United States General Accounting Office

GAO

Health, Education, and Human Services Division

September 1996

Health Financing and Systems Issue Area Plan

Fiscal Years 1997-99

GAO/IAP-96-26

Foreword

As the investigative arm of the Congress and the nation's auditor, the General Accounting Office is charged with following the federal dollar wherever it goes. Reflecting stringent standards of objectivity and independence, GAO's audits, evaluations, and investigations promote a more efficient and cost-effective government; expose waste, fraud, abuse, and mismanagement in federal programs; help the Congress target budget reductions; assess financial information management; and alert the Congress to developing trends that may have significant fiscal or budgetary consequences. In fulfilling its responsibilities, GAO performs original research and uses hundreds of databases or creates its own when information is unavailable elsewhere.

To ensure that GAO's resources are directed toward the most important issues facing the Congress, each of GAO's 32 issue areas develops a strategic plan that describes the significance of the issues it addresses, its objectives, and the focus of its work. Each issue area relies heavily on input from congressional committees, agency officials, and subject-matter experts in developing its strategic plan.

The Health Financing and Systems Issue Area examines the financing and delivery arrangements of America's complex health care marketplace. Its scope encompasses Medicare and Medicaid—the insurance programs for the elderly, disabled, and poor—as well as the provision of private health insurance and the organization of health services markets. Health Financing and Systems pays special attention to the federal and state government interactions that are built into Medicaid, the interactions between private markets and the Medicare and Medicaid programs, and comparisons of current programs with alternative models of financing and delivering health care. The issue area also focuses on the use of federal grants to states and localities to promote federal health care and other objectives.

GAO's work in Health Financing and Systems concentrates on the following issues:

- identifying actions to improve the management and financial integrity of the Medicare program and assessing how financing arrangements affect Medicare beneficiaries' access to quality care;
- examining new strategies for paying for Medicare and Medicaid services that promote cost containment while preserving quality and access;
- identifying measures to improve the management and accountability of the Medicaid program;

- assessing the impact of Medicaid managed care on vulnerable populations, such as the disabled;
- evaluating private- and public-sector innovations in health care delivery or financing that offer models for the Medicare and Medicaid programs;
- analyzing the interactions between the Medicare and Medicaid programs and the private health care marketplace; and
- assessing and developing methods for targeting federal intergovernmental grant funds to achieve program goals and enhance equity.

In the pages that follow, we describe our key planned work on these important issues.

Because events may significantly affect even the best of plans, our planning process allows for updating and the flexibility to respond quickly to emerging issues. If you have any questions or suggestions about this plan, please call me at (202) 512-7114.

William J. Scanlon
Director
Health Financing and Systems

Contents

Foreword 1

Table I: Key Issues 4

Table II: Planned Major Work 8

Table III: GAO Contacts 11

Table I: Key Issues

Issues	Significance
Medicare management and access: What actions are needed to improve the management and financial integrity of the Medicare program? How do financing arrangements, including increased enrollment in managed care, affect beneficiaries' access to quality care?	Medicare, the nation's largest single payer for health care, serves more than 37 million elderly and disabled people. In 1995, Medicare costs totaled approximately $180 billion—12 percent of the federal budget. The program is complex. Currently, it reimburses nearly a million providers and processes over 800 million individual claims each year. Effective management and oversight of the fee-for-service portion are essential to ensure that program dollars are well spent and that opportunities for fraud, waste, and abuse are reduced. The program also faces new challenges as more beneficiaries enroll in managed care plans, which present a new set of incentives to providers.
Medicaid management and accountability: What actions are needed to improve the management and financial integrity of the Medicaid program?	Medicaid, jointly administered by the federal government and the states, serves low-income vulnerable populations and reimburses a wide variety of providers. Effective management and oversight are essential to ensure that federal funds—in excess of $89 billion—are well spent and that opportunities for fraud, waste, abuse, and mismanagement are reduced. The Medicaid program faces new challenges, as more beneficiaries enroll in managed care plans, with new incentives for providers. Legislative proposals granting states greater latitude over program design and operation could lessen accountability to the federal government.
Medicaid managed care for select populations and services: How does managed care affect access to quality care for select populations?	Almost all states now offer some form of managed care, primarily to their AFDC populations. In 1995, about 12 million individuals were enrolled in Medicaid managed care. However, as states have attempted to shift their Medicaid populations into managed care, certain eligible populations, such as the disabled, and certain services, such as mental health, have presented challenges.
Medicare and Medicaid payment strategies: What new approaches to health care payment and what major modifications of current methods hold promise for restraining Medicare and Medicaid spending while preserving quality and access?	The collision of the large funding requirements for Medicare and Medicaid with the demands of deficit reduction underlies the appeal of curbing spending growth in these health care entitlements. But opportunities are shrinking for cutting provider payments sharply without threatening access to quality care. Hence, a search for different payment strategies, offering a curb on spending growth and the potential for adequate funding for quality care, is worthwhile. The shift toward managed care heightens the urgency for such innovations.
Alternative delivery, benefits, and financing models: What private- and public-sector efforts offer lessons for the Medicare and Medicaid programs?	The Congress is seeking alternative ways to provide Medicare and Medicaid benefits while controlling the growth of the programs. Both private and public experience with more effective models of financing and delivery of health care, as well as with the design of benefit packages, can guide improvements in Medicare and Medicaid.

Table I: Key Issues

Objectives	Focus of Work
—Identify methods to improve the efficiency of Medicare claims processing and to increase beneficiary satisfaction. —Identify methods to improve information provided to beneficiaries about the quality of health care Medicare managed care plans provide. —Determine measures that HCFA and the states can use to minimize fraud, waste, and abuse due to payment policies or oversight weaknesses. —Identify strategies to improve oversight of managed care plans that serve Medicare beneficiaries.	—HCFA's use of new technologies to improve its Medicare claims processing —Medicare's process for resolving provider appeals —HCFA efforts to develop measures of Medicare access to quality services for Medicare beneficiaries —HCFA efforts to improve information for Medicare beneficiaries in managed care plans —HCFA efforts to reduce fraud, waste, abuse, and mismanagement in Medicare —HCFA oversight activities of managed care plans' contracting arrangements and administrative procedures —HCFA and state reviews of managed care health plans' financial solvency —HCFA efforts to ensure managed care plans' compliance with quality assurance and operational requirements in their Medicare contracts
—Identify methods to improve consumer information about and oversight of managed care plans that serve Medicaid beneficiaries. —Examine budgetary implications of states' Medicaid program designs and policies. —Identify methods by which the states, HCFA, and the HHS Inspector General can minimize fraud, waste, and abuse in the Medicaid program.	—HCFA and state oversight of managed care plans' financial solvency, contracting arrangements, and administrative procedures —HCFA and state efforts to develop measures of access to quality services for Medicaid beneficiaries —State approaches to finance program services for current populations to accommodate constrained budgets —HCFA and state systems to prevent unqualified or fraudulent providers from participating in Medicaid
—Identify factors inhibiting access of select Medicaid populations, such as the disabled, to quality care. —Identify ways to improve delivery of select services (for example, mental health) to Medicaid beneficiaries.	—State activities to ensure access to health care for select Medicaid populations —State efforts to provide select services—such as mental health, substance abuse treatment, or long-term care—in managed care programs
—Identify payment strategies that provide incentives for quality care while curbing health care spending. —Determine ways to improve existing payment systems for nursing facility and home health providers to enhance efficiency and effectiveness. —Identify methods to ensure Medicare buys no more or pays no more than justified by the marketplace and quality. —Propose administrative and statutory changes to Medicare HMO payment methods. —Identify ways to improve the methods state Medicaid agencies use to set capitated payment rates for managed care plans.	—Payment methods for HMOs that combine elements of capitation and fee-for-service —HCFA's efforts to reform Medicare Part A payment methods for post-acute care —Medicare payments for physical therapy and other services for nursing home residents —Proposals for setting market-based rates for Medicare —Proposals for setting health plan rates that more accurately reflect the costs of serving enrolled beneficiaries
—Inform the Congress of alternative delivery, benefits, and financing models that offer fiscal or program improvements to current Medicare and Medicaid approaches.	—The role and effects of managed care in Medicaid —Medicare HMO premium changes in relation to market competition and beneficiary choice of plan —Competitive bidding and market-oriented methods of purchasing medical services or reimbursing providers and health plans —Disease management and case management techniques, and methods of paying for them

Table I: Key Issues

Issues	Significance
Interactions of public programs with private markets: What interactions between private health care markets and federal health programs, such as Medicare and Medicaid, affect program operations significantly?	Trends in private health care markets, such as erosion in employer-provided health insurance, impinge on Medicaid and Medicare. Responses of providers, health plans, and consumers to new legislation might undermine its intended effect. Changes in the methods of payment and in the administrative rules by which Medicare and Medicaid paid out more than $270 billion alter the playing field for all other actors.
Funding formulas for federal programs: To what extent are federal grants to states and localities allocated in accordance with their funding needs?	In 1996, roughly $170 billion will be distributed to state and local governments by formula, and over half of these funds will be for health programs. Continued oversight of these formulas is needed to determine if they allocate federal funds in line with changing regional and state needs.

Table I: Key Issues

Objectives	Focus of work
—Provide the Congress with information on how changes in Medicare rules may affect the private insurance market. —Determine implications of local market conditions and variations for federal programs. —Determine implications for Medicare and Medicaid of trends in the market for private health insurance —Assess the role of taxes and other factors in affecting the trend in employer-based coverage.	—Impact of changes in Medicare eligibility requirements on the private insurance market —Competitive bidding and related strategies, as used by Medicare and private entities in local markets —Impact of National Health Service Corps in local health insurance markets —Changing features of private health insurance policies, such as lifetime limits —Impact of changes in tax treatment of employee health premiums
—Improve the equity with which federal funding formulas allocate funds to states and localities. —Increase the extent to which federal funding formulas target funds to meet program objectives.	—Formulas for equitable allocation of Medicaid funds to states —Federal grants' effect on state and local spending

Table II: Planned Major Work

Issue	Planned Major Job Starts
Medicare management and access	—Review HCFA efforts to collect payments from other insurers in the Medicare Secondary Payer program. —Examine Medicare Part B appeals. —Examine differences across market areas in care Medicare beneficiaries receive from integrated delivery networks. —Examine the problems in Medicare's system for enrolling beneficiaries in HMOs and the lessons for Medicare in alternative private-sector and state systems of HMO enrollment. —Examine the potential for duplicate federal payments by Medicare for services received by beneficiaries in nursing facilities. —Examine managed care contracting and subcontracting arrangements where management and other intermediate entities receive funds but pass the financial risk of health care along to providers. —Review states' activities and ability to monitor and affect HMO financial solvency and administrative costs in managed care plans. —Review the effectiveness of the Medicare 50/50 rule, which requires that at least 50 percent of plan enrollees be commercial members, in protecting Medicare HMO enrollees from abuses and poor quality. —Examine the adequacy of HCFA's processes for reviewing new Medicare HMO applications.
Medicaid management and accountability	—Review states' ability to monitor managed care plans' financial solvency and administrative costs. —Examine contracting arrangements where states and managed care plans pass financial risk to providers. —Review states' ability to monitor the quality of Medicaid services, including the use of clinical encounter data systems. —Review states' efforts to promote competitive Medicaid managed care markets and secure efficient capitated payment rates for HMOs. —Examine the impact of Medicaid programs' long-term care policies on use of Medicare home health and nursing facility services. —Assess the effectiveness of the process for excluding providers from federal health programs who have been sanctioned by the HHS Inspector General or state Medicaid agencies. —Identify the barriers to the exchange of information among Medicaid agencies, Medicare contractors, other federal health programs, and the private sector that hamper efforts to reduce fraud and waste.
Medicaid managed care for select populations and services	—Review managed care programs for special needs populations, such as disabled children, focusing on access to adequate care. —Examine state initiatives to provide mental health and substance abuse services through managed care. —Assess the effectiveness of states' coordination of Medicaid services with other programs, such as Medicare, Title V, and home and community-based care.

(continued)

Table II: Planned Major Work

Issue	Planned Major Job Starts
Medicare and Medicaid payment strategies	—Examine the private sector's use of "bundled payments" for particular types of episodes of care and the potential for applying this technique more widely in Medicare. —Examine HMO payment methods for blending fee-for-service and capitated incentives (for example, risk corridors). —Assess HCFA's efforts to reform Medicare Part A payment methods for skilled nursing facilities and home health agencies. —Examine how the use of current Part B payment methods has affected volume and mix of services for Medicare beneficiaries in nursing homes. —Examine alternative methods for reimbursement of Medicare Part B home health services. —Examine payments for equipment and supplies and methods for HCFA to adjust payments to marketplace prices. —Review the Medicare rule that allows HMOs to enhance benefits for enrollees rather than passing on any part of above-average savings to the program. —Review the extent of federal overpayments to Medicare HMOs due to inadequacies in criteria for classifying beneficiaries as "institutionalized" and in monitoring of the accuracy of capitated payments for such beneficiaries. —Analyze how costs in the last year of life relate to Medicare HMO overpayments.
Alternative delivery, benefits, and financing models	—Review the major changes in the Medicaid program that accompanied the shift to managed care delivery models. —Analyze the effect of premium changes by Medicare HMOs on beneficiaries' decisions to switch plans or to switch to Medicare fee-for-service. —Review the private sector's use of strategies for purchasing health care coverage and their applicability to Medicare and Medicaid. —Identify successful examples of competitive bidding for medical services and supplies, and analyze the applicability of these examples and alternative bidding systems to Medicare. —Examine the degree to which the growth in HMO and indemnity plan premiums in the Federal Employees Health Benefit Plan was affected by market competition versus the FEHBP sponsor (the Office of Personnel Management). —Assess emerging managed care models, including benefit structure and payment methods, that attempt to integrate medical and social services.
Interactions of public programs with private markets	—Analyze the implications of raising the age threshold for Medicare eligibility (from 65 to 67) on Medicare outlays, private employers, and individuals. —Analyze the effect of competition in local markets on premiums charged by Medicare HMOs and its implications for Medicare, including the potential savings from competitive bidding. —Analyze the extent to which market responses counteract the impact of the National Health Service Corps on the local supply of health care providers. —Examine private health plans' use of lifetime limits on the amount of an enrollee's claims they will pay and the implications of eliminating or raising such limits. —Examine the nature and extent of cost-shifting among providers, commercial health plans, and Medicare resulting from changing private insurance features or Medicare requirements. —Identify sources of erosion in employer-based health care coverage, and examine the implications of that erosion for the tax treatment of health premiums.

(continued)

Table II: Planned Major Work

Issue	Planned Major Job Starts
Funding formulas for federal programs	—Assess equity differences by state in formulas for allocating Medicaid funds under block grants and other constrained federal contribution arrangements. —Examine alternatives for designing formulas to better achieve federal and state fiscal and program objectives, such as for preventive health services. —Analyze the extent to which states and localities have reduced their spending on programs aided by federal grants.

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