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**OFFICE OF
INSPECTOR GENERAL**

**STATE CHILDREN'S HEALTH
INSURANCE PROGRAM**

Assessment of State Evaluations Reports



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EXECUTIVE SUMMARY

PURPOSE

To assess States' evaluations of their performance goals, particularly those focused on reducing the number of uninsured children.

BACKGROUND

Many low-income children receive health care coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). SCHIP is designed to reduce the number of uninsured children by offering health care coverage to previously uninsured children. The program targets children with family income too high for Medicaid and too low to afford private insurance.

States annually report the results of SCHIP assessments to the Secretary of the Department of Health and Human Services. States also submitted evaluations of their programs and progress meeting goals to the Secretary by March 31, 2000.

The Balanced Budget Refinement Act of 1999 requires that the Office of Inspector General (OIG) sample States in order to: (1) evaluate whether States are correctly enrolling children in SCHIP or Medicaid, and (2) assess States' progress reducing the number of uninsured low-income children. The Act further requires the OIG to evaluate the progress sampled States have made to achieve their strategic objectives and performance goals. Sampled States must be selected from States only using SCHIP funds to operate SCHIPs separate from their Medicaid programs and cannot be selected from States using SCHIP funds to expand their Medicaid programs.

This is one of two reports on five States administering separate child health programs. This report focuses on five States' evaluations of their performance goals. In the companion report, we address State efforts to ensure that Medicaid eligibles are not enrolled in SCHIP.

FINDINGS

Questionable evaluations undermine the reliability of State reports of success

Sampled States report reductions in the number of uninsured children and mixed success meeting other goals. SCHIP reports rely heavily on enrollment data and tend to use descriptive information in lieu of evaluation. These problems may render State reports of reductions in the number of uninsured unreliable.

Evaluations have conceptual and technical weaknesses

States report, and our evaluations confirmed, that problems with data impair State evaluations. States often set progress goals without thoroughly conceptualizing how evaluations would be conducted. Program evaluation is generally a low priority for SCHIP administrators, and program staff often lack evaluation skills and training. State reporting also is impaired by unreliable data often not comparable among populations and based on small populations that move frequently in and out of the programs. State data is often incomplete.

RECOMMENDATIONS

The Health Care Financing Administration (HCFA) should develop a more specific framework for the content and structure of the reports States are required to submit.

The HCFA should identify a core set of evaluation measures that will enable all SCHIP States to provide useful information. HCFA should also develop a more specific framework for the content and structure of State evaluations.

HCFA and the Health Resources and Services Administration (HRSA) should provide guidance and assistance to States in conducting useful evaluations of their programs.

To conduct more useful evaluations, SCHIP staff would benefit from assistance and/or training regarding data collections and evaluation, and resource determination.

The HCFA and HRSA should assist States in building their capacity to collect required data, and work together to provide States with training and guidance. States would benefit from assistance regarding what data to collect, how to obtain specific data, how to determine if data is reliable, how to determine what the data is yielding, and how to evaluate the data. In addition, HCFA and HRSA should work with States to identify external sources of data and, as appropriate and necessary, work with these external sources to improve the reliability of data.

Currently, poor coordination exists between SCHIP administration and the evaluation of SCHIPs. Program administrators indicated that their current focus is on enrolling children into the SCHIPs and, consequently, less attention is paid to evaluation. They also indicated that Federal reporting requirements are burdensome and funds for robust evaluations are lacking. The HCFA and HRSA should provide training to administrators and staff to help reduce the poor coordination between administration and evaluation, and make normal staff activities part of the evaluation process. The HCFA and HRSA should also work with States to identify, where needed, additional evaluation resources.

AGENCY COMMENTS

The Health Care Financing Administration and the Health Resources and Services Administration provided formal comments to the draft report. Both concur with the findings and recommendations. The full text of their comments are included in Appendices A and B.

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INTRODUCTION

PURPOSE

To assess States' evaluations of their performance goals, particularly those focused on reducing the number of uninsured children.

BACKGROUND

Many low-income children receive health care coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). Both Medicaid and SCHIP are joint State-Federal programs that allow States administrative discretion within guidelines established by statute and the U.S. Department of Health and Human Services.

Medicaid, which was established in 1965, is the largest program providing health care services to America's poorest people. Within broad national guidelines set by the Federal Government, each State administers its own program, sets its own eligibility standards, determines the type, amount, duration and scope of services, and sets payment rates.

Total non-administrative expenditures for the Medicaid program were \$180.9 billion in 1999 (\$102.5 billion in Federal and \$78.4 billion in State funds). The Health Care Financing Administration (HCFA) reports that in 1998, 51 percent of all Medicaid recipients were children. In 1998, Medicaid paid an average of \$1,150 per child for the 20.6 million children who received services through the program.

The State Children's Health Insurance Program and uninsured children

Over 10 million children in the United States are uninsured. SCHIP is designed to help reduce the number of uninsured low-income children by providing them with health care coverage. Title XXI of the Social Security Act (SCHIP's enabling legislation) was created by the Balanced Budget Act of 1997 (P.L. 105-33). The law appropriated nearly \$40 billion over 10 years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private insurance.

Like Medicaid, SCHIP is a State and Federal partnership, but the Federal match for SCHIP expenses is greater than the match for Medicaid. States have three options for covering uninsured children under Title XXI: design a separate SCHIP program, expand Medicaid eligibility, or a combination of the two strategies. As of October 1, 2000,

15 States are administering separate SCHIPs, 23 run expanded Medicaid, and 18 have a combination of programs.¹ This report focuses on 5 of the 15 States operating separate SCHIP programs. These States are Arizona, Colorado, Delaware, Georgia, Kansas, Montana, Nevada, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington, and Wyoming.

Under Title XXI, a State must have an approved State plan for a fiscal year in order to receive an allotment that year. Each State submitted a SCHIP plan to HCFA, outlining program structures, use of funds, benefits, strategic objectives, and performance goals.

Close to two million children who would otherwise be without health insurance coverage were enrolled in SCHIP in fiscal year 1999. This is double the number reported enrolled in 1998, the first full year of the program. Of the 56 State and territorial children's health insurance programs to date, 53 were operational during fiscal year 1999. Of the nearly two million children covered as of September 30, 1999, over 1.2 million children were enrolled in separate State-designed children's health insurance programs and almost 700,000 were enrolled in Medicaid expansion plans.

Ensuring correct enrollment in SCHIP and Medicaid

To encourage States to expand child health insurance eligibility, the Federal match for States' Title XXI expenditures is greater than the match for Medicaid. The average federal match for Title XXI is 71 percent, while the average Federal match for Medicaid is 57 percent. Medicaid is an entitlement program, and States are required to enroll all eligible children. SCHIP is not an entitlement program and States have the discretion to cap enrollment for SCHIP eligibles or create waiting lists. So that States do not try to maximize SCHIP reimbursements by enrolling Medicaid eligibles in SCHIP, Title XXI requires States to screen SCHIP applicants for Medicaid eligibility. Children found eligible for Medicaid must be enrolled in Medicaid rather than in SCHIP. States receive only the Medicaid-level match for any child enrolled in Medicaid based on the eligibility standards that existed before Title XXI was enacted. Due to their effort to enroll children in new Title XXI funded programs, some States have noticed the so-called "woodwork effect"; by conducting outreach for SCHIP, they encourage greater numbers of Medicaid eligibles to apply for health care services as well.

Statutory Requirement for States to Evaluate SCHIP

Section 2107 of the SCHIP enabling legislation outlines the requirements for the programs' strategic objectives and performance goals. However, the language is fairly broad, requiring only that each SCHIP State plan include a description of the program's strategic objectives and performance goals. The strategic objectives must relate to increasing health coverage for low-income children. The State must establish at least one performance goal for each strategic objective.

¹ Currently, 50 States, 5 Territories and the District of Columbia administer Title XXI programs.

The SCHIP plans must also include the program performance measures that the State plans to use to assess the provision of health insurance to low-income children and other efforts to maximize health benefit coverage for low-income and other children. Performance measures must be measurable through objective, independently verifiable means. To determine State program performance, the measures are to be assessed against State goals described in the approved SCHIP plan.

Section 2108(b) of the Social Security Act requires each State to evaluate its Title XXI program. Each January 1, States must provide an annual report to the Secretary of the Department of Health and Human Services on the results of State assessments. In addition, each State was required to submit an evaluation to the Secretary by March 31, 2000. Information that the States provided to the Secretary in their March 2000 reports will be used in the Secretary's Report to Congress in 2001. A contractor is currently analyzing State evaluations and will report to the Secretary on States' efforts.

SCHIP Evaluation

The annual SCHIP report and the March 2000 evaluation report cover some of the same information. For this reason, HCFA allowed States to submit the most recent annual report as part of the March 2000 report. All States utilized a single framework for their State evaluation reports. The National Academy for State Health Policy developed the framework for the report, along with a group of State officials and representatives from HCFA. Congressional staff, State program administrators, and child advocates reviewed and commented on drafts of the report framework.

Evaluation reports submitted to HCFA in March 2000 were designed to provide information on the progress of State efforts to meet the strategic objectives they outlined in their SCHIP plans. The framework included a section for a summary description of key accomplishments in decreasing the number of uninsured low-income children. States were asked to provide information about how they developed estimates of insurance coverage, as well as how reliable they think their estimates are.

In order to indicate progress made to achieve a State's strategic objectives, the report framework includes a structure for States to report the data and methodology used to measure progress toward objectives and goals, and an assessment of any progress made. The report also includes significant background information on the SCHIP as well as local environmental factors and trends affecting the State program. States are asked to assess their experiences with enrollment, disenrollment, expenditures, access to care, and quality of care. The final section provides a chance for the State to reflect on successes and challenges facing the program.

Strategic objectives. Title XXI allows States to establish their SCHIP strategic objectives. As outlined in their SCHIP State plans, the States in our sample established strategic objectives focused on reducing the number of uninsured children and improving access to care for children.

State strategic objectives also relate to:

- increasing awareness of health care programs and options;
- conducting outreach and increasing public awareness of SCHIP;
- monitoring utilization of services;
- improving health care services or outcomes; and
- encouraging service use by program participants.

Performance goals. Most States identified a single goal for each of their strategic objectives. One sampled State went further, providing three to five goals for several of its objectives. The goals were developed as part of the SCHIP plans and were often developed by a group comprised of representatives from multiple State agencies. Two States specifically set up SCHIP, and thus their goals for the program, to match their existing Medicaid programs.

Legislative Requirement for OIG Studies

Section 703 of the Balanced Budget Refinement Act of 1999 required that the Office of Inspector General (OIG) sample States in order to: (1) evaluate whether States are correctly enrolling children in SCHIP or Medicaid as appropriate; and (2) assess the progress made by States to reduce the number of uninsured low-income children. The Act further required that the OIG evaluate the progress sampled States have made to achieve their strategic objectives and performance goals. Sampled States must be selected from States not using any SCHIP funds to expand Medicaid.

This is one of two reports focusing on a sample of five States administering separate SCHIP. This report focuses on States' evaluations of their performance goals. In a companion report entitled "State Children's Health Insurance Plan - Ensuring Medicaid Eligibles are not Enrolled in SCHIP," OEI-05-00-00241, we address State efforts to ensure Medicaid eligibles are not enrolled in SCHIP.

METHODOLOGY

Based on the requirements outlined in the Balanced Budget Refinement Act of 1999, we limited our universe to the 15 States utilizing their Title XXI allotments to operate separate child health programs. Two States, Wyoming and Washington, were excluded from the population because they began administering SCHIP in December 1999 and February 2000, respectively, and thus had no enrollees in fiscal year 1999.

We used a 2-stage stratified-cluster sampling plan to select 5 States from the 13 remaining States. The remaining 13 States were divided among 2 strata. Pennsylvania was a self-representing State as illustrated in Strata 1, based on the significantly large number of children enrolled in their SCHIP. From the remaining 12 States, we randomly selected 4 States, North Carolina, Oregon, Utah, and Vermont, for Strata 2. The chart on the following page outlines the number of children enrolled in SCHIP in each of the Strata and sample States in Fiscal Year 1999.

Selected Sample States

STRATA 1

States Selected	Number of Children Enrolled in SCHIP in FY 1999	Number of Cases Selected For Review
Pennsylvania	81,758	100
Totals	81,758	100

STRATA 2

States Selected	Number of Children Enrolled in SCHIP in FY 1999	Number of Cases Selected For Review
North Carolina	57,300	100
Oregon	27,285	100
Utah	13,040	100
Vermont	2,055	100
Totals	99,680	400

We reviewed the 5 States' Title XXI plans and the SCHIP evaluation reports submitted to HCFA in March 2000. We conducted on-site visits and met with staff at the agency administering the SCHIP in each of the five States.

We conducted case file reviews and discussed enrollment issues and goal attainment with State staff. We reviewed 100 randomly selected active SCHIP case files in each State in order to evaluate whether ineligible children were enrolled in SCHIP. We provided each State with randomly selected case numbers and staff pulled these cases in preparation for our visit. The results of our case review were analyzed using a statistical analysis package that takes into account complex sample designs.

One part of our discussions with SCHIP staff focused on State efforts to appropriately enroll children and safeguards used to ensure proper enrollment. We also discussed SCHIP evaluations. We collected documentation of State eligibility and enrollment practices and of evaluation efforts.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Questionable evaluations undermine the reliability of State reports of success

The five sampled States report success reducing the number of uninsured children, but they did not evaluate all of their goals. Further, the evaluations they conducted are impaired by their reliance on descriptive explanations, a lack of objective measurement, and problems with the data used in analysis.

State reports of reductions in number of uninsured may be unreliable

States report reductions in the number of uninsured children. Our analysis of States' data and methods used leads us to question the reliability of State figures.

Reports of reductions. The evaluation report in one of the sampled States notes that it is difficult to prove a causal relationship between increased SCHIP enrollment and a reduction in the number of uninsured. Evaluation reports in the other four States provide information on decreases in the number of uninsured children within the State and estimated pre-SCHIP baseline numbers of uninsured children. Two States estimate changes in the number of uninsured by comparing current (post-SCHIP implementation) estimates of uninsured to their baselines. The other States estimate reductions in the number of uninsured children by subtracting SCHIP enrollees from their original baseline estimates. The fifth State provides estimates of the total number of uninsured children and the number of uninsured SCHIP eligibles, and offers information about reductions in the number of uninsured children over the 1990's, but does not evaluate the impact the program has had on size of the uninsured population.

Census and State data. Three States report baseline and current estimates of uninsured children based on Census data. One State gets its data from rolling averages of Census data. The State indicates that its degree of confidence in the estimate is tempered by Census data limitations that may impact data reliability. Another State utilizes SCHIP and Medicaid enrollment numbers and State insurance data (based in part on Census numbers) to estimate a reduction in the size of the uninsured population. The State credits the change to increases in SCHIP rolls because between the 1997 baseline and the 1999 estimate, the percentage of low-income children on Medicaid remained constant, the percentage of children with other health insurance dropped, and the SCHIP program enrolled children for the first time.

Three States, including one that also uses some Census data, base their estimates on State-collected data. In one State, the Department of Health conducts a survey every 5 years which includes information that allows estimates to be made of the uninsured population. Other States rely on a State health insurance survey, a State population survey, and work done by a local university.

Size of change varies. State estimates of reductions in the number of uninsured children vary between the sampled States. It is difficult to compare the size of changes across States due to the differences between States in initial rates of uninsurance, overall State populations, and the size of SCHIP eligible populations. In the four States that offered both pre- and post-SCHIP implementation estimates, the change in the number of uninsured ranges from 5.8 to 21 percent. The State with the largest percent change in uninsured children had very low uninsurance rates even prior to SCHIP implementation. This State has both a small population and low initial and current number of uninsured, which makes the percent change in insurance so large. In addition, one State estimates the number of uninsured children under 200 percent of the Federal poverty level, while the others estimate the total number of uninsured children in their States.

Estimating different numbers. The four States that assessed change in uninsurance rates each used data derived from different sources to show progress toward different target numbers. One State focused its assessment of enrollment and “crowd out” on the number of uninsured children in families with incomes below 200 percent of the Federal poverty level. A second State, using 3 year rolling averages of U.S. Census Survey data, reported the change in the total number of uninsured children in the State.

Two other States each provided a baseline number of uninsured children from prior to implementation of SCHIP and subtracted the number of children enrolled in the program to show a decline in the percentage of uninsured children. Using this method, the State surpassed its projected decline in the number of children without insurance. The report did not indicate whether any children currently enrolled in SCHIP were enrolled in Medicaid or private insurance at the time the baseline uninsurance estimate was made.

Both the State that did not provide information on changes in the number of uninsured children and one of the States that made a projection indicated they had difficulties making estimates because current information is not available. One State relies on insurance information from the State Department of Health that is updated every 5 years. This State reports that its increase in SCHIP enrollment was not matched by losses in private coverage, suggesting that children now enrolled in SCHIP were represented in the State’s earlier count of uninsured children.

While States report success in enrolling children into SCHIP, not all States compared their progress to an established “goal” regarding enrollment or insurance coverage. One sampled State reports that it did not establish enrollment goals because it wants to enroll all eligible children. The State set benchmarks that it wanted to meet by certain dates but indicated that staff did not see these numbers as final enrollment goals. Another State indicated that it had not established an enrollment goal for the number of previously uninsured children but did use estimates of uninsured children and State resources to establish an initial enrollment goal.

States report mixed success meeting other goals

Just as States were allowed to design and assess their own strategic objectives and performance goals, they also had free reign to describe their progress meeting them.

The 5 States we sampled provided evaluations or descriptions of 57 percent of the 42 goals established among them. While State evaluations showed that some evaluated more of their goals than others, looking only at the percentage of goals assessed does not provide full information. The State that provided progress reports on all of its goals had poorly developed goals and did not provide a full evaluation of those goals. The State with the most unevaluated goals has more overall goals and, to a much greater extent than the other States, has rigorous goals that can be evaluated quantitatively.

States report success meeting between 67 and 100 percent of the goals on which they provided information. States reported the most success meeting goals that were assessed with simple quantitative measures -- particularly enrollment rates.

Enrollment rates. All five State evaluation reports provided information about increases in SCHIP enrollment. As States differ in their population size, initial rate of uninsured children, eligibility rules, and other program specifics, it is impossible to compare States' level of success enrolling children into SCHIP. Further, each State defined its own goals, so enrollment targets are not comparable among States. Three States met their self-defined enrollment goals, while a fourth did not. The fourth State's evaluation report explains that, although the program enrolled more than the number of children specified in its enrollment goal, a larger than expected number of children disenrolled during the program's existence. The fifth State did not set an enrollment goal, but instead used its enrollment numbers to show progress toward its goal of reducing the number of uninsured low-income children in the State.

One State in the sample established goals to increase access and improve service coordination by enrolling SCHIP children into managed care. The State was unable to meet these goals because the contracted managed care organizations shut down operations in the State. This forced the State to create its own managed care plan. During development, the State halted new managed care enrollments. The State did not evaluate how enrollment in managed care impacted access or service coordination.

Outreach. Three sampled States analyzed goals aimed at developing and implementing outreach plans for SCHIP and other health care programs for low-income children. These States used their reports to describe, rather than evaluate, their outreach programs. This may be in part because evaluating the success of outreach efforts is difficult and inherently somewhat subjective. These States focus more on their successful implementation of planned efforts than on whether the outreach programs encouraged enrollment in SCHIP and Medicaid.

Another State's outreach goal stressed the role State agencies should play in executing outreach strategies. While agency participation was not analyzed, the State commissioned a survey to determine whether outreach activities increased awareness of SCHIP and Medicaid among targeted families. The survey found public awareness of SCHIP rose considerably from before the media campaign to 6 months after the campaign's initiation.

Utilization and access. Two States tried to evaluate service utilization and all five States attempted to measure access to care. Both types of effort met with mixed success. One State's goals included monitoring enrollees' utilization patterns, including their use of primary care and well child visits. The evaluation report indicated that the level of primary care visits was comparable with national standards, but the rate of well care visits was lower than State-wide goals for all children. In addition, the State did not evaluate its other utilization goals, such as immunization rates, dental care, and client satisfaction.

Another State surveyed SCHIP families about whether enrolled children had a primary source of care, whether children were able to get needed care, and to what extent families were satisfied with their children's health care. The survey indicated that the State is meeting its goals in this area, as most children had a primary source of care, few children were unable to access health care, and an overwhelming majority of respondents were satisfied with their children's health care. The State indicates that as part of its next SCHIP survey, the State will administer the tool it developed to measure "crowd-out."

Other progress. All five State evaluations provided information about progress toward their goals in several other areas. One State assessed its attempts to improve enrollment practices by measuring what percentage of SCHIP applications they received through the mail or non-traditional sources. While the State did not meet its 50 percent goal, this assessment provided information about which applicants apply using the different methods. Another State described its efforts to expand its eligibility rules, restructure its data and operating systems, develop a unique coding system for SCHIP enrollees, and train staff to run the program. None of these descriptions are strictly evaluative, but they do provide updates on the activities taken by the SCHIP program administrators.

State reports are not very evaluative

SCHIP programs are required by statute to evaluate their programs. Section 2107 of Title XXI of the Social Security Act requires that SCHIP plans include strategic objectives and performance goals, and that measures be established to evaluate program performance. Performance measures must be "(A) measured through objective, independently verifiable means, and (B) compared against performance goals, in order to determine the State's performance."

Section 2108 of the Act outlines that each SCHIP must submit an annual assessment of "the operation of the State plan . . . including the progress made in reducing the number of uncovered low-income children." Evaluations must assess "the effectiveness of the plan in increasing the number of children with creditable health coverage." Additionally, each State must describe and analyze the effectiveness of elements of the State plan.

Much of the information provided in State evaluations is qualitative and subjective. Four of the five States extensively utilize qualitative descriptions in their evaluation reports to HCFA. Descriptive responses generally provide information about State efforts without assessing what impact efforts had on attaining specific goals. Further, any evaluation of such a program would be subjective and could not be independently verified. None of the sampled States attempted any evaluation of their outreach programs or offered an

explanation of how such programs impacted their measurable progress in enrollment or the level of uninsured children.

Several States provided information about what happened but were not able to explain why it happened. The sampled States have goals stating their outreach and other efforts will increase access to care, raise enrollment, or decrease the number of uninsured children in the State. State staff were unable to express how they chose their goals.

Despite goals that suggest State efforts and outcomes will be measured, several States provide information about SCHIP and Medicaid enrollment increases without offering an explanation of how enrollment is impacted by their outreach or other efforts. For example, one State goal outlines the State's intention to increase State government participation in outreach activities in order to increase access to health insurance. The evaluation provides information about the overall increase in SCHIP enrollment in the State but does not explain whether the goal (increasing government outreach efforts) was met or even what efforts were attempted. Further, the evaluation report does not indicate how such State efforts could be seen as causing the increased enrollment rates the State offers in its progress summary.

State evaluations rely heavily on enrollment data and descriptive information

Sampled States utilize a variety of data but rely most on enrollment and descriptive data. All five States used enrollment data to assess enrollment increases, decreases in uninsurance levels, and increases in access to coverage. On the whole, States were able to assess the goals that rely on enrollment data.

Some States also utilized survey and health care utilization data to evaluate their SCHIP progress. Two States utilized participant surveys to evaluate their goals, while another plans a survey, but has not implemented it yet. State surveys were used to identify improved access to care and increased public awareness of SCHIP and Medicaid. Planned surveys will measure "crowd out," use of preventative care, and client satisfaction.

One State compared Medicaid and SCHIP enrollees' utilization patterns for primary care and well child visits to National Committee for Quality Assurance standards. Three other States planned to evaluate utilization data, but did not do this for their March 2000 evaluation reports, in part because data was not available or did not exist in a format that allowed its analysis or comparison to other health information.

State reports tend to be descriptive rather than evaluative

While three States provide descriptions of SCHIP efforts, the information does not include assessments of the impact of State efforts on goals. Descriptions of expanded program rules, outreach efforts, and anti-"crowd-out" policies do not indicate how these efforts impact access to care or children's health status. One State uses its evaluation report to describe the changes to State program rules and procedures that established

SCHIP. As a summary of its progress in improving service provision through managed care enrollment, another State explains its use of an automated referral process.

States' descriptive progress summaries do not evaluate State efforts. States tend to employ such summaries when they do not have the skills or the available data to analyze the work they have done or show progress toward their goals. While they provide some useful information about SCHIP, they are not a viable alternative to concrete evaluations of the impact of State efforts on program goals.

Evaluations have conceptual and technical weaknesses

As described in the previous finding, State evaluations are flawed; some goals were not evaluated, and evaluations of others lacked objective measures of success. The reports were impacted by issues related to goal setting, staff skills and resources, program priorities, and data problems. States are aware of some of the flaws in their assessments and report barriers to conducting better evaluations.

Some goals were set without evaluation in mind

State goals are not always easy to evaluate, in part because the staff who crafted the goals often did not consider what it would take to evaluate them. Most States established their goals, as required, in their State plans. The State plans were often written by groups made up of representatives from different agencies, each with their own priorities for children's health. While this can help the State craft a more robust program, it also may mean that individuals not responsible for program implementation or evaluation establish goals without thought to how they will later be assessed. Sample States reported that their goals were designed at the time the State plan was written, but an explanation of how evaluation would occur was not developed. One State specifically noted that they established their plan without thinking about goal assessment.

Not considering how goals would be evaluated led to the creation of unmeasurable goals. One State reported they used a goal taken directly from the State plan but are now not able to measure it because information is not available, and definitions that would allow comparisons across populations do not exist. One respondent reported that he is not sure how to measure some of the State's goals and wondered how he should go about measuring coordination. Further, as the goal does not define what type of coordination should be assessed, he was not sure with what other agencies and organizations the program should be measuring the level of coordination.

A third State admitted that its goals may not be entirely measurable. For example, one goal is to improve access to care by increasing State government participation in the program. The analysis shows increased enrollment but does not explain what government participation has occurred or how that participation impacted enrollment or access. When asked whether the program intended to evaluate this connection, respondents reported that they did not think they could quantify this.

They further reported that they have no indicators to evaluate efforts and no interest in developing any.

Program administrators do not make evaluation a priority

The ultimate objective for SCHIP is to increase enrollment in health insurance programs to ensure that children receive appropriate health care services that maintain or improve health. Evaluation is important to ensure that State programs are meeting identified needs and are spending their allotments effectively, but ultimately program administrators are much more focused on running the programs than on assessing their success. Resources for evaluation are limited, particularly for smaller States which often feel constricted by the 10 percent cap on administrative activities.

Staff in one State reported they are not sure when they will find time to decide what indicators they will use to assess quality. They indicated that they will probably default to using established measures because they have limited staff and are more focused on running the program than on measuring quality.

Another sampled State reported doing a good job meeting its goals but is not doing a good job measuring its success. In part this is because States that believe they are successful may not be strongly motivated to evaluate themselves. Respondents in this State indicated that they are bringing a lot of children into the program and staff do not feel the need to assess what outreach efforts are working. They think that as long as they continue to enroll children, they will not worry about changing things.

Even when States are not as convinced that they are succeeding, evaluation is generally a low priority for SCHIP. When asked about whether they planned to evaluate their stated goals more fully than they had for the March 2000 evaluation report, staff at one State told us that they did not plan to further assess their reported goals. They did not think it would be worth the required effort to track down the connections between their actions and the outcomes they are seeing in the program. Another State that is more focused on evaluation reported that although they believe their goals are important, it is expensive to evaluate a large number of goals. The cost and time required to evaluate multiple progress goals is slowing down evaluation efforts.

Program staff lack evaluation skills and training

When State respondents were asked about evaluation issues such as how goals were developed or how assessments were conducted, they were often unable to provide meaningful information. Program staff were much more comfortable discussing the content of their goals than they were talking about how they decided to establish the goals or how they assessed progress. In several discussions, State staff were unable to explain why they thought an evaluation showed what it was intended to show.

For the most part, SCHIP staff are not trained evaluators. Their skills lie where they are needed on a daily basis -- in program management and ensuring the effective and efficient administration of their programs. The language of evaluation is also foreign to

many program administrators. Without a more thorough understanding of evaluation concepts and practices, program staff cannot be expected to turn out detailed assessments of program activities and outcomes.

The lack of trained evaluation staff may be a particular problem for States in which Medicaid and SCHIP are administered separately. SCHIP staffs are often small, and program administrators have difficulty hiring evaluation staff when program staff are needed.

Problems with data impair evaluations

Insufficient or flawed data caused problems for the sample States. States faced difficulties regarding unreliable data, missing data, non-comparable data sets, and small population sizes.

Unreliable data. Several States indicated that they rely on Census data to make estimates of uninsured children and eligible children in the State. The use of Census data is widely criticized, particularly for States with smaller populations. One State reported that its estimate of total SCHIP eligibles comes from Census Current Population Survey (CPS) data on children below 200 percent of the Federal poverty level. This State told us that staff fear the CPS numbers are “no good.” This concern is in large part based on the poor record of CPS estimates of low-income children in the State. The CPS data indicated that there were 150,000 children under 150 percent of poverty in the State, despite the fact that more than twice this many children are currently enrolled in Medicaid. The State changed their process for estimating the number of uninsured children, but their new formula still relies on the CPS for some parts of the calculation. They know the data is flawed but have no other data on which to base their estimates.

Another State relying on Census data reported frustration with the quality of Census information for small populations. State staff do not trust the Census data and have found that other population-based studies are not reliable for small States. This State reports its faith in the estimate of SCHIP eligible children in the State as “5” on a 1 (least reliable) to 10 (most reliable) scale.

Data collected by the States themselves also may be deficient. A State that relies on a health status survey administered by the State Department of Health expressed frustration with the age of the data. The survey, conducted every 5 years, provides baseline information on the number of uninsured children. Program administrators worry that the data is unreliable because it is old by the time they get it. Respondents from this State reported that on a scale from 1 to 10, they rated this data between 5 and 6.

The SCHIP administrator used State-collected data to calculate a new uninsured rate by subtracting the total number of SCHIP enrollees from an estimate of uninsured derived from survey data. The State administrator admits that this methodology assumes that all SCHIP enrollees were previously uninsured and would be uninsured without the program, but reports that the State does not have better numbers or methods on which to base calculations.

Missing data. Obtaining accurate and meaningful utilization data is a challenge for States, which means that any subsequent analysis may be incomplete. States often rely on the contracting managed care organizations for data on use of services. Although States contractually require participating managed care organizations to provide data, the receipt of this data may not be timely. One State reported that encounter data they used to calculate use of preventative services is 25 percent incomplete. Data from the managed care contractors is missing, despite the State's continued efforts to get complete data from the plans.

States may also have problems getting data from other agencies within their own department. One SCHIP program adopted a goal for immunization rates at the request of the Department of Health, which coordinates a State-wide immunization campaign. Another agency within the Department that administers SCHIP collects the immunization information, but its data collection system is not very mature.

Non-comparability. Comparing managed care and fee-for-service data was a problem for one State. The State intended to assess whether children received appropriate medical screenings but found that comparing children enrolled in different service types would require reorganizing the data, as utilization data from the SCHIP fee-for-service system is presented differently from their Medicaid managed care data. This State noted that Medicaid's managed care program is oriented toward prevention. This led to the establishment of specific data elements for health screening and other prevention services. The State set up its SCHIP program on a fee-for-service model that provides less specific information about the delivery of prevention services to children. The SCHIP does not have a single code for health screening similar to the one used in the Medicaid program. The administrator indicated that her staff is working on making the fee-for-service and managed care data consistent, but that they might have to abandon the goal if they cannot compare the two groups.

Small population. SCHIP is new, and even with strong enrollment, there may not be sufficient children in a State program to perform robust analysis. One State's utilization analysis were conducted for all children enrolled in State-sponsored health care. The State felt that there were too few children in SCHIP alone to allow for reliable evaluations, especially when information on specific age or other categories is required.

Another State report was based on 1 year of data. Few children were enrolled at the start of the year, and enrollment increased dramatically during that first year. The State administrator reports that because they experienced such a dramatic change in enrollment over a short time period, they cannot accurately determine the number of children who should make up the denominator for their health screening goal. Without this information, the State cannot assess whether the target number was met.

RECOMMENDATIONS

Over the past 3 years, States have been concentrating their efforts on getting the SCHIP program organized and operating by focusing on outreach and enrollment. There is now a need for States to shift their focus to evaluating the effectiveness of program administration and progress made towards the achievement of each State's goals and objectives, as outlined in their State Plans. While State administrators believe they are successfully enrolling eligible children and reducing the overall number of uninsured children, they admit that they do not evaluate their efforts well.

Improving States' ability to conduct useful evaluations may require a multi-stage process. Initial stages should focus on improving State program staffs' general understanding of evaluations, including the distinction between simply describing a process and true evaluation. Later stages should focus on staff knowledge of different types of evaluation and how these evaluation types can be used. In addition, SCHIP staff should become knowledgeable in preparing data for collection, determining the types of data that should be collected for various analysis, and evaluating data once it is collected.

Federal regulations and policy provide little guidance to States on what constitutes an acceptable evaluation. Without more specific guidance about what SCHIP evaluations should contain and assistance conducting assessments, the information States provide does little to ensure that Federal Title XXI dollars are used to the greatest possible advantage. To increase the usefulness of SCHIP evaluations and facilitate the ability of SCHIP staff to conduct such improved evaluations:

HCFA should identify a core set of evaluation measures and develop a more specific framework for the content and structure of the reports States are required to submit.

SCHIP staff need direction from HCFA on what kind of information it is seeking from States. The HCFA should identify a core set of evaluation measures that will enable all SCHIP States to provide useful information, independent of the way each State operates their SCHIP. The HCFA can do this by determining what information it needs evaluations to yield, how detailed this information must be, and what purpose the evaluations will serve. Providing this guidance will enable States to submit information best suited to address HCFA's issues and concerns.

The HCFA should develop a more specific framework for the content and structure of State evaluations. The HCFA should continue working with the National Academy for State Health Policy to create a template that provides States direction on how to address issues uniformly, leaving little room for ambiguity.

HCFA and the Health Resources and Services Administration (HRSA) should provide guidance and assistance to States in conducting useful evaluations of their programs.

To conduct more useful evaluations, SCHIP staff would benefit from assistance and/or training regarding data collection and evaluation, and resource determination.

Data Collection and Evaluation - The HCFA and HRSA should assist States in building their capacity to collect required data. The need for quality data is intensifying as Federal, State, and local governments rely more heavily on program evaluations to make important programmatic decisions. However, States are finding those evaluations difficult due to limited data capacity and a lack of reliable and useful data.

The HCFA and HRSA should work together to provide States training and guidance in the following areas: 1) what data to collect, 2) how to obtain specific data, 3) how to determine if the data is reliable, 4) how to determine what the data is yielding, and 5) how to evaluate the data. In addition, HCFA and HRSA should work with States to identify external sources of data and, as appropriate and necessary, work with these external sources to improve the reliability of data. For example, HCFA and other Federal agencies are working with the Census Bureau to increase the overall quality of CPS data. Because of States' reliance on CPS data to conduct evaluations, this and similar efforts would increase States access to quality data without requiring large resource commitments from States.

Resource Determination - Currently, poor coordination exists between SCHIP administration and the evaluation of SCHIPs. Program administrators indicated that their current focus is on enrolling children into the SCHIPs and, consequently, less attention is paid to evaluation. They also indicated that Federal reporting requirements are burdensome and funds for robust evaluations are lacking. The HCFA and HRSA should train administrators and staff to help reduce the poor coordination between administration and evaluation and make normal staff activities part of the evaluation process.

Existing staff resources may not allow some States to fully address their needs to conduct useful and meaningful evaluations. Therefore, HCFA and HRSA should work with States to identify, where needed, additional evaluation resources. Depending on the extent of this need, HCFA and HRSA may want to explore various options, including offering States matching funds, creating set-aside funds within SCHIP for evaluations, increasing the amount of SCHIP funds that can be used for administration (i.e., evaluation), or tapping into available Departmental evaluation funds.

Agency Comments

The Health Care Financing Administration and the Health Resources and Services Administration provided formal comments to the draft report. Both concur with the findings and recommendations. The full text of their comments are included in Appendices A and B.

The HCFA provided information regarding their work with States. The HCFA also noted they will continue to work in partnership with the National Academy for State Health Policy to develop a framework for Title XXI annual reports. The HRSA provided comments to clarify portions of the report. We made appropriate changes based on the comments we received.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: JAN - 9 2001

TO: June Gibbs Brown
Inspector General

FROM: Robert A. Berenson, M.D. *Robert A. Berenson M.D.*
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "State Children's Health Insurance Program – Assessment of State Evaluations Reports," (OEI-05-00-00240) and "State Children's Health Insurance Program – Ensuring Medicaid Eligibles are not Enrolled in SCHIP," (OEI-05-00-00241)

Thank you for the opportunity to review and comment on the above-referenced draft reports. As you know, health coverage for children continues to expand nationwide under the State Children's Health Insurance Program (SCHIP). The Health Care Financing Administration (HCFA) is releasing new national data showing that in Federal Fiscal Year 2000, over 3.3 million children received health care coverage through SCHIP, a 70 percent increase over the number of children enrolled in 1999. The Census Bureau recently released data showing a decline of 1.7 million people in the ranks of the uninsured between 1998 and 1999, two-thirds of whom were children. These numbers confirm that the Clinton Administration has made major strides in increasing enrollment in SCHIP and Medicaid.

We have carefully reviewed your two reports on the SCHIP program. We concur with the recommendations in the first report, and our detailed comments appear below.

While there were no recommendations or areas of improvement noted in the second report, we do concur with the OIG findings. The coordination policy, established by statute, requires that a child found to be potentially Medicaid eligible through the SCHIP eligibility screening process cannot be enrolled in a separate SCHIP unless there is a finding of ineligibility for Medicaid. The OIG review of five States confirms that States have been able to develop effective screening procedures. HCFA will continue to work with States to ensure that effective screening occurs. In addition, it is equally important that States develop effective systems to ensure that the children who are screened and found potentially eligible for Medicaid are enrolled in Medicaid. Otherwise, eligible children will remain uninsured.

Many States have developed effective "screen and enroll" procedures, and HCFA has issued guidance to States encouraging simplification of the application and enrollment process to promote coordination. We are also working with States to examine the redetermination process to assure that it promotes ongoing coverage of children who become ineligible for one program and eligible for the other program. Our final SCHIP regulations will provide further guidance in this area, and we will continue working with States on these issues and monitoring States'

programs through HCFA regional office onsite reviews. These reviews provide an opportunity to identify best practices, provide technical assistance to States, and assure compliance with the statute.

We appreciate the effort that went into these reports. Once again, thank you for the opportunity to review and comment on the issues raised. While we recognize the assessment that the States' March 31, 2000 evaluations lacked a significant amount of quantitative or evaluative information about progress with their SCHIP programs to date, we also feel it is important to note the States' significant level of innovation and commitment in developing, in many cases, entirely new programs in a relatively short period of time. Evaluating the success of a program within the first year of implementation can be extremely difficult. HCFA is committed to continuing to work with States on all of the areas discussed in this report and we are confident that as programs mature, more quantifiable information will become available. Our response to the recommendations in your first report follows.

OIG Recommendation

HCFA should identify a core set of evaluation measures and develop a more specific framework for the content and structure of the reports that States are required to submit.

HCFA Response

We concur. To assist States in complying with Title XXI, section 2108 of the SCHIP statute, HCFA, in partnership with the National Academy for State Health Policy, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- recognize the diversity of State approaches to Title XXI programs;
 - provide consistency across States in the structure, content, and format of the report;
 - build on data already collected by HCFA quarterly enrollment and expenditure reports; and
- enhance accessibility of information to stakeholders on the achievements under Title XXI.

The final rules include a provision that the Secretary will establish a core set of performance measures that will be reported by States in their annual reports. We will work with States to develop such measures in order to obtain comparable data across States.

OIG Recommendation

HCFA and the Health Resources and Services Administration should provide guidance and assistance to States in conducting useful evaluations of their programs.

HCFA Response

We concur. The guidance and assistance that HCFA provides the States is by way of policy letters, technical assistance visits, participation on SCHIP Technical Advisory Groups, and information exchanges at conferences.

Each State has independent responsibility to create the capacity for assembling a data collection plan and resources to implement such a plan that would support their unique SCHIP State plan evaluations. While we agree that staff resources in States may affect their ability to fully conduct useful and meaningful evaluations, certain of the recommendations would also likely

require statutory changes in States, including the need for a set-aside or increased amount of administrative funding. We note that matching funds are already available to States for evaluation activities, but these expenditures are subject to the statutory 10 percent limit on administrative costs.

HCFA concurs that the following elements, which were enumerated in the OIG recommendation, should be included in a State data collection plan: 1) what data to collect; 2) how to obtain specific data; 3) how to determine if the data is reliable; 4) how to determine what the data is yielding; and 5) how to evaluate the data.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
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Rockville MD 20857

DEC 12 2000

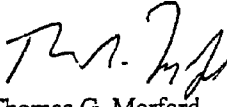
TO: Inspector General

FROM: Deputy Administrator

SUBJECT: Office of the Inspector General Draft Report "State Children's Health Insurance Program: Assessment of State Evaluations Reports," OEI-05-00-00240

Attached are the Health Resources and Services Administration's comments on the draft report.

Thank you for the opportunity to review and comment on the draft report. Staff questions may be referred to Jeanellen Kallevang on (301) 443-6507.



Thomas G. Morford

Attachment

Health Resources and Services Administration (HRSA) Comments on the
Office of Inspector General (OIG) Working Draft, "State Children's Health Insurance
Program: Assessment of State Evaluations Reports," OEI-05-00-00240

GENERAL COMMENTS

The Health Resources and Services Administration (HRSA) appreciates the opportunity to review this draft report. The report contains information regarding the status of State evaluation capabilities; however, the OIG's conclusions should acknowledge that States have appropriately focused on outreach and enrollment in this early stage of program implementation. As States develop more experience with the program, they may turn their attention to more substantive evaluations of program performance and impact on enrollees.

On page 5, "Findings" under "State reports of reductions in number of uninsured may be unreliable," 2nd paragraph: There is a discussion of how states report the reduction in the number of uninsured, yet there is no discussion of the role of secular trends in accurately assessing the impact of the State Children's Health Insurance Program (SCHIP), nor is there any acknowledgment of the challenge of accurately evaluating this type of data.

On page 8, "Findings" 1st paragraph: It is important to note that individual State SCHIP programs are still very new, and maintaining sustained enrollment of children over a 6 to 12 month period is often required before any substantive accurate performance data can be obtained. The report should provide some balance in critiquing States, yet acknowledging the challenges that States are confronting in initiating a major new children's health insurance program.

On page 8, "Findings": It is also imperative to discuss the problem with baseline measurement issues. Most States did not have data nor the time to acquire data with the passage of Title XXI legislation, to establish pre-SCHIP baseline data on the eligible population. This lack of baseline data greatly hinders States' ability to determine the impact of the program.

On page 12, under "Problems with data impair evaluations": It would be helpful to present some of the limitations inherent in using Current Population Survey (CPS) data, particularly for small States. The limited sample size makes the potential sampling error quite large in smaller states, and this limits the utility of CPS data in charting changes over time. Furthermore, it is important to note that despite increased funding for enhancement of the CPS in last year's budget, the increased funding was not sufficient to enhance the sample size to a level that would permit accurate State estimates of uninsured children.