

Prioritization of Mental Health Services in Oregon

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THE PROBLEMS OF ESCALATING COSTS AND LIMITED access are the primary focus of health care reform in the United States (Blendon and Donolan 1990; Clowe, Scalettar, and Todd 1993; Fein 1992; Himmelstein and Woolhandler 1989). Although health care services and technology continue to improve, they often become more expensive (Fuchs 1993; General Accounting Office 1991). Mental health is faced with similar financial pressures linked to improved treatments (including medications, behavioral therapies, and rehabilitation methodology) (Goodwin 1993; Michels and Marzuk 1993a,b). Nonetheless, growth in mental health expenditures will likely be constrained, at least in part because state governments (with their limited budgets) remain large providers of and/or payers for mental health services (Bevilacqua 1991; Bigelow and McFarland 1994). Consequently, the mental health service system (like that of health care generally) is undergoing dramatic change (Koyanagi et al. 1993). Although questions of cost con-

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tainment and universal access pertain to mental health, the field has its own special concerns as well.

One issue is integration. Historically, mental health services have been provided by a large variety of agencies, often in the "social service" sector (Mechanic and Rochefort 1992). Advocacy groups contend that recent research demonstrates mental conditions like schizophrenia or bipolar disorder to be "diseases" and thus more properly addressed in the health care system. President Clinton has stated: "There is no legitimate rationale for distinguishing between 'mental' illness and 'physical' illnesses in terms of research dollars, individual entitlements, and insurance benefits" (Mental Health Liaison Group 1993). The advocacy groups, of course, are not unaware of the relative wealth and power of the health care system vis-à-vis the social service system (Mechanic and Rochefort 1992). The rallying cry of the "integrationists" is parity—nondiscriminatory health insurance coverage for persons with mental illness (Sharfstein, Stoline, and Goldman 1993).

Opponents of integration argue that, for all its numerous and well-known deficiencies, the social service sector has at least provided some care for persons with severe mental illness. The fear is that the general health care system will consume funds earmarked for the severely mentally ill while directing resources to other populations (Mental Health Policy Resource Center 1992).

Another related argument from insurers and payers (especially employers) is that mental illness is characterized by the four "uns": undefinable, untreatable, unpredictable, and unmanageable (Bonstedt 1992; Pearson 1992). This "mythology of the uns" is, like many beliefs pertaining to persons with severe mental illness, a product of stigma and ignorance, leading easily to discrimination (Marshall 1992). In this context, discrimination takes the form of the penalty for chronicity. Chronic, potentially disabling physical conditions (e.g., diabetes) do not, ipso facto, preclude one from obtaining health care. However, chronic mental illness (e.g., schizophrenia) is often grounds for denying services (Judd 1990; Peterson, Christianson, and Wholey 1992). This discrimination is "justified" on the grounds that severely mentally ill people would consume "unmanageable" (or "unpredictable") amounts of service—in contradistinction to the physically ill, whose care can be both managed and predicted.

Another contentious issue is the question, What is a health care service and what is a social service? Persons with severe mental illness at dif-

ferent times may need a variety of services, such as case management, supported housing, psychosocial rehabilitation, or psychotropic medications (Lamb et al. 1993). Sharfstein and Stoline (1992) build on work by Astrachan, Levinson, and Adler (1976) to define these services from the provider's perspective as medical tasks, reparative tasks, humanistic tasks, and social controls. Some services (e.g., psychiatric diagnosis, medications, acute inpatient treatment) are clearly "medical tasks" contained in the health sector, whereas other services (e.g., supported housing) are clearly "reparative tasks" conducted in the social service sector. Some services (e.g., case management) might be found in either sector.

This situation places the mental health community itself in a serious dilemma (Koyanagi et al. 1993). Persons affected by mental disorders and providers of mental health services have consistently and continuously experienced inequities in coverage and reimbursement rates for mental health services (Judd 1990; Malloy 1991). The pressures around questions of participation in the health care planning process and obtaining equity for mental health are perhaps the most serious of those facing the mental health community in the United States (Havel 1992).

This article describes the Oregon mental health community's response to health care reform. We will present the health care planning process, highlight the methodology used in setting priorities, and focus on the mental health component. We will also describe attempts made in conjunction with the planning process to educate the public about the value of mental health services within the health care system. Finally, we suggest that this description contains models of strategies advocates can use to establish equity for mental health services in other health care systems.

Background

The prelegislative history and the specific legislation that authorized the Oregon Health Plan have been described in detail elsewhere (Brown 1991; Fox and Leichter 1991, 1993; McFarland et al. 1993; Oregon Health Services Commission 1991a; Strosberg, Weiner, and Baker 1992). To summarize, in 1989 the state legislature enacted several bills that created a health care plan for Oregon. The three main goals of the legislation were universal access, reasonable provider reimbursement rates, and cost containment.

To achieve these goals, a Health Services Commission (HSC) developed a prioritized list of health services, a portion of which would be defined as the basic coverage for persons included in the plan. The plan's coverage would apply to the Medicaid population, which would be expanded to include virtually everyone at or below the federal poverty level. A similar package of benefits would be provided to previously uninsured employed persons through a "pay or play" requirement applied to most employers. This approach contrasted with the previous system in which a relatively small number of persons (whose incomes were well below the federal poverty level) had access to a Medicaid program that offered essentially unlimited benefits for (physical) health care. The intent of the Oregon Health Plan was to provide "basic" health care coverage to a large number of individuals.

The idea of a prioritized list of health services was immediately labeled health care "rationing," and it attracted worldwide attention (Brown 1991; Callahan 1991; Fox and Leichter 1991). Oregonians found themselves being discussed by television commentators on *60 Minutes*, *20/20*, and the *MacNeil/Lehrer NewsHour*. Innumerable academic articles in journals like *Health Affairs*, the *Journal of the American Medical Association*, and the *New England Journal of Medicine* (see McFarland et al. [1993] for a bibliography) appeared almost concurrently with editorials in the *New York Times*, the *Washington Post*, and the *Wall Street Journal*. An early question in one of the 1992 presidential campaign debates pertained to the Oregon Health Plan. Nearly lost in this furor was the notion of integrating mental health services into a comprehensive health care system.

The Prioritization Process

The HSC, composed of physicians, other health providers, and laypersons (all appointed by the governor and confirmed by the state senate), initially created three committees to assist it in the daunting task of defining basic health care. The Health Outcomes Committee was to develop the prioritized list, the Social Values Committee was charged with determining the community values to be considered by the Health Outcomes Committee when sorting this list, and the Mental Health and Chemical Dependency (MHCD) Committee was to address the issues of

prioritizing mental health and chemical dependency services and (possibly) integrating them into the larger system.

The MHCD Committee members represented consumers, family members, and professionals in the mental health and chemical dependency fields. The MHCD Committee was chaired by a public health nurse (a commission member) and staffed by HSC personnel. The committee, which typically operated on the basis of consensus, met in public for work sessions and to take testimony from mental health professionals and researchers.

The existence of the MHCD Committee itself was a small victory for mental health advocates. As initially proposed, the draft legislation for the Oregon Health Plan omitted mental health and chemical dependency. Left to their own devices, legislators would have endorsed the mythology of the four "uns" and excluded MHCD conditions. Determined lobbying by the MHCD community resulted in a legislative mandate that the HSC establish a mental health and chemical dependency committee. However, the 1989 legislation contained a political trade-off: mandated mental health benefits were scheduled to disappear when the full Oregon Health Plan (i.e., including mental health and chemical dependency and involving both the working poor and the Medicaid population) began operating statewide. Although these mandated benefits were modest (amounting to about 20 outpatient visits and 10 hospital days per beneficiary per 24 months), they had become the *de facto* standard for mental health coverage in the state.

The 1989 lobbying effort stimulated the development of a coalition representing mental health and chemical dependency, consumer, family member, and professional organizations. The coalition has now been meeting regularly for five years under the leadership of the Mental Health Association of Oregon. The mailing list includes some two dozen organizations active in the MHCD field.

Participants in the prioritization process were aware of changes in the health and mental health systems that were proceeding in parallel with development of the Oregon Health Plan. Most dramatic was the shift away from fee-for-service (FFS) and toward managed care, chiefly in the form of health maintenance organizations (HMOs). Oregon's HMO enrollment would climb from approximately 15 percent of the population in 1989 to 30 percent in 1993. Enrollment in preferred provider organizations (PPOs) and other managed care systems was increasing rapidly as well. Providers could see the end of FFS health care financing. Indeed,

it was assumed that most, if not all, Oregon Health Plan beneficiaries would be enrolled in a prepaid system (McFarland et al. 1993). Oregon had been one of the first states to use prepaid health plans for Medicaid clients. In 1989, about 10 percent of the state's Medicaid clients were enrolled in HMOs, and another 10 percent or so were enrolled in different types of managed care systems. Members of the MHCD committee saw the Oregon Health Plan as a potential model for comprehensive managed care systems that provide mental health and chemical dependency services, as well as physical health care.

Other pertinent developments included the rise in Medicaid financing for public mental health clients and the accelerating shrinkage of the state mental hospitals (Lippincott 1989). Mental health services for Medicaid clients were provided solely by community mental health centers operating on an FFS basis. During the late 1980s and early 1990s, these local agencies substantially increased their Medicaid billings. Most dramatic was the rise in Medicaid-financed children's mental health services provided as part of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.

Although the Medicaid program brought federal matching funds into the public mental health system, it also put increasing demands on the state's general fund mental health dollars. In addition, the state mental health authority began to develop local general hospital programs to be used as alternatives to aging and isolated state mental hospitals. These local inpatient facilities were also able to bill Medicaid (whereas the state hospitals could not). Ironically, however, the state Medicaid program was sufficiently restrictive that many persons with chronic mental illness were found to be ineligible for coverage. For example, recipients of Supplemental Security Income (SSI) often had "too much" income to qualify for Medicaid. The state mental health authority estimated that only about half of the chronically mentally ill people in Oregon were Medicaid clients (Lippincott 1989). Services to chronically mentally ill people who were not Medicaid clients had to be financed entirely with state general fund dollars. The rapid rise in Medicaid expenditures, plus the large numbers of non-Medicaid community mental health clients, prompted the state mental health authority to appreciate the need for a Medicaid managed care system that could encompass persons with chronic mental illness. Consequently, state mental health administrators were very interested in seeing how the Oregon Health Plan developed (McFarland et al. 1993).

The Health Outcomes Committee and the Initial Methodology

The methodology that the Health Outcomes Committee initially considered was based on a health decision policy model derived from the work of Kaplan and colleagues (Kaplan and Anderson 1988; Kaplan 1992; Kaplan, Debon, and Anderson 1991). Committee members were ambivalent about the methodology: it seemed to offer a logical and relatively objective approach to the overwhelming task of valuing and sorting, on the one hand, but, on the other, its dependence on mathematical reductions of human conditions and the risk of error secondary to unreliable outcome and cost data made it suspect.

The Kaplan methodology links each health care condition with its appropriate treatment, leading to the concept of condition-treatment pairs (e.g., appendicitis and appendectomy). The rank order list that would ultimately be developed is a sequence of hundreds of such condition-treatment pairs. For each condition-treatment pair, outcome and cost data were to be obtained, entered into a quality of well-being (QWB) scale, and given a mathematical value for the treatment.

The data provided for each condition-treatment pair were to include estimates of the outcomes and costs for both when proper treatment was provided and when it was not. These outcome data were to be compared for each condition in order to estimate the relative QWB and costs of the proper treatment.

Kaplan developed a list of 23 symptom clusters (Appendix 1) that represent most human pathological conditions and three categories of impairment that relate to mobility, physical activity, and social activity. Mathematical weights (i.e., "utilities") were determined for each of the symptoms and impairments, based on a random telephone survey of Oregonians (Kaplan, Debon, and Anderson 1991). These weights were then used in the application of the QWB scale to the various condition-treatment pairs. The Health Outcomes Committee invited representatives from all the state's health care specialty and provider groups to provide outcome data for the development of the prioritized list.

The Social Values Committee

The Social Values Committee attempted to identify values that were not directly quantifiable in outcomes data or in the mathematical approach

utilized by the Health Outcomes Committee. These less tangible values, such as age, productivity, equity, and access to care, would be considered by the HSC in adjusting and modifying the final prioritized list (Pollack et al. 1993). A list of important community-identified values was reviewed and categorized as being important in one or more of the following ways: value to society, value to an individual, and value as a component of a basic health care package. These value references were later used in sorting the list of condition-treatment pairs (Hasnain and Garland 1990a,b).

The Mental Health and Chemical Dependency Committee

The MHCD committee felt that the Kaplan methodology, because of its reductionistic approach, its bias toward acute conditions, and its lack of consideration for social costs, could be a significant obstacle to an equitable rating of mental health services. Therefore, the committee was faced with a critical strategy decision: members had to decide whether to play the game or to abandon the process and wait to see what happened next. There were multiple risks attached to complying with the process; of these, the most salient was the potential reduction in funding that would result from public mental health services not being funded under a separate budget and the loss of state-mandated mental health insurance benefits. Not complying carried the risk that the process might move ahead and require funding increases, thus squeezing mental health budgets or significantly delaying the planning for the integration of mental health services into a basic health care package. In either case, delay would perpetuate the disadvantages that mental health experienced vis-à-vis other health services.

The metaphor used in this discussion was that of a train leaving the station. The committee could choose to ride that train (the prioritization planning process) and retain the option of jumping off if and when it appeared that the process would end in an unfair outcome for mental health. Or the committee could choose not to ride the train, watch it leave, and hope for the best. However, it would be impossible, or at least extremely difficult, to catch up to the train once it had left the station. After much discussion, the committee agreed to participate in the process.

When the MHCD Committee was first presented with the QWB methodology, there were only two symptom clusters (one was trouble

learning or remembering or thinking clearly, the other was often feeling upset or depressed) that had any mental health content. The committee succeeded in adding symptom clusters that were relevant to MHCD conditions to the symptom list.

The MHCD Committee accurately predicted that the mental health symptoms would be heavily weighted by the general public in the telephone survey. Indeed, three of the symptom clusters with mental health content (problems with alcohol or drugs, trouble learning or remembering or thinking clearly, and frequent episodes of feeling upset or depressed) were among the five highest ranked of the 23 symptom clusters. Even though the survey and its weighting of the symptoms had minimal influence on the ultimate prioritization methodology, the recognition of the importance accorded to mental health symptoms by survey respondents supported the committee's efforts to achieve parity for mental health services.

At the same time that the QWB methodology was being introduced to the MHCD Committee, the Social Values Committee was developing its plans for obtaining public opinion on health care issues through a community meeting process. Unfortunately, the initial plans of the Social Values Committee excluded reference to types of care that explicitly related to mental health conditions. For example, the case vignettes for the community discussions were restricted to medical-surgical problems. The MHCD Committee proposed inclusion of two types of care specifically and uniquely related to mental health (crisis mental health services and alcohol and drug dependency services) in the list of service types to be described in the community meetings. The committee also urged that some case examples for other types of care be about mental health conditions.

Part of the committee's rationale for these recommendations stemmed from the well-established notion of the stigma associated with mental health conditions. The committee similarly was concerned about the mistaken perception that psychiatric conditions have no biological or other factors that would make them comparable to other medical conditions. It was considered essential and ethically responsible proactively to establish the links between mind and body for the public in the context of this combined educational and opinion-gathering effort.

The Social Values Committee accepted these recommendations and correspondingly altered the community meeting format. Not surprisingly, the outcome of the community meetings reflected a high public value for mental health and chemical dependency services. This expres-

sion of concern about mental health issues, as reflected through both the random survey and the community meetings, was repeated in 12 statewide public hearings held by the commission. At these hearings, interested citizens advocated the types of health coverage to be included in a basic plan. People from the mental health community were highly visible and outspoken in their views that mental health conditions be given sufficient coverage.

A key component of the prioritization process was obtaining data on outcomes and costs of different treatments (including no treatment) for assorted conditions (i.e., diagnoses). The Health Outcomes Committee was charged by the HSC with compiling these outcome data.

The MHCD Committee convinced the Health Outcomes Committee of the need to gather data on mental health and chemical dependency conditions as well as other health care conditions, rather than wait until a later phase of the planning process. Because of the enormous volume of work, the MHCD Committee ended up with this responsibility. The committee proceeded, in parallel with the Health Outcomes Committee, to review the data gathered on MHCD conditions and to evaluate the computerized mathematical analysis of that data. The committee solicited help from the various groups of mental health professionals who expressed interest in providing data. Participants represented all aspects of mental health practice: child, adult, and geriatric populations; public and private sectors; academic, administrative, and clinical practice arenas; and clinicians from the chemical dependency field.

Data were obtained from a variety of sources: clinicians' opinions; the medical and social science literature; and administrative data from hospitals, indemnity insurers, and HMOs. Clinicians were concerned that administrative data might be biased because they were derived primarily from health plans with limited mental health benefits (i.e., the state mandates). Consequently, a group of clinicians began to develop treatment guidelines for each condition that might be added to the prioritized list (McFarland et al. 1993). Although not specifying the exact nature of treatment, these guidelines suggest the optimal amount of service provided to the "average" patient diagnosed with a mental health or chemical dependency condition, including estimated hours of outpatient visits and days of hospitalization that can be expected for a population of persons seeking MHCD treatment (George et al. 1994). The guidelines were combined with epidemiological data to help compute capitated

payment rates to organizations enrolling Oregon Health Plan beneficiaries (McFarland et al. 1993).

While the MHCD data were being gathered, the MHCD Committee reviewed the literature on mental health care outcomes, mental health delivery systems, and the recommendations regarding the inclusion of mental health services in a national health plan (American Psychiatric Association 1989; Robins and Regier 1991; Upton 1983). This process included review of past and current mental health systems in the state and the planning efforts of the state mental health authority (Lippincott 1989).

The mental health providers' data were reviewed by the MHCD Committee. After minor revisions, the data were entered into the computer in order to calculate the QWB benefit-to-cost ratios. The computer-generated values for all condition-treatment pairs conceivably could be compared and incorporated into one prioritized list.

Prioritization Problems and Solutions

A major complication in the use of outcome and cost data led to severe criticism of the validity of the QWB methodology: Many (nonmental health) provider organizations declined to generate the outcomes and costs of minimal or no treatment (McFarland et al. 1993). There were also difficulties in defining the relevant costs and time periods (McFarland et al. 1993).

The MHCD data fortunately included fairly complete and reasonably well-defined cost estimates. These data were used to create three kinds of computer-generated lists: (1) those based on outcomes for optimal treatments only; (2) those based on ratios of outcomes for optimal treatments divided by the costs of the treatments; and (3) those based on "net" outcomes (i.e., outcomes of optimal treatment minus outcomes from no treatment) divided by the "net" costs (i.e., costs of optimal treatment minus costs of no treatment). The first and second methods led to implausible rankings in which disorders of mild severity (e.g., phobias) were accorded high priority. The third (net outcomes divided by net costs) approach approximated the intent of the methodology's designers (Kaplan and Anderson 1988) and yielded a ranking that appeared to have face validity.

Because the outcome and cost data for the nonmental health conditions were seriously incomplete, the MHCD Committee was able to demonstrate the invalidity of the proposed methodology. Indeed, when the first computer-generated list of all conditions was released in May 1990, this methodological flaw became apparent (Fox and Leichter 1991). The MHCD data experiment and associated testimony contributed to an HSC decision to revise its methodology.

An Alternative Methodology Committee was created to explore other approaches to prioritization, with or without use of the computerized data. Two members of the MHCD Committee became active participants on this new committee, which eventually adopted a categorization-of-services approach (Pollack et al. 1993). It created a list of categories of care (Appendix 2) that encompassed all current conditions and treatments. Approximately half of these categories represented special preventive or clinical services for circumstances not associated with actual treatment of pathological conditions. These items included categories like preventive health and dental care for adults and children, maternity care, infertility services, and reproductive services.

The remaining categories contained the pathological conditions and were defined in relation to the various combinations of answers to three questions:

1. Is the condition acute or chronic?
2. Is the condition one that carries a significant risk of death and for which treatment restores or extends the individual's life?
3. Is the condition one whose treatment restores the individual to a level of function at or close to the premorbid level?

The convention for describing these categories is exemplified in phrases like "acute fatal—treatment prevents death with full recovery" or "chronic fatal—treatment improves life span and quality of life."

The Alternative Methodology Committee found this approach to defining the categories particularly appealing because it potentially allowed the use of revised cost and outcomes data for sorting the various condition-treatment pairs into a category. Definitions of the variables represented by the three questions were linked to specific mathematical values found in the data provided for the QWB approach. The condition-treatment pairs were sorted by the computer into categories.

After review, the discrepant items were manually sorted into what was consensually agreed to be the proper category.

The HSC then ranked the overall categories to create the general shape of the entire prioritized list. In doing so, they considered the value of each category to society, to the individual who might need the service, and as a component of a basic health care package. The commissioners' responses proved to be internally consistent. Each category was sorted according to computer-generated data on benefits of treatment. The entire list was carefully reviewed, and the commissioners made many adjustments, using clinical judgments about specific line items and their importance relative to other lines. This new version was completed in the early spring of 1991.

The MHCD Committee used an identical methodology to sort and rank the MHCD conditions. The ultimate mental health list was reviewed and generally accepted as plausible and valid (Appendix 3). The MHCD Committee then inserted the mental health items into the overall list. The insertion process resembled the one used by the HSC in making final adjustments to the nonintegrated list. Namely, the MHCD items were compared with the nonpsychiatric conditions in the same section of the list (Appendix 4). In doing so, the severity of the condition and the importance attached to its treatment in the context of community-identified values were carefully considered. Another prioritizing principle was to place higher on the list than their sequelae disorders that, if untreated, could lead to more serious conditions. The objective was to prevent the progression of the illness.

The commission's decision to use the ranked categorization as the primary sorting method had a significant impact on the relative ranking of the mental health items in the list. Most of the major mental health conditions were in the highest categories of care (primarily categories 1, 3, and 5). In other words, the MHCD conditions, if they were to be integrated, would more likely be included in the upper (i.e., funded) portion of the list.

Having developed a plausible integrated list that appeared to achieve parity for mental health, the MHCD Committee referred the list to the HSC for approval. The committee also recommended incorporating specific preventive mental health services into the Oregon Health Plan (Oregon Health Services Commission 1991b, appendix J). This document expands previous attempts (U.S. Preventive Services Taskforce 1989) to

identify age-related health history, screening, and immunization interventions so that primary care providers can identify certain preventable health care problems. It includes similar interventions specifically related to MHCD conditions, and it identifies certain target populations that might be at greater risk for these conditions. Other recommendations addressed concerns about potential legislative inconsistencies, the need for MHCD representation on the HSC itself, and the need to develop a coherent and interconnected health care delivery system. The HSC endorsed and accepted the integrated list and all the recommendations except the proposal for integrating the delivery system; its members felt this concern was beyond the scope of the commission's mandate.

Return to the Legislature

The commission presented its recommendations, including the prioritized list, to the 1991 session of the state legislature and to the governor. The recommendations included a proposal that a substantial and irreducible majority of the list—all the items in the first 13 categories—be contained in the state's health care package. These categories were identified as essential (categories 1–9) or very important (categories 10–13). The last four categories were labeled “valuable to certain individuals but significantly less likely to be cost-effective or to produce substantial long-term gain.”

The 1991 state legislature accepted the recommendations and agreed to provide additional funding beyond the amount originally allocated. Thus the state Medicaid budget was to be increased to a level that would accommodate the inclusion of 587 of the 709 items on the nonintegrated list. This increase would have led to the inclusion of virtually all items in the first 13 categories of care. However, approval was contingent on obtaining a Medicaid waiver from the federal government (Fox and Leichter 1991, 1993), which was denied by the Bush administration in August 1992 (Menzel 1992).

Modifications were made to the original prioritized list addressing concerns raised by the U.S. Health Care Financing Administration (McFarland et al. 1993). They were necessary to enable the state to obtain the federal waiver from Medicaid regulations so that the Oregon Health Plan could be accepted for funding and implementation. The prioritized list—and the order of the MHCD items—was only minimally

altered. The rationale and method for these changes are discussed elsewhere (McFarland et al. 1993) and had little impact on the resulting list.

Oregon was granted the Medicaid waiver by the Clinton administration in March 1993. The 1993 state legislature then began a lengthy and tumultuous debate about financing the plan. In essence, the desire to provide increased access to health care conflicted with the state's budget shortfall. Employers also became concerned about the financial implications of providing health insurance for the working poor. Integration of mental health and chemical dependency services was an additional challenge.

After considerable acrimonious discussion (accompanied by intense lobbying from numerous advocacy groups, including the mental health and chemical dependency coalition), the legislature ended the longest session in Oregon's history by agreeing to fund the Medicaid portion of the plan. Sufficient state funds (augmented by a new tax on cigarettes) were appropriated to cover conditions through line 616 (see Appendix 2), thereby covering most mental disorders and chemical dependency. The aspects of the plan dealing with the uninsured working population and employer mandates were deferred until July 1997 (for larger employers) and January 1998 (for employers with 25 or fewer employees).

Implementation

The Medicaid component of the Oregon Health Plan began to be implemented on February 1, 1994, in several steps. First, the state Medicaid agency solicited proposals from managed care entities (chiefly HMOs) and received a greater response than expected. Some 20 programs (of which 16 are fully capitated HMOs providing both inpatient and outpatient services on a prepaid basis) agreed to serve Medicaid clients. Consequently, the vast majority of the state's Medicaid beneficiaries will be enrolled in HMOs. Clients in rural areas will be served by four "physician care organizations" (which are prepaid for outpatient but not inpatient services). Clients in extremely isolated areas will remain in the FFS program.

The second aspect of implementation is an outreach program to inform newly eligible Oregonians about the health plan. A private organization has contracted with the state Medicaid agency to conduct public meetings around the state and to publicize the health plan in a variety of other ways. The contractor also handles enrollment of newly eligible

persons. Existing Medicaid clients must choose a health plan (typically an HMO). There is considerable competition among the health plans to enroll Medicaid clients. Potentially eligible Oregonians have also shown substantial interest in the plan. During the first week of February 1994, the outreach program's telephone lines were jammed by over 18,000 inquiries about enrollment. State officials estimate that during 1994 the Medicaid program will grow from its current size of 250,000 to some 370,000 clients.

During 1994, mental health and chemical dependency services will remain "carved out" of the Oregon Health Plan. These services are delivered by local community mental health agencies (either components of county governments or private nonprofit organizations) on an FFS basis. However, beginning in January 1995, the health plans participating in the Medicaid program must offer outpatient chemical dependency services on a prepaid basis. Residential chemical dependency services are not covered by the state Medicaid program *per se*. However, the state alcohol and drug agency is exploring ways to include them in the capitated program. Interestingly, the legislation initiating the Oregon Health Plan requires the state to test the hypothesis that integrating physical health and chemical dependency services will result in an "offset" effect that ultimately reduces medical and surgical costs.

The state legislature also mandated phased integration of mental health services into the Oregon Health Plan. Starting January 1, 1995, up to 25 percent of Medicaid clients will be eligible for a special program designed to test the impact of full integration on utilization of physical health services. The 25 percent of selected Medicaid clients must be representative of both urban and rural parts of the state. The state Medicaid and mental health agencies have established a network of committees involving consumers, family members, and providers, who will assist in defining the implementation process.

The state mental health authority has stated that its ultimate goal is the development of a fully integrated system in which Medicaid clients choose to enroll in a single, prepaid managed care entity that is responsible for delivering physical and mental health as well as chemical dependency services. Health plans may use different models in moving toward that goal. Some organizations may elect to provide all services in house. More likely, however, health plans will subcontract for a variety of services delivered by a range of provider organizations. Conversely, provider organizations (such as community mental health centers) may

subcontract with several health plans. The goal is to provide enrollees with a seamless system that can address physical, mental, and chemical dependency needs while recognizing that resources are not unlimited.

Quality assurance will obviously be a concern in a program operating almost entirely by means of prepaid care systems. One approach to assure quality is to make use of the treatment guidelines (George et al. 1994). Although the guidelines do not dictate provision of specific types of mental health treatment, they do offer estimates for hours of outpatient treatments, days in hospital, and other services that would be expected in a population of persons using MHCD services for a given condition. This approach provides a framework for regulatory authorities to monitor quality assurance using administrative data.

Financing the MHCD component of the Oregon Health Plan is also of considerable interest (McFarland et al. 1993). Capitation payment rates have been calculated for the different categories of Medicaid clients (e.g., persons receiving Aid to Families with Dependent Children [AFDC] and individuals receiving SSI). There are 14 different categories of eligible persons. The rates were determined by several actuarial methods using private insurance data, Medicaid data, and the state mental health information system (McFarland et al. 1993). As noted, the treatment guidelines were married with population prevalence estimates to compute a priori estimates of the costs to provide MHCD services to this population (McFarland et al. 1993). The payment rates per person per month for MHCD services range from about \$10 for the AFDC group to \$300 for some classes of disabled persons. The MHCD costs per person per month are about \$35 (Oregon Health Services Commission 1993). The MHCD costs range from about 10 percent of the total (physical, dental, and MHCD) for some enrollee categories to nearly 40 percent for others. For the entire population it is estimated that MHCD will comprise 20 percent of the costs. The higher figures apply chiefly to enrollees with chronic mental disorders like schizophrenia. It is estimated that the majority of the state's chronically mentally ill population will become Medicaid clients in 1995, whereas only about half are now currently enrolled in Medicaid. Consequently, stop loss insurance will be available for purchase from the state by participating health plans.

These plans are expected to deliver (or arrange to deliver) a full range of MHCD services in exchange for these capitation rates. Enrollees are guaranteed diagnosis, triage, and medically necessary treatment. Services to be delivered include assessment, case management, consultation, in-

dividual and group treatment, medications, medication management, rehabilitative services (e.g., day treatment), residential mental health treatment for children or adolescents, and acute hospital care (Oregon Health Services Commission 1993). Arrangements for persons who may need long-term (i.e., more than 30 days) inpatient care (or its equivalent) are presently under discussion, as are services for civilly committed persons. The health plans are not responsible for serving either incarcerated enrollees or beneficiaries found guilty except for insanity. Publicly funded residential alcohol and drug services are also not included but may be eventually folded into the program. Despite these uncertainties, health plans and community mental health agencies have shown considerable interest in participating.

The Committee's Values and Strategies

What values and decision processes guided the MHCD Committee? How did these values influence the committee's list and its recommendations for integrating MHCD conditions into the overall health plan?

The committee's primary goal was to achieve equitable coverage for mental health services. The committee read numerous eloquent descriptions of the traditional lack of parity accorded mental health in benefit packages, reimbursement rates, and research (Frank and McGuire 1990; Havel 1992; Judd 1990; Malloy 1991; Sharfstein and Stoline 1992; Sharfstein, Stoline, and Goldman 1993). Notable causes of this inequity include the following:

1. historical prejudices
2. the false mind/body dichotomy
3. lack of visible and viable advocacy for the mentally ill
4. confusion about the definition of mental illness
5. the belief that mental health treatments are not effective
6. the fear or belief that mental health services are too expensive

Attempts to achieve parity in the United States and elsewhere have generally failed, partly because they have not established the comparability of MHCD conditions with other health problems (Cutler, Bigelow, and McFarland 1992; Rochefort 1992). Some attempts to achieve parity have overcompromised and perpetuated the inequity by essentially ex-

cluding "nonbiologic" mental health conditions from coverage (Domenici 1992). Under this strategy, legislation and litigation would mandate that persons with specific mental health conditions, such as schizophrenia and major mood disorders, be given insurance coverage equivalent to that for other major medical conditions.

This partial approach, although it may succeed, will not achieve parity, but will merely shift a few psychiatric conditions from "mind" to "body." Such an approach may further the notion of the mind-body split and could prevent appropriate coverage of other mental health conditions.

Insurance mandates have obtained some MHCD benefits but usually with less than generous levels of coverage (including, for example, caps on numbers of outpatient visits, hospital days, or total dollars allowed for MHCD services). Mandates generally provide a uniform limit on services without regard to severity of the condition or the effectiveness of treatment (Frank and McGuire 1990; *Health Benefits Letter* 1992; Sharfstein and Stoline 1992; Sharfstein, Stoline, and Goldman 1993).

Although international comparisons fall outside the scope of this article, it is nevertheless germane to mention that mental health services are included in the health care systems of most industrialized nations (Cutler, Bigelow, and McFarland 1992). However, the lack of parity has been noted in other countries as well (Rochefort 1992). Where MHCD services are provided, either coverage is inadequate or indiscriminate coverage (irrespective of severity or effectiveness) leads to shortages or delays in treatment.

The inability or unwillingness to determine medical necessity, that is, conditions needing treatment and treatments for them, has hamstrung attempts to achieve parity (Glazer 1992). This problem does not apply exclusively to the area of MHCD services, but rather to all of health care. However, the beliefs that MHCD conditions are not as serious as "physical" conditions, that their causes are nonbiological, "illegitimate," or "undeserving," or that treatments for them are ineffective undermine the argument for including MHCD conditions in an integrated health care delivery system.

The committee's strategy was to obtain parity and protect current levels of coverage by preventing erosion of MHCD benefits. Because the result of the prioritization process was initially uncertain, the committee pursued the optimal outcome and avoided harmful compromises.

The means for accomplishing these goals are listed here roughly in the order of their adoption:

1. Insist that integration is achievable while reducing or eliminating barriers to it.
2. Educate the commission members and staff, as well as the legislators and general public, on the following topics:
 - a. The legitimacy of MHCD conditions.
 - b. The significance of MHCD conditions as demonstrated by personal suffering (including but not limited to morbidity and mortality statistics), health care costs, loss of productivity, and other indirect costs.
 - c. The pervasiveness, prevalence, and variability of MHCD conditions.
 - d. The inseparability of mind and body.
3. Adhere to the accepted prioritization methodology used with medical-surgical conditions whenever possible.
4. Identify ways to modify the commission's methodology to assure equitable treatment for all health care conditions, including MHCD.

In articulating his strong support for the concept of rationing care, Callahan (1987, 1990) has described several values and criteria for constructing a rationing system. Some of the principles he presents, listed below, are similar to those employed by the Oregon participants:

1. Valuing the provision of "caring" when the pursuit of "cure" seems counterproductive, insensitive, or futile.
2. Balancing value to the community against value to the individual.
3. Balancing the life-saving or life-extending benefits of a treatment against its ability to enable the person to recover a sufficient level of functioning.

The prioritization process clearly placed a higher value on treatment that would relieve suffering and offer supportive care and a lower one on the pursuit of costly and questionable attempts to reverse or curtail untreatable disease. In this way it resembled Callahan's approach.

Prioritization and Its Discontents

Like any innovation, the Oregon Health Plan has drawn criticism. Some say that it "experiments on poor women and children" and contend that

a radical restructuring of the health care system should not be tried first on a potentially vulnerable population (Rosenbaum 1992). Some have suggested (only half in jest) that legislators should try the experiment on themselves (or perhaps all state employees) before changing Medicaid. Nevertheless, the Oregon Health Plan will result in increased health care services to the poor. The list of covered conditions is a generous definition of "basic health care." The early fears about rationing have not (to date) been reflected in the actual list of condition-treatment pairs.

Another objection is that the prioritization process is unscientific because cost and outcome data are still incomplete (and are imperfectly defined) for many medical conditions and treatments (LaPuma and Lawlor 1990; Steinbrook and Lo 1992). At the same time, there is a sense of urgency that permeates the entire health care reform issue. Scientific progress is usually assumed to begin with testing an idea or theory and then refining it until a meaningful and acceptable result is achieved. Policy change, like scientific progress, has not always required an idea to be perfect before it can be implemented. We believe that Oregon is justified in proceeding with its health plan (despite its incompleteness and imperfections) because it will improve only with use and experience. Moreover, many acknowledge that the proposed plan is superior to the current system of care. Were the situation reversed, such that the Oregon Health Plan represented the status quo, a proposal to switch to the previous system would not be seriously considered (Eddy 1991).

A parenthetical note is that criticism of the 1991 Oregon Health Plan and the resulting delay in federal approval of the Medicaid waiver denied perhaps 100,000 people access to health insurance for at least two years. Data from Franks, Clancy, and Gold (1993) on the relationship between lack of health insurance and mortality imply that this delay may have caused an excess mortality equal to 250 deaths.

Some have suggested that the debate about prioritization is irrelevant, giving as an example that there are hospitals in Oregon operating at less than optimal efficiency (Fisher, Welch, and Wennberg 1992; Schramm 1992; Wennberg 1990). Resources could be saved by making them as efficient as others in the state. Although these concerns are justified, they are not relevant in the long run. Shifting from FFS to prepaid health care may address many concerns about hospital efficiency and some about administrative efficiency.

In the longer run, moreover, prioritization is inevitable. Advances in health care technology are generally beneficial but rarely curative. Dialy-

sis is the classic example of a health care service that is worthwhile, even life saving, yet does not reduce but rather increases costs (Fuchs 1993). Conceivably, clozapine and assertive case management for persons with schizophrenia might show a similar pattern: worthwhile but not leading to savings. In this situation, prioritizing occurs either covertly or overtly. The beauty of the Oregon Health Plan is that mental health and chemical dependency have been explicitly included in the process.

Planners and policy makers have also debated the advisability of incremental versus fundamental change. Will the former be followed by enough further change to accomplish meaningful outcomes? Will the latter gain the political and cultural acceptability needed to achieve it? The Oregon Health Plan combines elements of a fundamental shift in organizing, financing, and delivering services and is an initial step toward further changes and improvements, especially the development of a health plan that would apply uniformly to all (Ellwood, Enthoven, and Etheridge 1992; Starr 1992; Starr and Zelman 1993).

To choose a metaphor from the context of medicine, it is absurd to think of achieving a "cure" for many serious and persistent health care problems; instead, caring treatment that alleviates suffering is appropriate when it is not possible to eliminate the primary cause of the illness. This concept applies on a larger scale to political decisions, which include the process of setting priorities. It may even be irresponsible to wait for a solution that is scientifically "correct" rather than developing one that is scientifically "informed." Rudolf Virchow's observation that "politics is merely the practice of medicine writ large" can be interpreted as saying that the policy maker is society's "care provider," and it may also be read as implying that the society, or "patient," may require timely, educated interventions that are not either fully developed or absolutely proven to be effective (Shoemaker et al. 1993).

The prioritization methodology itself may have applications and value beyond the Oregon Health Plan, for example, as part of a comprehensive managed care delivery system (Ellwood, Enthoven, and Etheridge 1992; Starr and Zelman 1993). This approach to defining medical necessity and a basic health care package could as easily be applied to a single payer national health insurance program. Indeed, representatives from the health ministries of Australia, Canada, Denmark, England, Germany, Greece, Japan, the Netherlands, and New Zealand have visited Oregon to study this methodology. Similarly, a single payer national health insurance bill that incorporates a prioritization policy has been in-

roduced in the U.S. Senate using virtually the same language as the Oregon legislation (U.S. Congress 1992).

Implications of Integration

The process of integrating mental health items into the overall list reverberates far beyond the Oregon Health Plan. The mental health list appears to satisfy several concerns of the mental health community regarding the need for adequate coverage (Little Rock Working Group 1993; Mental Health Liaison Group 1993). Integrating these items with other health conditions underlines the inseparability of mind and body, and, by extension, clarifies the utility of a comprehensive delivery system that includes mental health services.

The list integrates mental health conditions irrespective of their etiologies (organic, psychological, and social). Conditions and their treatments are ranked according to their severity as experienced by patients, whereas the benefit is measured by outcome and cost. The list reflects a high priority for biological conditions such as schizophrenia and major mood disorders. The ranking gives preference to conditions that have a greater impact on children. The list also prioritizes conditions, like post-traumatic stress disorder and eating disorders, that, despite the presumption of their presumably psychological or environmental roots, cause widespread suffering and loss of function (American Psychiatric Association 1987, 1993). This method is superior and more inclusive than that of attempting to achieve parity for the biologically based psychiatric disorders. Even if the Oregon Health Plan is not implemented, the experience demonstrates that effective parity for mental health can be achieved.

Beyond the critical issue of parity, other significant considerations in designing an integrated health care system can be listed;

1. Integrating MHCD into a basic health care package may eliminate or reduce the possibility that MHCD items could be carved out or subsequently treated in a discriminatory fashion.
2. The blending of MHCD and other conditions may clarify the value of preventive services. A major, but relatively unheralded, accomplishment of the MHCD Committee was the development of prevention guidelines for the early identification of MHCD conditions

by primary care providers (U.S. Preventive Services Taskforce 1989; Oregon Health Services Commission 1991b, appendix J). These guidelines include recommendations for persons who may be at risk of developing MHCD problems (e.g., children whose parents themselves have MHCD conditions) and suggest screening procedures. The capitated payment rates for health plans include amounts earmarked for MHCD preventive services.

3. Integration of MHCD conditions implies development of an integrated treatment system with these considerations:
 - a. It is essential to include services for long-term care. If the delivery system is predicated on capitation, it must integrate the whole continuum of services, from hospital to community, so that patients can be served in the least restrictive setting and the state mental hospital will not become the dumping ground for persons who are deemed outliers or beyond the scope of treatment (Mechanic and Rochefort 1992; Mechanic 1993).
 - b. If MHCD is to be effectively integrated, people should receive comprehensive diagnostic evaluations that consider MHCD symptoms, risk factors, and conditions, as well as other health conditions, irrespective of the locus of service (e.g., health clinic, mental health clinic, school, or correctional facility). Access to consultants in other disciplines is essential for primary care providers to understand and treat or to refer persons with MHCD conditions, and, conversely, for MHCD providers to obtain appropriate primary and other specialty care for their patients (Pincus 1987).
 - c. The concept of integration may extend to blending the public and private sectors. The traditional two- or three-tiered system of care may give way to one that provides care to individuals irrespective of their socioeconomic status and that tends less often to categorize mistakenly patients' problems as being of either the "mind" or the "body." Models of care delivery may encourage private providers to serve groups of patients, such as the chronically mentally ill, who have not been effectively served or who have been denied treatment in the past. Similarly, public providers may be able to serve a broader array of patients. Collaborative efforts between public and private provider organizations may develop, such that the combined expertise may provide a seamless set of resources for a group of

subscribers to a prepaid care system (Mechanic and Rochefort 1992; Mechanic 1993).

Role of the Mental Health Community in Health Care Reform

For the past few decades, psychiatry has been treated as a second-class citizen in the community of medical disciplines and specialties (Judd 1990). This experience of discrimination has led the profession at times to adopt an apologetic tone or to push for corrective action in a tentative or fearful manner.

In recent years, the crisis in health care, especially the dramatic increases in costs, has caused the mental health professions to feel that they are at risk of further isolation or marginalization in the health care system (Mental Health Policy Resource Center 1992). Now is the time for the mental health community assertively to establish a clear and equitable position for mental health services. Some national health care legislation is likely to be passed in the next few years. If parity for mental health is not obtained soon, it will signal a major lost opportunity, both for now and for the future (Judd 1990; Koyanagi et al. 1993; Little Rock Working Group 1993; Mental Health Liaison Group 1993; Mental Health Policy Resource Center 1992).

The experiences of the MHCD Committee and other mental health providers who participated in the Oregon Health Plan demonstrate two important points about mental health and health care reform. First, this process is a model for achieving true parity without tilting toward conditions that are legitimized by their "biological" foundation. Second, mental health providers can and should be active participants in health care reform. Psychiatry can provide more insight and depth through its biopsychosocial perspective. Psychiatric understanding of group process can aid the complex decision making that goes into creating major change in the health care delivery system.

The debate in Oregon's legislature foreshadows national discussion on health care reform and the integration of mental health services into a larger system of care (Mechanic 1993). Especially troubling to legislators were the costs of increased access, the untested approaches for implementing the integration of services, and the financial implications of caring for severely mentally ill persons who previously had limited access to

services. Interestingly, the state legislation (and the federal Medicaid waiver) requires a detailed evaluation of this new approach to universal health care. Particularly intriguing is the "natural experiment" afforded by the planned phasing in of mental health services. Perhaps research may add weight to the moral argument that we must end discrimination against persons affected by mental illness.

Conclusion

We have presented a description of the process by which mental health services were included in the basic health care package for a controversial state health reform plan. The methods, values, and strategies for achieving mental health parity have been detailed and discussed. The implications for integration of mental health are far reaching and may apply to other, very different, health care systems. An increased, more respected, role for mental health professionals in the health reform process has been advocated. The opportunity to achieve parity for mental health must not be delayed or compromised, because to do so would worsen the lives of persons already affected by the trauma and stigma associated with mental illness.

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Appendix 1

Major Symptoms

1. Loss of consciousness such as seizure (fits), fainting, or coma (out cold or knocked out)
2. Burn over large areas of face, body, arms, or legs
3. Pain, bleeding, itching, or discharge (drainage from sexual organs—does not include normal menstrual [monthly] bleeding)
4. Trouble learning, remembering, or thinking clearly
5. Any combination of one or more hands, feet, arms, or legs either missing, deformed (crooked), paralyzed (unable to move), or broken—includes wearing artificial limbs or braces
6. Pain, stiffness, weakness, numbness, or other discomfort in chest, stomach (including hernia or rupture), side, neck, back, hips, or any joints or hand, feet, arms, or legs
7. Pain, burning, bleeding, itching, or other difficulty with rectum, bowel movements, or urination (passing water)
8. Sick or upset stomach, vomiting or loose bowel movement, with or without fever, chills, or aching all over
9. General tiredness, weakness, or weight loss
10. Coughing, wheezing, or shortness of breath, with or without fever, chills, or aching all over
11. Spells of feeling upset, being depressed, or crying
12. Headache, or dizziness, or ringing in ears, or spells of feeling hot, or nervous, or shaky
13. Burning or itching rash on large areas of face, body, arms, or legs
14. Trouble talking, such as lisp, stuttering, hoarseness, or being unable to speak

(continued)

Appendix 1 (continued)

Major Symptoms

15. Pain or discomfort in one or both eyes (such as burning or itching) or any trouble seeing after correction
 16. Overweight for age and height or skin defect of face, body, arms or legs, such as scars, pimples, warts, bruises, or changes in color
 17. Pain in ear, tooth, jaw, throat, lips, tongue; several missing or crooked permanent teeth—includes wearing bridges or false teeth; stuffy runny nose, or any trouble hearing—includes wearing a hearing aid
 18. Taking medication or staying on a prescribed diet for health
 19. Wearing eyeglasses or contact lenses
 20. Has trouble falling asleep or staying asleep
 21. Has trouble with sexual interest or performance
 22. Is often worried
 23. Has trouble with the use of drugs or alcohol
-

Source: Based on Kaplan, Debon, and Anderson 1991.

Appendix 2

Ranked Categorization of Services

Seventeen (17) categories of health services determined by the commission, ranked from most to least important^a

1. *Acute fatal*: treatment prevents death with full recovery
2. *Maternity care*
3. *Acute fatal*: treatment prevents death without full recovery
4. *Preventive care for children*
5. *Chronic fatal*: treatment improves life span and quality of life
6. *Reproductive services*: (excludes maternity and infertility services)
7. *Comfort care*: palliative therapy for conditions in which death is imminent
8. *Preventive dental care*
9. *Proven effective preventive care for adults*
10. *Acute nonfatal*: treatment causes return to previous health state
11. *Chronic nonfatal*: one-time treatment improves quality of life
12. *Acute nonfatal*: treatment without return to previous health state
13. *Chronic nonfatal*: repetitive treatment improves quality of life
14. *Acute nonfatal*: treatment expedites recovery of self-limiting conditions
15. *Infertility services*
16. *Less effective preventive care for adults*
17. *Fatal or nonfatal*: treatment causes minimal or no improvement in quality of life

Examples of MHCD services by category^b

1. Major depression, single episode; acute posttraumatic stress disorder and drug-induced delirium
 3. Alcohol and drug abuse diagnoses
 5. Dysthymia, chronic post-traumatic stress disorder, eating disorders, bipolar disorder, recurrent major depression, and schizophrenia
-

^aMost categories are either acute or chronic, fatal or nonfatal, with treatment improving either quality or length of life.

^bMost are in categories 1, 3, and 5.

Source: Oregon Health Services Commission.

Appendix 3

Mental Health Conditions from the Oregon Health Plan's Integrated Prioritization List^a

Line placement on integrated list	Diagnosis/condition
1. 88	Rumination disorder of infancy
2. 143	Anorexia nervosa
3. 144	Reactive attachment disorder of infancy or early childhood
4. 158	Schizophrenic disorders
5. 159	Major depression, recurrent
6. 160	Bipolar disorders
7. 181	Abuse or dependence on psychoactive substance
8. 182	Major depression; single episode or mild
9. 183	Brief reactive psychosis
10. 184	Attention deficit disorders with hyperactivity or undifferentiated
11. 237	Acute post-traumatic stress disorder
12. 238	Separation anxiety disorder
13. 260	Adjustment disorders
14. 261	Oppositional defiant disorder
15. 262	Tourette's disorder and tic disorders
16. 296	Chronic post-traumatic stress syndrome
17. 297	Obsessive-compulsive disorders
18. 330	Panic disorder with and without agoraphobia
19. 331	Agoraphobia without history of panic disorder
20. 365	Conduct disorder, mild/moderate: solitary aggressive, group type, undifferentiated

(continued)

Appendix 3 (continued)

Mental Health Conditions from the Oregon Health Plan's
Integrated Prioritization List^a

Line placement on integrated list	Diagnosis/condition
21. 366	Overanxious disorder
22. 367	Bulimia nervosa
23. 368	Anxiety disorder, unspecified; generalized anxiety disorder
24. 382	Paranoid (delusional) disorder
25. 415	Dysthymia
26. 416	Acute delusional mood anxiety, personality, perception and organic mental disorder caused by drugs; intoxication
27. 417	Borderline personality disorder
28. 418	Identity disorder
29. 419	Schizotypal personality disorders
30. 424	Conversion disorder, child
31. 425	Functional encopresis
32. 426	Avoidant disorder of childhood or adolescence; elective mutism
33. 427	Psychological factors affecting physical conditions (e.g., asthma, chronic gastrointestinal conditions, hypertension)
34. 457	Eating disorder NOS
35. 458	Dissociative disorders: depersonalization disorder; multiple personality disorder; dissociative disorder NOS; psychogenic amnesia; psychogenic fugue
36. 459	Chronic organic mental disorders including dementias
37. 474	Stereotypy/habit disorder and self-abusive behavior due to neurological dysfunction
38. 518	Simple phobia
39. 519	Social phobia
40. 578	Impulse disorders
41. 579	Sexual dysfunction
42. 580	Conduct disorder, severe
43. 581	Somatization disorder; somatoform pain disorder
44. 632	Factitious disorders
45. 633	Hypochondriasis; somatoform disorder; NOS and undifferentiated
46. 634	Conversion disorder, adult
47. 650	Pica
48. 681	Personality disorders excluding borderline, schizotypal, and antisocial

49.	682	Gender identification disorder
50.	697	Transsexualism
51.	727	Antisocial personality disorder

^aApril 1993 version.

Abbreviation: NOS, not otherwise specified.

Source: Oregon Health Services Commission.

Appendix 4

MHCD and Nonpsychiatric Conditions

Examples of how certain MHCD diagnoses are ranked in relation to nonpsychiatric conditions^a

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- 156: Asthma
 - 157: Respiratory failure
 - 158: *Schizophrenic disorders*
 - 159: *Major depression, recurrent*
 - 160: *Bipolar disorders*
 - 161: Burn full thickness greater than 10 percent of body surface
 - 162: Pemphigus
 - 163: Disorders of fluid, electrolyte, and acid-base balance
 - 164: Thyrotoxicosis with or without goiter, endocrine exophthalmos; chronic thyroiditis
 - 165: Hypertensive heart and renal disease

 - 177: Fracture of hip, closed
 - 178: Hereditary angioneurotic edema
 - 179: Lymphoid leukemias other than acute lymphocytic leukemia
 - 180: Preventive services for adults with proven effectiveness
 - 181: *Abuse of or dependence on psychoactive substance*
 - 182: *Major depression; single episode or mild*
 - 183: *Brief reactive psychosis*
 - 184: *Attention deficit disorders with hyperactivity or undifferentiated*
 - 185: Hypertension and hypertensive disease
 - 186: Ulcers, gastritis, and duodenitis
 - 187: Cancer of endocrine system, treatable
 - 188: Cancer of testis, treatable

 - 361: Atherosclerosis, peripheral
 - 362: Congenital pulmonary valve stenosis
 - 363: Rheumatoid arthritis and other inflammatory polyarthropathies
 - 364: Rheumatoid arthritis, osteoarthritis, and aseptic necrosis of bone

(continued)

Appendix 4 (*continued*)

MHCD and Nonpsychiatric Conditions

Examples of how certain MHCD diagnoses are ranked in relation to nonpsychiatric conditions^a

- 365: *Conduct disorder, mild/moderate: solitary aggressive, group type, undifferentiated*
366: *Overanxious disorder*
367: *Bulimia nervosa*
368: *Anxiety disorder, unspecified; generalized anxiety disorder*
369: *Esophagitis*
370: *Nonsuperficial open wounds*
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^aApril 1993 version of the integrated prioritization list.

Source: Based on material from the Oregon Health Services Commission.