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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 Health Financing and Systems issue area. This report contains assignments that were ongoing as of August 17, 1998, 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.

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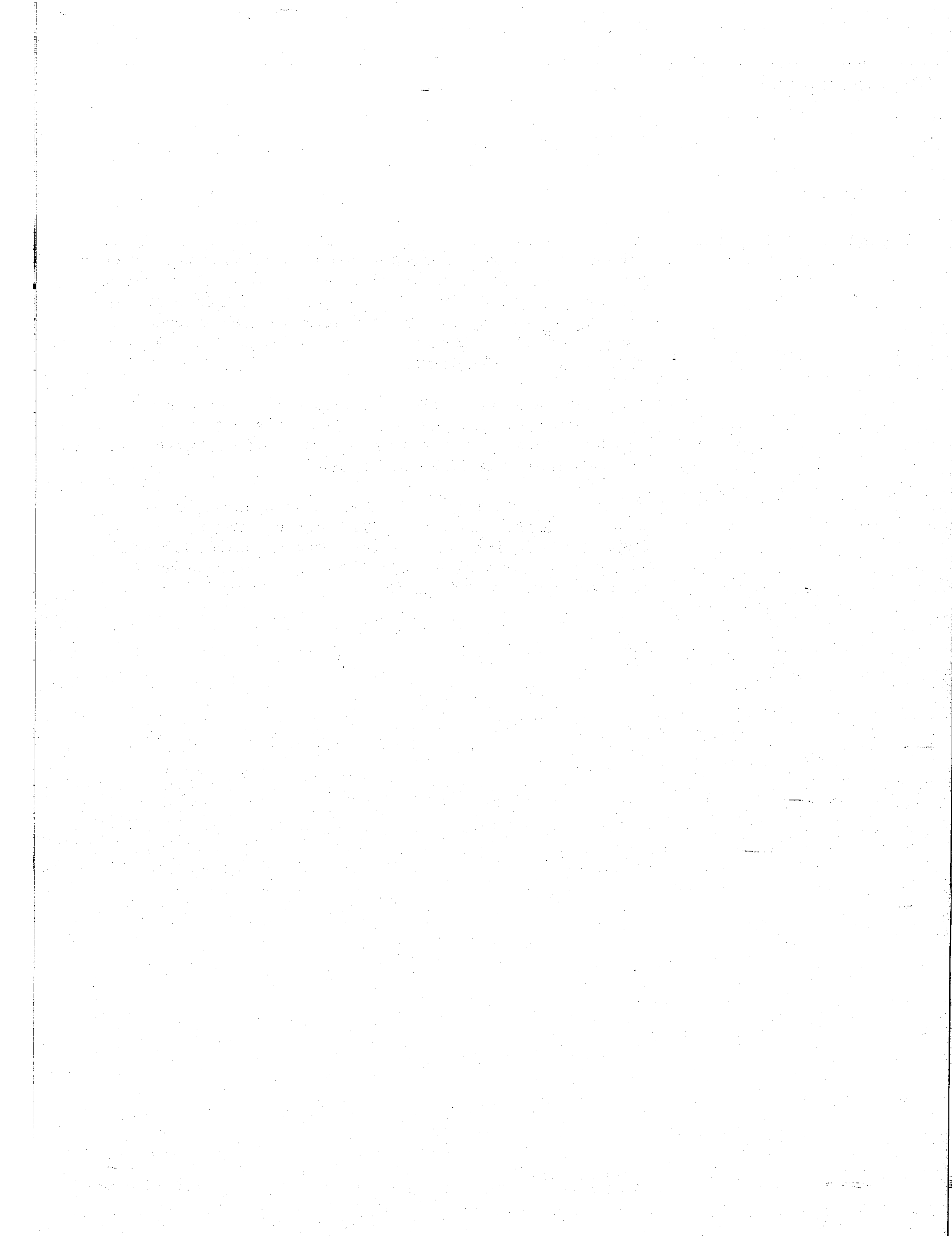

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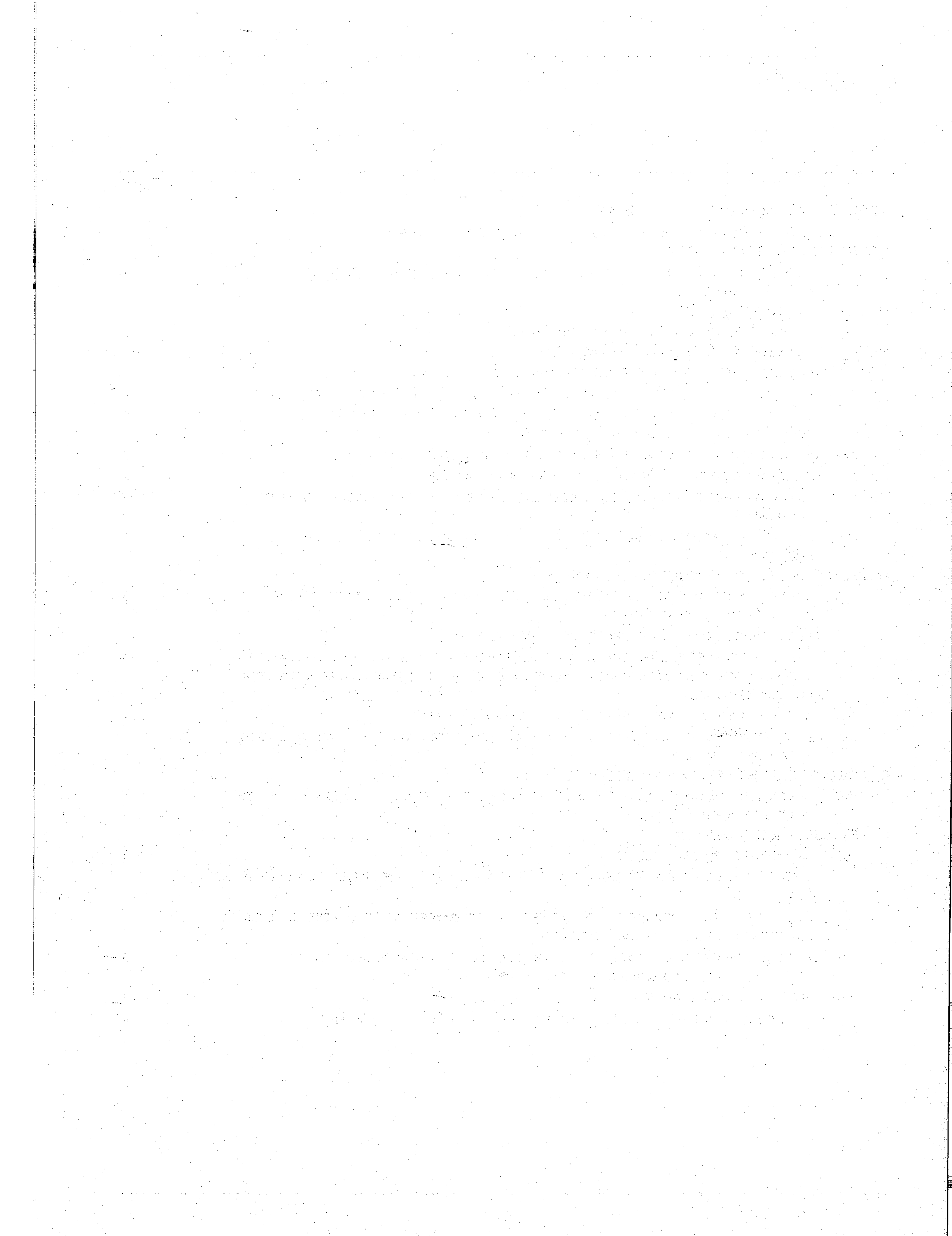

MEDICAID OVERSIGHT/ACCOUNTABILITY

TITLE: **STATES' MEDICAID PROGRAMS FOLLOWING FEDERAL WELFARE REFORM (101762)**

KEY QUESTIONS : Recent data indicate that Medicaid enrollment is down from prior years. HCFA has recently stressed the importance of the states employing innovative strategies and procedures to protect families' Medicaid eligibility, regardless of their eligibility for Temporary Assistance for Needy Families (TANF)-funded assistance. (1) What are the recent Medicaid enrollment trends for families and children following welfare reform? (2) What procedures and protections do states use to ensure that Medicaid-eligibles are enrolled, including revised or innovative application procedures and coordination with state welfare reform strategies to divert low-income people from cash assistance? (3) What are the implications of recent trends and states' policies and practices for future Medicaid enrollment?

MEDICARE & MEDICAID ACCESS

TITLE: **ACCESS TO AND QUALITY OF MENTAL HEALTH SERVICES PROVIDED UNDER MEDICIAD MANAGED CARE ARRANGEMENTS (101570)**

KEY QUESTIONS : To contain costs & improve service delivery, more states are using capitated managed care to provide Medicaid mental health (MH) services. The number of states implementing such programs jumped from 1 in 1991 to 30 in 1997. In many states, beneficiaries--including those with mental disabilities--have little or no choice of managed MH plans. For states with separate provider networks--carve-outs-- for managed MH services, we will examine: (1) How do state governments structure their managed MH programs for disabled beneficiaries? (2) How do state governments assure/monitor access to and the quality of MH services? (3) How have states designed payment policies to influence access to and quality of MH care? For all three objectives, how does the federal government exercise program oversight?

PRIVATE HEALTH INSURANCE

TITLE: **MEDICAL SAVINGS ACCOUNTS (MSAS): FINAL REPORT (101737)**

KEY QUESTIONS : This is the final report on the Medical Savings Accounts (MSAs) evaluation mandated by the Health Insurance Portability and Accountability Act of 1996. GAO is transmitting an analysis done by an outside contractor. (1) What is the response of the health insurance industry and market to MSAs? (2) What is the scope of high deductible plans purchased in conjunction with MSAs?

MEDICARE MANAGEMENT/PROGRAM INTEGRITY

TITLE: **CONSUMER INFORMATION ON MEDICARE MANAGED CARE DRUG BENEFIT (101713)**

KEY QUESTIONS : Understandable and accurate information is important to Medicare beneficiaries in choosing the health plan that best meets their needs. The prescription drug benefit illustrates the complex task they face. The requester is concerned that the lack of accurate, comparative information makes it impossible for beneficiaries to compare this benefit. (1) What drug benefit information is available to beneficiaries prior to and after joining a Medicare managed care health plan? (2) Is the terminology health plans use to explain the drug benefit clear and consistent? (3) What role do formularies play in the valuation of the drug benefit and how is this value calculated and reported to HCFA?

TITLE: **REVIEW OF THE HEALTH CARE FINANCING ADMINISTRATION'S (HCFA'S) OVERSIGHT OF CONTRACTORS THAT PROCESS AND PAY CLAIMS AND PERFORM SAFEGUARD ACTIVITIES (101741)**

KEY QUESTIONS : HCFA administers Medicare largely through claims processing contractors. In 1965, when Medicare was enacted, private insurers were contracted to process and pay claims because of their expertise in performing these functions. GAO has reported that problems in funding program safeguards and HCFA's limited oversight of contractors contributes to program losses. While recent legislation has enhanced program safeguard funding, questions concerning HCFA's oversight of its contractors remain. (1) What resources does HCFA devote to the oversight of contractors? (2) How is contractor oversight administered and what is HCFA doing to ensure that contractors protect program dollars and only pay appropriate claims? (3) What is the impact of HCFA's oversight or lack thereof?

TITLE: **COSTS OF NATIONAL MEDICARE EDUCATION CAMPAIGN (101747)**

KEY QUESTIONS : The Balanced Budget Act of 1997 (BBA) requires that the Secretary of HHS provide comparative information to Medicare-eligibles to support informed choice. To fund these new education activities, Congress authorized the Secretary to collect $200 million in user fees from private, Medicare+Choice plans, like HMOs. This figure was reduced in Appropriations, based on questions about expenditure estimates. (1) What are the component activities and costs underlying the Health Care Financing Administration's expenditure estimates for the National Medicare Education Campaign? (2) What are the bases for the agency's estimates? (3) Are these expenditure estimates only for new activities required by the BBA, or do they also include activities that were in prior budgets?

TITLE: **PREVALENCE AND EFFECTIVENESS OF CORPORATE COMPLIANCE PROGRAMS (101748)**

KEY QUESTIONS : Many federal agencies are fighting Medicare fraud and abuse. The Department of Justice, using the False Claims Act and other authority, has recouped over $100 million in Medicare overpayments, penalties and damages from thousands of hospitals. The HHS-OIG encourages providers to adopt corporate compliance programs (CCPs) to prevent or detect fraudulent or abusive practices. It has issued model CCPs for hospitals and clinical labs, and will issue others covering providers such as home health and durable medical equipment. (1) How many & what kinds of CCPs have been implemented in the health care industry? (2) What are the costs to a health care provider of implementing a CCP? (3) What are the potential benefits of effective CCPs, and the evidence to show these benefits are being realized?

TITLE: **TESTIMONY ON HCFA BALANCED BUDGET ACT IMPLEMENTATION (101757)**

KEY QUESTIONS : In January and May 1998, GAO testified on the management challenges faced by HCFA in implementing new Medicare mandates contained in the 1997 Balanced Budget Act (BBA). We have been asked to provide an update on three issues. (1) What is the overall status of HCFA's implementation of BBA Medicare provisions? (2) What is the status of the Medicare Choice+ beneficiary information campaign and its user fee financing system? (3) What is our assessment of the prospective payment system (PPS) for skilled nursing facilities (SNF) that HCFA began implementing on July 1, 1998?

TITLE: **ANALYSIS OF HHS' FY98 $50 MILLION SUPPLEMENTAL FUNDING FOR THE MEDICARE INTEGRITY PROGRAM (MIP) (101764)**

KEY QUESTIONS : The Medicare Integrity Program (MIP), established by the Health Insurance Portability and Accountability Act (HIPAA), ensures funding for Medicare program safeguards. The Medicare Trust Fund, which provides this program with a stable and increasing source of revenue, provided $500 million for program safeguard spending in FY98. To further enhance program safeguard spending during this period, Congress allocated an additional $50 million from HHS' FY98 appropriation. (1) How did HHS use the additional $50 million in appropriated funds that Congress provided in FY98?

TITLE: **CASE STUDY OF BLUE CROSS/BLUE SHIELD (BC/BS) OF ILLINOIS' MEDICARE CONTRACT PERFORMANCE (101765)**

KEY QUESTIONS : On 7/16/98, Health Care Service Corporation (HCSC), which also does business as Blue Cross/Blue Shield of Illinois, entered into a voluntary settlement with DOJ, agreeing to pay $144 million to avoid court action. This settlement resulted from a whistleblower lawsuit filed by an HCSC employee alleging that HCSC altered documentation, falsified workload reports, & destroyed claims. HCSC admitted some of the allegations & agreed to enter a criminal plea. (1) What were HCSC's general performance & alleged illegal activities, & what impact did its actions have on the Medicare program? (2) What regulatory & oversight measures did HCFA have in place, & why did they not detect these problems? (3) What additional measures must HCFA put in place to gain better control over its Medicare contractors?

MEDICARE PAYMENT AND PRICING STRATEGIES

TITLE: **REVIEW OF MEDICARE PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS (HMOS) FOR INSTITUTIONALIZED BENEFICIARIES (101514)**

KEY QUESTIONS : 1)What are the characteristics of the institutional beneficiaries and the institutions in which they reside? 2)What is the basis for institutionalized payments and is the additional amount that HMOs receive justified by higher health care costs for institutionalized beneficiaries? 3)Does HCFA pay the higher institutional rate for beneficiaries who are not in institutions?

TITLE: **HRA:5 EVALUATION OF THE CORRECT CODING INITIATIVE (101599)**

KEY QUESTIONS : Some providers, instead of submitting one claim for a set of related services, inappropriately bill Medicare for each service separately. In 1996, as part of the Correct Coding Initiative, HCFA provided carriers with an extensive listing of services that should not be billed together (i.e., bundled). (1) Have Medicare carriers implemented HCFA's instructions to screen claims for unbundled services? (2) How do the savings from the Correct Coding Initiative compare to the administrative costs? Has the Correct Coding Initiative reduced the number of inappropriately unbundled services submitted by providers? (4) Are providers manipulating their claims to circumvent bundling screens?

TITLE: **HRA:5 AUDITING OF MEDICARE COST REPORTS FOR USE IN ESTABLISHING PROSPECTIVE PAYMENT SYSTEMS RATES FOR SKILLED NURSING FACILITIES, HOME HEALTH AGENCIES, AND OUTPATIENT HOSPITAL SERVICES (101704)**

KEY QUESTIONS : HCFA is required to develop within the next two years prospective payment systems (PPS) for Medicare services provided in Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), outpatient hospital departments (OHD), and Rehabilitation hospitals (Rehab). To ensure that Medicare pays a reasonable amount under these PPSs, base year costs used to set PPS rates need to be adequately audited. (1) What has been the extent of Medicare's cost reports audit effort and how has it changed over time? (2) To what extent has HCFA audited, or have plans to audit, base year cost reports for the SNF, HHA, OHD, and Rehab PPS? (3) Will the conducted or planned audits provide an adequate cost basis for PPS rate setting?

TITLE: **REVIEW OF MEDICARE COVERAGE OF DISPOSABLE INFUSION PUMPS (101734)**

KEY QUESTIONS : Drug infusion therapy is generally provided to beneficiaries through infusion pumps, which are covered under Medicare's durable medical equipment benefit. Disposable infusion pumps are not considered durable medical equipment and, therefore, are not covered by Medicare. Private fee-for-service plans and health maintenance organizations (HMOs), on the other hand, cover disposable infusion pumps because they provide certain advantages. (1) What are the potential advantages and disadvantages of Medicare covering disposable infusion pumps as a substitute for durable electronic infusion pumps? (2) What are private health plans' coverage and payment policies on disposable infusion pumps and other disposable items?

TITLE: **EVALUATION OF HOW THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) MAKES MEDICARE COVERAGE DECISIONS (101742)**

KEY QUESTIONS : Kidney failure almost always results in anemia because the kidneys no longer produce adequate amounts of erythropoietin. Before the development of the drug EPOGEN (EPO) which stimulates the production of red blood cells, most End Stage Renal Disease (ESRD) dialysis patients were severely anemic resulting in low hematocrit (HcT) readings. Low HcT readings are associated with increased morbidity and poor quality of life. In 1997, HCFA implemented a new policy that resulted in a payment denial if a patient's HcT was higher than the approved FDA level for EPO recipients. (1) How are changes to HCFA coverage policy made and justified? (2) How were EPO coverage decisions made and was the process consistent with HCFA's procedures for making such decisions?

EMERGING HEALTH CARE OVERSIGHT ISSUES

TITLE: **DESIGN AND COORDINATION ISSUES ASSOCIATED WITH IMPLEMENTING THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) (101723)**

KEY QUESTIONS : The Balanced Budget Act of 1997 created a new Children's Health Insurance Program (CHIP) that allows states to extend health insurance coverage for uninsured children by expanding Medicaid eligibility, establishing a new state program, or combining both. (1) What are states' considerations when choosing among Medicaid expansions, stand-alone and combination programs, and what are their approaches to implementing CHIP, particularly for eligibility, cost sharing, benefits, data collection, and quality review? (2) How are states planning to coordinate CHIP with Medicaid, employer arrangements, and private insurance and what problems are they encountering in their coordination efforts? (3) What innovative strategies are states pursuing to overcome any design or coordination difficulties?

OTHER ISSUE AREA WORK - HF&S

TITLE: **LAW ENFORCEMENT BLOCK GRANT (101724)**

KEY QUESTIONS : The Local Law Enforcement Block Grant (LLEBG) allocates funds among counties, cities, townships and Indian tribes based on their share of violent crimes within the state. A provision that cities would reach an agreement to share funds with the overlying county (where the county performed courts and corrections functions for the city) is problematical to administer. The subcommittees are considering revising the formula to use criminal justice expenditures to shift funds to overlying counties. (1) What is the effect on LLEBG allocations between cities and counties by including an additional factor in the formula for criminal justice expenditures?

TITLE: **EFFECTS ON STATE FUNDING OF CHANGES IN FORMULA FOR ALLOCATING OLDER AMERICANS GRANT FUNDS (101725)**

KEY QUESTIONS : The Congress will reauthorize the Older Americans Act and is considering formula revisions suggested in past GAO reports. The requester asked for our assistance as the Congress considers the various options suggested by GAO and others. (1) What are the funding implications of reflecting the elderly population in need and insuring equitable funding for states?

TITLE: **A REVIEW OF THE DEMOGRAPHIC OF THE SEVERELY DISABLED POPULATION AND THE AVAILABILITY AND USE OF PERSONAL ATTENDANT SERVICES (101727)**

KEY QUESTIONS : A number of people have severe disabilities and many need the help of personal attendants. Yet, little is known about this population and the services they use. (1) What are the demographic characteristics of individuals with severe disabilities and what is the nature of their disabilities? (2) In addition to Medicaid personal care services and Medicaid waivers, what federal programs serve this population and what types of personal attendant services are provided? (3) What evidence exists on the displacement effect of formal services, i.e., the substitution of formal services for services provided by family and friends?

TITLE: **SIMULATIONS OF REVISIONS TO SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) BLOCK GRANT FUNDING FORMULA (101735)**

KEY QUESTIONS : Changes made by the Substance Abuse and Mental Health Services Administration (SAMHSA) to data used in the Substance Abuse and Mental Health block grant formulas have resulted in substantial shifts in state allocations of federal funding. The requester is considering legislative changes that would provide for a transition to the new formula or make corrections in the formula to lessen the impact on states. We have been requested to conduct analyses of formula options for the requester to consider. (1) What alternatives should be considered for lessening the impact on states of formula adjustments intended to improve the distribution of federal funds among states?

TITLE: **STATE ALLOCATIONS UNDER THE TOBACCO SETTLEMENT (101738)**

KEY QUESTIONS : The current tobacco settlement legislation distributes the money from the tobacco settlement to the states. GAO has been asked to assist in constructing allocation formula options to distribute these funds. (1) What type of formula elements should enter into the allocation formula for the tobacco settlement money? (2) How should the small state minimum allocations be structured?

TITLE: **INVESTIGATION OF ISSUES RELATED TO SURETY BONDS FOR HOME HEALTH AGENCIES (101761)**

KEY QUESTIONS : HCFA originally issued the regulations requiring Home Health Agencies (HHAs) to have a surety bond as a condition of participation in the Medicare and/or Medicaid programs on Jan. 5, 1998. At a hearing, HCFA announced a delay in implementing the rule and would be issuing technical changes to the rule. The revised rule was issued on June 1, 1998. In a compromise between members of Congress and HCFA, the agency agreed to suspend implementation of the June 1 rule and have GAO study and report on the surety bond issue. (1)Considering the intent of the Congress and HCFA, what is the most appropriate type of surety bond for HHAs now, and in the future? (2)How do bonds affect costs for HHAs? (3)To what extent and under what conditions are HHAs able to obtain surety bonds?