United States General Accounting Office

GAO

Health, Education and Human Services Division

May 1998

Health Financing and Systems Issue Area

Active Assignments

GAO/AA-98-15(2)

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 May 3, 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.

If you have questions or would like additional information about assignments listed, please contact William Scanlon, Director, on (202) 512-4561; or Leslie Aronovitz, Associate Director, on (202) 512-7104; Kathryn Allen, Associate Director, on (202) 512-7059; or Laura Dummit on (202) 512-7118.

Contents

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?

TITLE: **ALLEGATIONS OF ABUSE IN CALIFORNIA NURSING HOMES (101700)**

KEY QUESTIONS : Based on a review of death certificates from 1986 through 1993, a California law firm has alleged that many residents of California nursing homes died from avoidable malnutrition and other types of abuse and neglect. (1) Do the allegations have merit? (2) How effective are federal and state programs intended to monitor quality of care for nursing home residents in California? (3) Could California's method of reimbursing nursing homes for Medicaid patients contribute to unsatisfactory care?

PRIVATE-PUBLIC MARKET INTERACTION

TITLE: **EFFECT OF THE ERISA PREEMPTION CLAUSE ON MEDICAL MALPRACTICE CLAIMS AT MANAGED CARE PLANS (101562)**

KEY QUESTIONS : Many people with employer-sponsored health insurance are enrolling in managed care plans. This transition to managed care raises questions about who can be held liable for injuries caused by benefit denials or malpractice because the Employee Retirement Income Security Act (ERISA) may shield plans from law suits. (1) What are the rights and responsibilities of employers, managed care plans, participants, and providers when participants are injured by benefit denials and malpractice at managed care plans? (2) What remedies does ERISA provide to compensate injuries? (3) What is the status of case law with regard to ERISA and benefit denial and malpractice cases in the courts? (4) What are the possible ramifications of changing ERISA for key groups?

TITLE: **LARGE EMPLOYERS' ACCESS TO HEALTH INSURANCE (101591)**

KEY QUESTIONS : The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires GAO to issue a report to Congress on large employers' access to health insurance coverage by February 21, 1998. HIPAA is intended to improve the access, portability, and renewability of health insurance coverage. The Act provides, among other things, for guaranteed availability of health insurance to the small group market. To address the large group market, the Act requires the GAO and the Secretary of HHS to report on issues relating to large employers. HHS' report to Congress is due after December 2000. (1) To what extent are classes of employers in different states able to obtain access to health insurance coverage? (2) What are the circumstances (if any) for lack of access to health coverage?

TITLE: **HEALTH COVERAGE FOR THOSE 55-64 YEARS OLD (101592)**

KEY QUESTIONS : The continued erosion of employer-based health coverage is striking in the case of older Americans under the age of 65, the age at which most individuals qualify for Medicare. For this group, the link to employer-based coverage is often severed because of retirement, job displacement, or poor health. (1) Given that many Americans are also uninsured, why is the insurance status of this group important? (2) What are the historical and current health insurance trends for older Americans both in terms of employers offering and individuals accepting coverage?

TITLE: **KIDS-ONLY HEALTH INSURANCE (101710)**

KEY QUESTIONS : H.R. 1159 would require individual market insurance carriers to offer a policy rated specifically for children only. (1) What are "kids-only" health insurance policies and how do they differ from other individual market policies? (2) How available are "kids-only" policies in different parts of the U.S.?

MEDICARE MANAGEMENT AND ACCOUNTABILITY

TITLE: **REVIEW OF DURABLE MEDICAL EQUIPMENT (DME) MEDICAL POLICIES (101524)**

KEY QUESTIONS : (1) Have DME use and claims patterns changed since the consolidation of DME claims processing contractors? (2) Are identified changes linked to the increased number and/or standardization of DME coverage policies?

TITLE: **HRA:5 REVIEW OF HHS-OIG PHYSICIANS AT TEACHING HOSPITALS (PATH) AUDITS (101589)**

KEY QUESTIONS : The Health and Human Services Office of Inspector General (HHS/OIG) and the medical community strongly disagree over Medicare billing for physicians at teaching hospitals. The HHS/OIG argues that double billing and upcoding are pervasive at many institutions. It has already reached settlements with some, and plans more audits. The medical community argues the HHS/OIG is unfairly applying 1995 regulations retroactively. At issue is the dissemination, interpretation, and timing of Medicare billing rules. (1) Does the OIG have sufficient legal basis for conducting the physician at teaching hospital (PATH) audits? (2) Did the OIG follow an acceptable approach and methodology in conducting the audits? (3) How significant are the billing problems identified in completed audits?

TITLE: **COMPARISON OF MEDICARE APPEAL REQUIREMENTS AND QUALITY COMMISSION RECOMMENDATIONS ON APPEALS (101709)**

KEY QUESTIONS : A recent report by the President's Quality Commission states that all consumers have the right to an independent system of external review for appeals. The requesters are interested in Medicare's process for external review of HMO appeals and how Medicare's experience may be applicable to the commercial sector. (1) What are the specific elements the Commission has recommended in regard to external review? (2) What process is available to Medicare beneficiaries to appeal an initial determination and how has the process performed? (3) In recent years, what have been the number and type of complaints? (4) What proportion of complaints have been resolved in favor of the beneficiaries versus the HMO? (5) What have been the predominant complaints?

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: **THE HEALTH CARE FINANCING ADMINISTRATION'S (HCFA'S) IMPLEMENTATION OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT'S (HIPAA'S) MEDICARE INTEGRITY PROGRAM (101716)**

KEY QUESTIONS : Through the Health Insurance Portability and Accountability Act (HIPAA), Congress provided important new resources and tools to fight health care fraud and abuse. In addition to the Health Care Fraud and Abuse Control Program, HIPAA established and funded HCFA's Medicare Integrity Program (MIP). The MIP subsumes HCFA's previous safeguard activities, such as claims review and provider audits. How well HCFA uses funding and authority provided in MIP remains to be seen. (1) What additional resources and authorities did Congress provide HCFA through MIP, and how has HCFA used them? (2) What results has HCFA achieved from MIP so far? (3) Does HCFA have an adequate plan to successfully implement MIP and assure that future MIP funds are well spent?

TITLE: **TESTIMONY: HEALTH CARE FINANCING ADMINISTRATION'S (HCFA'S) PROGRESS IN MEETING THE CONGRESSIONAL MANDATE TO PROVIDE CLEAR, COMPARATIVE INFORMATION TO CONSUMERS ABOUT MEDICARE PLANS (101721)**

KEY QUESTIONS : GAO has worked to identify and report Medicare's past failure to provide useful information for informed choice among HMOs. This work contributed to mandates in the Balanced Budget Act of 1997 (BBA) for comparative information on plan benefits and costs, and on performance and quality indicators. The requester asked GAO's assistance in helping the Congress assess the tasks HCFA faces and the progress it is making in implementing the law. (1) How has HCFA progressed toward implementation of BBA mandates for consumer information? (2) Is HCFA's approach to providing comparative information effective and efficient? (3) What complexities and challenges do consumers face in understanding and comparing information made available on Medicare coverage?

TITLE: **HRA:5 REVIEW OF THE USE OF THE FALSE CLAIMS ACT IN THE HEALTH CARE FIELD (101722)**

KEY QUESTIONS : The Justice Department has used the False Claims Act to combat fraud and abuse in the Medicare program. Some groups, including the American Hospital Association, contend that this tactic punishes health care providers for simple mistakes. Threatened with the penalties provided by the act, many hospitals simply reach a settlement with Justice rather than risk losing in court. (1) How has the False Claims Act been used in combating health care fraud? (2) What guidelines do federal agencies use in deciding to institute a case under the act? (3) What unique aspects of health care may raise concerns over the applicability of the act to this area? (4) What are the major policy issues, including impact on providers and beneficiaries, involved with applying this act to health care?

MEDICARE/MEDICAID PAYMENT 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: **TRANSPORTATION COSTS ASSOCIATED WITH PORTABLE DIAGNOSTIC EQUIPMENT (101530)**

KEY QUESTIONS : HCFA changed its policy for paying providers' transportation costs for off-site diagnostic tests on nursing home residents. Beginning in 1996, only transportation costs relating to x-rays and EKGs were allowed (in prior years transportation for ultrasound tests could have been paid at the discretion of Medicare's claims' processing contractors). HCFA further revised its policy by excluding transportation costs for EKG services starting in 1997. (1) What is the impact of HCFA's decision on Medicare program costs? (2) What is the impact of the decision on the welfare of Medicare beneficiaries and the quality of care they receive?

TITLE: **MEDICARE'S REIMBURSEMENT SYSTEM FOR MEDICAL EQUIPMENT AND SUPPLIES (101581)**

KEY QUESTIONS : In 1996, Medicare spent over $4.3 billions for medical products using a reimbursement system that results in unreasonably high payment rates. Congress is concerned that HCFA's efforts to address overpricing are slow and ineffectual. To determine the scope of the problem, the Senate Aging Committee asked GAO to do a broad study of Medicare's reimbursement system for medical products. (1) How are medical equipment and supplies reimbursed under Medicare Part B? (2) How do Medicare payment levels compare to market prices and suppliers' costs? (3) Does the Medicare payment system enable timely adjustments to payment levels? (4) If the system needs changing, what are some options?

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?

EMERGING HEALTH CARE OVERSIGHT ISSUES

TITLE: **REVIEW OF STATE ALTERNATIVE MECHANISM APPROACHES TO INDIVIDUAL MARKET GUARANTEED ACCESS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) (101736)**

KEY QUESTIONS : On February 25, 1998, GAO reported on the first year implementation of the Health Insurance Portability and Accountability Act (HIPAA)(HEHS-98-67). Among other issues, we reported that high premium rates were emerging for "HIPAA eligibles" among some of the 13 states using federal rules to guarantee access to individual market coverage. The requester expressed interest in the more recent experiences of the remaining states that implemented alternative rules to providing the access guarantee. Accordingly, we were asked to summarize the characteristics of these approaches for use in possible late April hearings. (1) What is the overall approach used by each state? (2) What risk spreading or financial subsidy mechanisms are contained under each approach?

OTHER ISSUE AREA WORK - HF&S

TITLE: **EFFECTS OF REVISIONS TO THE SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION'S (SAMHSA) FORMULA ON FUNDING FOR OHIO (101714)**

KEY QUESTIONS : Proposed changes to the Substance Abuse and Mental Health Services Administration's (SAMHSA) block grant formula would result in a 20 percent loss in federal funds to Ohio. We have been requested to conduct analyses to show how various changes in the factors used in the formula would affect the distribution of federal funds among states. (1) What effect would changes in the various factors used in the funding formulas for the Substance Abuse and Mental Health Block Grants have on state allocations of federal funds?

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 the severely disabled and the nature of their disabilities? (2) What Federal and Federal/State programs serve this population and what types of services are provided? (3) What authority exists to provide these services under Medicaid and which states provide them under their state plans? (4) What are the number and nature of any Medicaid waivers States have obtained to provide personal attendant services to this population? (5) 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?