United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Domestic Policy, Committee on Oversight and Government Reform, House of Representatives

For Release on Delivery
Expected at 2:00 p.m. EDT
Wednesday, May 2, 2007

MEDICAID

Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services

Statement of James Cosgrove
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May 2, 2007

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Highlights

Highlights of GAO-07-826T, a testimony before the Subcommittee on Domestic Policy, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

The 31 million children enrolled in Medicaid are particularly vulnerable to tooth decay, which, if untreated, may lead to more serious health conditions and, on rare occasion, result in death. Congress established a comprehensive health benefit for children enrolled in Medicaid to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, which include dental services. The Centers for Medicare & Medicaid Services (CMS) is responsible for oversight of these services. States are responsible for administering their state Medicaid programs in accordance with federal requirements, including requirements to report certain data on the provision of EPSDT services.

GAO was asked to address the data that CMS requires states to submit on the provision of EPSDT dental services and the extent to which these data are sufficient for CMS oversight of the provision of these services.

This testimony is based on reports GAO issued from 2000 through 2003. GAO updated relevant portions of its earlier work through interviews conducted in April 2007 with officials from CMS; state Medicaid programs in California, Illinois, Minnesota, New York, and Washington (states contacted for GAO's 2001 study or referred to GAO by another official); and national health associations. GAO also reviewed relevant literature provided by officials from CMS and other organizations.

www.gao.gov/cgi-bin/getrpt?GAO-07-826T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact James Cosgrove at (202) 512-7118 or cosgrovej@gao.gov.

What GAO Found

CMS requires states to report annually on the provision of certain EPSDT dental services through form CMS 416. The CMS 416 is designed to provide information on state EPSDT programs in terms of the number of children who receive child health screening services, referrals for corrective treatment, and dental services from fee-for-service providers and under managed care plans. Data captured on dental services include the number of children receiving any services, any preventive services, and any treatment services.

The CMS 416s, however, are not sufficient for overseeing the provision of dental and other required EPSDT services in state Medicaid programs. We reported in 2001 that not all states submitted the required CMS 416s on time or at all. CMS 416s that states did submit were often based on incomplete and unreliable data. States faced challenges getting complete and accurate data, however, particularly for children in managed care. According to agency officials, CMS has taken steps since our 2001 report to improve the data. For example, CMS has conducted reviews of some states' EPSDT programs that included assessments of states' CMS 416 data. CMS officials said that 11 states' EPSDT programs had been reviewed since 2002. CMS has also required since 2002 that states collect data on utilization of dental and other required EPSDT services from managed care plans. State and national health association officials told us that these data have improved over time. But concerns about the CMS 416 remain. Concerns cited by state and national health association officials we contacted included inconsistencies in how states report data, data inaccuracies, and problems with the data captured that preclude calculating accurate rates of the provision of dental and other required EPSDT services. Further, the usefulness of the CMS 416 for federal oversight purposes is limited by the type of data currently requested. First, rates of dental services delivered to children in managed care cannot be identified from the data. Second, the data captured do not address whether children have received the recommended number of dental visits. And third, the data do not illuminate factors, such as the inability of beneficiaries to find dentists to treat them, which contribute to low use of dental services among Medicaid children.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you examine the Centers for Medicare & Medicaid Services' (CMS) oversight of dental care for the 31 million children from low-income families enrolled in the Medicaid program,[1] including the significant number of children covered by managed care. Medicaid is the joint federal-state program that provides health care coverage for certain low-income individuals. According to the Centers for Disease Control and Prevention, tooth decay is one of the most common chronic infectious diseases among U.S. children: 28 percent of children aged 2 to 5 have had decay in their primary (baby) teeth, about 50 percent by age 11. Untreated tooth decay may result in pain, dysfunction, and other problems that may lead to more serious health conditions and, on rare occasion, result in death. Low-income children—such as those enrolled in Medicaid—are estimated to be twice as likely to have untreated tooth decay as children in families with higher incomes.

In 1967, Congress established a comprehensive health benefit for children enrolled in Medicaid to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.[2] In 1989, Congress further defined EPSDT services to specifically include dental services.[3] As the agency responsible for overseeing the administration of states' Medicaid programs, CMS has an important role in ensuring that states comply with federal requirements, including that each state report annually to CMS on certain aspects of dental and other EPSDT services. Despite the known prevalence of tooth decay in the Medicaid population, recent CMS estimates of the provision of dental services, based on state reports to CMS, indicate that only about one-third of Medicaid children received a dental service in fiscal year 2005.

[1]Estimated enrollment for all children in Medicaid in fiscal year 2006.

[2]Social Security Amendments of 1967, Pub. L. No. 90-248, §302, 81 Stat. 821, 929 (1968) (codified, as amended, at 42 U.S.C. §1396d(a)(4)).

[3]Omnibus Budget Reconciliation Act of 1989 (OBRA), Pub. L. No. 101-239, § 6403(a), 103 Stat. 2106, 2262 (1989)(codified, as amended, at 42 U.S.C. §1396d(r)). EPSDT services include comprehensive, periodic evaluations of health, developmental, and nutritional status and dental, vision, and hearing services for individuals under age 21. EPSDT dental services must include dental services that are (1) provided at intervals that meet reasonable standards of dental practice; (2) provided at other intervals as medically necessary to determine the existence of a suspected illness or condition; and (3) include relief of pain and infections, restoration of teeth, and maintenance of dental health.

My remarks today will address the data that CMS requires states to submit on the provision of EPSDT dental services and the extent to which these data are sufficient for CMS oversight of the provision of EPSDT dental services for children enrolled in Medicaid. My testimony is based on reports we issued from 2000 through 2003,[4] an assessment of CMS's reporting requirements and state-submitted reports obtained from CMS in April 2007, and a review of selected CMS reports on EPSDT services and of related literature in April 2007. Our past work on the data CMS requires states to submit focused on the broad range of required EPSDT services, including dental services, but did not focus specifically on dental services data. We have supplemented these findings with information from our past work on oral health, including factors contributing to low use of dental services by low-income populations. We also updated relevant portions of our earlier information through interviews conducted in April 2007 with officials from CMS and state Medicaid programs in California, Illinois, Minnesota, New York, and Washington—states we contacted in our earlier work[5] or which were referred to us by an official from a national health association who considered the states' experiences to be relevant to our current work. We interviewed officials from national health associations, including the Children's Dental Health Project, Medicaid/SCHIP Dental Association, the National Academy of State Health Policy, the National Oral Health Policy Center, and the George Washington University Medical Center for Health Services Research and Policy. All of our work was conducted in accordance with generally accepted government auditing standards.

In summary, CMS collects annual data from states for purposes of overseeing the delivery of dental and other required EPSDT services. Each year, states must submit EPSDT reports known by the form on which they are submitted, the CMS form 416. The CMS 416 report (hereafter called the CMS 416) is designed to capture data such as the number of children who received any dental service, a dental preventive service, or a dental treatment service. CMS has indicated that the CMS 416 is used to assess

[4]*See Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care*, GAO-03-222 (Washington, D.C.: Jan. 14, 2003); *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001); and *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149 (Washington, D.C.: Sept. 11, 2000).

[5]For our 2001 study on federal government efforts to ensure state Medicaid programs provided covered EPSDT services, we contacted selected states, including Washington, and we visited California, Connecticut, Florida, New York, and Wisconsin. See GAO-01-749.

the effectiveness of state EPSDT programs to determine the number of children provided child health screening services, referred for corrective treatment, or receiving dental services.

The CMS 416s, however, are not sufficient for overseeing the provision of dental and other required EPSDT services in state Medicaid programs. We reported in 2001 that not all states submitted the required CMS 416s on time or at all. CMS 416s that states did submit were often based on incomplete and unreliable data. States faced challenges getting complete and accurate data, however, particularly for children in managed care. According to agency officials, CMS has taken steps since our 2001 report to improve the data. For example, CMS has conducted reviews of some states' EPSDT programs that included assessments of states' CMS 416 data. CMS officials said that 11 states' EPSDT programs had been reviewed since 2002. CMS has also required since 2002 that states collect data on utilization of dental and other required EPSDT services from managed care plans. State and national health association officials told us that these data have improved over time. But concerns about the CMS 416 remain. Concerns cited by state and national health association officials we contacted included inconsistencies in how states report data, data inaccuracies, and problems with the data captured that preclude calculating accurate rates of the provision of dental and other required EPSDT services. Further, the usefulness of the CMS 416 for federal oversight purposes is limited by the type of data currently requested. First, rates of dental services delivered to children in managed care cannot be identified from the data. Second, the data captured do not address whether children have received the recommended number of dental visits. And third, the data do not illuminate factors, such as the inability of beneficiaries to find dentists to treat them, which contribute to low use of dental services among Medicaid children.

We discussed the key findings of our testimony with CMS officials and obtained from them technical corrections, which we incorporated as appropriate. CMS commented on our earlier reports upon which our testimony is primarily based.[6]

[6]CMS generally agreed with the two related recommendations we made in 2001, that CMS work with states to improve EPSDT reporting and that CMS develop a mechanism for sharing model practices among states for providing EPSDT practices.

Background

Medicaid is one of the largest programs in federal and state budgets. In fiscal year 2005, the most recent year for which complete information is available, total Medicaid expenditures were an estimated $317 billion. The estimated federal share that year was about $182 billion. States pay qualified health providers for a broad range of covered services provided to Medicaid beneficiaries, and the federal government reimburses states for their share of these expenditures. The federal matching share of each state's Medicaid expenditures for services is determined by a formula defined under federal law and can range from 50 percent to 83 percent. Each state administers its Medicaid program in accordance with a state plan, which must be approved by CMS.[7] Medicaid is an open-ended entitlement program, under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under each state's federally approved Medicaid plan.

States have considerable flexibility in designing their Medicaid programs, including certain aspects of eligibility, covered services, and provider payment rates. But under federal law, states generally must meet certain requirements for what benefits are to be provided, who is eligible for the program, and how much these beneficiaries can be required to pay in sharing the cost of their care. States are required, for example, to cover certain services under their state plans, such as physician, hospital, and nursing facility services, as well as EPSDT services for beneficiaries under the age of 21.[8]

EPSDT Services

EPSDT services are designed to target health conditions and problems for which children are at risk, including obesity, lead poisoning, dental disease, and iron deficiency. EPSDT services are also intended to detect and correct conditions that can hinder a child's learning and development, such as vision and hearing problems. For many children, particularly those with special needs related to disabilities or chronic conditions, EPSDT services can help to identify the need for, and make available, essential medical and support services.

[7]In order to qualify for federal matching funds, a state plan must detail certain elements of a Medicaid program, including the populations served, the services the program covers, and the rates of and methods for calculating payments to providers. Any changes a state wishes to make to the state plan must be submitted to CMS for review and approval in the form of a state plan amendment.

[8]See 42 U.S.C. §§ 1396a(a)(10)(A),1396d(a).

State Medicaid programs are required to cover EPSDT services for Medicaid beneficiaries under 21.[9] These services are defined as screenings, which must include a comprehensive health and developmental history, a comprehensive unclothed physical exam, appropriate immunizations, laboratory tests (including a blood-lead assessment), and health education. Other required EPSDT services include

- dental services, which must include relief of pain and infections, restoration of teeth, and maintenance of dental health;
- vision services, including diagnosis and treatment for vision defects, and eyeglasses;
- hearing services, including diagnosis and treatment for hearing defects, and hearing aids; and
- services necessary to correct or ameliorate physical and mental illness discovered through screenings, regardless of whether these services are covered under the state's Medicaid plan for other beneficiaries.[10]

Although state Medicaid programs must cover EPSDT services, states have some flexibility in determining the frequency and timing of screenings, including the provision of dental services. Federal law requires states to provide dental services at intervals that meet reasonable standards of dental practice, and each state determines these intervals after consulting with recognized dental organizations.[11] Each state must also develop dental periodicity schedules, which contain age-specific timetables that identify when dental examinations should occur.

Medicaid Delivery and Financing

States generally provide Medicaid services through two service delivery and financing systems—fee-for-service and managed care. Under a fee-for-service model, states pay providers for each covered service for which they bill the state. Under a managed care model, states contract with managed care plans, such as health maintenance organizations, and prospectively pay the plans a fixed monthly fee, known as a capitated fee,

[9]42 U.S.C. §1396d(a)(4)(B).

[10]See 42 U.S.C. §1396d(r).

[11]See 42 U.S.C. §1396d(r)(3)(A). State Medicaid programs, however, must also provide dental services whenever necessary to identify a suspected illness.

per Medicaid enrollee to provide or arrange for most medical services.[12] This model is intended to create an incentive for plans to provide preventive and primary care to reduce the chance that beneficiaries will require more expensive treatment services in the future. However, this model may also create a financial incentive to underserve or deny beneficiaries access to certain services.

State Medicaid agencies use a variety of delivery and payment approaches to provide dental services under Medicaid. These include (1) paying managed care plans with which they have contracts to cover or arrange for the provision of dental services; (2) "carving out" or not requiring the provision of dental services from the group of services provided by managed care plans and paying dentists on a fee-for-service basis; or (3) carving out the dental services and paying specialized dental managed care plans to provide Medicaid dental benefits, giving the managed care dental plan flexibility in managing the program in exchange for a capitated payment to cover dental services. According to the American Dental Association, 18 states and the District of Columbia used one or more managed care dental plans to provide Medicaid dental benefits in 2004.

Much of the Medicaid population is covered by some form of managed care, and consequently Medicaid managed care plans often provide EPSDT services. In 1991, 2.7 million beneficiaries were enrolled in some form of Medicaid managed care. According to CMS statistics, this number grew to 27 million in 2004—a tenfold increase—after the Balanced Budget Act of 1997 (BBA) gave states new authority to require certain Medicaid beneficiaries to enroll in managed care plans.[13] CMS estimates that in 2004,

[12]Throughout our testimony, the term managed care refers to capitated managed care arrangements and fee-for-service arrangements that include primary care case management arrangements. In our earlier work on states' approaches to monitoring children's access to care, we included primary care case management arrangements as fee-for-service arrangements because participating providers were predominately paid on a fee-for-service basis.

[13]The BBA allowed states to implement mandatory managed care through amendments to their state plans, as opposed to obtaining CMS approval to waive certain federal statutory provisions. The BBA also required the establishment of consumer protections in such areas as access to and quality of care for Medicaid managed care enrollees. See BBA, Pub. L. No. 105-33, §§ 4701, 4704-4705, 111 Stat. 251, 489-501(1997) (codified, as amended, at 42 U.S.C. §1396u-2).

about 60 percent of Medicaid enrollees received benefits through some form of managed care.[14]

CMS Requires States to Report Annually on Provision of EPSDT Dental Services through the CMS 416

CMS requires states to report annually on the provision of EPSDT dental services through the CMS 416, the agency's primary tool for overseeing the provision of dental services to children in state Medicaid programs. The CMS 416 is used to report a range of EPSDT services. CMS implemented the CMS 416 to comply with the Omnibus Budget Reconciliation Act of 1989 (OBRA), which required that the Secretary of Health and Human Services establish state-specific annual goals for children's participation in EPSDT services. OBRA and implementing regulations mandated state-established periodicity schedules for health, dental, vision, and hearing screenings and related services.[15] CMS initially required states to provide only one type of dental-related data: the dental assessments provided. This requirement was expanded in 1999 to collect more detailed data.

According to CMS, the CMS 416 is used to assess the effectiveness of state EPSDT programs in terms of the number of children who are provided child health screening services, referrals for corrective treatment, and dental services. Child health screening information is used to calculate the provision of health screenings and states' progress in meeting an 80 percent screening participation goal. For dental services, the CMS 416 captures, by age group, the total number of eligible children

- receiving any dental services,

[14]All states except Alaska, New Hampshire, and Wyoming have all or a portion of their Medicaid population enrolled in managed care. CMS's statistics include the Medicaid population enrolled in capitated plans and primary care case management models. These latter programs were not included as part of our 2001 and 2003 reviews related to managed care. In 2001, we reported that compared to primary care case management enrollment, about five times as many beneficiaries were enrolled in capitated managed care plans. CMS's statistics do not define the extent that Medicaid beneficiaries are enrolled in managed care that specifically cover dental services.

[15]OBRA also required blood-lead assessments (for lead poisoning) appropriate for age and risk factors. OBRA also imposed new EPSDT reporting requirements, specifically requiring states to report annually to the Secretary of Health and Human Services, by age group and by basis of eligibility, (1) the number of children provided child health screening services, (2) the number of children referred for corrective treatment, (3) the number of children receiving dental services, and (4) the state's results in attaining defined participation goals. OBRA, Pub. L. No. 101-239, § 6403, 103 Stat. at 2263 (1989) (codified, as amended, at 42 U.S.C. §1396d(r)).

- receiving any preventive dental services (each child is counted only once even if more than one preventive service is provided), and
- receiving dental treatment services (each child is counted only once even if more than one treatment service is provided).

CMS officials told us in April 2007 that CMS had not established a participation goal or other standard that states are expected to meet specifically for the provision of dental services. CMS officials told us they calculate state and national ratios only for child health screenings and participation.

The CMS 416 also requires states to report the number of individuals eligible for EPSDT services who are enrolled in managed care at any time during the reporting year.[16] States are required to report information on all EPSDT dental services provided to children, regardless of whether those services are provided under a fee-for-service or managed care arrangement.

Quality of CMS Data on EPSDT Dental Services Has Improved, but Data Have Limited Usefulness for Oversight

We have issued a number of reports that highlighted various problems in the delivery of EPSDT dental services and with the reporting of dental and other required EPSDT services provided.[17] Problems we found in 2001 with the CMS 416 reporting included states not submitting CMS 416s on time or at all and states submitting reports that were not complete because of challenges they faced collecting accurate data. In our 2001 report, we recommended that CMS work with states to improve EPSDT reporting and the provision of EPSDT services. According to agency officials, CMS has taken steps to improve the CMS 416 data.[18] However, state and national health association officials continue to cite concerns about the data's completeness and sufficiency for purposes of overseeing the provision of dental and other required EPSDT services.

[16]The CMS 416 instructions for managed care include reporting any capitated arrangements, such as health maintenance organizations or individuals assigned to a primary care provider or primary care case manager, regardless of whether reimbursement is on a fee-for-service or capitated basis (many primary care case management arrangements are paid on a fee-for-service basis).

[17]See related GAO products listed at the end of this report.

[18]Our recommendation was made to the Administrator of CMS. In the same 2001 report, we recommended that CMS develop mechanisms to share successful state, plan, and provider practices with states for reaching children in Medicaid.

State CMS 416s Are Not Always Submitted or Complete

Some states have submitted their CMS 416s late, and others have not submitted the CMS 416s at all. Further, states that did submit reports may have provided incomplete data because of challenges in collecting the data. Therefore, the reports cannot be used to provide national estimates of the provision of dental and other required EPSDT services to children in Medicaid or to assess every state's progress in providing services. We first reported this problem in July 2001. States were required to submit their fiscal year 1999 CMS 416 reports by April 1, 2000. But as of January 2001, 15 states had not submitted their reports, and another 15 states' reports had been returned by CMS because they were deficient. As of April 2007, 7 states had not submitted their CMS 416s for fiscal year 2005 (due to CMS by April 1, 2006), and another 2 states had submitted reports, but CMS considered them deficient and was working with the states to improve their reports. We estimate that these 9 states account for 20 percent of all children enrolled in Medicaid nationwide.

Another long-standing concern with the CMS 416s submitted by states has been the completeness of the data on dental and other required EPSDT services used to compile the reports. Our July 2001 report found that states faced challenges collecting data on EPSDT services from both fee-for-service providers and managed care plans. Under the fee-for-service approach, providers bill the state for each EPSDT service they deliver. Thus, data on EPSDT services are often collected by the state as part of the payment process. Most of the states we examined for our 2001 report had some difficulty obtaining complete and accurate data from fee-for-service providers—for example, due to coding or system issues. States faced more extensive problems obtaining data from capitated managed care plans. Unlike fee-for-service arrangements, when capitated managed care plans pay their participating providers a flat fee per beneficiary regardless of services provided, the providers do not need to submit information on each service provided in order to receive payment. Thus plans have had difficulty reporting on the provision of specific EPSDT services separately as required by states.

CMS Has Taken Steps to Improve Quality of the Data, but Concerns Remain

CMS officials have reported taking several actions in response to our 2001 recommendation that the Administrator of CMS improve EPSDT reporting.[19] CMS reported, for example, that it had started assessing states' CMS 416s as part of periodic focused reviews conducted by CMS regional offices. We reported in 2001 that CMS regional office reviews of states' EPSDT programs had been helpful in highlighting policy and process concerns, as well as innovative state practices. Since 2002, according to CMS in April 2007, the agency had conducted focused reviews in 11 states. These reviews have evaluated, among other things, state data collection and reporting, including the extent to which the state develops its CMS 416 in accordance with instructions and uses the data to measure progress and define areas for improvement. During these reviews, CMS found deficiencies, such as incorrect coding and incomplete data. CMS made specific recommendations to the states that would improve the reliability of the state-generated CMS 416 data.

Another step CMS has taken that has improved the quality and completeness of the data states can use to compile their 416s was to require states to gather encounter data from Medicaid managed care plans. The BBA and implementing regulations require states that contract with managed care plans to implement a quality assessment and improvement strategy that included procedures for monitoring and evaluating the quality and appropriateness of services provided under the contracts. States are also required to ensure that managed care plans maintain a health information system and report encounter data.[20] CMS also developed a protocol for states' use for validating encounter data. Officials from several states and national health associations we contacted in preparation for this hearing generally said that, although problems remain, the quality and completeness of the underlying data, such as managed care encounter data, that states used to prepare the CMS 416, had improved since 2001. CMS officials indicated a number of efforts were underway to

[19]See footnote 23.

[20]The BBA required states that contract with managed care plans to implement a quality assessment and improvement strategy that includes procedures for monitoring and evaluating the quality and appropriateness of services provided under the contracts. Pub. L. No. 105-33, §4705, 111 Stat. 498-501 (1997) (codified, as amended, at 42 U.S.C. §1396u-2). Implementing regulations published in 2002 required, for example, that states ensure that managed care plans maintain a health information system that collects, analyzes, integrates, and reports data. This health information system must collect data on enrollee and provider characteristics as specified by the state and on services furnished to enrollees through an encounter data system or other methods as may be specified by the state. See 42 C.F.R. § 438.242.

evaluate other quality and outcome measures of dental services provided to children enrolled in Medicaid. For example, one measure CMS is considering is the Quality Compass developed by the National Committee for Quality Assurance that provides plan-specific, comparative, and descriptive information for use as a health plan benchmarking tool.

But despite these improvements, officials from states and from national health associations remain concerned that the CMS 416s are unreliable for developing national estimates of the provision of dental and other required EPSDT services and therefore insufficient for oversight purposes. Although some officials cited some uses of the CMS 416, for example, as a set of basic indicators of the extent to which children use dental services over time, the officials cited several different problems.

- **Inconsistent data collection**. Citing differences in how states collected data on dental EPSDT services, an April 2005 National Oral Health Policy Center report stated that comparing the number of children receiving services over time or examining the rate of dental utilization across states should be done with caution. The Center's director provided several examples. For instance, some states inappropriately reported oral health assessments conducted in group settings, such as those performed by nurses or other non-dentist health providers in schools, as dental examinations. Likewise, some states inappropriately reported oral health assessments provided by hygienists as dental examinations. According to the director, such assessments should not be considered dental examinations.

- **Coding inconsistencies and anomalies**. CMS 416s may not accurately reflect the provision of dental and other required EPSDT services, according to an official from the National Academy for State Health Policy speaking about research she had done in 2002 and 2004. States have reported that discrepancies exist between managed care plans and state Medicaid agencies in the definitions of ESPDT services. Similarly, we reported in 2001 that states faced such issues in collecting CMS 416 data for the range of EPSDT services that might be provided during a comprehensive office visit. For example, providers in Florida were required to use a specific EPSDT code and a claim form to document the components of EPSDT services they provided. However, according to state officials, providers often chose to use other codes instead. According to the officials, some providers submitted claims under a comprehensive office-visit code for a new patient that paid a higher rate than an EPSDT screening, or used other comprehensive office-visit codes that required less documentation. Specific to dental EPSDT services, the George Washington University Medical Center reported in December 2003 that

several Medicaid program representatives said that it was difficult to separate specific provided services in EPSDT data reported by managed care plans to determine the provision of dental screening services because providers did not always bill for those services separately.[21]

- **Changes in beneficiary eligibility**. Gaps in children's eligibility for Medicaid and movement of children between Medicaid and other health insurance plans may also cause problems in accurately determining the extent that Medicaid children received dental and other required EPSDT services. One official told us that interrupted Medicaid eligibility, accompanied by the implementation of the State Children's Health Insurance Program,[22] has also caused problems in the data on the number of children eligible for services. As children move between health insurance programs as their program eligibility changes, officials reported that it becomes difficult to maintain an accurate count of Medicaid-eligible children. Without an accurate count, an accurate rate of the provision of the dental and other required EPSDT services to eligible children cannot be calculated.

CMS 416s Have Limitations for Oversight Purposes

The type of data collected on the CMS 416 has limited usefulness for purposes of oversight, as officials from states and national health associations have noted. Many officials from national health associations told us that the CMS 416 did not provide enough information to allow CMS to assess the effectiveness of states' EPSDT programs. One official who works with many state Medicaid agencies told us that states do not generally use the CMS 416 to inform their monitoring and quality improvement activities, but instead rely on other sources of data. Some state officials reported using the CMS 416 data, but noted that they supplement the data with additional information.

[21]See *Accountability in Medicaid Managed Care: Implications for Pediatric Health Care Quality*, the George Washington University Medical Center School of Public Health and Health Services, December 2003. Funded by the David and Lucile Packard Foundation.

[22]The State Children's Health Insurance Program (SCHIP) is a federal and state program that finances health insurance for children and certain adults whose incomes are low, but are above Medicaid's eligibility requirements. States may implement SCHIP programs by expanding Medicaid programs, developing separate SCHIP programs, or a combination of both. If a state elects Medicaid expansion, it must provide EPSDT services to SCHIP beneficiaries.

The limitations noted generally fell into three categories. First, while states report the total number of children enrolled in managed care plans, dental and other required EPSDT services delivered to managed care enrollees are not reported separately from fee-for-service enrollees. Consequently, the data captured by the CMS 416 cannot be used to specifically monitor the provision of dental and other required EPSDT services under either fee-for-service or managed care arrangements.

Second, the information captured by the CMS 416 is limited to summary statistics, such as age group, eligibility, state requirements, and services delivered, and does not provide information that would illuminate whether children have received the recommended number of visits for dental and other required EPSDT services. For example, a concern raised by a national health association official was that the CMS 416 did not provide information about whether eligible children had received the number of biannual preventive dental visits that are required by the state or recommended by the American Academy of Pediatric Dentistry. Because each child is counted only once each fiscal year, regardless of the number of dental services or preventive dental services the child received that year, the data do not reflect the total number of dental appointments each child had in any given year.

Third, CMS 416s do not contain information that would illuminate any of a number of factors that may contribute to low use of dental and other required EPSDT services among children enrolled in Medicaid. Our 2001 report found that children's low utilization of EPSDT dental and other services could have been attributed to program-related matters, such as limited provider participation in Medicaid or inadequate methods for informing beneficiaries of available services. In addition, some beneficiary-related factors, such as changing eligibility status or language barriers, could have limited utilization of services. Also, our 2000 report on factors contributing to low utilization of dental services by Medicaid and other low-income populations found that the primary contributing factor among low-income persons with coverage for dental services was difficulty finding dentists to treat them. Dentists generally cited low payment rates, burdensome administrative requirements, and such patient issues as frequently missed appointments as the reasons why they did not treat more Medicaid patients.[23] Additional, more specific information

[23]GAO/HEHS-00-149.

would be needed to supplement the information collected in the CMS 416 to further understand these factors.

Concluding Observations

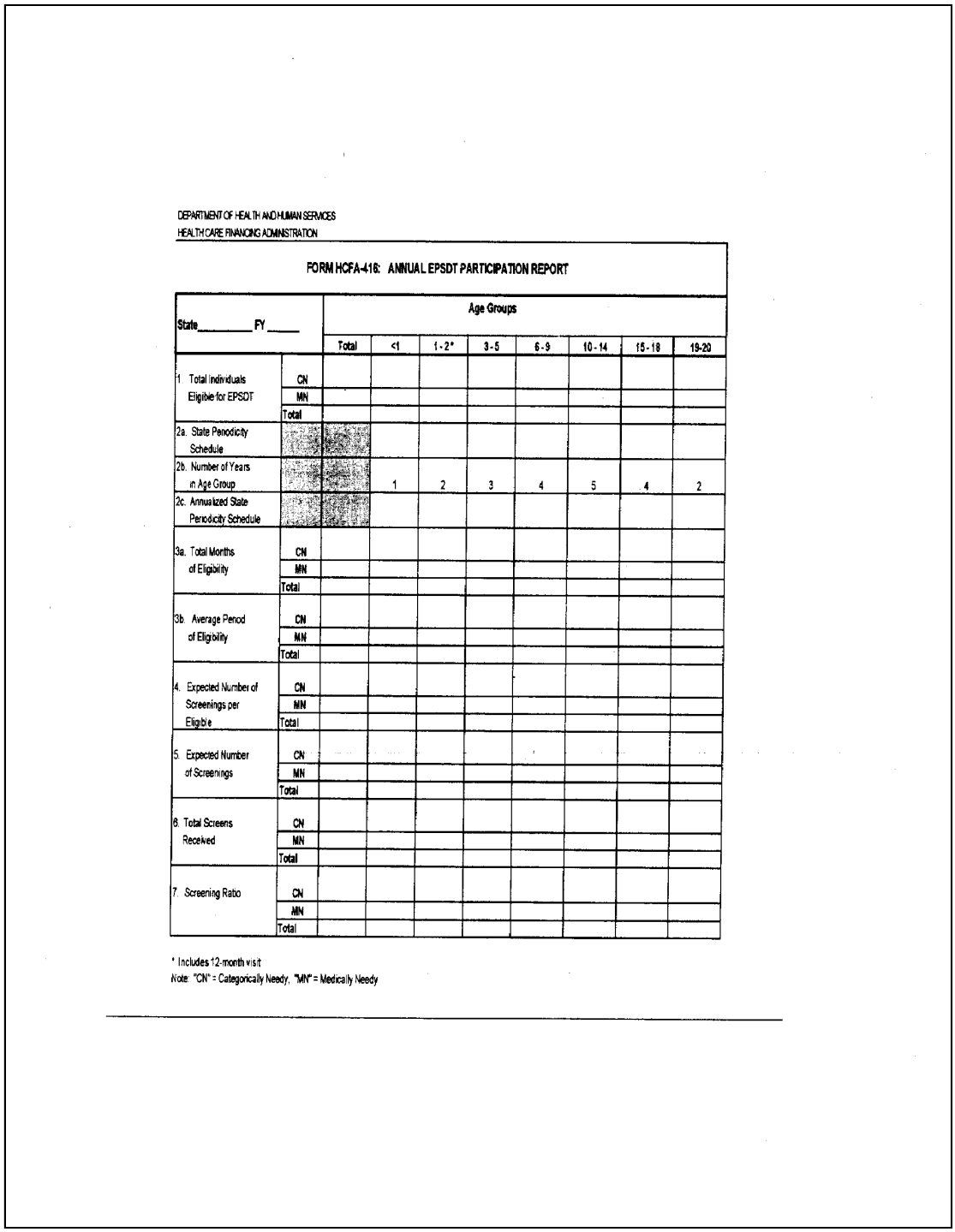
Millions of low-income children enrolled in Medicaid should have access to important services to treat dental disease, as intended by Congress in mandating the coverage of and reporting on the provision of EPSDT dental services. Services to identify and treat tooth decay—a chronic problem among low-income populations and a preventable disease—are critical for ensuring that the nation's children and adolescents are healthy and prepared to learn. Unfortunately, as we reported in 2001 and 2003, data for gauging Medicaid's success in providing these important services to enrolled children are unreliable and incomplete. CMS and states have taken a number of steps to improve the data, but problems persist. Moreover, concerns have been raised that the reported data on EPSDT dental services have limited utility for determining how to improve children's access to these services. Strengthening the safety net for children in Medicaid will require additional efforts to gather more complete and reliable information on the delivery of dental and other ESPDT services.

Mr. Chairman, this concludes my prepared remarks. I would be pleased to respond to any questions that you or other members of the Subcommittee may have at this time.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please contact James C. Cosgrove at (202) 512-7118 or at cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Katherine Iritani, Assistant Director; Emily Beller; Terry Saiki; and Timothy Walker made key contributions to this statement.

Appendix I: CMS Form 416



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

State_____ FY ____		Age Groups							
		Total	<1	1-2*	3-5	6-9	10-14	15-18	19-20
1. Total Individuals Eligible for EPSDT	CN								
	MN								
	Total								
2a. State Periodicity Schedule									
2b. Number of Years in Age Group			1	2	3	4	5	4	2
2c. Annualized State Periodicity Schedule									
3a. Total Months of Eligibility	CN								
	MN								
	Total								
3b. Average Period of Eligibility	CN								
	MN								
	Total								
4. Expected Number of Screenings per Eligible	CN								
	MN								
	Total								
5. Expected Number of Screenings	CN								
	MN								
	Total								
6. Total Screens Received	CN								
	MN								
	Total								
7. Screening Ratio	CN								
	MN								
	Total								

* Includes 12-month visit
Note: "CN" = Categorically Needy, "MN" = Medically Needy

State_____ FY_____		Age Groups							
		Total	<1	1 - 2 *	3 - 5	6 - 9	10 - 14	15-18	19-20
8. Total Eligibles Who Should Receive at Least One Initial or Periodic Screen	CN								
	MN								
	Total								
9. Total Eligibles Receiving at Least One Initial or Periodic Screen	CN								
	MN								
	Total								
10. Participant Ratio	CN								
	MN								
	Total								
11. Total Eligibles Referred for Corrective Treatment	CN								
	MN								
	Total								
12a. Total Eligibles Receiving Any Dental Services	CN								
	MN								
	Total								
12b. Total Eligibles Receiving Preventive Dental Services	CN								
	MN								
	Total								
12c. Total Eligibles Receiving Dental Treatment Services	CN								
	MN								
	Total								
13. Total Eligibles Enrolled in Managed Care	CN								
	MN								
	Total								
14. Total number of Screening Blood Lead Tests	CN								
	MN								
	Total								

* Includes 12-month visit

Note: "CN" = Categorically Needy, "MN" = Medically Needy

Related GAO Products

Medicaid and SCHIP: States Use Varying Approaches to Monitor Children's Access to Care. GAO-03-222. Washington, D.C.: January 14, 2003.

Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services. GAO-01-749. Washington, D.C.: July 13, 2001.

Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations. GAO/HEHS-00-149. Washington, D.C.: September 11, 2000.

Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations. GAO/HEHS-00-72. Washington, D.C.: April 12, 2000.

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