

**GAO**

Health, Education and Human Services  
Division

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October 1995

**Medicare and Medicaid  
Issue Area**

**Active Assignments**

065358/155483

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## ***Medicare and Medicaid***

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### **MEDICARE PAYMENT METHODS**

**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 expenditures? (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: 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?

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### **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?

### **MEDICARE AND 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 greatly change services for adults with mental retardation and developmental disabilities. In the past most of this population received care in institutions paid for by Medicaid, where current per capita costs are above \$80,000. Today most of this population receives care at home or in the community, largely through Medicaid.

**KEY QUESTIONS :** Key questions are to (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.

**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?

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# Foreword

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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 October 2, 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/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?

**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?

**TITLE: STATES' RESPONSE TO THE SPENDING CAPS IMPOSED BY A MEDICAID BLOCK GRANT (101366)**

**BACKGROUND :** Under this year's budget resolution the annual growth of the \$80 billion-plus federal Medicaid program will be limited. During the next 5 years, the proposed limit on annual growth will slightly exceed 4 percent. There are questions about the states being able to rapidly adopt Medicaid cost control measures.

**KEY QUESTIONS :** (1) How will states respond to federal spending caps in the Medicaid program? (2) Will states place their beneficiaries in managed care programs? (3) How will states deal with periods of economic recession? (4) What savings can be achieved if federal "micro management" is removed?

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### **MEDICARE/MEDICAID MANAGEMENT**

**TITLE: ASSISTANCE IN ANALYZING FORMULA OPTIONS FOR ALLOCATING MEDICAID FUNDS (118116)**

**BACKGROUND :** As the Congress seeks to control federal spending, it is focusing on changes to reduce Medicaid spending, which cost the federal government about \$81 billion in FY 1994. The authorizing committees plan to explore various options for changing the methods used for allocating federal Medicaid funds to the states.

**KEY QUESTIONS :** (1) What are the equity principles that could serve as criteria for evaluating fairness in the distribution of federal aid? (2) What need indicators are required to develop equitable formulas for distributing federal aid among the states? (3) How would the distribution of federal aid have to change to achieve more equitable outcomes?

### **ALTERNATIVE DELIVERY & FINANCING 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 occurring 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?

**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?

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### **ALTERNATIVE DELIVERY & FINANCING MODELS**

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

**BACKGROUND :** To help assure access to basic hospital services in frontier counties (6 or fewer persons per square mile), Montana created medical assistance facilities (MAFs). The first MAF opened in 1990. MAFs are eligible for cost-based reimbursement for Medicare services, until 7/97. Sen. Baucus wants to make this program permanent & expand it to frontier counties in other states.

**KEY QUESTIONS :** What is the cost to Medicare of providing services through MAFs and how do those costs compare to costs at acute-care hospitals?

### **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?

**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?

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### **OTHER ISSUE AREA WORK: MEDICARE AND MED**

**TITLE: STUDY OF MEDICARE MANAGED CARE PROGRAM GROWTH (101333)**

**BACKGROUND :** About 20% of the people with private health insurance are enrolled in an HMO. In contrast, about 9% of Medicare beneficiaries have chosen managed care option. While the number of Medicare beneficiaries enrolling in HMOs has grown steadily since 1985, growth has increased tremendously during the past 3 years with little government intervention.

**KEY QUESTIONS :** (1) How has the Medicare managed care program grown since the program began? (2) Why is Medicare managed care now growing so rapidly? (3) Why does program growth vary throughout the country? (4) What factors may impact on future Medicare managed care growth? (5) What issues should the Congress consider when addressing growth?

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

**BACKGROUND :** Medicaid spends more than \$10 billion per year to support nearly 150,000 persons with mental retardation or other developmental disabilities (MR/DD) in residential facilities (ICFs/MR). Several recent 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) describe the federal role in oversight of large public facilities for persons with developmental disabilities; (2) determine the nature and magnitude of problems related to quality of care that have been identified; (3) examine follow-up actions taken to correct identified deficiencies; and (4) identify weaknesses or limitations in HCFA's oversight.

**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?

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### **OTHER ISSUE AREA WORK: MEDICARE AND MED**

**TITLE: DATA ON THE NUMBER OF MEDICARE BENEFICIARIES ENROLLING IN HMOS WITH MEDICARE RISK CONTRACTS (101370)**

**BACKGROUND :** Most people 65 years of age and older receive coverage for their health care through the Medicare program. Medicare pays for this health care primarily on a fee-for-service basis. However, during the past decade, Medicare beneficiaries have had the option of enrolling in Health Maintenance Organizations (HMOs)--a form of managed care on a prepaid basis.

**KEY QUESTIONS :** (1) How has the number of Medicare beneficiaries enrolled in HMOs changed between 1987 and 1994 by state, region, and nationwide? (2) How has the number of HMOs that enroll Medicare beneficiaries changed between 1987 and 1994 by state, region, and nationwide? (3) How do recent Medicare HMO enrollments compare to private sector HMO enrollments in each state?

**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: SURVEY OF MEDICARE PART B APPEAL PROCESS (106424)**

**BACKGROUND :** Disputes over Medicare claims can be appealed to SSA's Administrative Law Judges (ALJ). Most Medicare appeals are from providers and make up less than 3 percent of ALJ's work. Because of ALJ backlogs, some Medicare claimants are waiting almost 2 years for a decision. In 1994, the average time for a Part B appeal was 522 days (nearly twice that of any other ALJ appeal).

**KEY QUESTIONS :** (1) What are the causes for delays in the appeals process? (2) Why do Medicare Part B appeals before an ALJ take twice as long as any other type of appeal? (3) Can the appeal process for Medicare be streamlined? (4) Where can improvements be made in the process? (5) Will SSA's independent status affect this process?

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**OTHER ISSUE AREA WORK: MEDICARE AND MED**

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

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