may not be released or published without permission from the HCFA project officer within the first 4 months following the receipt of the report by the HCFA project officer. The final report will contain a disclaimer that the opinions expressed are those of the awardee and do not necessarily reflect the opinions of HCFA.

25. Certain key personnel, as designated by the HCFA project officer, are considered to be essential to the work being performed on specific activities. Prior to altering the levels of effort of any of the key personnel among the various activities for this project, or to diverting those individuals to other projects outside of the scope of this award, the awardee shall notify the HCFA Grants Officer and the HCFA project officer reasonably in advance and shall submit justification (including name and resume of proposed substitution) in sufficient detail to permit evaluation of the impact on the project. No alteration or diversion of the levels of effort of the designated key personnel from the specified activities for this project shall be made by the awardee without the approval of the HCFA Grants Officer and the HCFA project officer.
26. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must submit to HCFA analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired, or generated under the award and/or data furnished by HCFA. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the HCFA project officer. The negotiated format(s) could include both file(s) that would be limited to HCFA internal use and file(s) that HCFA could make available to the general public.
27. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must deliver to HCFA any materials, systems, or other items developed, refined, or enhanced in the course of or under the award. The awardee agrees that HCFA shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal Government purposes.

28. HCFA reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, HCFA will be liable for only normal close-out costs.
29. In order to track expenditures under this demonstration, your State's Medicaid office must submit the following forms for the "Oregon Reform Demonstration" on a quarterly basis. Submit only one set of HCFA-64s for the project.

HCFA-64.9	HCFA-64.9a
HCFA-64.9p	HCFA-64.9o
HCFA-64.10	HCFA-64 Certification
HCFA-64.10p	HCFA-64 Summary

Report all administrative and service expenditures allowed under the waivers approved for this demonstration. Do not include expenditures related to research and evaluation activities. These activities are funded separately.

**DRAFT**

## POLITICAL POSITIONS ON THE OREGON WAIVER

### PRIOR STATEMENTS ON THE OREGON DEMONSTRATION PROPOSAL BY THE PRESIDENT

As reported by the Associated Press on May 13, 1992,

"The Arkansas governor said that if he were president he would give the state [of Oregon] the federal Medicaid waiver it needs for its health care plan, which would cover uninsured working poor people while rationing some costly medical treatments. Clinton said such rationing would not be necessary if a national health care system was implemented."

During the Richmond, Virginia, Presidential campaign debate, the President articulated clear support for the Oregon Medicaid demonstration proposal.

In recent discussions with the National Governors Association, but without direct comment on Oregon's proposal, the President indicated support for State flexibility in addressing Medicaid costs and funding.

### PRIOR STATEMENT ON THE OREGON DEMONSTRATION PROPOSAL BY THE VICE PRESIDENT

Then-Senator Gore, in an April 10, 1992 press release (attached),

"urged President George Bush and Secretary Louis Sullivan ...to deny the [Oregon] waiver...."

"'While the nation debates how we can together craft a health care system that will cover everyone, Oregon proposes a plan that has poor people taking from other poor people, creates a tattered system, and leaves poor women and children at risk,' said Gore. 'The plan is seductive to policy makers but dangerous to the people who really need help.'"

[This statement preceded the second application and came before an agreement was reached that prevents Oregon from altering their package of benefits without HHS approval.]

### CONGRESSIONAL POLITICAL IMPLICATIONS

Oregon delegation - The entire delegation has been generally supportive of the Oregon waiver.

Rep. Ron Wyden (D-OR) has been the most vocal supporter of the Oregon waiver in the House. He also has pressured this Administration to treat him as the lead Congressional proponent of the waiver, ahead of the Senate Republican members of the Oregon delegation.

Sen. Bob Packwood (R-OR) has been the strongest supporter of the Oregon waiver in the Senate and was largely responsible for the inclusion of language favorable to Oregon's plan in the urban aid legislation (H.R. 11), vetoed last year.

Sen. Mark Hatfield (R-OR) also has supported the waiver. Though he has not been as vocal as Packwood, he made a lengthy statement favoring the waiver during the NIH bill consideration. Hatfield withdrew a proposed amendment to the NIH bill on the waiver issue after receiving a letter from Secretary Shalala promising a decision by March 19.

Rep. Mike Kopetski (D-OR), though generally supportive of the waiver, has expressed concern for the impact of the prioritized list on mental health services. Currently these services and their users are not part of the prioritization process or the initial demonstration; they are covered under the old Medicaid rules. HCFA terms and conditions would require any change in Oregon's prioritized list (including the ranking of mental health services when these are added in to the demonstration) to be reviewed by the Department.

Rep. Peter DeFazio (D-OR), Rep. Bob Smith (R-OR), and Rep. Elizabeth Furze (D-OR), have all been generally supportive of the waiver.

#### Other Key Congressional Interests

Rep. Waxman had strenuously opposed the Oregon waiver, objecting to limiting services for the Medicaid population, resorting to rationing to reduce costs, discriminating against the disabled, and other grounds. However, last week Rep. Waxman indicated that he will not take legislative action to overturn presidential approval of the Oregon plan if two specific conditions, agreed to by Governor Roberts and incorporated into the proposed terms and conditions, are imposed and enforced.

- 1) For the period 1993-1995, Oregon will maintain the list of covered condition-treatment pairs for all eligibles at the level submitted to HHS; and
- 2) For the entire demonstration period, if the State is forced by budget pressures to reduce covered benefits in subsequent years, it will obtain prior approval from the Secretary before any adjustments are made.

Rep. Dingell, who once opposed it, has supported the Oregon waiver in recent months.

ADA sponsors and supporters, including Sen. Harkin (D-Iowa), Sen. Kennedy (D-MA), Rep. Hoyer (D-MD), and Rep. Owens (D-NY) have strong concerns about the Oregon waiver. They regard it as crucial that the demonstration not violate the ADA. At the same time they strongly prefer that the ADA not be used again as the basis for denial, fearing such an outcome would hurt the ADA. If ADA issues are resolved satisfactorily, they are unlikely to oppose the waiver strenuously, especially given Waxman's recent statement.

Sen. Riegle (D-MI) is chairman of the Senate Finance Subcommittee with jurisdiction over Medicaid. However, he has not taken a position in favor or in opposition to the waiver.

### STATE AND LOCAL POLITICAL IMPLICATIONS

Oregon State Officials - Governor Barbara Roberts and the state legislative leadership vigorously support the waiver application. Oregon has invested a tremendous amount of time and energy in this proposal, and Presidential disapproval will unleash a vocal protest from all Oregon officials. The Secretary and key HHS personnel have had several with the Governor and numerous discussions with her staff.

The National Governors Association - The National Governors Association has endorsed the Oregon waiver, and disapproval of the waiver would send a negative signal to that crucial organization and to all governors regarding the Administration's flexibility towards Medicaid waivers.

The National Conference of State Legislatures - NCSL, while not taking a position on the merits of the Oregon plan, supports the waiver on the grounds that the Administration should not reject a reasonable waiver passed by a state legislature. NCSL will certainly join the chorus with NGA on this issue.

Cities and Counties - National organizations representing cities and counties apparently have not taken a position on the Oregon waiver, although they generally support increased federal flexibility in program administration.

### INTEREST GROUP POLITICAL IMPLICATIONS

Disability Organizations - National Disability Rights Organizations have voiced strong opposition to the waiver. They are strongly opposed to any waiver which would violate the ADA, and they strongly dislike the signals the waiver would send. Nonetheless, if ADA issues have been satisfactorily resolved, national disability organizations seem unlikely to sue but there remains some chance of litigation.

Other Advocacy Groups - A number of advocacy groups, including the Children's Defense Fund, oppose the Oregon waiver because they believe it rations health care services and sets the precedent that a state may explicitly provide poor persons with second-class care. Nonetheless, if terms and conditions which the Department would impose and the State has accepted to maintain the cut-off line are understood, these groups seem unlikely to litigate should the waiver be granted.

Congressional Contacts, Oregon Waiver Decision

Senator Bob Packwood  
Senator Mark Hatfield  
Senator Pat Moynihan  
Senator Ted Kennedy  
Senator Tom Harkin  
Senator Don Riegle

Congressman Ron Wyden  
Congressman Henry Waxman  
Congressman John Dingell

Congressman Mike Kopetski  
Congressman Peter DeFazio  
Congressman Bob Smith  
Congresswoman Elizabeth Furse

Governor Barbara Roberts

(staff contacts)

Donald Shriber (Energy and Commerce Committee)  
Andy Schneider (Energy and Commerce Health Subcommittee)  
Howard Cohen (Energy and Commerce Minority)  
David Schulke (Office of Rep. Wyden)  
Paul Offner (Finance Committee)  
Ed Mihalski (Finance Committee minority)  
David Nexon (Labor and Human Resources Committee)  
Peter Reineke (Office of Sen. Harkin)

NEWS FROM

# U.S. Senator Al Gore



(D - Tennessee) SR 393 Russell Building, Washington, D.C. 20510 (202) 224-4944

FOR IMMEDIATE RELEASE  
FRIDAY, April 10, 1992

Contact: Maria Romash  
202-224-7155  
301-585-9408 (H)

**GORE AMPLIFIES CONCLUSIONS IN NEW STUDY FAULTING OREGON PLAN  
Says Health Care Rationing Plan Moves Policy in Wrong Direction  
IN LETTER, URGES ADMINISTRATION TO DENY WAIVER**

WASHINGTON -- A new Congressional study questioning the state of Oregon's plan to ration health care services for poor people -- including families and children -- should convince the federal Department of Health and Human Services to deny the state's request for a waiver of Medicaid rules needed for the plan to be funded, said Sen. Al Gore, D-TN, one of the Members of Congress who requested the study.

'New and innovative approaches to cutting health care costs and expanding coverage are urgently needed but this plan to ration health care would leave too many vulnerable and would hurt most those who have the least,' said Gore. 'This new study should convince the Administration to reject Oregon's request for the waiver that would allow this program to be funded.'

Gore urged President George Bush and Secretary Louis Sullivan of the Department of Health and Human Services to deny the waiver in separate letters sent today as the Office of Technology Assessment released its report on the Oregon proposal.

'While the nation debates how we can together craft a health care system that will cover everyone, Oregon proposes a plan that has poor people taking from other poor people, creates a tattered system, and leaves poor women and children at risk,' said Gore. 'This plan is seductive to policy makers but dangerous to the people who really need help.'

The Oregon Medicaid plan creates a list of medical services --ranked according to cost and benefits by a special state panel - and refuses to pay for certain services that fall below a predetermined line. Medicaid provides health care to the poor and while Oregon officials claim their rationing plan would provide health care coverage to a larger number of people, the ranking of services would reduce the level of care provided.

Sen. Al Gore/ April 10/ p2

'There are no guarantees that tighter budgets won't produce a shorter list of allowed services, almost indiscriminately deciding who gets care and for what and in the process severely reducing services. And it's clear that even under current circumstances, critical -- and sometimes fatal -- illnesses will not be covered,' said Gore.

The OTA study questions the list; the rankings of treatments, the fact serious -- and potentially fatal -- conditions are below the cut off and that categories are omitted. The OTA study also expresses concern that some pregnant women and young children might be ineligible for benefits under the new rules. And, it questions the usefulness of the Oregon program as a demonstration that could provide useful lessons to other states.

At issue is whether the federal government will waive existing Medicaid rules to allow Oregon to use Medicaid funds to pay for this rationing plan. Avoiding strong Congressional opposition, state officials have sought the waiver from the Department of Health and Human Services which has said a decision would be made this spring.

##

Bruce?  
Yes

March 25, 1993

MEMORANDUM

TO: Mss. Laura Tyson                      Messrs. Leon Panetta  
         Carol Rasco    Tony Lake  
         Katie McGinty     Robert Rubin  
         Sally Katzen     Jack Gibbons

FROM: Jack Quinn  
         Counsel to the Vice President

RE: Regulatory Review file

Attached is a discussion draft of a proposal for regulatory planning and review. This approach has been reviewed and approved in concept by the President and the Chief of Staff, and they and the Vice President expect us to build upon it and report back to them with a more expansive set of recommendations.

In order to begin the process of developing this proposal further, we will meet at 3:30 p.m. on Monday, March 29, in the Vice President's ceremonial office (Rm. 272-OEOB). If you cannot attend, you are welcome to send a designee.

Many thanks.

*Jack Quinn*  
J.Q.

Attachment

cc: Mack McLarty  
     Mark Gearan  
     Alice Rivlin  
     Bernard Nussbaum  
     John Podesta  
     Greg Simon  
     Phil Lader  
     Bruce Reed  
     Joe Stiglitz  
     Ellen Seidman

March 26, 1993

### Regulatory Review Reform

Regulatory review reform is a vital part of both our commitment to put people first and our mission to reinvent government. This document sets forth an organizational framework to govern regulatory review in the Clinton-Gore Administration. It also incorporates and supplements the attached regulatory review principles drafted by OMB.

1. In the future, regulatory review must be carried out within the framework of a process that reflects major reform. Among other changes, the process must be more open to public view than has been the case in the recent past. And, the process must be accessible on equal terms to all interested parties; it must not provide special access -- as it has in the past -- to narrow interests whose goal is to subvert agency implementation of statutory mandates. The process must also be streamlined to minimize the delays it creates in the rulemaking process. Finally, regulatory review must be guided by the policy objectives of the new Administration and a regulatory philosophy that encourages innovation, flexibility and negotiation in the rulemaking process.
2. On a day-to-day basis, the regulatory review process should be carried out by OIRA. The work of OIRA should

be guided and supplemented by a regulatory planning and review committee that would have the following functions:

- a. to review, on a periodic basis, the regulatory agendas and priorities of the departments and agencies in order to (i) ensure that they reflect the President's policies and (ii) identify emerging regulatory issues that are likely either to create conflict within the government or to have exceptionally significant effect on the economy, the environment, public health or safety, American competitiveness or competition or the efficient functioning of markets;
- b. to facilitate resolution of matters that create conflicts between departments, or between OMB and a department; monitor the regulatory process with regard to exceptionally significant initiatives; encourage the use of negotiated rulemaking and other innovative regulatory techniques; and
- c. to provide to the President recommendations for his resolution of regulatory conflicts that do not lend themselves to resolution at the OIRA or review committee levels.

The committee process of reviewing rulemaking proceedings would be available only to heads of government agencies, the OMB Director and the Director

of OIRA. Private parties would not be entitled to seek review of regulatory matters at the White House level.

3. The planning and review committee would be chaired by the Vice President and include the Chief of Staff (or his deputy); the Chair of the Council of Economic Advisers (or a member of the Council designated by the Chair); the Director of Office of Management & Budget (or his deputy); the Director of the National Economic Council (or his designee); the Domestic Policy Adviser (or her deputy); the National Security Advisor (or his deputy); the Director of the Office of Science & Technology Policy; the Director of the Office on Environmental Policy; and any other agency and Departmental representatives as are invited by the Vice President to serve on an ad hoc basis. Members of the committee would be permitted to act through an authorized designee, and the committee would have a small staff commensurate with its modest responsibilities.

4. As an initial matter, the committee should form a working group of staff designees to make recommendations to the committee with respect to implementing the proposals described above as well as --

- a. the details of a new Executive Order to replace or revise the Orders that presently govern the regulatory review process;
  - b. the process by which the regulatory agendas and priorities required of each Department and agency will be prepared, submitted, evaluated and acted upon by the committee;
  - c. the procedures by which disputed or exceptionally significant regulatory issues are identified and brought before the committee (or review subcommittees made up of some, but not necessarily all, committee members or their designees); and
  - d. the manner in which the regulatory review process will be opened to public scrutiny and made more accountable by the application of "sunshine" rules that, among other things, require the disclosure of all non-governmental contacts on regulatory review matters while preserving the confidentiality of intra-governmental deliberations and communications.
5. The new regulatory review Executive Order should outline a philosophy of openness, efficiency, economy, fairness and "putting people first." As an integral part of the effort to reinvent government, the new review process should stress the Administration's commitments to --

- a. vindicating constitutional and statutory rights;
- b. making the process more responsive and accessible to the citizenry it serves;
- c. the efficient functioning of markets and the economy;
- d. improved quality of life, preservation of the natural environment, efficient and rational use of the world's resources, enhancing the health and safety of the American people as well as ensuring that those who must comply with regulatory requirements are not burdened by unnecessary or unjustified costs of compliance.
- e. streamlining the regulatory process to reduce significantly the number of proposed rules reviewed by OIRA each year;
- f. discouraging unnecessary litigation and administrative proceedings; and
- g. easing the burden on state and local government.

## PRINCIPLES OF REGULATORY REVIEW

- A new executive order should be issued that would replace existing executive orders on regulatory review. The new executive order would implement the regulatory principles set forth below.
- The purpose of regulatory review is to help regulatory agencies carry out their statutory functions effectively and in a manner consistent with the Administration's overall regulatory policy; it should not usurp or duplicate agency regulatory functions.
- Regulatory review should resolve conflicts among federal agencies to ensure that citizens are not burdened with duplicative or inconsistent regulations emanating from different agencies.
- Regulatory review should reduce the total burden of regulation on the economy by ensuring that the costs of regulations are justified by their benefits, that innovative and less costly approaches to meeting policy goals have been considered, and that regulations are as simple and easy to understand as possible.
- Regulatory review can provide a useful management function not only by identifying in advance particularly significant rules so that they may be issued and reviewed in an orderly and expeditious manner, but also in identifying those areas where a number of agencies have a legitimate interest.
- Regulatory review should be as expeditious as possible; deadlines for review should be set and enforced. To ensure timely review, there should be early consultation and coordination between OMB and the agencies.
- Regulatory review should be fair; there should be no opportunity for private parties to subvert the regulatory process, and the procedures adopted should reflect the value of openness.
- OMB and the agencies should strive to resolve all issues raised during review without the necessity of appeal. In the exceptional case where issues remain unresolved after OMB review, those issues should be presented for resolution to the Vice President, or if necessary, to the President.

Oregon

THE WHITE HOUSE  
WASHINGTON

Grandfathered in preg. women/  
Children

Say otherwise only perhaps  
100 children statewide  
that will be difficult

THE WHITE HOUSE

WASHINGTON

March 17, 1993

93 MAR 17 P12:21

MEMORANDUM FOR THE PRESIDENT

FROM: Carol H. Rasco *CHR*

SUBJECT: Oregon Waiver

I. SUMMARY

Attached is a memorandum from Secretary Shalala on the Oregon Medicaid Demonstration Waiver. This is to be a Secretarial decision and she is prepared to sign it; she has promised a decision to Governor Roberts by Friday, March 19.

II. DISCUSSION

In addition to the main memo with Tabs A, B, and C are two memos which are (1) a Q and A about the project and (2) a political memo (this is the only copy) which outlines statements by you and the Vice-President.

I have asked the Vice-President's office and the Secretary's office to arrange for a briefing of the Vice-President today or tomorrow.

The only outstanding question for you now is whether or not you want a briefing/discussion with the Secretary and appropriate HHS staff members along with the Vice-President and members of your staff.

- Inform the Secretary to proceed
- I want a formal briefing/full discussion before the Secretary proceeds

*you or I should talk w/ Gov (it's  
 true that to make our success  
 no problem but if it doesn't,  
 I'd say go ahead - I take it  
 you agree - Do you?*



MAR 16 1993

## MEMORANDUM FOR THE PRESIDENT

SUBJECT: Oregon Medicaid Reform Demonstration Waiver

### I. ACTION-FORCING EVENT

Oregon's legislature, currently in session, meets only every two years. I have promised the State a final decision on its Medicaid Reform demonstration proposal by March 19.

### II. BACKGROUND/ANALYSIS

The Oregon Health Plan is a comprehensive, legislatively-approved package of reforms intended to provide universal health insurance coverage to all State citizens, and to introduce cost control. One component is the Oregon Medicaid Reform Demonstration Plan which would cover all Oregonians below the Federal poverty line for defined treatment interventions connected to a specified set of medical conditions. Both the expansion of eligibility and the limitation of coverage to specified condition-treatment pairings would require Federal waivers.

Under Section 1115 of the Social Security Act, I am granted very broad waiver authority for any demonstration which, "in the judgment of the Secretary is likely to assist in promoting the objectives" of the Social Security Act. No other guidelines are listed in the authorizing legislation, and previously this Department has mainly sought assurances that any proposed demonstration was legal and budget neutral to the Federal government.

The proposal itself has many strengths. These include: universal protection, promotion of access and cost containment through managed care, and a thoughtful, open and inclusive development process. Moreover, approving the proposal would signal the Federal Government's trust and respect for state experimentation and initiative. It is a bold experiment. We at HHS believe the proposal is evaluable and could yield useful information on various questions regarding delivery and access to health care.

Plan Methodology -- A number of major concerns ought to be considered, most of which involve the overall methodology of the Plan and its perceived "rationing" of health care services.

The Oregon Health Services Commission (five physicians, two registered nurses, one medical social worker, four consumer advocates), supported by groups of medical specialists, used evidence on cost and effectiveness as well as subjective judgements in developing and ranking a series of condition-treatment pairs. The total list prioritizes 688 condition-treatment pairs. The Oregon legislature has decided that it is currently able to fund coverage of the top 568. The present list of uncovered services (e.g.,

The President -- 2

number 586, surgical treatment of benign neoplasms of the digestive system; number 594, reconstructive breast surgery following cancer surgery; number 587, acute and chronic disorders of the back without spinal cord injury) does not appear to raise highly disturbing ethical or medical issues, largely because the Commission used its subjective judgement to move any procedures which would raise serious concerns above the cut-off point.

ADA Legal Issues -- Two broad issues arise with regard to the methodology. The first is legal. In particular, does the plan violate the Americans with Disabilities Act (ADA)? The former HHS Secretary decided in August 1992 he could not approve the Oregon Medicaid demonstration pending resolution of legal issues related to the ADA.

Oregon sought to address those ADA concerns in its resubmission. Nonetheless, one legitimate, but in our view resolvable concern, raised as early as last October, remained: whether the methods used for ranking non-lethal condition-treatment pairs violate the ADA by appearing to favor outcomes in which the patient is freed of all symptoms. After face-to-face discussions on this issue in Oregon late last week, our General Counsel and the Civil Rights Division of the Justice Department believe the ADA issues have been successfully resolved. In essence, Oregon has agreed to re-rank the condition-treatment pairs without regard to symptomatic-asymptomatic considerations. (See Tab A on legal issues.) We do not believe that this re-ranking by the Commission will significantly alter the list of covered services.

Appropriateness of the "Rationing" System -- The larger issue concerns the validity of rationing at all, especially prior to wringing all possible inefficiencies out of the current system. To opponents of the plan, it provides additional coverage for one group of poor persons, in part, by reducing benefits to another. It is also said to signal that the poor deserve less medical care than others. Certain groups such as the elderly and disabled are excluded initially from the demonstration, so they are not being rationed. This initial exclusion raises questions of equity. (Oregon says it expects to add these groups within a couple of years; when the State's proposal for including these groups becomes available, it will be carefully assessed by this Department.) Finally, opponents raise legitimate questions about the scientific basis for the rankings in the first place.

*This is already true*

Supporters counter that all states' Medicaid programs "ration" health care, usually through obscure, budget-based executive branch decisions to limit benefits' amount, scope and duration, or to exclude optional services. Oregon proposes, instead, an alternative rationing scheme which attempts to exclude the least important services through an open and accessible process, rather than using arbitrary service limitations.

The list of excluded services does not appear to present serious problems as the standards are currently drawn. Opponents often complain less about the current list of exclusions, and more about the possibility that as budget pressures grow, Oregon will begin to exclude far more serious conditions. Partly in response to these concerns, we

The President -- 3

have negotiated very strict conditions with Oregon. Should the waiver be granted, any change in the rankings or the list of covered condition-treatment pairs will require HHS approval. We have made clear we would be skeptical about major new exclusions. Most opponents have been unaware of this new condition, and in several cases, including Representative Waxman, learning of it has reduced -- but certainly does not eliminate -- concerns about the plan.

Budgetary Issues -- There are other concerns as well. We are skeptical that Oregon can do all the things it promises at the budgetary cost they project. We have built in extremely strong Federal financial protection into the waiver, and Oregon has accepted these conditions. Thus the Federal financial exposure is minimal. If the costs are higher than expected, Oregon will have to pay them. But budget pressures could push Oregon to seek either additional expanded Federal financial support or a significant change in the list of excluded services in the future.

Connection to Health Reform -- Finally, important questions remain about the connections between Oregon's plan and health reform. While the overall goals of the two efforts are quite similar, Oregon's plan seems likely to be different from the proposal you will eventually develop in several important ways. If health reform is passed, major parts of the plan would have to be reformulated (and, in concept, Oregon has agreed to make changes which may be necessary). Some worry that accepting the Oregon waiver will be interpreted as a signal of where national health reform is headed and, if we are to argue that such an interpretation is incorrect, the question then becomes why are we approving an approach which cannot be synchronized with the overall health reform plan. (A summary of key issues is at Tab B.)

### III. OPTIONS

Negotiations with Oregon have progressed to the stage where the basic decision now is either accept or reject the waiver. We must decide whether to approve the proposal, subject to terms and conditions which include (a) requirements of prior approval by HHS of changes in the prioritization list and (b) limitation on the degree of Federal financial exposure. (A draft list of special terms and conditions is at Tab C.)



Donna E. Shalala

#### Attachments:

- Tab A -- Legal Issues
- Tab B -- Key Issues
- Tab C -- Special Terms and Conditions

TAB A

Analysis of ADA Concerns with Oregon's Revised  
Methodology for Prioritizing Health Care Services

BACKGROUND

On August 3, 1992 former Secretary Sullivan informed Governor Barbara Roberts of Oregon that the State's Medicaid Demonstration proposal could not be approved until a number of identified concerns arising under the Americans With Disabilities Act (ADA) were resolved. Department officials worked with Oregon over the next few months and on November 13, 1992, Oregon submitted a revision to its methodology for prioritizing health care services under its demonstration.

Oregon's Revised Methodology. Oregon's revised methodology is based on the Health Services Commission's attempt to rank services according to their medical effectiveness. The Commission measured effectiveness first by the ability of a treatment to prevent death as a result of a condition. When two or more treatments were tied on this basis, the Commission looked to the degree to which a person is likely to be asymptomatic after treatment. Remaining ties were broken by ranking treatments according to their cost, with lower cost treatments being ranked higher.

The Commission then reviewed a computer-generated ranking of health services, based on the above methodology, and made "hand" adjustments to the list to reflect the following social values that Oregonians had expressed at public meetings and hearings:

Highly valued services were--

- Healthy mothers and healthy babies
- Comfort care
- Family planning services
- General preventive services
- Prevention ranked before treatment for the disease
- Treatment for contagious diseases

The following services were considered less important--

- Treatments for conditions that get better on their own
- Cosmetic services
- Infertility services
- experimental services

Problems with the Revised Methodology. While the revised methodology is fully responsive to the concerns that were

originally raised, the Department of Justice<sup>1</sup> and a number of disability advocacy organizations have criticized the new proposal as also being inconsistent with the ADA, but for new reasons arising out of the revised methodology. The specific concerns raised by the Department of Justice are the following:

After the initial ranking of treatments according to ability to prevent death, the treatments that are equally effective in that regard are ranked according to their ability to return an individual to an asymptomatic state. As between two treatments ~~that are equally effective in preventing death,~~ a treatment that is more likely to return an individual in his or her previous health state will be ranked higher than one that may result in residual symptoms. Since Oregon defines symptoms with reference to conditions such as "functional impairment" as well as residual medical conditions, individuals whose medical conditions may leave them disabled even after treatment will rank lower on this scale.

Because of the substantial hand movements made by the Commission, this factor may not ultimately have much actual impact on placement of a particular condition on the list. However, sanctioning its use in this demonstration could be found to violate the ADA in that treatment for an individual may be given lower priority "by reason of disability."

We have proposed that ~~Oregon should rerank the condition/treatment pairs without using this factor.~~ It should be fairly easy for the Commission to generate a new list without using that factor and then to apply the hand adjustments according to the factors that were previously used. The Congressional Office of Technology Assessment has indicated that because of the extensive hand movements, the ranking methodology used by Oregon ultimately had only a small effect on the final rankings. Therefore, this revision should not have a substantial effect on the prioritized list.<sup>2</sup>

While it is not clear that a court would invalidate the waiver under the ADA because of this factor, there is certainly some risk of that outcome should litigation ensue. We understand that the mainstream disability advocacy organizations are not anxious to file suit against an Oregon waiver and that they definitely would not sue if this change is made. For that reason we have strenuously urged Oregon to make these changes.

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<sup>1</sup> See attached letter from the Assistant Attorney General, Office of Legal Counsel to the Acting General Counsel, Department of Health and Human Services dated January 19, 1993.

<sup>2</sup>Office of Technology Assessment Health Program Staff Memorandum, Re: Brief Analysis of Medicaid Waiver Resubmission, December 23, 1992, pp. 1, 4.

Oregon has agreed to make the changes we suggested, including adding a new criterion to the list of factors used to make hand adjustments that would reflect medical effectiveness. This criterion could not, however, reflect functional limitations but must be based only on medical factors. Oregon and we recognize that this is only an interim step and that we will work with the State to help them to develop a revised methodology that does not implicate the ADA.

The other legal issues involving the waiver were much more easily resolved. In particular--

- o The Department of Justice criticized the ranking system because it used "value laden" judgments about the importance of certain health states. In particular, infertility services were given a low priority by the Commission in its hand movements.<sup>3</sup> Because infertility is undoubtedly a disability under the broad definition in the ADA, the Department of Justice questioned whether it is permissible under the ADA to devalue that service simply because it is considered less important than other services.

Oregon will resolve this problem either by excluding infertility services altogether from the Medicaid program (which it is permitted to do) or by applying content neutral criteria (such as cost or medical effectiveness) in determining what priority should be accorded these services.

- o The Department of Justice observed that some of the considerations applied by the Commission in making hand adjustments are described at such a level of generality that it is not possible to conclude on the present record that factors impermissible under the ADA had no effect on the ranking process.

The Department of Justice did not have the benefit of considerable additional information, including computer runs, analyses of movements on the list, minutes of

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<sup>3</sup> None of the other criteria applied by the Commission is as condition-specific as its treatment of infertility. The other criteria, discussed above, relate to health and societal values that are content neutral, i.e., they do not measure the value of a treatment with reference to a condition that may be a disability. Therefore, we believe that if the problems the Department of Justice identified with relation to infertility can be resolved, the issue of "value laden" criteria will be resolved as well.

Commission meetings, evidence of substantial involvement of the disabled community in the ranking process, and other information that has been made available to us by Oregon. All of this information indicates that the movements made by the Commission were done so for the reasons indicated, i.e. to reflect the health policy considerations they had adopted and that (with the possible exception of the low priority for infertility services) are content neutral and permissible considerations under the ADA. The Justice Department has indicated that this additional information fully resolves its concerns in this regard.

- o Although not raised by the Department of Justice, advocacy organizations representing the disabled have pointed out that some treatments that are below the line, while not of high priority to ordinary individuals, may be of extreme importance to impaired individuals. In administering the Oregon plan, providers who are not fully educated on all the items on the list, but who merely know which items fall below the list, may believe that important treatments for individuals with co-morbidities will not be covered. The vagueness of the descriptions of some condition/treatment pairs exacerbates this concern. Since the ADA prohibits the use of methods of administration that discriminate by reason of disability, this failing may violate the ADA.

Oregon has agreed to adopt policies that will ensure that before denying treatment for an unfunded condition for individuals with a disability or a co-morbid condition, providers will be required to determine whether the individual also has a funded condition or a condition comparable to a funded condition that can be treated. The State has also agreed to consider maintaining an information line to assist providers in making these determinations.

### Conclusion

We believe that, with the revisions discussed above, approval of the Oregon demonstration proposal would not be inconsistent with the ADA. We have shared these views with the Department of Justice and they agree.

TAB B  
THE OREGON WAIVER REQUEST  
Key Issues

The Oregon Health Plan is a comprehensive, legislatively approved package of reforms intended to provide universal health insurance coverage and cost control to all State citizens. This will be accomplished through an expansion of Medicaid eligibility to all poor citizens, private insurance reform, risk pooling, and phased-in employer mandates ("pay or play"). One component, implementation of which would require Federal waivers, is the Oregon Medicaid Reform demonstration plan.

This memo discusses key issues regarding the plan. We have organized the discussion of the key issues around six questions:

1. What are the strengths of Oregon's proposal?
2. Does the proposal violate the Americans with Disabilities Act?
3. Does the Oregon proposal constitute unacceptable rationing of care?
4. Can Oregon really provide the coverage it proposes within the budget it promises?
5. Is it evaluable?
6. What is the relationship between the Oregon proposal and national health care reform?

I. What are the strengths of Oregon's proposal?

Universal Access

Under the Medicaid waiver, all Oregonians below the poverty level would be covered by Medicaid. Thus, over 5 years some 90,000 single adults, childless couples, and families with children with incomes above the current eligibility levels would be brought into Medicaid eligibility an increase of 36%. An especially attractive feature of this arrangement is a substantially simplified eligibility determination process.

In addition to the expansion of Medicaid, State statutes mandate that by a set future date, all employers must "play or pay" -- that is, help finance health insurance coverage for their employees or pay into a state insurance pool.

The State has also legislated a "risk pool" to enroll persons considered medically uninsurable.

Promotion of Access and Cost Containment Through Managed Care

The State proposes to move virtually all Medicaid beneficiaries into one or another model of managed care. Some -- mainly those in urban areas -- will go into fully-capitated health plans from fee-for-service. Others will go into "Physician Care Organizations," a partial capitation model through which the State now contracts for

ambulatory care services for 65,000 Medicaid beneficiaries. Residents of sparsely-populated areas will be enrolled in managed fee-for-service systems.

Thoughtful, Open, Inclusive Development Process

X | Whatever other shortcomings the proposal might have, the openness and inclusiveness with which the reform proposal was developed represents a "best practices" process. In addition to the legislative hearings and deliberations, a Health Services Commission was established, staffed, and supported by the work of expert physician panels. As specified by law, the Commission: held 12 public hearings and 47 two-hour community meetings at which over 1500 people testified; met with health care providers; conducted a telephone survey of 1,001 Oregonians to ask them what value they attach to different health states; and obtained expert reaction to the proposed methodology.

Signal About the Federal Government's Respect for and Trust in States

The elements of the proposal described above are clearly compatible with a number of the basic principles underlying the Administration's approach to health reform -- universal coverage, case management of health services, cost containment, and a broadly-participatory design process that involves the people affected. Approval would recognize this effort on Oregon's part and would signal confidence in the creativity and responsibility of the states as partners in the health reform process.

**II. Does the proposal violate the Americans with Disabilities Act?**

In August of 1992, the Justice Department determined that one aspect of the priority ranking process was "based in substantial part on the premise that the value of the life of a person with a disability is less than the value of a life of a person without a disability," hence violative of the then-recently passed Americans with Disabilities Act (ADA). It was on this basis that former Secretary Sullivan declined to approve the original proposal.

Oregon re-submitted its proposal on November 13, 1992, including a number of changes designed to address ADA-related matters. However, on January 19, 1992, the Justice Department again informed the Department of Health and Human Services (HHS) that the Oregon priority ranking process was deficient because the ranking favored condition-treatment pairs which return patients to an asymptomatic state over those which leave patients with remaining symptoms. That is, a condition-treatment pair where the patient had symptoms which were completely cured or relieved by the treatment was ranked higher than a condition-treatment pair where the symptoms were not fully cured or relieved (as might be the case with someone who was left disabled). This ranking process was construed as a bias against those with disabilities and contrary to requirements of the ADA.

Since that time, the Department has had extensive discussions with officials of the Oregon State government regarding further modifications of their prioritization process. These discussions culminated in face-to-face discussions on this issue in Oregon late last week between key HHS and State personnel, following which our General Counsel and the Civil Rights Division of the Justice Department believe the ADA issues have been successfully resolved. (See Tab A on legal issues.)

### III. Does the Oregon Proposal Constitute Unacceptable Rationing of Care?

#### "Rationing" as a Strategy for Limiting Costs

For most opponents, the decision to explicitly exclude certain condition-treatment pairs is at the heart of their worries about the proposal. The concerns are as much philosophical and symbolic as substantive. Is it fair and appropriate to "ration" care to low-income families while care is not necessarily "rationed" to other Oregonians in the same fashion? Or to put the matter even more bluntly, is it appropriate to increase coverage for some poor persons by reducing the protection granted to others? Many fear that accepting the Oregon plan legitimizes a strategy with a very slippery slope which will ultimately lead to second class medical coverage and care for the poor, both in Oregon and, if adopted more broadly, elsewhere. They worry that budget pressures will cause Oregon to reduce sharply the number of covered condition-treatment pairs. And most importantly they argue it sends the worst kinds of signals about the rights of poor persons to medical coverage.

When one moves beyond the signals and symbols, the substance gets more ambiguous for three reasons. First, everyone agrees that Medicaid services are now rationed in more hidden ways (like low reimbursements which limit provider participation, and limitations on the amounts of mandatory services that are covered).

Second the amount of actual rationing via application of the current cut-off point in the prioritization list appears to be modest. Indeed, the Department's view is that the costs associated with the list of uncovered services are so modest that the State's expectations that it will achieve significant savings by their exclusion are unrealistic. Nonetheless, there is a substantial argument that the removal of system inefficiencies ought precede even minor benefit reductions.

Covered services will include expanded benefits for adult preventive care, dental care, and hospice services. The enumerated list of State-covered Medicaid condition-treatment will serve as the basic employee benefit package when mandated employer coverage is phased in. Excluded services include procedures such as surgical treatment of benign neoplasms of the digestive system (no. 586), reconstructive breast surgery following cancer surgery (no. 594), and acute and chronic disorders of the back without spinal cord injury (no. 587).

Third the State has already agreed to conditions whereby it could not modify the list in any way nor reduce the covered treatments without prior approval from HHS. Most opponents are unaware of this condition--something to which HHS and Oregon agreed to some time ago. Indeed, a number of the most vociferous opponents, including Representative Waxman and Sarah Rosenbaum, seem much more comfortable with the plan so long as this proviso is included and applied rigorously.

#### Initial Exclusion of Aged and Disabled

Initially the aged and disabled, and mental health and substance abuse services are not included in the demonstration. These groups and services are covered under the old Medicaid rules. This exclusion cuts two ways. On the one hand, it blunts criticism with respect to rationing for the aged and disabled. On the other hand, it raises the argument that services are being reduced for women and children while protecting other, more politically powerful groups. At some point in the future, the State anticipates bringing these groups and services into the demonstration. HHS approval of the State's specific implementation plans for these populations groups and services will be required.

#### The Oregon Ranking Process and its Scientific Validity

The Oregon Health Services Commission (five physicians, two registered nurses, one medical social worker, four consumer advocates), supported by groups of medical specialists, used evidence on cost and effectiveness as well as subjective judgements in ranking procedures.

Unfortunately the data and evidence for such rankings is often weak -- in part because the needed studies do not exist. The Office of Technology Assessment (OTA) recently released a report critical of Oregon's procedures, especially the Commission's re-ranking of some 25 percent of condition-treatment pairs based on members' subjective tests of "reasonableness." OTA and others point out that a procedure often is cost-effective for one person with a particular condition and wasteful for another, so a single ranking with blanket inclusions and exclusions often may lack patient-specific clinical appropriateness. Many critics question the whole notion of ranking procedures on the basis of some "average patient," and argue that the data are far too limited to rank things adequately even if one thought it appropriate to do so.

### **IV. Can Oregon Really Provide the Coverage it Proposes Within the Budget it Promises?**

#### The Costs/Savings From the Program

The State originally estimated additional federal costs of \$140 million; Oregon now estimates that the demonstration will save \$3 million in Federal costs over 5 years. Against a base program cost of more than \$5 billion over the period, either of these estimates, whether for costs or savings, is imprecise but comparatively insignificant.

Oregon's goal is to save money by reducing the number of covered Medicaid services and by using managed care. They intend to use the savings to cover the low-income population. However, as noted previously, excluding these services may not save much money. In addition, under this plan, Medicaid payments to providers are required by State statute to be set and maintained at a level sufficient to cover providers' costs; this will substantially enhance payments to providers and significantly raise costs with managed care incentives alone working to wring out inefficiencies from the system.

Thus, the possibility of significant out-year savings is largely dependent upon two factors: (a) savings from broad enrollment in managed care which, while potentially quite substantial, are, to date, modest; and (b) movement of Medicaid beneficiaries out of Medicaid and onto employer-sponsored coverage under Oregon's "play-or-pay" mandate. In both cases, any net savings are at least several years away and costs are expected to increase in the short run.

#### Budget Implications Now and for the Future

In response to concerns about the potential costs of the program, the Department has developed procedures that sharply limit Federal expenditures under the demonstration. OMB and HHS both believe that the Federal government is well protected by these procedures. The State is left to fund any excess costs under the current conditions of the waiver.

Nonetheless, there seems likely to be pressure on the Federal government to either contribute more money or to allow Oregon to significantly alter the list of covered services if the budget is understated as we believe. Oregon is experiencing a taxpayer "revolt," raising questions regarding the State's ability to support its share of the costs throughout the life of the demonstration. If Oregon is unable to pay for the services it has promised, HHS will again be confronted with difficult choices between increased Federal spending and further rationing with continuing political fallout.

#### **V. Is the Demonstration Evaluable?**

You have committed yourself to granting waivers only if they are truly evaluable, a view HHS strongly shares. In our view, important lessons can be learned from the experiment.

Massive state-wide demonstrations always pose some difficult evaluation questions for there is no way to create a reliable control group. Moreover, it is extremely difficult to judge the impacts of alternative service delivery mechanism and coverage arrangements on health outcomes. Nonetheless, the Oregon plan does offer the best opportunity yet to learn about the impact of comprehensive managed care and capitation plans, pay or play strategies for the uninsured, and the impact of alternative coverage rules. Oregon

seems committed to learning from the demonstrations and to providing the data necessary for an effective evaluation.

In our view, Oregon is likely to set off a rather massive set of investigations and evaluations funded both by government and by foundations. If Oregon is able to implement all the measures they propose both inside Medicaid and without, considerable insights about the strengths and limitations of a variety of strategies are likely to emerge.

## VI. What is the Relationship Between the Oregon Proposal and National Health Care Reform?

Oregon and other states initiated health reform plans during a period when action at the Federal level did not seem likely. While details of your health reform plan are still being developed, there is reason to anticipate that components of Oregon's plan (and those of other States) will prove at variance or incompatible with some principles and specifications of your plan. Indeed, under some scenarios, the Oregon plan would never go into effect even if the waiver were approved. Moreover, other States may seek to follow Oregon's lead and seek similar waivers. It would appear odd to approve a series of plans which may prove at least partially incompatible with the ultimate health reform proposal.

Opponents of granting the waiver argue that many groups will see approval of the waiver as a signal of where the Administration is likely to move on health reform. Here again, the symbolism may be more important than substance. There is virtually no chance the health care reform task force will use a condition-pair ranking process. Still some services will be excluded from any basic benefit package under national health reform, thus confusion may arise in the press.

At the same time were Oregon's Medicaid reform demonstration to be approved, there would be a period of some months before it would become operational. That period would allow time to renegotiate aspects of the State's proposal that may need to conform with Federal requirements. As a general matter, Governor Roberts has indicated the State's willingness to resolve any remaining problems associated with the Oregon proposal.

**DRAFT**

**HEALTH CARE FINANCING ADMINISTRATION  
SPECIAL TERMS AND CONDITIONS**

**NUMBER:** 11-P-90160/0-01  
**TITLE:** Oregon Reform Demonstration  
**AWARDEE:** Oregon Department of Human Resources

1. Oregon will, within 60 days of this approval, rerank the condition/treatment pairs without relying on data which it collected with respect to whether treatment returned an individual to an asymptomatic state. Oregon may, at its discretion, add the criterion of "medical effectiveness" to those criteria which served as the bases for the Health Services Commission to adjust the placement of condition/treatment pairs. The medical effectiveness criterion may not take into account changes in individuals' functional limitations as a result of treatment. Pursuant to term and condition 5 below, the revised priority list must be submitted and approved by the Health Care Financing Administration (HCFA).

Oregon may conduct additional analyses of medical effectiveness and may revise its methodology for determining the placement of condition/treatment pairs to include data regarding medical effectiveness. Such a revised methodology shall be submitted to HCFA for comment before its use and any revised priority list of condition/treatment pairs must be approved by HCFA.

2. Oregon will revise the list of criteria used by the Health Services Commission to make hand adjustments to the list to exclude the factor relating to infertility services. If Oregon decides to cover infertility services under the demonstration (which it is not required to do), it will rank infertility services along with other services using content neutral factors that do not take disability into account.
3. Oregon will adopt policies that will ensure that before denying treatment for an unfunded condition for any individual, especially an individual with a disability or with a co-morbid condition, providers will be required to determine whether the individual has a funded condition or a condition comparable to a funded condition that would entitle the individual to treatment under the program. Oregon will provide through a telephone information line and/or through the applicable appeals process for expeditious resolution of questions raised by providers and beneficiaries in this regard.

4. The State shall define a minimum data set (which at least includes inpatient and physician services) and require all providers to submit these data. The State must perform periodic review, including validation studies, in order to ensure compliance. The State shall have provisions in its contract with health plans to provide the data and be authorized to impose financial penalties if accurate data are not submitted in a timely fashion. The State shall develop a workplan showing how collection of plan encounter data will be implemented and monitored; the workplan shall also identify State resources that will be assigned to this effort. The workplan shall describe how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis. If the State fails to provide accurate and complete encounter data for any managed-care plan, it will be responsible for providing (at 100 percent State cost) to the designated HCFA evaluator data abstracted from medical records comparable to the data which would be available from encounter reporting requirements.
5. Any revision to the October 30, 1992 priority list of 688 condition/treatment pairs, including the cut-off line for covered services, shall be submitted to HCFA for review and approval.
6. The State shall provide quarterly expenditure reports (HCFA-64s) that provide expenditures on both the currently eligible and the newly eligible populations under the demonstration. HCFA will provide Federal Financial Participation only for annual expenditures that do not exceed pre-defined limits on the number of demonstration eligibles and costs incurred, following the attached budget guidelines. (NOTE: For reporting and budget neutrality purposes, currently eligible shall be defined as the AFDC populations, women who are pregnant (plus 60 days postpartum eligibility) with incomes to 133% of the Federal Poverty Level (FPL), children under age six with incomes to 133% of FPL, and children born after September 30, 1983 with incomes to 100% of FPL.)
7. The State shall submit a tentative timeline and detailed proposal on how mental health and chemical dependency service and the elderly and disabled will be incorporated into the demonstration. The tentative timeline should be submitted by October 1, 1993. The detailed proposal will be submitted as a later waiver amendment.
8. Prior to the start date of the demonstration, the State must submit evidence that health plan and physician capacity is adequate to serve the expected enrollment. This will include an discussion on how individuals who currently rely on FQHCs and RHCs will continue to have access to health care through the managed care delivery system.

9. The State must also fully meet the usual Medicaid disclosure requirements for contracting providers prior to the start date of the demonstration.
10. For those plans that do not meet section 1903(m) requirements, prior to award of contract to these plans, the State shall submit for HCFA approval a description of their delivery system, their financial viability, and their quality assurance system.
11. The State will submit to ORD and to the HCFA Regional Office copies of all financial audits of participating health plans and quality assessment reviews of these plans.
12. The State will submit quarterly progress reports, which are due 60 days after the end of each quarter. The first quarterly report will be due September 1, 1993. The reports should include a discussion of events occurring during the quarter that affect health care delivery, quality of care, access, financial results, benefit package, and other operational issues. The report should also include proposals for addressing any problems identified in the quarterly report. Utilization of health services should be reported on a quarterly and cumulative basis.
13. The State will submit a draft annual report, documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties by April 1, 1994. Within 30 days of receipt of comments from ORD, a final annual report will be submitted.
14. Within 30 days of the date of award, the State shall submit revised waiver cost estimates reflecting the start date of the demonstration. As a minimum, these tables should include revised estimates of per capita cost and number of eligibles for each year of the demonstration. These estimates must be consistent with the December 1992 revisions to the State's waiver cost estimate.
15. During the last 6 months of the demonstration, no enrollment of individuals who would not be eligible under current law will be permitted.
16. Oregon must implement procedures so that hospitals will be able to distinguish individuals who are eligible under current law from individuals who are only eligible because of the demonstration. The proposed procedure must be submitted to HCFA for approval within 60 days of the date of approval.
17. Oregon will implement modifications to the demonstration by submitting revisions to the original proposal. The State shall not submit amendments to the approved State plan relating to the new eligibles.

18. The State's new eligibility rules under the demonstration will not adversely affect Medicaid eligibility of persons who:
  - (a) have been determined to be eligible for Medicaid prior to the start date of the demonstration; and
  - (b) remain eligible as of the day immediately prior to the start date of the demonstration;

but only to the extent that these persons continue to meet the Medicaid eligibility criteria in effect on the day immediately prior to the start date of the demonstration.

19. A draft final report should be submitted to the HCFA project officer for comments. HCFA's comments should be taken into consideration by the awardee for incorporation into the final report. The awardee should use the HCFA, Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy attached) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.
20. The HCFA project officer or designee will be available for technical consultation at the convenience of the awardee within 5 working days of telephone calls and within 10 working days on progress reports and other written documents submitted.
21. HCFA may suspend or terminate any grant in whole, or in part, at any time before the date of expiration, whenever it determines that the awardee has materially failed to comply with the terms of the grant. HCFA will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date.
22. The awardee shall assume responsibility for the accuracy and completeness of the information contained in all technical documents and reports submitted. The HCFA project officer shall not direct the interpretation of the data used in preparing these documents and reports.
23. The awardee shall develop and submit detailed plans to protect the confidentiality of all project-related information that identifies individuals. The plan must specify that such information is confidential, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project, and that informed written consent of the individual must be obtained for any disclosure.

24. The HCFA project officer shall be notified prior to formal presentation of any report or statistical or analytical material based on information obtained through this grant. Formal presentation includes papers, articles, professional publications, speeches, and testimony. In the course of this research, whenever the principal investigator determines that a significant new finding has been developed, he or she will immediately communicate it to the HCFA project officer before formal dissemination to the general public.

The final report of the project may not be released or published without permission from the HCFA project officer within the first 4 months following the receipt of the report by the HCFA project officer. The final report will contain a disclaimer that the opinions expressed are those of the awardee and do not necessarily reflect the opinions of HCFA.

25. Certain key personnel, as designated by the HCFA project officer, are considered to be essential to the work being performed on specific activities. Prior to altering the levels of effort of any of the key personnel among the various activities for this project, or to diverting those individuals to other projects outside of the scope of this award, the awardee shall notify the HCFA Grants Officer and the HCFA project officer reasonably in advance and shall submit justification (including name and resume of proposed substitution) in sufficient detail to permit evaluation of the impact on the project. No alteration or diversion of the levels of effort of the designated key personnel from the specified activities for this project shall be made by the awardee without the approval of the HCFA Grants Officer and the HCFA project officer.
26. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must submit to HCFA analytic data file(s), with appropriate documentation, representing the data developed/used in end-product analyses generated under the award. The analytic file(s) may include primary data collected, acquired, or generated under the award and/or data furnished by HCFA. The content, format, documentation, and schedule for production of the data file(s) will be agreed upon by the principal investigator and the HCFA project officer. The negotiated format(s) could include both file(s) that would be limited to HCFA internal use and file(s) that HCFA could make available to the general public.
27. At any phase of the project, including at the project's conclusion, the awardee, if so requested by the project officer, must deliver to HCFA any materials, systems, or other items developed, refined, or enhanced in the course of or under the award. The awardee agrees that HCFA shall have royalty-free, nonexclusive and irrevocable rights to reproduce, publish, or otherwise use and authorize others to use the items for Federal Government purposes.

28. HCFA reserves the right to withdraw waivers at any time if it determines that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, HCFA will be liable for only normal close-out costs.
29. In order to track expenditures under this demonstration, your State's Medicaid office must submit the following forms for the "Oregon Reform Demonstration" on a quarterly basis. Submit only one set of HCFA-64s for the project.

HCFA-64.9	HCFA-64.9a
HCFA-64.9p	HCFA-64.9o
HCFA-64.10	HCFA-64 Certification
HCFA-64.10p	HCFA-64 Summary

Report all administrative and service expenditures allowed under the waivers approved for this demonstration. Do not include expenditures related to research and evaluation activities. These activities are funded separately.

### Monitoring Budget Neutrality for the Oregon Reform Demonstration

Oregon will be at risk for the per capita costs provided in the proposal for both current and new eligibles, but not at risk for the number of current eligibles. By providing Federal Financial participation (FFP) for all current eligibles, Oregon will not be at risk for changing economic conditions. However, by placing Oregon at risk for the per capita costs provided in the proposal for both current and new eligibles, HCFA assures that the demonstration expenditures will reflect Oregon's estimates of savings from managed care and the priority list. Oregon will be at partial risk for the number of new eligibles by using the State's estimate of the ratio of new eligibles to old eligibles to limit the number of new eligibles for which FFP will be provided.

#### LIMITS ON FEDERAL EXPENDITURES

- o Eligibility Groups Subject to the Limit - The Oregon per capita cost estimate for the current eligible population (as defined in term and condition number 6, above) and newly eligible populations will be the basis for establishing the limits on FFP. The costs of populations not included in the demonstration, such as the Supplemental Security Income (SSI) eligibles, will not be included in the limits.
- o Limit on Demonstration Expenditures - The annual limits are defined as follows:
  - a. Current Eligibles: Actual number of current eligibles times the Oregon estimate of per capita cost for current eligibles; and
  - b. New Eligibles: Actual number of current eligibles times the Oregon ratio of new eligibles to current eligibles times the Oregon estimate of per capita cost for new eligibles.

## MONITORING SYSTEM

The form HCFA 64, Quarterly Medicaid Statement of Expenditure for the Medical Assistance Program, will be used for monitoring Oregon expenditures under the demonstration.

Oregon will continue to submit a HCFA 64 for the entire Medicaid program and additional HCFA 64s for the AFDC population. The additional HCFA 64s will provide eligibility counts and expenditure data on:

- o All current AFDC (including PLM children and adults) and new eligibles;
- o All current AFDC eligibles (including PLM children and adults); and
- o All new eligibles.

These HCFA 64s will be used to monitor Oregon expenditures. FFP will be provided to the State for its actual expenditures, but limited to the caps.

# DRAFT

## Talking Points for Oregon Waiver

\*Oregon waiver is an experiment by one state that is attempting to grapple with the health care crisis.

\*Oregon officials are to be commended for their hard work and efforts to be innovative in dealing with a very complex problem.

\*Oregon's plan seeks to control costs through managed care.

\*Their plan provides universal coverage for all Oregon residents--no one now covered will be excluded.

\*Oregon officials applied a thoughtful process to developing a plan that provides a reasonable level of coverage to its citizens.

\*The level of coverage provided by the Oregon plan is stable. It cannot be varied without prior approval from the U.S. Department of Health and Human Services.

\*The Oregon plan is budget neutral for American taxpayers. Oregon has agreed to bear any additional costs if it fails to produce the savings officials envision.

\*This waiver should not be interpreted as signalling where the administration plans to go on our health care reform proposal.

\*Oregon officials acknowledge that their plan may have to be modified to make it consistent with our national health care plan which will be presented in the next few months.

\*Oregon is a small, largely rural state with a modest population. What works for Oregon may not necessarily work as the national model of health care reform.

\*What we envision is a much broader, more comprehensive plan for America that:

- \*Provides universal coverage while controlling costs and preserving quality of care.
- \*Empowers consumers by uniting them in large purchasing co-ops that can bargain for better deals.
- \*Eliminates inefficiencies and waste that drive up costs in the system.
- \*Addresses the issues of drug price reform, defensive medicine and malpractice suits.
- \*That embraces new technological advances in medicine.

# DRAFT

## Q. and A. on Oregon Waiver Decision

1) Why did administration approve this waiver if it is inconsistent with your vision of Health Care Reform?

A. This waiver is being granted to give one state the flexibility to experiment with what it hopes will be a solution to the health care crisis that is facing the nation. It is one solution but not the only solution and officials acknowledge that their plan may have to be modified.

2. How can you approve a plan that sanctions rationing services?

A. This plan does limit benefits but every state limits benefits in some form or another. What Oregon officials did was to thoughtfully develop a plan that provides a reasonable level of coverage for all its citizens based on a standard of medical effectiveness and common sense.

3. Does this plan now comply with the provisions of the Americans with Disability Act?

A. Oregon officials have addressed our concerns with the ADA by changing the procedures by which medical services are ranked and changing the criteria pertaining to quality of life and perceived efficacy of treatment as it applies to persons with disabilities.

4. Were the changes made as a direct result of pressure from the disabled community?

A. We met with the disabled community and heard their concerns. We also consulted with legislative leaders on Capitol Hill. Oregon officials were willing to work with us to address these issues because the ADA is the law of the land.

5. Whose decision is this? Is this waiver being granted just because President Clinton promised to do it during the campaign?

A. As Secretary of Health and Human Services, this is my decision made after much consultation with President and my staff. It is being granted because it is the right thing to do and will give the State of Oregon the flexibility it needs to grapple with the health care crisis until a comprehensive national plan is put into place.

6. Despite your assertions, many will see this as a signal of what's likely to be included in the Clinton Health Care Proposal.

A. Let me stress that Oregon is a small state that is largely rural. What may work to cure Oregon's problems with health care may not work for the nation. We envision a broader version of health care reform that controls costs, preserves the quality of care and provides universal coverage for all Americans. Our plan will do that but it must also address such issues as drug price and medical malpractice reform, squeezing the waste and inefficiencies out of the system, and greater access to technological advances.

Pg. 2

7. Won't this make passage of your plan harder especially since Health Care Reform won't be in the budget reconciliation package?

A. We believe that Congress is sophisticated enough to understand that the Oregon plan is not a blueprint for national health care reform. It recognizes the role states must play in developing their own solutions and the fact that a national plan must be flexible enough to work for Oregon or New York, or Texas or Illinois.

8. What about the people who were going to immediately lose coverage if this waiver was granted--what happens to them?

A. Oregon officials have agreed to grandfather in the several hundred people who may have been targeted to lose coverage under their original proposal. With regard to the disabled and the chemically dependent, they will continue to receive all the services for which they are currently eligible. This will continue until, with HHS approval, Oregon expands its program to include the disabled, the chemically dependent and the elderly.

9. Oregon has drawn a line and decided that all the services that fall beneath the line should not be covered. What's to stop them from moving the line up at some later point if they discover the cost of this universal coverage is too high?

A. Under terms of our agreement, the list of services covered under the terms of the waiver cannot be altered without prior approval from the Department of Health and Human Services. We have also made clear to Oregon officials that the burden is theirs to bear if this experiment does not yield the cost savings they envision. The American taxpayer is protected.

**DRAFT**

## POLITICAL POSITIONS ON THE OREGON WAIVER

### PRIOR STATEMENTS ON THE OREGON DEMONSTRATION PROPOSAL BY THE PRESIDENT

As reported by the Associated Press on May 13, 1992,

"The Arkansas governor said that if he were president he would give the state [of Oregon] the federal Medicaid waiver it needs for its health care plan, which would cover uninsured working poor people while rationing some costly medical treatments. Clinton said such rationing would not be necessary if a national health care system was implemented."

During the Richmond, Virginia, Presidential campaign debate, the President articulated clear support for the Oregon Medicaid demonstration proposal.

In recent discussions with the National Governors Association, but without direct comment on Oregon's proposal, the President indicated support for State flexibility in addressing Medicaid costs and funding.

### PRIOR STATEMENT ON THE OREGON DEMONSTRATION PROPOSAL BY THE VICE PRESIDENT

Then-Senator Gore, in an April 10, 1992 press release (attached),

"urged President George Bush and Secretary Louis Sullivan ...to deny the [Oregon] waiver...."

"'While the nation debates how we can together craft a health care system that will cover everyone, Oregon proposes a plan that has poor people taking from other poor people, creates a tattered system, and leaves poor women and children at risk,' said Gore. 'The plan is seductive to policy makers but dangerous to the people who really need help.'"

[This statement preceded the second application and came before an agreement was reached that prevents Oregon from altering their package of benefits without HHS approval.]

### CONGRESSIONAL POLITICAL IMPLICATIONS

Oregon delegation - The entire delegation has been generally supportive of the Oregon waiver.

Rep. Ron Wyden (D-OR) has been the most vocal supporter of the Oregon waiver in the House. He also has pressured this Administration to treat him as the lead Congressional proponent of the waiver, ahead of the Senate Republican members of the Oregon delegation.

Sen. Bob Packwood (R-OR) has been the strongest supporter of the Oregon waiver in the Senate and was largely responsible for the inclusion of language favorable to Oregon's plan in the urban aid legislation (H.R. 11), vetoed last year.

Sen. Mark Hatfield (R-OR) also has supported the waiver. Though he has not been as vocal as Packwood, he made a lengthy statement favoring the waiver during the NIH bill consideration. Hatfield withdrew a proposed amendment to the NIH bill on the waiver issue after receiving a letter from Secretary Shalala promising a decision by March 19.

Rep. Mike Kopetski (D-OR), though generally supportive of the waiver, has expressed concern for the impact of the prioritized list on mental health services. Currently these services and their users are not part of the prioritization process or the initial demonstration; they are covered under the old Medicaid rules. HCFA terms and conditions would require any change in Oregon's prioritized list (including the ranking of mental health services when these are added in to the demonstration) to be reviewed by the Department.

Rep. Peter DeFazio (D-OR), Rep. Bob Smith (R-OR), and Rep. Elizabeth Furze (D-OR), have all been generally supportive of the waiver.

#### Other Key Congressional Interests

Rep. Waxman had strenuously opposed the Oregon waiver, objecting to limiting services for the Medicaid population, resorting to rationing to reduce costs, discriminating against the disabled, and other grounds. However, last week Rep. Waxman indicated that he will not take legislative action to overturn presidential approval of the Oregon plan if two specific conditions, agreed to by Governor Roberts and incorporated into the proposed terms and conditions, are imposed and enforced.

- 1) For the period 1993-1995, Oregon will maintain the list of covered condition-treatment pairs for all eligibles at the level submitted to HHS; and
- 2) For the entire demonstration period, if the State is forced by budget pressures to reduce covered benefits in subsequent years, it will obtain prior approval from the Secretary before any adjustments are made.

Rep. Dingell, who once opposed it, has supported the Oregon waiver in recent months.

ADA sponsors and supporters, including Sen. Harkin (D-Iowa), Sen. Kennedy (D-MA), Rep. Hoyer (D-MD), and Rep. Owens (D-NY) have strong concerns about the Oregon waiver. They regard it as crucial that the demonstration not violate the ADA. At the same time they strongly prefer that the ADA not be used again as the basis for denial, fearing such an outcome would hurt the ADA. If ADA issues are resolved satisfactorily, they are unlikely to oppose the waiver strenuously, especially given Waxman's recent statement.

Sen. Riegle (D-MI) is chairman of the Senate Finance Subcommittee with jurisdiction over Medicaid. However, he has not taken a position in favor or in opposition to the waiver.

### STATE AND LOCAL POLITICAL IMPLICATIONS

Oregon State Officials - Governor Barbara Roberts and the state legislative leadership vigorously support the waiver application. Oregon has invested a tremendous amount of time and energy in this proposal, and Presidential disapproval will unleash a vocal protest from all Oregon officials. The Secretary and key HHS personnel have had several with the Governor and numerous discussions with her staff.

The National Governors Association - The National Governors Association has endorsed the Oregon waiver, and disapproval of the waiver would send a negative signal to that crucial organization and to all governors regarding the Administration's flexibility towards Medicaid waivers.

The National Conference of State Legislatures - NCSL, while not taking a position on the merits of the Oregon plan, supports the waiver on the grounds that the Administration should not reject a reasonable waiver passed by a state legislature. NCSL will certainly join the chorus with NGA on this issue.

Cities and Counties - National organizations representing cities and counties apparently have not taken a position on the Oregon waiver, although they generally support increased federal flexibility in program administration.

### INTEREST GROUP POLITICAL IMPLICATIONS

Disability Organizations - National Disability Rights Organizations have voiced strong opposition to the waiver. They are strongly opposed to any waiver which would violate the ADA, and they strongly dislike the signals the waiver would send. Nonetheless, if ADA issues have been satisfactorily resolved, national disability organizations seem unlikely to sue but there remains some chance of litigation.

Other Advocacy Groups - A number of advocacy groups, including the Children's Defense Fund, oppose the Oregon waiver because they believe it rations health care services and sets the precedent that a state may explicitly provide poor persons with second-class care. Nonetheless, if terms and conditions which the Department would impose and the State has accepted to maintain the cut-off line are understood, these groups seem unlikely to litigate should the waiver be granted.

Congressional Contacts, Oregon Waiver Decision

Senator Bob Packwood  
Senator Mark Hatfield  
Senator Pat Moynihan  
Senator Ted Kennedy  
Senator Tom Harkin  
Senator Don Riegle

Congressman Ron Wyden  
Congressman Henry Waxman  
Congressman John Dingell

Congressman Mike Kopetski  
Congressman Peter DeFazio  
Congressman Bob Smith  
Congresswoman Elizabeth Furse

Governor Barbara Roberts

(staff contacts)

Donald Shriber (Energy and Commerce Committee)  
Andy Schneider (Energy and Commerce Health Subcommittee)  
Howard Cohen (Energy and Commerce Minority)  
David Schulke (Office of Rep. Wyden)  
Paul Offner (Finance Committee)  
Ed Mihalski (Finance Committee minority)  
David Nexon (Labor and Human Resources Committee)  
Peter Reineke (Office of Sen. Harkin)

NEWS FROM

# U.S. Senator Al Gore



(D - Tennessee) SR 393 Russell Building, Washington, D.C. 20510 (202) 224-4944

FOR IMMEDIATE RELEASE  
FRIDAY, April 10, 1992

Contact: Marla Romash  
202-224-7155  
301-585-9408 (H)

**GORE AMPLIFIES CONCLUSIONS IN NEW STUDY FAULTING OREGON PLAN  
Says Health Care Rationing Plan Moves Policy in Wrong Direction  
IN LETTER, URGES ADMINISTRATION TO DENY WAIVER**

WASHINGTON -- A new Congressional study questioning the state of Oregon's plan to ration health care services for poor people -- including families and children -- should convince the federal Department of Health and Human Services to deny the state's request for a waiver of Medicaid rules needed for the plan to be funded, said Sen. Al Gore, D-TN, one of the Members of Congress who requested the study.

"New and innovative approaches to cutting health care costs and expanding coverage are urgently needed but this plan to ration health care would leave too many vulnerable and would hurt most those who have the least," said Gore. "This new study should convince the Administration to reject Oregon's request for the waiver that would allow this program to be funded."

Gore urged President George Bush and Secretary Louis Sullivan of the Department of Health and Human Services to deny the waiver in separate letters sent today as the Office of Technology Assessment released its report on the Oregon proposal.

"While the nation debates how we can together craft a health care system that will cover everyone, Oregon proposes a plan that has poor people taking from other poor people, creates a tattered system, and leaves poor women and children at risk," said Gore. "This plan is seductive to policy makers but dangerous to the people who really need help."

The Oregon Medicaid plan creates a list of medical services --ranked according to cost and benefits by a special state panel - - and refuses to pay for certain services that fall below a predetermined line. Medicaid provides health care to the poor and while Oregon officials claim their rationing plan would provide health care coverage to a larger number of people, the ranking of services would reduce the level of care provided.

Sen. Al Gore/ April 10/ p2

'There are no guarantees that tighter budgets won't produce a shorter list of allowed services, almost indiscriminately deciding who gets care and for what and in the process severely reducing services. And it's clear that even under current circumstances, critical -- and sometimes fatal -- illnesses will not be covered,' said Gore.

The OTA study questions the list; the rankings of treatments, the fact serious -- and potentially fatal -- conditions are below the cut off and that categories are omitted. The OTA study also expresses concern that some pregnant women and young children might be ineligible for benefits under the new rules. And, it questions the usefulness of the Oregon program as a demonstration that could provide useful lessons to other states.

At issue is whether the federal government will waive existing Medicaid rules to allow Oregon to use Medicaid funds to pay for this rationing plan. Avoiding strong Congressional opposition, state officials have sought the waiver from the Department of Health and Human Services which has said a decision would be made this spring.

##

SUBJECT: Oregon Waiver

I. Attached is a memorandum from Secretary Shalala on the Oregon Medicaid Demonstration Waiver. This is to be a secretarial decision and she is prepared to sign it; she has promised a decision to Governor Roberts by Friday, March 19.

II. In addition to the main memo with Tabs A, B, C are two memos which are (1) a Q and A about the project and (2) a political memo (this is the only copy) which outlines statements by you and the Vice-President.

I have asked the Vice-President's office and the Secretary's office to arrange for a briefing of the Vice-President today or tomorrow.

The only outstanding question for you now is whether or not you want a briefing/discussion with the Secretary and appropriate HHS staff members along with the Vice-President and members of your staff.

\_\_\_\_\_ Direct Secretary to proceed

\_\_\_\_\_ I want a briefing/full discussion before the Secretary proceeds

\_\_\_\_\_ Other:

MEMORANDUM

TO: CAROL RASCO  
FROM: MARK GEARAN *mg*  
RE: GOVERNOR WEICKER PHONE CALL  
DATE: 17 MARCH 1993

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Governor Lowell Weicker called today to express his concern that in a telephone conversation with the President, he was assured that someone would call him on Medicaid penalties, and a certain provision of psychiatric care. I am sure this message never reached you. The Governor asked that someone call his Director of the Office of Policy and Management (our OMB) Bill Ciebes at 203-566-8070. He indicated that there is some urgency in this since they are in the middle of the budget process.

As a footnote, Bill Ciebes is a former Democratic State Legislator in Connecticut and leader of pro-income tax position in the state. He ran for Governor in the Democratic primary. Weicker recruited him once he won.



CENTER FOR HEALTH POLICY RESEARCH

Number of sheets including cover sheet: 7

TO: Carol Rasco

PHONE: \_\_\_\_\_

FAX: 456-2557

FROM: Sara Rosenbaum

PHONE: 296-6922

FAX: \_\_\_\_\_

Message:

March 2, 1993

MEMORANDUM

To: The Secretary  
Fr: Sara Rosenbaum  
RE: Oregon Waiver

As you prepare the decision memorandum for the President on the Oregon waiver request, I assume that you have asked HCFA to prepare a review of the policy and legal issues raised by the proposal. I do not know how thorough the HCFA briefing documents will be, nor would I guess that Harriet Raab has had a great deal of time yet to delve into the legal background surrounding the waiver. Therefore, I want to raise several issues for you which I think should be identified and addressed if the President decides to grant the state's request.

I assume that you are preparing the memo in two parts: first, whether the President appeals the waiver; and second, if so, which conditions should attach to the waiver to assure that the goals the state seeks to achieve are realized without undue harm or unintended adverse consequences. This memorandum is written on the assumption that the first question is answered in the affirmative. It is designed to soften the demonstration's adverse consequences and protect both you and the President from litigation brought on behalf of children and women.

The issues raised here all could be dealt with as conditions on the waiver grant. These conditions would not impede the state's ability to carry out the waiver. Moreover, they would be consistent with your interest in conducting federal research which furthers the objectives of the Social Security Act (the standard of review you must use under §1115). They are as follows:

1. the complete loss of eligibility for Medicaid both now and in the future by pregnant women and children currently eligible for benefits. It is likely that this loss of eligibility will lead to litigation against you alleging that your decision to grant the waiver is both ultra vires and in violation of federal human subject research protections that apply to all federally funded research and demonstrations conducted by the Department. The suit could arise well in advance of any decision by the state to reduce benefit levels, since it would be ripe as soon as the first pregnant women and children lose their coverage outright. In this event, the Administration could stand accused, on the eve of its national health reform plan, of sanctioning a project that completely disinsured children and pregnant women.

2. the loss of access to health care by migrant farmworker families who depend on your own federally funded migrant health centers for care when they are in the state and who will not qualify for Medicaid under the waiver; and

3. the diminution of benefits for patients in the experiment below acceptable levels.

Below is a brief background on each issue presented as well as options for resolving each matter if the President decides to proceed.

### 1. Loss of eligibility by children and pregnant women

Background: As you may be aware, the Medicaid program bases financial eligibility on net, rather than gross, income. Working poor families are given several income disregards of considerable importance. As a result, under current law pregnant women and children under age 6 with gross income in excess of 133% of poverty nonetheless qualify for coverage if their net income is at or below the 133% cutoff. Children ages 6 and older born after September 30th, 1983, are eligible if their net incomes are at or below 100 percent of the FPL. The state proposes to retain the 133 percent test for pregnant women and children under 6 but to use the gross income standard. Similarly, the state proposes to use a gross income standard for children age 6 and older.

In its review of the Oregon proposal, the Congressional Office of Technology Assessment found that the state has proposed to eliminate the net income test for pregnant women and children in favor of a gross income test.<sup>1</sup> This substitution could lead to the loss of Medicaid coverage for significant numbers of pregnant women and children eligible both now and in the future. In addition, the state proposes to eliminate several other mandatory Medicaid eligibility statutory provisions for pregnant women and children.<sup>2</sup>

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<sup>1</sup>OTA, Evaluation of the Oregon Medicaid Proposal (Washington, D.C., 1992) ch.5

<sup>2</sup> These include prohibition against grandparent and sibling deeming and retroactive coverage. The former rule avoids the loss of Medicaid that otherwise would ensue for children living in extended families with grandparents or other siblings with modest amounts of income of their own. The latter rule ensures that providers will furnish prompt care to persons with emergencies who have not yet applied for Medicaid, since it permits coverage to be retroactive to a period prior to the application date.

In addition, the state proposes to eliminate its medically needy program for pregnant women and children. This is an option,

OTA estimates that between 1 and 9 percent of all potentially eligible children and pregnant women could be affected by these changes.<sup>3</sup>

Options: The outright elimination of women and children from the program does not appear to be related to the medical benefits research the state proposes to carry out. However, the proposal also reflects a desire on the state's part to simplify the eligibility determination process. Your options are as follows:

1. Allow the state to use the income determination test as proposed.

Pros: This permits a simplified eligibility process to proceed.

Cons: Because the loss of coverage completely presents a major risk to the women and children affected without any off-setting benefits, your approval could be challenged in court on several grounds. First, plaintiffs will claim that your approval was ultra vires, since such an experiment furthers no national objective of the Social Security Act, as required under §1115. Second, your approval will have been made without application of federal human subject protections. Under the annual appropriations act, these protections are applicable to all federal demonstrations.

To the best of my knowledge, the prior Administration did not follow the human subject procedures. Thus, the entire demonstration is potentially subject to litigation (as are your other §1115 experiments -- one federal action already has been filed using this theory). The complete loss of Medicaid would certainly be the best fact pattern with which to proceed in court.

2. Have the state modify its gross income standard for pregnant women and children to a higher level. This would take into account the loss of the disregards and effectively eliminate the class of women and children losing coverage completely. Data suggest that if the state used a 160% gross income test for pregnant women and children under 6 and a 125% gross income test for children age 6 and over, this would take care of nearly all pregnant women and children with gross incomes over the eligibility cutoff but net incomes at or below the cutoff.

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however, that any state can pursue at any time.

<sup>3</sup> Evaluation, op. cit., pp. 5-11 and 5-12.

Pros: This keeps the simplicity the state desires while adjusting the income levels to reflect the higher standards that apply to pregnant women and young children. Moreover, it assures that older children also retain their eligibility protections now accorded under federal law.

Cons: The state will have to use a couple of different income standards (one for pregnant women and children and one for others). However, even with the waiver, the state will still need to employ numerous eligibility determination standards in assessing coverage for its non-experimental populations.

## 2. Services to migrant and seasonal farmworkers served by the Public Health Service

Background : Oregon has thousands of migrant families. These families are seldom eligible for Medicaid because of their transience and federal Medicaid residency and legal status requirements. The state has not sought waiver of either of these federal statutory barriers to Medicaid eligibility for migrants. At the same time, moreover, it seeks authority to reduce Medicaid payments to your migrant health centers for the relatively few Medicaid patients they do serve. The loss of Medicaid payments to these centers will place even greater pressure on their programs, since they will get little if any relief in the way of better insurance coverage for their patients as an offset to loss of payments under the state's price reductions.

### Options:

1. Require the state to maintain the special payment rules for migrant centers now contained in current law.

Pros: There are only a handful of these clinics in the state (about 8). Together they see approximately 30,000 patients annually, very few of whom in fact will be in the state's experiment. Retention of the current payment rules under Medicaid will affect the state's budget insignificantly. At the same time, it will ensure the PHS grants used to support services to these families will not instead be used to offset lost Medicaid revenues.

Cons: The state will have to retain a different payment methodology for these clinics, thereby causing some administrative burden.

2. Give the clinics additional PHS grants to offset any Medicaid losses.

Pros: Allows the state to avoid a separate payment methodology for the clinics.

Cons: This diverts your grants away from other states that need the funds into a state that is receiving millions of dollars in new Medicaid funding. Moreover, you are prohibited under your own PHS law from using PHS dollars to offset Medicaid shortfalls. You cannot waive this prohibition.

3. Allow the state to proceed and take no action

Pros: This allows the state to avoid the additional administrative burden.

Cons: The loss of services to migrant families, a consequence not consistent with any objective of the Social Security Act and inconsistent with the PHS Act.

### 3. Benefits

Background: The most publicized aspect of this waiver is the desire on the state's part to set a budget and then limit covered condition and treatments as (and if) funds start to run out<sup>4</sup>. The question is whether the state will simply be allowed to move the treatment line up without further review.

#### Options:

1. Require the state to maintain coverage at its original line as proposed in its latest submission or else risk loss of the demonstration funding.

Pros: This assures the preservation of at least a minimum benefit level, which is consistent with the President's own beliefs about national health reform.

Cons: This prevents the state from reducing coverage in the face of budget constraints, which is a central aspect of its proposal.

2. Require the state to resubmit for review any plans to roll back benefits so that you can do an appropriate risk/benefit analysis and assure that the benefits of continuing the waiver outweighs its risks.

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<sup>4</sup> It is worth asking HCFA how recently it sought updated information from the state on both the cost of the waiver and the sufficiency of its funds to keep benefit levels adequate. The recession that has now hit the West, along with Proposition 5 and its consequences, may have made some of the original cost estimates (already questioned by OTA) even shakier. If the cost estimates are far off, then the state and you could be left with an inadequately funded experiment.

Pros: This protects you and the President against deep reductions by the state without your approval.

Cons: This would add a new administrative responsibility to the state.

## **MEMORANDUM TO CAROL RASCO**

**DATE:** March 9, 1993  
**FROM:** Charlotte Hayes  
**SUBJECT:** Oregon Medicaid Waiver

### **INTRODUCTION**

Greg Simon and I thought that I should present a couple of the special concerns surrounding the Oregon Medicaid Waiver Application to you for your review. It would be great to talk to you about this issue soon.

### **STATUS**

Secretary Shalala is on record as promising to issue a decision on the waiver request and notify the Governor and the congressional delegation no later than March 19.

### **SPECIAL CONCERNS ABOUT THE WAIVER APPLICATION**

The stated and laudable purpose of the waiver is to extend Medicaid eligibility to all of the poor population of Oregon. This memo is confined to two fundamental concerns about the waiver: that granting the waiver would subject the President to legal liability on two counts and in principle subvert one of the most important goals of the President's health reform effort: universal coverage (which includes health benefits for the most vulnerable Americans, children and women.) This memo does not address additional problems (that could be solved by adding conditions to its approval), e.g., those related to the Americans With Disabilities Act, migrant workers, current Oregon budget crisis and the failure of the plan to provide a core benefit package for poor women and children.

#### **1. The Oregon Plan Would Subject the President to Legal Liability for Removing Currently Eligible Pregnant Women and Children From Medicaid**

**The Oregon Plan would remove pregnant women and children by changing the eligibility standards for Medicaid benefits.**

Under current Medicaid law, pregnant women and children under 6 years with gross income in excess of 133 percent of poverty qualify for coverage if their net income is at or below the 133 percent cutoff. Children ages 6 and older born after September 30, 1983 are eligible if their net incomes are at or below 100 percent of the federal poverty level.

By contrast under the waiver, pregnant women and children under 6 years would be taken off the Medicaid rolls, because the state would apply a gross income standard to the 133 percent test. This change has a significant effect on such individuals. Elimination of the income disregards, such as for child care expenses, etc. add up to a few hundred dollars thereby putting families over the eligible income level and out of the Oregon Medicaid program.

Recently, the Office of Technology Assessment conducted a month long study in a typical Oregon County and found that thousands of pregnant women and children (1 to 9

percent of families applying for benefits) **would no longer be eligible** under the income eligibility changes in the waiver. The state had estimated that 1 percent of the women and children would lose benefits. The President could be sued when the first pregnant woman or child loses their Medicaid card. Furthermore, in addition to being attacked for away benefits from pregnant women and children, the President could be cast as subverting his stated goal of universal coverage in the impending health care reform plan.

## **2. The Oregon Plan Would Subject the President to Legal Liability Because It Violates the Standards on Experiments on Human Subjects**

**Removing these pregnant women and children from the Medicaid program would constitute potentially dangerous research on human subjects.**

According to Section 1115 of the Social Security Act, the standard of review for Oregon's application is the interest of the Secretary in conducting federal research which furthers the objectives of the Act. Federal regulatory standards for federally-funded research involving human subjects require that if an experiment is conducted certain safeguards and standards must be met. The research provisions in the annual appropriations legislation constitute a Department-wide mandate that no research program or project can "present a danger to the physical, mental or emotional well-being of a participant." The appropriations law does not distinguish between research and experiments funded under the various research authorities of the Public Health Service Act and those funded through other agencies of the Department.

The waiver would be classified as research on human subjects under the basic interpretation of the Department's research regulations. The next determination would be whether the plan constitutes a danger to the thousands of pregnant women and children who would lose medically necessary health care coverage, thousands more who would be denied medically necessary care should the plan's budgetary constraints cause a condition to fall below the line for coverage, and perhaps hundreds who could have care withdrawn by providers under the plan. In the context of a law suit, it is difficult to conceive how the court could not determine that the research poses a danger to at least currently insured women and children.

## **3. The Oregon Plan Would Not Be Necessary if Oregon Raised Its Medicaid Contribution to the National Average of Other States**

Among the fifty states, Oregon is one of lowest contributors to Medicaid. In FY 1991, dedicated only 4.3 percent of its state funds to the Medicaid program and ranked 39th among states in Medicaid spending. Meanwhile the state spent 11.1 percent of its state funds on administrative expenses for Medicaid, the highest of all states. The average state Medicaid contribution was 7.5 percent.

NOTE: Arkansas dedicated only 4.6 percent of its state funds to Medicaid and ranked 37th among states in spending on Medicaid. However, Arkansas spent only 3.6 percent of its state funds on administrative expenses and is a poorer state receiving 74.41 percent in federal matching funds. Oregon is a wealthier state receiving 62 percent in federal matching funds.

It was estimated that if Oregon had increased its effort to a level similar to that made

of most states, it could have added 250,000 new Medicaid beneficiaries with the full package of services the state provides.

## **SOME OPTIONS FOR THE OREGON WAIVER APPLICATION**

If the waiver is granted some changes would eliminate the legal liability attendant to the loss of Medicaid benefits for pregnant women and children.

### **1. Modifying Gross Income Standard**

The Secretary could require the state to modify its gross income standard for pregnant women and children to a higher level to restore Medicaid eligibility to the class of women and children who would lose coverage under the waiver. According to some data, women and children with gross incomes over the eligibility cutoff but with net incomes at or below the cutoff would be included under a 160 percent gross income test for pregnant women and children under 6 years and a 125 percent test for children 6 years and older.

This condition would keep some of the simplicity the state desires while adjusting the income levels to reflect the higher standards that apply to pregnant women and children. The state will have to use at least two different income standards: one for pregnant women and children and one for others.

### **2. Apply the Waiver Plan Only to New Applicants for Medicaid**

The Secretary could require that the waiver plan apply only prospectively, which would avoid eliminating eligibility for thousands of pregnant women and children who are now covered.

This condition is not terribly costly and also addresses the imbalance in the state coverage of Oregonians. Currently elderly, who are not included in the plan, make up 20 percent of the program but account for 80 percent of the expenditures, while women and children who comprise 80 percent of people in Medicaid account for only 20 percent of expenditures.

## **CONCLUSION**

The Oregon Plan as proposed:

1. Would subject the President to legal liability for removing currently eligible pregnant women and children from the Medicaid program, by changing the eligibility standards for benefits;
2. Would subject the President to legal liability because it violates the standards on experiments on human subjects because the waiver removes pregnant women and children from the Medicaid program which is potentially dangerous to the physical, mental or emotional well-being of the participants; and
3. The Oregon Plan would not be necessary if Oregon raised its Medicaid contribution to the national average of other states.



March 9, 1993

**DRAFT**

MEMORANDUM TO THE SECRETARY

**DO NOT DISTRIBUTE**

THROUGH: COS \_\_\_\_\_  
ES \_\_\_\_\_

FROM: *Anna Boyd*  
Anna Boyd, Policy Coordinator/Health

SUBJECT: Meeting on the Oregon Medicaid Waiver: **BRIEFING**

Time: 8:30 a.m., Wednesday Place: The Secretary's  
March 10, 1993 Conference Room

**Participants:**

- The Chief of Staff
- Claudia Cooley
- David Ellwood
- Beverly Dennis
- Patsy Fleming
- Betty James
- Jerry Klepner
- Avis LaVelle
- Karen Pollitz
- Harriet Rabb
- Bill Toby
- Jacquelyn White

**Purpose:** This meeting will review the progress on the tasks discussed at the your February 25 meeting on the Oregon waiver, and will include discussion of the substantive issues involving the proposal.

**Discussion:**

One of the main items for discussion is the memorandum for the President. The draft, prepared by HCFA and ASPE, is attached at Tab A. HCFA has prepared a brief status report on the other tasks which is attached at Tab B. It addresses the following issues:

- . Evaluation of the demonstration,
- . Other terms and conditions,
- . Legal issues,
- . Discussion with OMB.

At Tab C is a list of substantive issues for discussion.

Attachments

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**TAB A**

draft

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3/8/93pm

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**MEMORANDUM FOR THE PRESIDENT**

**FROM:** Secretary, Department of Health and Human Services

**SUBJECT:** Oregon Reform Demonstration

**I. ACTION-FORCING EVENT:** The State of Oregon's legislature, currently in session, meets only every two years. So that the legislature may take such steps as may be necessary, I have committed to provide a final decision to the State on the Oregon Medicaid Reform demonstration proposal by March 19.

**II. BACKGROUND:** The Oregon Health Plan is a comprehensive, legislatively-approved package of reforms intended to provide universal health insurance coverage to all State citizens and to introduce cost control. These will be accomplished through a permanent expansion of Medicaid eligibility to all poor citizens, substantially expanded enrollment in managed care programs, private insurance reform, risk pooling, and phased-in employer mandates ("pay or play").

One component is the Oregon Medicaid Reform demonstration plan, implementation of which requires Federal waivers. The demonstration would establish a basic set of benefits different from the current Medicaid program, to be available to all Oregonians below the poverty line. The basic package of covered benefits reflects a prioritized ranking of 688 condition-treatment pairs, developed by the Oregon Health Services Commission based in part on community values (established through a broad-based citizen participation process) and expert provider panel recommendations related to the effectiveness of medical interventions for various conditions. This clearly qualifies as a major experiment and demonstration.

The former HHS Secretary decided in August 1992 he could not approve the Oregon Medicaid demonstration pending resolution of legal issues related to the Americans with Disabilities Act.

**III. DISCUSSION**

The priority ranking of conditions and treatments is the most controversial component of the Oregon Medicaid Reform proposal.

-- Of the 688 prioritized service-treatment pairs, for budgetary reasons the Oregon legislature has decided initially to fund coverage of only the top 568. Should Oregon wish, for budgetary reasons, to diminish coverage in

later years (i.e., reduce the line to, say, 540), it would be required to apply for DHHS permission to do so.

- Covered services will include expanded benefits for adult preventive care, dental care, and hospice services. (The state-covered Medicaid condition-treatment pairs will serve as the basic employee benefit package when mandated employer coverage is phased in.)
- Excluded services include, for example, surgical treatment of benign neoplasms of the digestive system (no. 586), reconstructive breast implants (no. 594), and acute and chronic disorders of the back without spinal cord injury (no. 587). Fewer services are excluded than under the original waiver application.
- Initially excluded from the demonstration will be (a) aged, blind and disabled Medicaid beneficiaries (who will continue to receive the current Medicaid benefit package), and (b) most mental health and chemical dependency services. These are not likely to be incorporated until the second year of the demonstration or later at unknown costs.

There is a philosophical issue: is it fair and appropriate to ration explicitly care to low-income families while care is not rationed to other Oregonians? Since the current list of rationed services is not very great, the argument hinges largely on whether the principle is acceptable or whether it starts the country on a slippery slope of explicitly accepting that the poor and disabled are to receive fewer medical services than other people. On the other hand, everyone agrees that Medicaid services are now rationed in more hidden ways (like low reimbursements which limit provider participation).

A second concern involves whether the method for ranking services is science or pseudo-science. While Oregon has attempted to use evidence of cost and effectiveness in ranking procedures, the data and evidence for such rankings is often weak. This is partly because the needed studies do not exist. The Office of Technology Assessment recently released a report critical of Oregon's procedures. Others point out that a procedure often is cost-effective for one person with a particular condition and wasteful for another, so a single ranking with blanket inclusions and exclusions often does not seem particularly sensible. Ideally, the health system would determine what is effective on an individual rather than collective basis.

#### IV. ISSUES

Costs: Oregon's goal is to save money by reducing the number of covered Medicaid services and by using managed care. They intend to use the savings to cover the low-income population. However, excluding these services probably will not save much money. In

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The President - 3

addition, under this plan, Medicaid payments to providers are required by State statute to be set and maintained at a level sufficient to cover providers' costs; this will significantly raise costs and means that any future cost savings must come from benefit reductions.

Thus, the possibility of significant out-year savings is largely dependent upon two factors: (a) savings from broad enrollment in managed care which, while potentially quite substantial, are, to date, modest; and (b) movement of Medicaid beneficiaries out of Medicaid and onto employer-sponsored coverage under Oregon's "play-or-pay" mandate, any savings from which will be several years away.

The State originally estimated additional federal costs of \$140 million; Oregon now estimates that the demonstration will save \$3 million in Federal costs over 5 years. The Department has developed procedures to limit Federal expenditures under the demonstration. However, it seems likely the plan will cost more than Oregon estimates and the State is experiencing a taxpayer "revolt" raising questions regarding the State's ability to support its share of the costs throughout the life of the demonstration. We think pressure to pay more in Medicaid to support the Oregon experiment is likely in the future.

**Rationing:** Although the public perception continues to be that Oregon is testing rationing of services, this is largely inaccurate. Because budget-driven changes in covered services must be approved by the Department, the amount of real rationing in the demonstration appears to be very modest. Most non-covered services, when fully understood, are relatively non-controversial.

**Eligibility:** Under the demonstration, Oregon proposes to make all those under the poverty line eligible for Medicaid. This will erase current Medicaid eligibility categories (which are widely criticized) and newly bring into Medicaid eligibility many indigent single adults, childless couples and others who are ineligible for coverage under the present Oregon system. However, because of changed eligibility criteria, some children and pregnant women -- likely to be few in number -- who in future years would have become Medicaid-eligible under the current eligibility structure, will not.

**Legal:** A January 19 letter from the Office of Legal Counsel, Department of Justice (DOJ), concluded that the new Oregon methodology is still inconsistent with the ADA. Disability advocacy groups have criticized the proposal for the same reason. The Department believes that relatively modest changes to the methodology, if agreed to by Oregon, would eliminate these problems and satisfy the concerns of the DOJ and the mainstream

The President - 4

disability community. I also believe that approval or disapproval should be made on policy, not ADA, grounds.

**Relation to Health Care Reform:** Oregon and other states initiated health reform plans during a period when action at the Federal level did not seem likely. While details of your health reform plan are still being developed, there is reason to anticipate that components of some states' reforms -- including Oregon's -- will prove at variance or incompatible with the principles or the specifications of your plan.

Were Oregon's Medicaid reform demonstration to be approved, there would be a period of some months before the demonstration became operational. That period would allow time to renegotiate aspects of the State's proposal that may need to conform with Federal requirements. As a general matter, Governor Roberts has indicated the State's willingness to resolve any remaining problems associated with the Oregon proposal.

Disapproval of the Oregon proposal could discourage States from attempting to deal with their health financing and access problems, and might appear to contradict your efforts to make States our allies in health care reform. On the other hand, its approval need not set a precedent.

**Evaluation:** While some aspects will be methodologically difficult and potentially expensive to evaluate, there is no question that the demonstration itself is evaluable and that important information could be gained. The Department would award a multi-million dollar, multi-year evaluation contract to independently examine the impacts of the demonstration on cost, access and quality. However, findings would be likely to emerge rather late to substantially affect the course of health reform.

#### V. ARGUMENTS IN FAVOR OF APPROVING OREGON'S PROPOSAL

- o Oregon's Medicaid reform demonstration goals are fully consistent with the Administration's Health Care Reform goals: universal, affordable, quality health care for the poor, while controlling cost, and a joint emphasis on
  - managed care;
  - support for preventive services;
  - private health insurance reform;
  - medical liability reform.
- o The proposal is a legitimate, policy-relevant demonstration from which potentially valuable lessons could be learned.
- o In response to budgetary constraints and political pressures, all states' Medicaid programs ration services,

The President - 5

usually through limitations on benefits' amount, duration and scope. Oregon's proposal is unique both in the basis by which limits have been set and in acknowledging their existence.

- o The proposal has received bipartisan backing from most elected Oregon officials and wide community support from employers, providers, insurers, and citizens. The National Governors Association has endorsed granting a waiver.
- o Approval would signal the Administration's support for State flexibility in reforming the health care delivery system.
- o Oregon has made a good faith effort to accede to federal concerns throughout a very long process (see Attachment for brief chronology). Approval would establish the Administration's own good faith, and would clear up a piece of very old business.

**VI. ARGUMENTS IN FAVOR OF DISAPPROVING OREGON'S PROPOSAL**

- o Oregon's broader health reform proposal, of which the Medicaid Reform demonstration is only a part, is inconsistent with certain Administration's positions -- especially the failure to guarantee a minimum set of basic benefits, and partial reliance on benefit reductions for cost containment.
- o Expanded Medicaid eligibility is to be financed in part through reduction of services for current eligibles, and the benefit package has been developed through a process perceived by the public to be rationing.
- o Many groups and individuals oppose granting of the waiver including some Oregon legislators, the Children's Defense Fund, Consortium for Citizens with Disabilities, Senator Harkin, Congressmen Henry Waxman and Peter Stark, and Sarah Rosenbaum.
- o Especially as the aged, blind and disabled, and mental health and chemical dependency services are brought into the

demonstration, Oregon may find that for budgetary and/or for other reasons, they cannot maintain an adequate basic benefit package. Significant new exclusions in benefits would make the proposal far more controversial and would raise much more serious questions of rationing.

The President - 6

- o We are likely to be sued for approving and the State for conducting a demonstration claimed to violate the Americans with Disabilities Act (ADA).
- o It may be premature to approve a major State health care reform demonstration until the Administration has announced its own health care reform principles and design.

DONNA E. SHALALA

**OPTIONS AND DECISIONS**

OPTION 1 Approve the proposal, subject to terms and conditions to (a) protect beneficiaries from significant reductions in coverage and (b) the Federal government from additional financial exposure.

Approve\_\_\_\_\_ Disapprove\_\_\_\_\_ Other\_\_\_\_\_ Date\_\_\_\_\_

OPTION 2 Approve the proposal, but in addition to terms and conditions in Option 1, establish clear check points at which federal approval for the project is revisited. Examples of such check points include:

- Annual assessment of program performance and expenditures, with termination possible if Oregon's expenditure growth greatly exceeds expectations.
- Submission of an implementation plan (in early 1994) for the inclusion of the elderly and disabled, and mental health/chemical dependency services into the program.
- Implementation of employer mandates (in 1995).

Approve\_\_\_\_\_ Disapprove\_\_\_\_\_ Other\_\_\_\_\_ Date\_\_\_\_\_

OPTION 3 Disapprove the proposal.

Approve\_\_\_\_\_ Disapprove\_\_\_\_\_ Other\_\_\_\_\_ Date\_\_\_\_\_

BRIEF CHRONOLOGY

- o August 1991 - Oregon proposal submitted to the Department of Health and Human Services.
- o August 1992 - Former HHS Secretary decides that he could not give final approval to the proposal until legal issues related to the Americans with Disabilities Act were resolved.
- o November 1992 - Oregon submits proposal revised in response to legal concerns.
- o January 19, 1993 - Department of Justice issues an opinion that the revised proposal still violates the Americans with Disabilities Act.

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**TAB B**

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**Status Report on the Oregon Medicaid Demonstration  
Briefing for Secretary Shalala  
March 10, 1993**

- o Completion of Decision Memo for President

HCFA and ASPE have drafted a decision memo for the President on the Oregon Reform Demonstration. The memo provides background and summarizes the pros and cons for approving the demonstration.

- o Resolution of Evaluation Issues between HCFA and ASPE

HCFA and ASPE agree that the demonstration is evaluable, and that important policy relevant information will be gained through an evaluation. Oregon is capable of producing the necessary individual level data needed for the evaluation. HCFA is working with Oregon to assure that the data will be available in the most efficient manner possible.

- o Resolution of Special Terms and Conditions with Oregon

In a March 5 conference call, HCFA, ASPE, OGC and Oregon officials reviewed all the proposed special terms and conditions for the demonstration.

- Oregon reiterated that the special term and condition which requires HCFA prior approval of any Medicaid plan modification which resulted in a Federal cost impact of \$3 million was unacceptable. Although no commitment was made, HCFA and ASPE agree this special term and condition should be dropped. In a meeting on March 9, OMB concurred.

- With respect to the requirement to provide individual level ambulatory encounter data for Kaiser Permanente, the State agreed to reassess Kaiser's capabilities to produce Medicaid data, perhaps as part of Kaiser's plans to pilot test its new system.

- o Status of Legal Issues

We have consulted with the Department of Justice and they have agreed with us that relatively modest changes to the methodology, if agreed to by Oregon, would eliminate the ADA problems. Perhaps more importantly, these changes would also alleviate the concerns of the mainstream disability community.

Initial contacts with the staff level of the Oregon Health Services Commission indicated the Commission would resist these changes. We need to discuss further with the political officials in Oregon.

o Status of Discussion with OMB

A meeting was held with Nancy Ann Min, Program Associate Director for Health at OMB, and her staff on March 9. They concur with our proposal to delete the \$3 million prior approval condition. They also are comfortable with our other requirements, including the budget neutrality condition and the need for encounter data for evaluation purposes.

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**TAB C**

**OREGON MEDICAID DEMONSTRATION  
BRIEFING FOR SECRETARY SHALALA**

**DRAFT**

**March 10, 1993**

- 1) What's positive about Oregon's proposal?
  - o Attempts to cover all
  - o Thoughtful, inclusive and open process
  - o Example of best practice in developing state initiative
  - o Improved access through managed care
  - o Signals trust in states
  
- 2) Is it legal?
  - o Issues still on table
  
- 3) How much rationing?
  - o Symbols, perceptions and reality
  - o All states ration
  - o Ranking procedures, drawing line
  - o Aged, disabled, mental health, substance abuse not part of experiment initially, covered under old system
  
- 4) Do the budget numbers add up?
  - o Line drawn in way that saves little
  - o Raising provider reimbursement
  - o Covering more people
  - o Savings for managed care and pay or play
  - o Federal government protected
  - o Future problems?
  
- 5) What about health reform?