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Health Financing and Public Health Issue Area Plan

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Foreword

As the investigative arm of 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 fraud, waste, abuse, and mismanagement in federal programs; help Congress target budget reductions; assess financial and information management; and alert 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 Congress, each of GAO's 35 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 Public Health issue area focuses on federal and state financing and operations of Medicare and Medicaid—the insurance programs for the elderly, disabled, and poor—and national and public health issues associated with access to care and research and regulatory activities. It also reviews programs and practices of the Health Care Financing Administration (HCFA), the Food and Drug Administration (FDA), and other Public Health Service agencies in the Department of Health and Human Services (HHS).

GAO's work on health financing and public health generally focuses on the following issues:

- improving the management and financial integrity of the Medicare and Medicaid programs;
- evaluating new approaches to current payment methods that could curb Medicare spending growth;
- assessing how financing arrangements affect Medicare and Medicaid beneficiaries' access to quality care;
- identifying private and public sector efforts that offer lessons for the Medicare and Medicaid programs and for the ongoing congressional deliberations on insurance reform;
- determining if the Public Health Service agencies are meeting the public health needs of the nation efficiently and effectively;

- evaluating the efficiency and effectiveness of the Food and Drug Administration's regulation of medical products; and
- identifying opportunities for improving the nation's health care and ensuring accountability for performance.

In the pages that follow, we describe our key planned work on these pivotal 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) 512-7119.

Sarah F. Jaggar
Director
Health Financing and Public Health Issue Area

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Table I: Key Issues

Issue	Significance
Medicare and Medicaid management: What actions are needed to improve the management and financial integrity of the Medicare and Medicaid programs?	Medicare and Medicaid are complex programs serving vulnerable populations and reimbursing a wide variety of providers. Effective management and oversight are essential to ensure that program dollars are well spent and that opportunities for fraud, waste, and abuse are reduced. Both programs also face new challenges as more beneficiaries enroll in managed care plans, which present a new set of incentives to providers.
Medicare payment methods: What new approaches and changes in current payment methods hold promise for restraining Medicare spending growth?	The demands of deficit reduction and Medicare's large funding requirements underlie the appeal of curbing Medicare's 10-percent projected annual growth. Changes in payment methods are one major tool for controlling spending.
Medicare and Medicaid access: How do financing arrangements affect beneficiaries' access to quality care?	Historically, providing beneficiaries with access to care of acceptable quality has been difficult for Medicaid and, for some rural areas, for Medicare. The importance of this issue is growing, as more beneficiaries in both programs enter prepaid health plans with incentives towards limiting services.
Alternative delivery, benefits, and financing models: What private and public sector efforts offer lessons for Medicare and Medicaid programs and for the ongoing congressional deliberations on insurance reform?	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 delivering of health care, as well as with the design of benefit packages, can guide improvements in Medicare and Medicaid and can shape incremental insurance reforms.

Table I: Key Issues

Objectives	Focus of work
—Improve the efficiency of Medicare claims processing and increase beneficiary satisfaction. —Identify methods by which HCFA and the states can minimize fraud, waste, and abuse in the Medicare and Medicaid programs. —Improve the oversight of managed care plans that serve Medicare and Medicaid beneficiaries. —Improve methods HCFA and state Medicaid agencies use to set capitated payment rates. —Improve HCFA's approach to introducing new technologies as covered services in Medicare.	—HCFA use of new technologies to improve its Medicare claims processing — HCFA and state oversight activities of managed care plans'contracting arrangements and administrative procedures — HCFA and state review of managed care health plans' financial solvency — HCFA and state Medicaid agency methods for setting capitated payment rates for Medicaid managed care plans — Medicare process for resolving providers' appeals
—Improve Medicare's payment methods for providers and health plans.	—HCFA efforts to reform Part A payment methods —Proposals to revise physician payment methodology —Proposals for setting health plan rates competitively —Methods of risk adjustment for HMO payments — Medicare payments for physical therapy and other services for nursing home residents
— Identify barriers to health care for Medicaid beneficiaries. — Identify ways to improve information given to beneficiaries about the quality of health care Medicare and Medicaid contract plans provide.	—HCFA efforts to develop measures of Medicare and Medicaid access to quality services for Medicare and Medicaid beneficiaries —HCFA efforts to improve information for Medicare beneficiaries in managed care plans — State activities to ensure access to health care for Medicaid beneficiaries — HCFA and state efforts to ensure managed care plans comply with quality assurance and operational requirements in their Medicare and Medicaid contracts
— Inform Congress of alternative delivery, benefits, and financing models for federal health care financing and insurance programs.	—Use of disease- and case-management techniques to improve quality of care and control costs —Opportunities for using new technologies to deliver Medicare services

Table I: Key Issues

Issue	Significance
Public Health Service: Are the Public Health Service agencies meeting the public health needs of the United States efficiently and effectively?	By October 1996, HHS' Public Health Service intends to implement major changes in the structure and organization of its subagencies and programs. These changes are occurring within the context of budget deficit reduction and reinventing government. Specific HHS discretionary programs are to be consolidated into performance partnerships or block grants. The new budgetary situation raises concerns about future priorities and capabilities of the Public Health Service agencies, as well as mechanisms to ensure accountability by grant recipients.
Drug and medical device regulation: Does FDA regulate medical products efficiently and effectively?	FDA's regulatory responsibilities have continued to increase over recent years. The drug, device, and biotechnology industries have claimed that there is now excessive regulation and unwarranted delays in product approvals, and they and other critics are proposing fundamental changes in FDA's role and policies. In response, FDA is changing some procedures and Congress is considering a wide range of reforms.
Access and accountability in health service delivery: How can the United States improve health care and ensure accountability for performance?	As health care is increasingly taking place in a managed care environment, there are increasing bipartisan concerns about access to effective care, particularly for vulnerable populations, and ways to hold plans accountable for performance.

Table I: Key Issues

Objectives	Focus of work
—Assess the ability of Public Health Service agencies and programs to conduct health service activities after organizational and structural changes have been made. —Assess the need for and type of federal oversight and accountability measures that can be used to ensure federal dollars are effectively used under performance partnerships. —Identify ways to strengthen the National Institutes of Health's management and oversight of federally funded health research.	—The Centers for Disease Control's capacity to respond to public health threats —Effectiveness of current federal organ allocation policy to distribute organs equitably —Development of performance measures for block grants/performance partnerships —Financial and scientific oversight of research projects of the National Institutes of Health
—Assess changes in FDA's processes for reviewing and approving new medical products. —Determine the adequacy of FDA's post-market surveillance programs in identifying and analyzing adverse product experiences. —Provide a factual basis for assessing various regulatory reform proposals.	—FDA's regulatory standards and approval processes for new medical devices —Alternative approaches to expedite FDA's approval of new drugs while maintaining safety and efficacy standards —FDA's post-market surveillance activities for medical products, including adverse reaction reporting processes —Adequacy of surveillance and enforcement operations associated with importation of drugs —FDA's regulation of the drug advertising and promotion activities of pharmaceutical companies
—Provide Congress with an assessment of the impact of managed care systems on access to services for special populations. —Identify lessons from private sector approaches for enhancing cost-effectiveness that have implications for the management of federal health insurance programs.	—Access to specialty services in managed care plans —Impact of Medicaid managed care on access to services for low-income children and other special populations —Health plan accountability in the Federal Employees' Health Benefits Plan —Cost-effectiveness of the gatekeeper approach for resource allocation in managed care organizations

Table II: Planned Major Work

Issue	Planned major job starts
Medicare and Medicaid management	•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 managed care plans' financial solvency and administrative costs. •Review states' activities and ability to promote competitive Medicaid managed care markets and secure efficient capitated reimbursement rates. •Examine potential duplication of payments by Medicare for certain home health services. •Review HCFA efforts to collect payments from other insurers in the Medicare Secondary Payer program. •Examine Medicare Part B appeals. •Examine the potential for duplicate payments by Medicare and Medicaid for services received by beneficiaries in nursing facilities.
Medicare payment methods	•Assess HCFA's efforts to reform Medicare Part A payment methods. •Examine how the use of current Part B payment methods has affected the volume and mix of services for Medicare. •Examine alternative methods for reimbursement of Part B home health services.
Medicare and Medicaid access	•Examine the adequacy of HCFA's processes for reviewing new Medicare managed care plan applications. •Review states' ability to monitor quality of Medicaid services. •Review managed care programs for chronically ill Medicaid beneficiaries and those with special needs, focusing on access to quality care. •Examine differences in care Medicare beneficiaries in traditional and managed care plans receive from integrated delivery networks.
Alternative delivery, benefits, and financing methods	•Identify private and public sector techniques to negotiate with managed care plans and determine their applicability to federal health programs. •Examine disease management approaches of pharmaceutical firms to determine their applicability to federal health programs.

Table II: Planned Major Work

Issue	Planned major job starts
Public Health Service	•Evaluate management and priorities of the Centers of Disease Control in responding to public health threats. •Assess the effectiveness of current federal organ allocation policy to distribute organs equitably. •Review the development of performance measures for block grants/performance partnerships. •Examine financial and scientific oversight of research projects of the National Institutes of Health.
Drug and medical device regulation	•Assess FDA's regulatory standards and approval processes for new medical devices in comparison to the European Union approach. •Analyze alternative approaches to expedite FDA's approval of new drugs while maintaining safety and efficacy standards. •Assess FDA's post-market surveillance activities for medical products, including adverse reaction reporting processes. •Evaluate the adequacy of surveillance and enforcement operations associated with importation of human drugs. •Review FDA's regulation of the drug advertising and promotion activities of pharmaceutical companies.
Access and accountability in health care delivery	•Evaluate access to specialty services in managed care plans, particularly for vulnerable populations. •Review gatekeeper mechanisms in health plans in the Federal Employees' Health Benefits Program. •Analyze cost-effectiveness of the gatekeeper approach for resource allocation in managed care organizations. •Examine use of federal practice guidelines in federal employees health plans to ensure access to quality care. •Assess cost-effectiveness of federally funded rural and other underserved area programs. •Evaluate impact of Medicaid managed care on access to services for low-income children and other special populations.

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