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Medicare and Medicaid Issue Area

Active Assignments

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Foreword

This report was prepared primarily to inform Congressional members and key staff of ongoing assignments in the General Accounting Office's Medicare and Medicaid issue area. This report contains assignments that were ongoing as of July 6, 1995, and presents a brief background statement and a list of key questions to be answered on each assignment. The report will be issued quarterly.

This report was compiled from information available in GAO's internal management information systems. Because the information was downloaded from computerized data bases intended for internal use, some information may appear in abbreviated form.

If you have questions or would like additional information about assignments listed, please contact Sarah Jaggar, Director, on (202) 512-7119; Jonathan Ratner, Associate Director, on (202) 512-7107; or William Scanlon, Associate Director, on (202) 512-4561.

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Medicare and Medicaid

MEDICARE PAYMENT METHODS

TITLE: **HRA 5: MEDICARE PAYMENTS FOR MEDICAL SUPPLIES AND SURGICAL DRESSINGS (101310)**

BACKGROUND : Medicare has paid unusally high amounts for surgical dressings, according to recent congressional hearings. HCFA is attempting to address this problem by strengthening controls on Part B carriers, but has not addressed it for Part A intermediaries. HCFA's recent expansion of its surgical dressing benefits adds to concerns about controls.

KEY QUESTIONS : (1)What circumstances allowed the payment of unusally high surgical dressing claims? (2)Are Medicare's current internal controls adequate to prevent the payment of such claims?

TITLE: **MEDICARE COSTS UNDER THE RBRVS SYSTEM (101329)**

BACKGROUND : In 1992, Medicare stopped paying doctors based on "usual and customary rates." Medicare's new fee schedule incorporates estimates of doctors' (a) time and effort, (b) practice costs, and (c) malpractice insurance costs. Fees are updated based on total physician expenditures in prior years. This payment method was expected to control Medicare costs and encourage primary care.

KEY QUESTIONS : (1) How has the new system changed physician fees and total expend- itures? (2) Have changes in physician fees affected the number and type of physician services under Medicare? (3) Could changes to Medicare's formula for updating fees yield additional savings? (4) How might other proposed changes to Medicare's physician payment system affect program costs?

TITLE: **TESTIMONY ON "MEDICARE'S METHOD FOR PAYING HMOS NEEDS TO BE REFORMED" (101350)**

BACKGROUND : Under the Medicare risk contract program, HMOs are paid a capitated rate (theAAPCC) for each Medicare beneficiary they attract. The current method for determining AAPCC rates is considered flawed in several respects--resulting in rates too high in some places and too low in others. As a result, participation in, or access to, managed care option is very low in some areas.

KEY QUESTIONS : (1) Describe the problems with the current method of determining the AAPCC. (2) What are the possible short-term and long-term solutions to these problems? (3) What are the known merits or shortcomings of the various solution options?

MEDICARE PAYMENT METHODS

TITLE: **MEDICARE REIMBURSEMENT OF PROVIDERS' LEGAL EXPENSES (101353)**

BACKGROUND : Current Medicare regulations treat providers' legal expenses as allowable charges. As a result, the Medicare program may be unintentionally encouraging unscrupulous providers to bring unfair and frivolous suits against fiscal intermediaries and HCFA.

KEY QUESTIONS : 1) Has HCFA issued guidelines to fiscal intermediaries that describe the conditions under which providers' legal fees are reimbursable by Medicare? 2) Has HCFA compiled information that would allow it to determine how much Medicare spends annually on providers' legal costs? 3) Are certain types of providers more likely to appeal denied claims and cost report adjustments?

TITLE: **REVIEW OF END STAGE RENAL DISEASE (ESRD) MEDICAL SERVICES (106416)**

BACKGROUND : Providers of dialysis treatments for End Stage Renal Disease (ESRD) patients receive two types of payments from Medicare--(1) a standard fixed "composite rate" payment for each treatment provided and (2) payments for "separately billable" services that are not included in the composite rate.

KEY QUESTIONS : (1) Does the current composite rate payment include services that are not actually provided? (2) Which, if any, separately-billable services could potentially be included in a future prospectively-determined composite rate?

TITLE: **RECENT GROWTH OF MEDICARE HOME HEALTH CARE (106422)**

BACKGROUND : Medicare home health has experienced tremendous growth in recent years and is presently the most rapidly growing component of Medicare expenditures. Medicare home health benefit expenditures have grown from $2.12 billion in 1988 to $10.5 billion in 1993; HCFA predicts that expenditures will reach $22.3 billion in 1999.

KEY QUESTIONS : 1) How have utilization patterns changed in the past 5 years? 2) What current control problems exist in paying for this benefit? 3) How can Medicare expenses for the home health care benefit be brought under control?

MEDICARE PAYMENT METHODS

TITLE: **REVIEW OF IMPLEMENTATION OF MEDICARE INSURED GROUP (MIG) DEMONSTRATION PROJECTS (106426)**

BACKGROUND : OBRA 87 (P.L. 100-203, S.4015) authorizes HHS to conduct 3 demonstration projects coordinating Medicare with employer or union sponsored retiree health plans. The law also sets restrictions and requirements involving capitation payments & other procedures. GAO is required to monitor & report periodically on the status of each project.

KEY QUESTIONS : (1) What is the status of HCFA contracts awarded to study MIG health plan projects? (2) How have OBRA 87 requirements affected MIG projects and are these requirements being met? (3) How are MIG projects being implemented and what data is being used to assess them?

TITLE: **UTILIZATION PATTERNS OF HOSPITAL-BASED HOME HEALTH AGENCIES (106428)**

BACKGROUND : Use of the Medicare home health beneift has increased dramatically in the last 5 years - with expenses to Medicare growing from $2.2 billion in 1989 to $12 billion in 1994. Much of this growth has occurred among hospital-based HHAs. In 1989 there were 1,486 hospital-based HHAs; in March 1995, 2,279 hospital-based HHAs were providing services to Medicare beneficiaries.

KEY QUESTIONS : 1) What are the utilization patterns of hospital-based home health agencies compared to other types of HHAs?

MEDICAID ACCESS

TITLE: **FEDERAL PROGRAMMING AND STATE INNOVATIONS IN LONG-TERM SERVICES FOR PERSONS WITH MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (101341)**

BACKGROUND : States have used Medicaid waivers to shift the locus of services for adults with mental retardation and developmental disabilities, from institutional care, where per capita costs are above $80,000 a year, to services delivered mainly at home or in the community. With this shift in services, questions have arisen about affects on costs, access to services, and service quality.

KEY QUESTIONS : (1) Examine how states use Medicaid waiver flexibility to provide care for adults with developmental disabilities in the community rather than in institutions, (2) review lessons from state experience on how to contain costs and the effect of cost control on access to services, and (3) examine state experience in assuring service quality.

MEDICAID ACCESS

TITLE: **COST OF STATEWIDE MEDICAID 1115 WAIVERS (101343)**

TITLE: **HEALTH CARE REFORM: STATES' USE OF MEDICAID WAIVERS TO EXPAND ACCESS (108200)**

BACKGROUND : State health care reform initiatives have confronted three serious roadblocks: (1) the inability to tax/regulate self-insured employer health plans, (2) state budget shortfalls, and (3) federal restrictions on the delivery of Medicaid services. The administration seems willing to remove this last impediment by quickly approving Medicaid waivers.

KEY QUESTIONS : (1) How are states using Medicaid 1115 demonstration waivers to expand access to health care coverage? (2) How are these expansions being financed? (3) How do these demonstration waivers interface with broader state health care initiatives?

MEDICARE/MEDICAID MANAGEMENT

TITLE: **MEDICARE/MEDICAID BILLING ABUSES BY PROVIDERS OF PRODUCTS AND SERVICES TO NURSING HOME RESIDENTS (101291)**

BACKGROUND : Since implementation in 1990 of the Nursing Home Reform Act, some states have seen an increasing oversupply of products and rehabilitation services to nursing home residents and thus excessive charges to Medicare and to Medicaid. State officials believe entrepreneurs are seizing new opportunities to take advantage of program loopholes and bypass program safeguards.

KEY QUESTIONS : 1. Is there evidence of inappropriate and abusive billings for services and supplies to nursing facility residents? 2. What factors make Medicare and Medicaid vulnerable to such abuses? 3. How can these programs reduce wasteful payments for nursing home residents and billing abuses by providers?

MEDICARE/MEDICAID MANAGEMENT

TITLE: **MEDICARE'S USE OF DATA TO MONITOR PERFORMANCE OF HMOS (101315)**

BACKGROUND : HMO growth remains strong in Medicare. Past GAO work focused on problems in the care provided to enrollees in Medicare HMOs reimbursed through capitation payments. The Senate Special Committee on Aging and the Subcommittee on Health, House Ways and Means Committee, would like GAO to assess the strength of HHS' monitoring and enforcement procedures to assure the quality of care.

KEY QUESTIONS : (1) What assurances does the government provide that Medicare beneficiaries in HMOs receive the medical services to which they are entitled? (2) Is the appeals process effective for resolving disputes over HMO refusals to provide care? (3) Is HHS' oversight process supported by credible enforcement tools and procedures?

TITLE: **HCFA'S ROLE IN THE MEDICAID WAIVER PROCESS (101327)**

BACKGROUND : Section 1115, SSA Act, authorizes HCFA to waive Medicaid requirements to test innovations to enhance access or quality. States are increasingly using waivers to significantly change their programs, including expanding eligibility. Concern exists that the original purpose and protections of Medicaid may not be served and about potential increases in federal costs.

KEY QUESTIONS : How does HCFA's Medicaid 1115 waiver review and approval process ensure that (1) the costs of the projects will not exceed the traditional program costs, (2) the implementation is adequately planned, and (3) health care will be accessible and of good quality?

TITLE: **PROBLEMS AND POTENTIAL IMPROVEMENTS IN HCFA'S PROGRAM ADMINISTRATION AND MANAGEMENT (101339)**

BACKGROUND : Much of our recent work on Medicare fraud and abuse has identified shortcomings in program safeguards and undue delays in implementing changes (e.g. job code 101311). This aspect also arises in our ongoing assignment on controlling Medicare costs (101336). The committee has asked us to elaborate on these issues and explore ways to achieve improvement.

KEY QUESTIONS : The committee asked us to address three specific questions. 1) What statutory impediments are faced by HCFA in improving its program management? 2) What criteria are applied to providers seeking authorization to bill Medicare? 3) What concessions does HCFA make to "start-up" companies serving Medicare beneficiaries?

MEDICARE/MEDICAID MANAGEMENT

TITLE: **TESTIMONY ON MEDICARE FRAUD AND ABUSE (101355)**

KEY QUESTIONS : Using ongoing and past work on fraud, waste, and abuse (1) what weaknesses make Medicare vulnerable to exploitation and (2) what issues need to be addressed to make Medicare less vulnerable?

TITLE: **ESTABLISHING ACCOUNTABILITY STANDARDS FOR A MEDICAID BLOCK GRANT (101356)**

KEY QUESTIONS : (1) How could the Single Audit Act be utilized in establishing accountability standards for a Medicaid block grant?; (2) How could the Government Performance and Results Act be utilized in establishing accountability standards for a Medicaid block grant?

TITLE: **MEDICAID: STATEWIDE SECTION 1115 DEMONSTRATIONS' IMPACT ON ELIGIBILITY, SERVICE DELIVERY, AND PROGRAM COSTS (101357)**

MEDICARE/MEDICAID MANAGEMENT

TITLE: **HCFA WASTE, FRAUD, AND ABUSE IN THE MEDICARE PROGRAM (101359)**

TITLE: **FORMULA OPTIONS FOR SLOWING GROWTH IN MEDICAID (118115)**

BACKGROUND : Over the past decade, Medicaid costs have quadrupled from $35 billion in 1983 to $131 billion in 1993. To slow the growth in federal spending, the Congress is likely to consider changes in the formula used to determine state reimbursements. Such changes could range from a simple scale back in current reimbursement rates to a block grant with a predetermined appropriation.

KEY QUESTIONS : What are the potential effects on states' Medicaid programs if federal matching payments are reduced?

ALTERNATIVE FINANCING & DELIVERY MODELS

TITLE: **REVIEW OF THE TENNCARE MANAGED CARE PROGRAM FOR MEDICAID BENEFICIARIES AND UNINSURED PERSONS (101308)**

BACKGROUND : Tennessee has been experiencing budget shortfalls due to limited growth in revenues and high growth in Medicaid expenditures. In order to improve access to health care and expand coverage to the state's uninsured population, the state has implemented a prepaid managed care program. The plan has been criticized by experts. HHS approved the program as an R&D waiver.

KEY QUESTIONS : (1) How is the TennCare Program funded? (2) In funding the program, is there cost shifting occuring between the state and federal governments? (3) Are the capitation rates set reasonable and are the managed care organizations financially sound? and (4) What is the status of the program's quality assurance systems and what does it tell us about adequacy of care?

ALTERNATIVE FINANCING & DELIVERY MODELS

TITLE: **REVIEW OF ARIZONA'S HEALTH CARE COST CONTAINMENT SYSTEM (101325)**

BACKGROUND : The Arizona Health Care Cost Containment System (AHCCCS), operating under an 1115 waiver, is a state-wide Medicaid managed care program with reportedly low cost growth. AHCCCS has nearly 450,000 enrollees, 1/3 living in rural areas. The state's competitive process for awarding contracts and accurate encounter data to set capitation rates are often cited as reasons for success.

KEY QUESTIONS : 1. How has AHCCCS controlled cost growth over the last 4 years, how does it compare to other states, and what factors contribute to the differences? 2. Has AHCCCS succeeded in establishing adequate managed care provider networks, particularly in rural areas? 3. How does AHCCCS oversee quality of care and what are future expansion plans?

TITLE: **REVIEW OF ACCESS TO MEDICAL SERVICES UNDER RURAL NETWORKS (106425)**

BACKGROUND : To maintain access to health care without expending large Medicare sums to keep rural hospitals operating, in 1989 Congress authorized a HCFA program to build networks among essential community hospitals (EACHs) & rural primary care hospitals (RPCHs). RPCHs will downsize & adopt a mission to provide ambulatory care & stabilize sicker patients for transfer to EACHs.

KEY QUESTIONS : (1) How is the Essential Access Community Hospital (EACH) program and the Rural Primary Care Hospital (RPCH) program achieving the goal of maintaining access to medical services in rural areas? (2) How have recent changes in the law affected this goal.

OTHER ISSUE AREA WORK: MEDICARE AND MED

TITLE: **HCFA MANAGEMENT OF MEDICARE MEDICAL POLICIES (101307)**

BACKGROUND : Although Medicare is a national program, carriers establish most medical coverage policies with little federal oversight. These policies which determine when medical services are paid or denied vary widely by carrier. While some carriers have effective policies to protect program dollars, other carriers without policies pay for inappropriate medical services.

KEY QUESTIONS : (1) How do Medicare carriers decide which procedures require medical policies and payment controls; (2) what is the impact of medical policies and payment controls on Medicare benefits and spending; and (3) what should be the role of the Health Care Financing Administration (HCFA) in managing carrier medical policies and payment controls?

OTHER ISSUE AREA WORK: MEDICARE AND MED

TITLE: **STUDY OF MERGERS AND ALLIANCES BETWEEN PHARMACEUTICAL MANUFACTURERS AND PHARMACY BENEFIT MANAGEMENT COMPANIES (101316)**

BACKGROUND : Recent mergers and alliances between drug manufacturers and pharmacy benefit management companies (PBMs) have changed the drug industry. Because PBMs control drug costs through formularies and price negotiations with manufacturers, there are questions about the effect these ventures may have on drug prices and competition in the industry.

KEY QUESTIONS : (1) What are the objectives of the recent mergers and alliances? (2) What concerns exist about their impact on competition? (3) To what extent, if any, have the PBMs given preference to their manufacturer partners' drugs? (4) What procedures have the manufacturers and PBMs developed to ensure that the manufacturers' drugs are not given unwarranted preference?

TITLE: **INAPPROPRIATE PRESCRIPTION DRUG USE AMONG THE ELDERLY (101328)**

BACKGROUND : A study based on 1987 data, estimates that almost 25 percent of the elderly are prescribed drugs inappropriate for their age group. The prescribing of inappropriate drugs can cause unnecessary medical complications, such as hospitalization and even death, and result in higher medical costs borne in part by either Medicare or Medicaid.

KEY QUESTIONS : (1) Is the prescribing of inappropriate drugs to the elderly still a significant problem? (2) What are the causes of inappropriate prescribing? (3) How do physicians, pharmacists, and patients obtain information about drugs? (4) How have trends in the health care system affected prescribing of inappropriate drugs to the elderly?

TITLE: **MANAGED HEALTH CARE TRENDS IN THE PRIVATE SECTOR AND THE MEDICARE PROGRAM (101333)**

BACKGROUND : Managed care plans enroll about half of the people with employer-sponsored health insurance. As employers pursue cost control strategies, these enrollments will grow. In contrast, managed care plans enroll only 9% of Medicare beneficiaries. Inspired by the private sector, many in the Congress hope to curb Medicare spending by expanding managed care greatly.

KEY QUESTIONS : (1) What are the trends in managed care in both Medicare and non-Medicare markets? (2) What factors have influenced managed care plans to enter the Medicare market? (3) What new efforts (e.g., new product and marketing strategies) are managed care plans now undertaking to increase their Medicare enrollments?

OTHER ISSUE AREA WORK: MEDICARE AND MED

TITLE: **REVIEW OF FEDERAL OVERSIGHT OF FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES (101342)**

BACKGROUND : HCFA's Medicaid program spends about $10 billion per year to support nearly 150,000 persons with mental retardation or other developmental disabilities in residential facilities. Several news accounts and reports by GAO and others have identified continuing problems with standards of care and protection of resident rights in many of these facilities.

KEY QUESTIONS : GAO was asked to (1) determine the extent of federal oversight of large residential facilities for persons with developmental disabilities; (2) describe the problems related to quality of care and residents' rights that have been identified; and (3) examine actions and follow-up efforts taken by HCFA and the Department of Justice (DOJ) to correct identified deficiencies.

TITLE: **REVIEW OF LOCAL JURISDICTIONS CONTRIBUTION TO THE NON-FEDERAL COST OF MEDICAID (101345)**

KEY QUESTIONS : (1) What financial contributions do localities in the various states make, if any, to non-federal Medicaid matching funds?

TITLE: **FRAUD AND ABUSE IN MANAGED HEALTH CARE (101349)**

BACKGROUND : As managed health care evolves and serves more Americans, concerns about new fraud and abuse schemes are increasing. There are concerns about (1) financial arrangements that create the incentive to underserve, (2) marketing abuses such as false enrollments, and (3) the lack of mechanisms to ensure that beneficiary rights are protected.

KEY QUESTIONS : (1) What types of managed care fraud and abuse schemes occur? (2) How do such activities differ from health care fraud and abuse in a fee-for-service environment? (3) What is the status of activities to address fraud and abuse in managed care plans?

OTHER ISSUE AREA WORK: MEDICARE AND MED

TITLE: **DISABLED MEDICARE BENEFICIARIES' ABILITY TO OBTAIN DURABLE MEDICAL EQUIPMENT (106417)**

BACKGROUND : Medicare is consolidating claims processing for DME at 4 regional carriers (RCs). These RCs proposed major changes to medical review criteria for DME that could restrict patient access to such equipment, especially customized equipment used by disabled beneficiaries.

KEY QUESTIONS : (1) Do Medicare carriers' coverage criteria restrict disabled beneficiaries' access to customized durable medical equipment (DME)? (2) What have been the trends in assignment and denial rates for customized DME? (3) How have these trends affected disabled beneficiaries' liability for amounts not paid for by Medicare?

TITLE: **LOSS RATIO EXPERIENCE FOR MEDIGAP INSURANCE IN 1992 (106423)**

BACKGROUND : Our prior work for Chairman Stark made significant improvements in the regulation of Medigap insurance purchased by 25 million elderly Medicare beneficiaries. This year, for the first time, many years of data on loss ratios for individual policies will be available. This will enable us to provide needed new analyses on Medigap insurance to the Congress.

KEY QUESTIONS : (1) What was the loss ratio experience of Medigap policies in 1992 and how did that experience compare with 1988-91? (2) How many insurers failed to meet federal loss ratio requirements?

TITLE: **MEDICARE PART B: FACTORS THAT CONTRIBUTE TO VARIATION IN DENIAL RATES FOR MEDICAL NECESSITY ACROSS SIX CARRIERS (TESTIMONY) (973426)**