Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ASSESSING STATES' PROGRESS IN MEETING STATE CHILDREN'S HEALTH INSURANCE PROGRAM GOALS

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EXECUTIVE SUMMARY

OBJECTIVES

1. To assess States' progress in reducing the number of uninsured low-income children.
2. To assess States' progress in meeting performance goals related to the State Children's Health Insurance Program (SCHIP).

BACKGROUND

The Balanced Budget Refinement Act of 1999 requires that every 3 years the Office of Inspector General (1) evaluate whether States are enrolling Medicaid eligible children in their SCHIP programs and (2) assess States' progress in reducing the number of uninsured low-income children, including their progress in meeting the strategic objectives and performance goals included in State plans. This study addresses the second mandate. The first mandate is addressed in a separate study.

The Balanced Budget Act of 1997 created SCHIP to provide health insurance coverage to uninsured low-income children. To receive SCHIP funding, a State must submit a State plan that describes the purpose, nature, and scope of its SCHIP program. States must annually assess the operation of their State plans in Annual Reports. In the Annual Reports, States must report their progress in reducing the number of uninsured low-income children and meeting performance goals.

To assess States' progress in reducing the number of uninsured low-income children, we analyzed the percentage change between 2002 and 2005 in the number of uninsured low-income children out of the total population of low-income children. To assess States' progress in meeting their performance goals, we analyzed all performance goals listed in States' fiscal year (FY) 2006 Annual Reports and compared progress to FY 2005.

FINDINGS

Nationally the percentage of uninsured low-income children decreased between 2002 and 2005. Nationally the percentage of uninsured low-income children had a statistically significant decrease from 20 percent in 2002 to 18.5 percent in 2005.

However, no State had a statistically significant change in the percentage of uninsured low-income children. While each State's sample showed changes in the percentage of uninsured low-income children, none of the changes were significant when projected to the entire State at the 90-percent confidence level. Because of small State sample sizes, statistical tests are limited in accurately detecting modest changes at the State-level.

In 2006, 37 States met or made progress in meeting at least half of their performance goals. Almost half of the 37 States met or made progress in meeting between 50 percent and 74 percent of their goals. Of the States that reported progress, the largest number of States reported progress for performance goals related to increasing access to care and increasing the use of preventative care.

Despite improvements made by CMS to the Annual Report template, States' progress remains difficult to assess. Although the Centers for Medicare & Medicaid Services (CMS) made improvements to the Annual Report template, issues remain that make assessing States' progress difficult. Concerns about using the U.S. Census Bureau (Census) data to measure States' progress in reducing the number of uninsured low-income children continue. States and CMS cited small State sample sizes as a limitation. Also, States' use of nondirectional performance goals as well as goals and measures missing from Annual Reports limit the usefulness of the Annual Reports in assessing States' progress in meeting performance goals.

RECOMMENDATIONS

CMS should continue efforts to address States' Census data concerns. Small State sample sizes appear to limit the usefulness of State-level estimates of the percentage of uninsured children. Therefore, we suggest that CMS continue departmental efforts to collaborate with Census to address these concerns.

CMS should provide to States guidance on developing directional performance goals with a target. CMS should provide States with guidance and technical assistance regarding the development of specific, reasonable, and targeted goals.

CMS should ensure that States report on all goals and measures. CMS should ensure that States include all of their goals in their Annual Reports. CMS should also work with States to ensure that each goal in the Annual Reports includes a report of progress.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS indicated general support for our findings and recommendations. However, CMS took issue with the presentation of the second finding and had a few comments related to the recommendations and their implementation.

With respect to the second finding, CMS suggested that we highlight State changes in the percentage of uninsured low-income children. Because none of the State changes were statistically significant, we opted not to highlight them in the findings. However, we do present State-level data in Appendix A.

In regard to our first recommendation that CMS should continue efforts to address States' Census data concerns, it pointed out that it has limited ability to effect a change at Census. We recognize that the issues with Census data are not unique to CMS and that a Federal solution is required. However, we believe that CMS can have impact regarding this issue by continuing to contribute to departmental efforts to collaborate with Census to address data concerns.

Finally, CMS expressed concern with our suggestion that States update their State plans to reflect their current goals. Based on CMS's comments, we now suggest that CMS create a comprehensive list of States' current performance goals.

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2. To assess States' progress in meeting performance goals related to the State Children's Health Insurance Program (SCHIP).

BACKGROUND

Section 703 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 requires that every 3 years the Office of Inspector General (OIG) (1) evaluate whether States are enrolling Medicaid eligible children in SCHIP and (2) assess States' progress in reducing the number of uninsured low-income children, including their progress in meeting the strategic objectives and performance goals included in State plans.[1] This study addresses the second mandate. OIG is addressing the first mandate in a separate study.

SCHIP

The Balanced Budget Act of 1997 created SCHIP to provide health insurance coverage to uninsured low-income children.[2] The program's overall goal is to expand coverage to uninsured children in households with incomes greater than States' Medicaid eligibility but below 200 percent of the Federal poverty level.[3] States have the option of (1) instituting a separate children's health insurance program, (2) expanding Medicaid eligibility, or (3) instituting both a separate SCHIP and a Medicaid expansion, known as a combination program.[4]

SCHIP funding is allocated per State using the Annual Social and Economic Supplement of the U.S. Census Bureau's Current Population Survey's (hereinafter referred to as Census) estimation of the number of uninsured low-income children per State.[5]

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[1] Public Law 106-113 and 42 U.S.C. § 1397hh(d)(1).

[2] Public Law 105-133 and 42 U.S.C. §§ 1397aa et seq.

[3] Sections 2101(a) and 2110(b) of the Social Security Act, 42 U.S.C. §§ 1397aa and 1397jj(b).

[4] Section 2101(a) of the Social Security Act, 42 U.S.C. §§ 1397aa(a), and 42 CFR § 457.70(a).

[5] Section 2104(b)(2)(B) of the Social Security Act, 42 U.S.C. 1397dd(b)(2)(B), and 42 CFR § 457.608(e).

To encourage States to implement SCHIP, the Federal match for State SCHIP expenditures is greater than the Medicaid match.[6] In fiscal year (FY) 2007, the average Federal match for Medicaid is 59 percent, while the average for SCHIP is 71 percent.[7]

SCHIP funds are due for reauthorization on September 30, 2007. In FY 2006, Federal spending for SCHIP reached $5.5 billion with over 6.6 million children enrolled.[8] The FY 2008 proposed Administration budget increases SCHIP spending to nearly $30 billion over the next 5 years.[9]

SCHIP State Plan

To receive SCHIP funding, a State must submit, and the Centers for Medicare & Medicaid Services (CMS) must approve, a State plan that describes the purpose, nature, and scope of its SCHIP program.[10] States are required to amend their original State plans with any changes and submit these for approval from CMS.[11]

SCHIP Annual Report

States must annually assess the operation of their SCHIP State plans in their Annual Reports.[12] Among other things, States must report their progress in reducing the number of uninsured low-income children and meeting State-specific performance goals (hereinafter referred to as goals) in the Annual Reports.[13] States must also report their progress on a core set of national performance measures developed by CMS.

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[6] Section 2105(a) of the Social Security Act, 42 U.S.C. § 1397ee(a).

[7] 70 Federal Register 71586, November 30, 2005.

[8] Kaiser Family Foundation, "Total SCHIP Expenditures, FY 2006." Available online at http://www.statehealthfacts.org/cgibin/healthfacts.cgi?action=compare&category=category=Medicaid+%26+SCHIP&topic=Total+SCHIP+Spending%2C+FY2006. Accessed on April 10, 2007.

CMS, "FY 2006 Number of Children Ever Enrolled Year – SCHIP by Program Type." Available online at http://www.cms.gov/NationalSCHIPPolicy/downloads/FY2006StateTotalTable.pdf. Accessed on June 7, 2007.

[9] Office of Management and Budget, "Budget of the United States Government, Fiscal Year 2008," February 5, 2007. Available online at http://www.whitehouse.gov/omb/budget/fy2008/hhs.html. Accessed on May 8, 2007.

[10] Section 2101(b) of the Social Security Act, 42 U.S.C. § 1397aa(b), and 42 CFR § 457.50.

[11] Section 2107(b) of the Social Security Act, 42 U.S.C. § 1397ff(b), and 42 CFR § 457.60 (2001).

[12] 42 CFR § 457.750(a) (2001).

[13] Section 2108(a) of the Social Security Act, 42 U.S.C. § 1397hh(a), and 42 CFR § 457.750(b)(1) (2001).

CMS annually refines the Annual Report template and recently created a Web-based template system that enables States to submit their Annual Reports to CMS via the Internet.[14]

Reporting progress in reducing the number of uninsured low-income children. CMS inputs Census data in each State's Annual Report to assist States in reporting its progress in reducing the number of uninsured. Census data are the main source of data on the uninsured and have the largest sample size of any national survey with data on the uninsured.

CMS enters 3-year averages of the number and percentage of uninsured low-income children into each State's Annual Report. In the 2006 Annual Reports, CMS included five overlapping 3-year averages between 1996 and 2005, along with the percentage changes between 1996–1998 and 2003–2005.

According to Census, 3-year averages should be used to estimate the number and percentage of uninsured low-income children at the State level to improve precision.[15] However, Census notes that small State sample sizes can limit the usefulness of these State level estimates.

States may substitute an alternative source of data for Census data to measure and report progress in reducing the number of uninsured low-income children. If States elect to use an alternate data source, States must explain their methodology and reasons for using the alternative source.[16]

Reporting on State-specific performance goals. The Annual Report template instructs States to report on the goals specified in their State plans. States must categorize their goals into one of five strategic objectives developed by CMS.[17] The strategic objectives are: (1) reducing the number of uninsured low-income children, (2) SCHIP

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[14] Department of Health and Human Services, "FY 2007 HHS Annual Plan, Strategic Goal 3." Available online at http://www.hhs.gov/budget/07plan/sGoal3.html#prog3e. Accessed on May 8, 2007.

[15] "Source and Accuracy of Estimates for Income, Poverty, and Health Insurance Coverage in the United States: 2005." Available online at: http://www.census.gov/prod/2002pubs/p60-219sa.pdf. Accessed on May 17, 2007.

[16] 42 CFR § 457.750(c)(1)(ii) (2001).

[17] CMS, 2006 SCHIP State Annual Reports, section IIC. Available online at http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1199208&intNumPerPage=10. Accessed on July 16, 2007.

enrollment, (3) Medicaid enrollment, (4) increasing access to care, and (5) increasing the use of preventative care.

CMS requires States to report their progress in meeting each goal.[18] To measure progress, CMS directs States to identify their data source(s), population, methodology, and baseline measurement.[19] The 2006 Annual Report template prompts States to report progress on each goal for the current year and the previous 2 years to track progress over time. Prior versions of the template prompted States to report progress for the current year only.

Reporting on CMS national performance measures. The Annual Report template instructs States to report information on a core set of national performance measures developed by CMS. The measures are well-child visits, use of appropriate medications for children with asthma, and children's access to primary care practitioners.[20] CMS contracted with an evaluation agency to analyze the data reported in the States' 2003 SCHIP Annual Reports and to provide States with guidance to improve the completeness and quality of their reporting on these national performance measures. The evaluation agency issued two reports in 2005 that summarize States' reporting on these measures.[21]

Previously Mandated OIG Studies

In accordance with the BBRA mandate to assess States' progress, OIG has issued two prior reports related to States' progress in reducing the number of uninsured low-income children and meeting goals.[22] In 2001, OIG could not assess States' progress in meeting goals because of

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[18] Section 2108(b)(1) of the Social Security Act, 42 U.S.C. § 1397hh(b)(1), and 42 CFR § 457.750(b)(1) (2001).

[19] CMS, SCHIP State Annual Report Template. Available online at http://www.cms.hhs.gov/ NationalSCHIPPolicy/ 06_SCHIPAnnual Reports.asp# Top Of Page. Accessed on May 8, 2007.

[20] 42 CFR § 457.750(b)(1) and CMS, 2006 SCHIP State Annual Reports, section IIA. Available online at http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER/itemdetail.asp?filterType=none&filterByDID=0&sortByDID=1&sortOrder=descending&itemID=CMS1199208&intNumPerPage=10. Accessed on July 16, 2007.

[21] "Improving Performance Measures in the State Children's Health Insurance Program," Mathematica Policy Research, Inc., July 18, 2005, and "Beyond Coverage: SCHIP Makes Strides Toward Providing a Usual Source of Care to Low-Income Children," Mathematica Policy Research, Inc., December 23, 2005.

[22] "State Children's Health Insurance Program: Assessment of State Evaluations Reports," OEI-05-00-00240, February 2001.

"SCHIP: States' Progress in Reducing the Number of Uninsured Children," OEI-05-03-00280, August 2004.

States' conceptually and technically weak evaluative measures. In 2004, OIG found that CMS did not ensure that States reported on their progress in reducing the number of uninsured children in the Annual Reports and instead accepted enrollment data as a proxy for this information.

The BBRA also requires the Government Accountability Office (GAO) to monitor OIG evaluations of SCHIP.[23] GAO responded favorably to the findings and recommendations of OIG's two reports with a recommendation in response to OIG's 2001 evaluation.[24] The BBRA mandate requires only that OIG assess States that administer SCHIP separately from their Medicaid programs. To better inform Congress, GAO recommended that OIG include States that administer Medicaid expansion programs and Medicaid-SCHIP combination programs.[25] OIG agreed with the recommendation and expanded subsequent reviews to include all SCHIP program types.

METHODOLOGY

Scope

To determine States' progress in reducing the percentage of uninsured low-income children, we included all 50 States and the District of Columbia. In keeping with GAO's recommendation that we use our authority to expand the scope of the evaluations to include other SCHIP options, such as the Medicaid-expansion and combination programs, as a way to provide Congress a more comprehensive and meaningful review of State progress. We expanded our review even further to include all States, regardless of whether they had a SCHIP program. Thus, Tennessee is included in our review even though it did not have an SCHIP program in FY 2006. All States, regardless of whether they have a SCHIP program, face multiple factors affecting the number of uninsured low-income children.

[23] 42 U.S.C. § 1397hh(d)(3).

[24] "Children's Health Insurance: Inspector General Reviews Should Be Expanded To Further Inform the Congress," GAO-02-512, March 29, 2002.

"Children's Health Insurance: Recent HHS-OIG Reviews Inform the Congress on Improper Enrollment and Reductions in Low-Income, Uninsured Children," GAO-06-457R, March 9, 2006.

[25] "Children's Health Insurance: Inspector General Reviews Should Be Expanded To Further Inform the Congress," GAO-02-512, p. 19. March 29, 2002.

To determine States' progress in meeting and reporting on their goals, we included all States that had SCHIP programs in 2006. This decision reflects GAO's recommendation to include States with all program types. This includes 49 States and the District of Columbia. We did not include Tennessee because it started its program in January 2007. Therefore Tennessee was not required to submit a 2006 Annual Report.

We assessed States' progress in reducing the percentage of uninsured low-income children. We did not determine whether any change in the percentage of uninsured low-income children was attributable to SCHIP. Many factors, including those outside the control of a State, contribute to whether a State experiences a change in the percentage of uninsured low-income children.

We focused only on States' goals and did not assess national performance measures required by CMS because of previous evaluations of these measures.

Data Collection

As part of the evaluation, we reviewed current SCHIP State plans, State plan amendments, the 2006 Annual Report template, States' 2006 Annual Reports, and Census data. We also reviewed CMS's oversight documents, including the Annual Reports Requirement checklist, the Regional Office Monitoring handbook, and the "Guide to Quality Measures Compendium." We also held discussions with CMS officials about their review of goals in the State plans and Annual Reports and their guidance to States regarding the development and measurement of their goals.

Data Analysis

Assessing States' progress in reducing the number of uninsured low-income children. We independently obtained national and State-level Census data on the number of uninsured low-income children.[26] We calculated four 3-year averages from 2000 to 2005 (2000-2002, 2001-2003, 2002-2004, and 2003-2005).

To assess change, we compared the first 3-year average, 2000–2002 (hereinafter referred to as 2002) and the last 3-year average, 2003–2005 (hereinafter referred to as 2005) to assess progress in reducing the

[26] We define the "percentage of uninsured low-income children" as the number of uninsured children among the population of low-income children, not among the population of all children as Census defines it.

number of uninsured low-income children. We assessed whether changes were statistically significant at the 90-percent confidence level.[27]

Our analysis starts with 2000 Census data. We started with 2000 rather than the beginning of SCHIP in 1997 because starting in the 2000 Census survey a "verification" question that improved estimates of the uninsured was included.[28] It asks individuals that responded "no" to all questions about specific types of health insurance coverage to verify whether they were actually uninsured.[29] Accordingly, estimates based on the revised Census data are not directly comparable with estimates from earlier years.

We analyzed whether States made progress in reducing the number of uninsured low-income children by determining the percentage change in the number of uninsured low-income children out of the total population of low-income children.

Assessing States' progress in meeting goals. We reviewed whether States made progress in meeting their goals in FY 2006 as compared with FY 2005 as reported in their 2006 Annual Reports. We identified a total of 555 goals listed in either State plans or Annual Reports. However, only 368 goals were in the Annual Reports, and 20 of these were marked discontinued. Therefore, our analysis included 348 continuing goals listed in States' Annual Reports.

We measured progress in relation to each goal's specificity. We categorized goals into three types. We defined "directional goals with a target" as goals that had a defined benchmark (i.e., increase SCHIP enrollment by 5 percent). We defined "directional goals without a target" as goals that stated a general direction (i.e., increase access to primary care physicians). Lastly, we defined "nondirectional" goals as goals that lacked direction and a finite target (i.e., immunizations). These goals were typically not quantifiable.

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[27] Census analyzes its data at the 90-percent confidence level. U.S. Census Bureau, "Source and Accuracy of Estimates for Income, Poverty, and Health Insurance Coverage in the United States: 2005." Available online at: http://www.census.gov/prod/2002pubs/p60-219sa.pdf. Accessed on May 17, 2007.

[28] U.S. Census Bureau, "The March CPS Health Insurance Verification Question and Its Effect on Estimates of the Uninsured." Available online at http://www.census.gov/hhes/www/hlthins/verif.html. Accessed on April 12, 2007.

[29] U.S. Census Bureau, Current Population Reports, "Health Insurance Coverage: 2000," September 2001.

Based on the States' report of progress, we coded goals as "met," "making progress," or "not making progress." See Table 1 for the criteria we used to assess States' progress in meeting their goals.

Table 1: Criteria to Assess States' Progress in Meeting Their Goals

	Progress		
Type of Goal	**Met**	**Making Progress**	**Not Making Progress**
Directional Goal With a Target	State reached the target.	State was at least half of the way to achieving the target.	State was below the halfway mark to achieving the target.
Directional Goal Without a Target	Trend of the data matched the goal direction.	State maintained status from previous year.	Trend of the data moved in opposition to the goal direction.
Nondirectional Goal	Task was completed.	State attempted the task.	State did not attempt the task.

Source: OIG Analysis of States' 2006 Annual Reports, 2007.

We also analyzed States' progress in meeting goals by the strategic objective categories developed by CMS.

Assessing States' reporting of goals. We conducted two levels of review to assess States' reporting of goals. First, we assessed whether each goal listed in a State plan was in the Annual Report. For each goal listed in a State plan but not in the Annual Report, we determined whether the goal was outdated. We considered any goal with a completion date earlier than 2006 to be outdated.

Second, for the 368 goals included in the Annual Report, we assessed whether a State reported on its progress anywhere in the Annual Report. If a State did not include a report of progress, we analyzed the reasons that a State provided for not reporting. We coded the reasons the State provided as one of three categories: (1) the State discontinued the goal, (2) the State indicated a lack of sufficient data to analyze the goal, or (3) the State did not provide a reason for not reporting progress.

Limitations

Census may undercount Medicaid recipients which may affect estimates of the number of uninsured low-income children. In 2005, Census estimated 21.3 million Medicaid recipients, while CMS data indicated 28.2 million recipients.[30] The Urban Institute developed the Transfer Income Model which adjusts for this undercounting. However, Urban Institute officials stated that Medicaid recipients may be incorrectly

[30] U.S. Census Bureau, Current Population Survey, CENSUS, 2005, and Centers for Medicare & Medicaid Services, "2005 CMS Statistics," 2005.

reporting that they have employer-based or private insurance instead of Medicaid. This error would affect the underestimation of Medicaid recipients but may not affect the estimate of the number of uninsured.

We determined that Census data was adequate for our study because we are assessing change in the uninsured population, rather than assessing change in the number of Medicaid recipients. We acknowledge that Census data may overestimate the number of uninsured as a by-product of the underestimate of Medicaid recipients.

We did not independently verify the information reported by States regarding their goals.

Standards

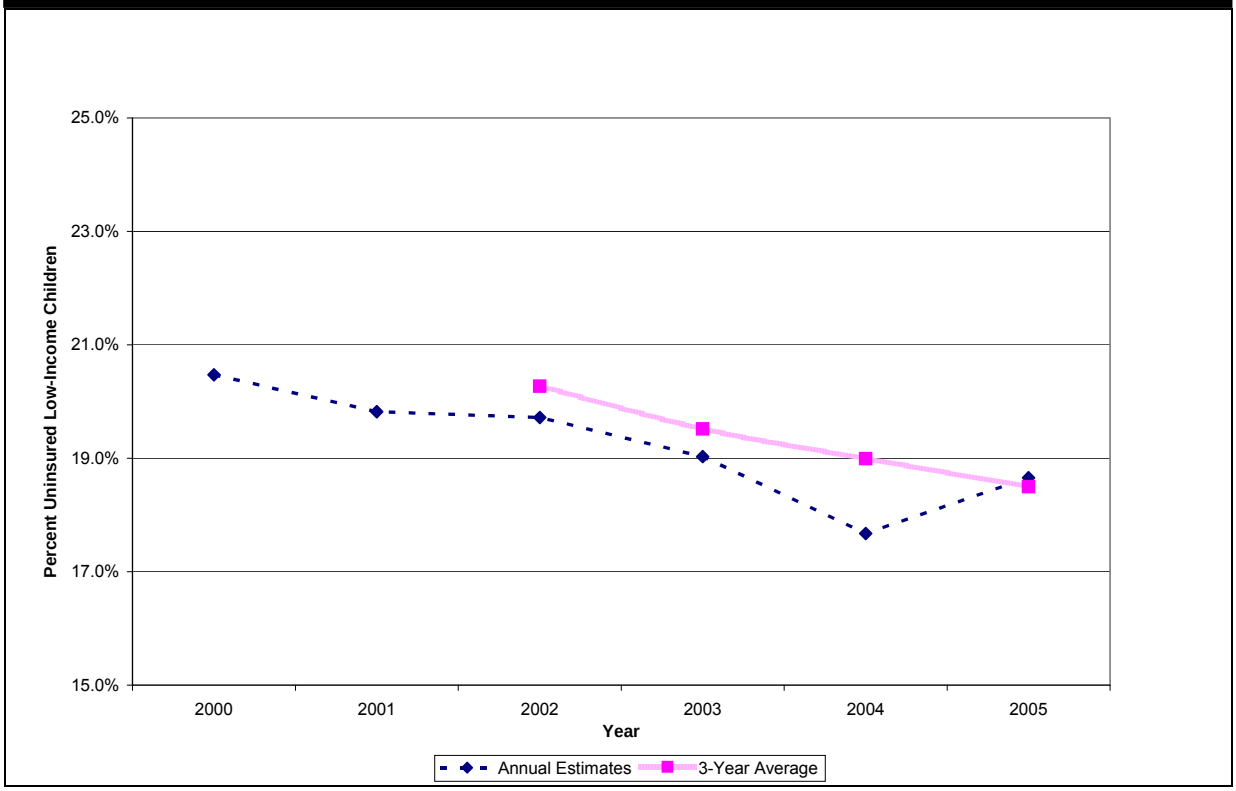
This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

Nationally the percentage of uninsured low-income children decreased between 2002 and 2005

Nationally the percentage of uninsured low-income children had a statistically significant decrease between 2002 and 2005. In 2005, 18.5 percent of low-income children were uninsured nationally, down from 20 percent in 2002.

See Graph 1 for national estimates of the percentage of uninsured low-income children annually from 2000 to 2005 and 3-year averages between 2002 and 2005.

Graph 1: National Percentage of Uninsured Low Income Children From 2000 to 2005



Source: OIG Analysis of Census data, 2007.

The national percentage of uninsured low-income children decreased during the same time that both SCHIP and Medicaid enrollment of

children increased. SCHIP enrollment increased by 15 percent[31] and Medicaid increased enrollment by 18 percent,[32] between 2002 and 2005.

However, no State had a statistically significant change in the percentage of uninsured low-income children

Although the national percentage of uninsured low-income children decreased, no State experienced a statistically significant change in the percentage of uninsured low-income children between 2002 and 2005.

While each State's sample showed changes in the percentage of uninsured low-income children, none of the changes were significant when projected to the entire State at the 90-percent confidence level. Because of small State sample sizes, statistical tests are limited in accurately detecting modest changes at the State-level. See Appendix A for the percentage of uninsured low-income children by State in 2002 and 2005.

Many factors contribute to whether a State experiences a change in the percentage of uninsured low-income children. For instance, SCHIP and Medicaid enrollment, State and national economic climates, shifts in low-income populations, and private insurance rates all contribute to changes in a State's percentage of uninsured low-income children.

In 2006, 37 States met or made progress in meeting at least half of their performance goals

Thirty-seven States met or made progress in meeting at least half of their goals. Almost half of these 37 States met or made progress in meeting between 50 percent and 74 percent of their goals. In general, States varied on the number of goals they had, ranging from 1 to 25 goals. In total, States had an average of seven goals.

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[31] CMS, "SCHIP Enrollment Reports: FY 2002 and 2005 Annual Enrollment Reports." Available online at: http://www.cms.hhs.gov/NationalSCHIPPolicy/SCHIPER /list.asp#TopOfPage. Accessed on June 25, 2007.

[32] CMS, "Fiscal Year 2002 National MSIS Tables." Available online at: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/MSISTables2002.pdf. Accessed on June 25, 2007. CMS, "2005 CMS Statistics." Available online at: http://www.cms.hhs.gov/CapMarketUpdates/Downloads/2005CMSStats.pdf. Accessed on June 25, 2007.

Only six States met or made progress toward all of their goals. One of these States had only one goal and another State had three goals. The remaining four States had four to six goals each.

Four States did not meet or make progress on any of their goals. Of these States, two States had only one goal each and the other two States had three goals each. See Table 2 for a breakout of States by the percentage of goals that were classified as met or making progress.

Table 2: Number of States by the Percentage and Number of Goals Classified as Met or Making Progress

Percentage of Goals Classified as Met or Making Progress	Number of States	Average Number of Goals per State by Quartile
100%	6	4
≥ 75% and < 100%	14	8
≥ 50% and < 75%	17	8
≥ 25% and < 50%	8	8
≥ 1% and < 25%	1	7
0%	4	2
Total	**50**	

Source: OIG Analysis of States' 2006 Annual Reports, 2007.

See Appendix B for each State's progress towards meeting its goals.

States made progress in meeting goals in all strategic objective categories

Of the States that reported progress, the largest number of States reported progress for goals related to increasing access to care and increasing the use of preventative care. Thirty-one States met or made progress in meeting at least half their goals related to increasing access to care. Of these 31 States, 19 met all goals related to increasing access to care. In addition, 28 States met or made progress in meeting half the goals related to increasing the use of preventative care, with 18 States meeting all of their goals related to increasing the use of preventative care.

States with goals related to SCHIP enrollment also experienced progress. Twenty-five States met or made progress in meeting at least half of their goals related to SCHIP enrollment. Of these 25 States, 18 States met all of their goals related to SCHIP enrollment.

States made less progress meeting goals related to reducing the number of uninsured low-income children. While 24 States met or made progress in meeting at least half their goals related to reducing the number of uninsured low-income children, 17 States did not meet half of

their goals. Of these 17 States, 16 did not meet any goals related to reducing the number of uninsured low-income children.

Seven States met or made progress in meeting at least half their goals that did not fit into any strategic objective. These goals concerned either enrollee satisfaction with the State's SCHIP program or SCHIP outreach.

See Table 3 for the number of goals in each strategic objective category for each State and the percentage of these goals that were classified as met or making progress.

Table 3: Number of States by the Percentage of Goals Classified as Met or Making Progress by Strategic Objective Category

Strategic Objective	Number of States That Reported at Least One Goal	States' Average Number of Goals Per Strategic Objective	Number of States by the Percent That Made Progress or Met Goals	
			0–49 Percent	50–100 Percent
Increasing access to care	41	2	10	31
Increasing use of preventative care	35	3	7	28
SCHIP enrollment	33	2	8	25
Reducing the number of uninsured low-income children	41	2	17	24
Medicaid enrollment	20	1	9	11
Other	10	1	3	7

Source: OIG Analysis of States' 2006 Annual Reports, 2007.

Despite improvements made by CMS to the Annual Report template, States' progress remains difficult to assess

OIG's previous SCHIP reviews reported significant difficulties using the Annual Reports to assess States' progress in reducing the uninsured and meeting goals. In 2001, OIG could not assess States' progress in meeting goals because of States' conceptually and technically weak evaluative measures. OIG recommended that CMS develop a framework for the Annual Reports and provide guidance to States in conducting useful evaluations of their program.[33] Since then, CMS created the Annual Report template and annually reevaluates this template. Also, CMS developed a compendium of quality measures to provide States with various approaches to measuring data for CMS's national performance measures.

[33] "State Children's Health Insurance Program: Assessment of State Evaluations Reports," OEI-05-00-00240, p. 15. February 2001.

In 2004, OIG found that CMS did not ensure that States report their progress in reducing the number of uninsured low-income children and instead accepted enrollment data as a proxy in their Annual Reports.[34] Since then, CMS automatically enters Census data on the number and percentage of uninsured low-income children into States' Annual Reports.

Although CMS has improved the Annual Report template and started measuring rates of uninsured, issues that make it difficult to measure States' progress remain. There continue to be concerns about using Census data to measure States' progress in reducing the number of uninsured low-income children. Also, States' use of nondirectional goals as well as goals and measures missing from Annual Reports limit the usefulness of the Annual Reports in assessing States' progress in meeting goals.

Concerns with using Census data for State-level assessments persist

States continue to report concerns with the use of Census data to measure their progress in reducing the uninsured in their Annual Reports. In 2002, 11 States reported limitations to Census data.[35] In 2006, 20 States reported limitations. Despite the increased sample size of the Census survey in 2002, the most common limitation cited by States in their 2006 Annual Reports was small State sample sizes. States also cited the undercounting of Medicaid recipients and the use of income thresholds that may differ from States' specific SCHIP eligibility criteria as limitations to Census data.

CMS staff also expressed concern with Census data. CMS staff shared State concerns regarding the small State sample sizes and the undercounting of Medicaid recipients. CMS staff also expressed concern that Census data includes non-U.S. citizens, who would not be eligible for SCHIP.

Despite 20 States reporting concerns with Census data in 2006, only 6 of these States used an alternative data source to report their progress in reducing the uninsured. In total, 10 States used alternative data sources to report their progress in reducing the number of uninsured low-income children in 2006. Nine of these States used State surveys

[34] "SCHIP: States' Progress in Reducing the Number of Uninsured Children," OEI-05-03-00280, p. 12. August 2004.

[35] Ibid, p. 13.

and one State used the Center for Disease Control's Behavioral Risk Factor survey.

It is more difficult to assess progress of States with nondirectional goals

Across all States, one-third of goals were nondirectional and not quantifiable. Ten States had a majority of nondirectional goals. Thirty-three States had at least one nondirectional goal. See Appendix C for a complete list of States' goals by their level of specificity.

Nondirectional goals do not provide a desired direction of change nor are they quantifiable. Given these characteristics, it is hard to ascertain what constitutes progress for nondirectional goals. For instance, if a State's nondirectional goal was "monitor utilization of specialty care" the State would have met the goal if it mentioned a monitoring system. In contrast, directional goals with targets have clear criteria by which to assess progress. For instance, if a State's goal is "increase well-child visits annually by 5 percent" it is clear that only a 5-percent increase constitutes meeting the goal.

Because of the nature of the State-Federal SCHIP partnership, States have the discretion to develop goals that are nondirectional and not quantifiable. CMS does not dictate or provide written guidance concerning the content, quality, or specificity of States' goals.

States failed to report on all goals listed in their State plan

Only seven States reported on all goals from their State plans in their 2006 Annual Reports as required. Twenty-nine States included at least half of the goals from their State plan. Three States did not report on any goals from their State plans.

Twenty-eight percent of all goals from States' plans that were not included in the 2006 Annual Reports were outdated. Thus, States' failure to report on 72 percent of goals from their State plans was not due to the goals being outdated. In addition, 32 States included in their Annual Reports new goals that were not listed in their State plans.

States did not provide reports of progress for all goals in the Annual Reports

Not all goals included in States' Annual Reports included information on States' progress as required. Fourteen States did not report any information for at least one goal in their Annual Reports. Of these 14 States, 11 reported that data were not available for these goals.

RECOMMENDATIONS

The national percentage of uninsured low-income children experienced a statistically significant decrease between 2002 and 2005. In addition, 37 States met or made progress in meeting at least half of their goals. However, measuring States' progress remains difficult because of Census data concerns and nondirectional goals, as well as goals and measures missing from Annual Reports. Therefore, we recommend the following:

CMS should continue efforts to address States' Census data concerns

States continue to report limitations to using Census data for State-level estimations of the change in the number and percentage of uninsured low-income children. These State-level estimates are important because they are used not only to assess States' progress in reducing the number of uninsured, but they are also used when allocating SCHIP funding.

The most commonly cited limitation was small State sample sizes. Our analysis also revealed that, because of small State sample sizes, statistical tests may not be able to accurately detect modest changes in a State's percentage of uninsured low-income children. Therefore, we suggest that CMS continue departmental efforts to collaborate with Census officials to address these concerns. Possible solutions include increasing State sample sizes or pursuing alternative methodologies, such as small-area estimations.

In addition to small State sample sizes, CMS and States reported the undercounting of Medicaid recipients by the Census, the concern that Census data include non-U.S. citizens, and the use of income thresholds that may differ from States' specific SCHIP eligibility criteria. We suggest that CMS explore the appropriateness of using adjusted Census estimates in the Annual Reports. Microsimulation models have been developed that adjust Census estimates to address these limitations.

We also suggest that CMS work with States that reported limitations to Census data but did not utilize an alternative data source to identify alternative data sources or methodologies for reporting the percentage change in uninsured low-income children.

CMS should provide to States guidance on developing directional performance goals with a target

One-third of States' 2006 goals were nondirectional. These goals did not provide a desired direction of change nor were they quantifiable. Given these characteristics, it is hard to ascertain what constitutes progress for nondirectional goals. To address this, CMS should provide States

with guidance and technical assistance regarding the development of specific, reasonable, and targeted goals.

CMS should ensure that States report on all goals and measures

The Annual Report is the tool by which CMS assesses States' progress in meeting their performance goals. CMS has been successful in ensuring that all States submit their Annual Reports. However, in their Annual Reports, States failed to report on all goals listed in their State plans and not all goals included in the Annual Reports had information on States' progress.

To ensure that Annual Reports reflect progress on goals States committed to achieving for the current year, we suggest that CMS create and maintain a comprehensive list of States' current goals. This list should begin with goals listed in States' plans and be updated with goals that were added or discontinued in previous Annual Reports, and updated annually thereafter.

States can choose to discontinue a goal from their State plan or Annual Report. We suggest that CMS change the Annual Report template to require that States provide an explanation when a goal is marked discontinued.

Fourteen States did not report any information for at least one goal in their Annual Reports. This was largely a result of States reporting that data were not available. To help ensure that States annually report progress on all goals, we suggest that CMS work with States that have difficulty reporting on all of their goals. CMS has already provided a compendium of measures which outlines various approaches to measuring different goals. CMS could use this compendium to work with States to select meaningful measures. CMS could also facilitate interaction between States that are having difficulty measuring progress and States that have been successful in measuring progress.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS indicated general support for our findings and recommendations. However, CMS took issue with the presentation of the second finding and had a few comments related to the recommendations and their implementation.

With respect to the second finding, CMS suggested that we highlight State changes in the percentage of uninsured low-income children.

Because none of the State changes were statistically significant, we opted not to highlight them in the findings. However, we do present State-level data in Appendix A.

In regard to our first recommendation that CMS should continue efforts to address States' Census data concerns, CMS pointed out that it has limited ability to effect a change at Census. It also stated that a solution across Federal agencies is needed. On the other hand, CMS indicated a willingness to continue to work with the Census to convey States' concerns. We recognize that the issues with Census data are not unique to CMS and that a Federal solution is required. However, we believe that CMS can have impact regarding this issue by continuing to contribute to departmental efforts to collaborate with Census to address data concerns.

Finally, CMS expressed concern with our suggestion that States update their State plans to reflect their current goals. CMS indicated that State plans only need to be updated for reasons outlined in 42 CFR § 457.60, which does not include changes to performance goals. However, to assess States' progress using the Annual Report, it is necessary to know what goals States have committed to assess. We used the goals listed in the State plans because the mandate directs us to, and because CMS does not maintain a comprehensive list of States' current goals. Based on CMS's comments, we now suggest that CMS create a comprehensive list of States' current performance goals.

For the full text of CMS's comments, see Appendix D.

PERCENTAGE OF UNINSURED LOW-INCOME CHILDREN NATIONALLY AND BY STATE

Table 4: Percentage of Uninsured Low Income in 2005 and 2002

State	Current Program Type*	2005	2002	Difference Between 2005 and 2002		
				Percentage Difference†	Confidence Intervals	
				(2005–2002)	Lower 90 Percent	Upper 90 Percent
United States	N/A	18.5%	20.0%	-1.5%‡	-2.6%	-0.5%
Alabama	Separate	9.7%	15.9%	-6.1%	-12.3%	0.0%
Alaska	Expansion	14.7%	19.7%	-5.0%	-12.9%	3.0%
Arizona	Separate	24.6%	26.4%	-1.8%	-10.9%	7.3%
Arkansas	Combination	10.9%	15.7%	-4.8%	-11.0%	1.4%
California	Combination	19.9%	22.9%	-3.0%	-6.7%	0.7%
Colorado	Separate	27.7%	27.5%	0.2%	-10.6%	10.9%
Connecticut	Separate	17.4%	16.0%	1.3%	-8.2%	10.8%
Delaware	Combination	19.1%	14.0%	5.1%	-4.8%	15.0%
District of Columbia	Expansion	11.3%	11.5%	-0.2%	-8.1%	7.7%
Florida	Combination	25.7%	25.6%	0.1%	-5.7%	5.8%
Georgia	Separate	19.7%	19.5%	0.2%	-7.1%	7.6%
Hawaii	Expansion	8.7%	12.4%	-3.7%	-9.7%	2.3%
Idaho	Combination	16.7%	21.2%	-4.5%	-12.2%	3.1%
Illinois	Combination	18.7%	19.8%	-1.1%	-6.8%	4.5%
Indiana	Combination	14.8%	19.5%	-4.7%	-11.7%	2.3%
Iowa	Combination	14.0%	12.8%	1.2%	-6.3%	8.7%
Kansas	Separate	13.1%	16.7%	-3.7%	-11.2%	3.9%
Kentucky	Combination	15.0%	16.1%	-1.0%	-8.2%	6.1%
Louisiana	Expansion	15.3%	19.5%	-4.2%	-11.5%	3.1%
Maine	Combination	10.1%	11.5%	-1.4%	-8.3%	5.4%
Maryland	Combination	17.5%	18.6%	-1.1%	-10.4%	8.2%
Massachusetts	Combination	11.6%	8.7%	2.9%	-3.2%	9.0%
Michigan	Combination	9.1%	12.6%	-3.5%	-8.0%	1.0%
Minnesota	Expansion	14.7%	13.2%	1.4%	-7.0%	9.8%
Mississippi	Separate	17.1%	14.1%	3.0%	-4.0%	9.9%
Missouri	Expansion	13.4%	9.5%	3.9%	-2.6%	10.3%
Montana	Separate	22.9%	19.8%	3.1%	-6.8%	12.9%

Table 4: Percent of Uninsured Low Income Children in 2005 and 2002 (Continued)

State	Current Program Type*	2005	2002	Difference Between 2005 and 2002		
				Percentage Difference†	Confidence Intervals	
				(2005–2002)	Lower 90 Percent	Upper 90 Percent
Nebraska	Expansion	12.6%	11.6%	0.9%	-6.5%	8.4%
Nevada	Separate	25.6%	28.8%	-3.2%	-13.1%	6.7%
New Hampshire	Combination	10.6%	13.2%	-2.6%	-11.9%	6.7%
New Jersey	Combination	22.7%	21.2%	1.6%	-7.0%	10.1%
New Mexico	Expansion	22.4%	21.8%	0.6%	-8.1%	9.3%
New York	Separate	12.6%	14.6%	-2.0%	-5.6%	1.6%
North Carolina	Combination	18.7%	18.5%	0.2%	-5.9%	6.4%
North Dakota	Combination	18.2%	14.5%	3.6%	-5.4%	12.7%
Ohio	Expansion	14.7%	16.3%	-1.6%	-7.1%	3.9%
Oklahoma	Expansion	21.2%	22.6%	-1.4%	-9.9%	7.2%
Oregon	Separate	17.2%	19.7%	-2.5%	-11.1%	6.1%
Pennsylvania	Separate	16.6%	16.6%	0.1%	-5.4%	5.5%
Rhode Island	Combination	10.8%	9.2%	1.5%	-5.6%	8.7%
South Carolina	Expansion	14.3%	12.5%	1.8%	-4.9%	8.6%
South Dakota	Combination	12.3%	13.6%	-1.3%	-8.4%	5.8%
Tennessee	N/A	16.5%	10.4%	6.1%	-0.6%	12.9%
Texas	Separate	28.6%	33.8%	-5.2%	-10.5%	0.1%
Utah	Separate	18.1%	17.8%	0.2%	-7.6%	8.0%
Vermont	Separate	7.3%	6.8%	0.5%	-5.2%	6.2%
Virginia	Combination	15.7%	18.8%	-3.1%	-11.3%	5.1%
Washington	Separate	12.7%	15.7%	-3.0%	-10.1%	4.1%
West Virginia	Separate	10.7%	14.2%	-3.5%	-9.8%	2.8%
Wisconsin	Combination	12.4%	8.7%	3.7%	-2.3%	9.7%
Wyoming	Separate	14.6%	22.9%	-8.3%	-19.5%	3.0%

Source: Office of Inspector General (OIG) Analysis of Annual Social and Economic Supplement of the U.S. Census Bureau's Current Population Survey (Census) data, 2007.

* Combined = Combined Medicaid and SCHIP program, Expansion = Medicaid Expansion program, Separate= Separate SCHIP program

† Figures have been rounded to the nearest tenth.

‡ Statistically significant at the 90-percent confidence level.

STATES' PROGRESS IN MEETING GOALS

Table 5: Number of Goals by States' Progress

	Progress of Goal				
State	Met	Making Progress	Not Making Progress	Progress Unreported/ Data Does Not Measure Goal	Total Number of Goals
Alabama	6	3	2	1	12
Alaska	2	2	0	0	4
Arizona	1	5	0	0	6
Arkansas	1	2	0	2	5
California	5	1	0	6	12
Colorado	0	0	3	0	3
Connecticut	2	1	4	3	10
Delaware	0	0	1	0	1
District of Columbia	4	0	0	0	4
Florida	1	0	5	1	7
Georgia	6	1	1	0	8
Hawaii	2	3	2	2	9
Idaho	1	3	3	0	7
Illinois	2	0	0	6	8
Indiana	1	3	0	2	6
Iowa	7	1	1	0	9
Kansas	0	2	1	1	4
Kentucky	2	2	1	2	7
Louisiana	1	0	2	0	3
Maine	4	0	1	0	5
Maryland	0	2	1	2	5
Massachusetts	5	0	1	1	7
Michigan	7	0	1	3	11
Minnesota	3	0	0	1	4
Mississippi	7	1	1	1	10
Missouri	0	0	3	0	3
Montana	4	1	0	1	6
Nebraska	5	5	1	1	12
Nevada	1	1	4	1	7
New Hampshire	2	1	1	1	5
New Jersey	12	6	3	4	25
New Mexico	1	0	2	1	4
New York	2	1	0	0	3
North Carolina	4	0	1	1	6
North Dakota	2	4	4	5	15

Table 5: Number of Goals by States' Progress (Continued)

	Progress of Goal				
State	Met	Making Progress	Not Making Progress	Progress Unreported/ Data Does Not Measure Goal	Total Number of Goals
Ohio	2	3	0	0	5
Oklahoma	1	1	0	1	3
Oregon	2	1	0	5	8
Pennsylvania	7	2	1	0	10
Rhode Island	1	0	0	0	1
South Carolina	5	0	0	2	7
South Dakota	5	1	3	0	9
Texas	4	1	1	0	6
Utah	1	5	1	1	8
Vermont	0	0	0	1	1
Virginia	3	2	3	0	8
Washington	1	3	0	1	5
West Virginia	3	2	0	1	6
Wisconsin	0	6	3	0	9
Wyoming	5	3	1	0	9

Source: OIG Analysis of States' 2006 Annual Reports, 2007.

STATE GOALS BY SPECIFICITY

Table 6: Number of Goals by Specificity per State

		Type of Goal		
State	**Total Number of Goals**	**Directional Without Target**	**Directional With Target**	**Nondirectional**
Alabama	12	5	3	4
Alaska	4	1	0	3
Arizona	6	0	6	0
Arkansas	5	1	0	4
California	12	8	0	4
Colorado	3	3	0	0
Connecticut	10	6	0	4
Delaware	1	1	0	0
District of Columbia	4	0	0	4
Florida	7	7	0	0
Georgia	8	3	1	4
Hawaii	9	4	0	5
Idaho	7	0	7	0
Illinois	8	4	2	2
Indiana	6	0	6	0
Iowa	9	3	6	0
Kansas	4	0	3	1
Kentucky	7	2	5	0
Louisiana	3	1	2	0
Maine	5	3	0	2
Maryland	5	4	0	1
Massachusetts	7	2	2	3
Michigan	11	0	1	10
Minnesota	4	1	0	3
Mississippi	10	0	5	5
Missouri	3	3	0	0
Montana	6	3	3	0
Nebraska	12	1	0	11
Nevada	7	4	1	2
New Hampshire	5	5	0	0
New Jersey	25	6	15	4
New Mexico	4	4	0	0

Table 6: Number of Goals by Specificity per State (Continued)

		Type of Goal		
State	**Total Number of Goals**	**Directional Without Target**	**Directional With Target**	**Nondirectional**
New York	3	1	1	1
North Carolina	6	5	0	1
North Dakota	15	3	11	1
Ohio	5	2	3	0
Oklahoma	3	1	1	1
Oregon	8	4	0	4
Pennsylvania	10	2	0	8
Rhode Island	1	1	0	0
South Carolina	7	5	1	1
South Dakota	9	7	0	2
Texas	6	0	0	6
Utah	8	0	5	3
Vermont	1	0	1	0
Virginia	8	6	2	0
Washington	5	4	0	1
West Virginia	6	0	1	5
Wisconsin	9	7	0	2
Wyoming	9	0	6	3
Total	**348**	**133**	**100**	**115**

Source: OIG Analysis of States' 2006 Annual Reports, 2007.

APPENDIX ~ D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

SEP 1 0 2007

Office of the Administrator
Washington, DC 20201

RECEIVED
2007 SEP 11 AM 9:46
OFFICE OF INSPECTOR GENERAL

TO: Daniel R. Levinson
Inspector General

FROM: Kerry Weems
Acting Administrator

SUBJECT: Office of the Inspector General's (OIG) Draft Report: "Assessing States' Progress in Meeting State Children's Health Insurance Program Goals" (OEI-05-07-00330)

Thank you for the opportunity to review the OIG's congressionally mandated report on States' progress in meeting State Children's Health Insurance Program (SCHIP) goals. This report assessed States' progress both in reducing the number of uninsured low-income children and in meeting performance goals related to SCHIP.

The intent of SCHIP was to provide child health assistance to uninsured, low-income children. In fiscal year (FY) 2006, SCHIP afforded health coverage to 6.6 million children in the United States, an increase of 8.2 percent over FY 2005 enrollment. Although estimates of insurance coverage for children vary, the U.S. Census Bureau's Current Population Survey (CPS) is the most widely cited source. As noted in the OIG report, published national data show a statistically significant decrease in the percentage of uninsured low-income children, from 20 percent in 2002 to 18.5 percent in 2005. We agree with this finding. Additionally, an analysis of 2004 CPS data conducted by the Urban Institute[1] determined that less than 1.1 million children were Medicaid or SCHIP eligible, but uninsured. This number represents 3.6 percent of low-income children.

The CMS agrees with OIG's description of the limitations of the CPS and wants to emphasize the concerns with inadequate sample size the Medicaid undercount in accurately determining the number of uninsured children at the State level. We are concerned however that this report holds CMS accountable for the Census Bureau's CPS data, over which CMS has no ultimate control. This is a funding issue and funding for increasing the sample size can only be provided through an allocation by the Congress.

We appreciate the effort put forth by the OIG in making these assessments and concur with several of the report findings. The second finding in the report states that, "No State had a statistically significant change in the percentage of uninsured low-income children." We suggest that the OIG use the findings in Table 4, to more accurately state and to use as their

[1] The Urban Institute conducted an analysis of Medicaid and SCHIP eligibility among the uninsured using the Transfer Income Model, version 3 (TRIM3). In determining program eligibility, the simulation used State-specific eligibility levels, rather than 200 percent of the Federal poverty level.

section headline, that "There were 29 States that showed a decline in the percentage of low income uninsured children in their State. However, because of small State sample sizes, statistical significance could not be shown on a State-by-State basis." This change would need to be reflected in the findings section of the executive summary, as well as on Page 11 of the findings section of the report.

The third finding, which states that, "In 2006, 37 States met or made progress in meeting at least half of their performance goals," is consistent with our internal review of the 2006 Annual reports and we concur with this finding.

We also concur with the fourth finding which states that, "Despite improvements made by CMS to the Annual report template, States' progress remains difficult to assess," which is primarily due to States' use of inadequate goals and goals lacking defined metrics. As an immediate response to address this issue, we have already implemented a change to our SCHIP monitoring visit protocol, which directs CMS staff to conduct a targeted review of State performance goals as part of the overall review, rather than simply reviewing the goals during general technical assistance if requested by the State. Three State monitoring visits (Colorado, Minnesota and Georgia) have been conducted since completion of the targeted review. CMS will provide more State-specific technical assistance to the States identified as not presenting directional performance goals with a target.

We request further discussion of the finding on Page 15 of the report that States failed to report on all goals listed in their State plan. States may change performance measures for their SCHIP program without submitting a State plan amendment (SPA). CMS considers the Annual Report a "living document" which reflects the current operations in the State's SCHIP program. If a State chooses to change its goals it may do so by changing the entry in its Annual Report submission.

The OIG offered three recommendations based on its assessment. Below you will find our detailed responses to the recommendations in the draft report.

Recommendation

CMS should continue efforts to address States' Census data concerns. Small State sample sizes appear to limit the usefulness of State-level estimates of the percentage of uninsured children. Therefore, we suggest that CMS continue departmental efforts to collaborate with Census to address these concerns.

CMS Response

The CMS agrees with OIG's description of the limitations of the CPS in accurately determining the number of uninsured children at the State level, including lags in obtaining data on the number of uninsured children, the lack of consistent measures over time (States are free to change their baselines), and inadequate sample sizes to develop reliable measures. There are multiple agencies that use CPS data and multiple population databases that different agencies use when estimating the uninsured. However, a solution across Federal agencies is needed to come up with a database that can be uniformly used with assurance that the sample size is sufficient and the data adequately represents the number of uninsured. The

Department continues to work on these efforts and most recently released an analysis conducted by the Urban Institute, which estimates uninsurance rates by using data from the Transfer Income Model (TRIM).

The CMS is willing to continue its work with the Census Bureau to convey States' concerns; however, we are not able to effect a change at the Census Bureau to address States' concerns about Census data based on small sample sizes. The Census Bureau designs the instrument and survey methodology used for the CPS. Although the Census Bureau has consulted with CMS regarding the sample size and survey methodology, CMS has no ability to increase the sample size of the CPS, as that would require funding only available from Congress. This issue is not unique to CMS or to SCHIP and we recommend that the OIG recognize that there is little CMS can do to impact how the Census Bureau determines the survey sample size and that this is not unique to CMS and requires a solution across Federal agencies.

The CMS agrees with the OIG that we should continue efforts to address States' Census data concerns, and we will continue to do that. In addition, the SCHIP Annual Report template provides guidance to States regarding development of accurate estimates of the number of uninsured children. CMS prompts States to report on alternate estimate methodologies and an assessment of the estimate's reliability including standard errors, confidence intervals, and p-values. CMS posts the Annual Reports on the CMS Website and States may review other States' submissions and consider adopting alternative methods for developing estimates.

Recommendation

CMS should provide States guidance on developing directional performance goals with a target. CMS should provide States with guidance and technical assistance regarding the development of specific, reasonable, and targeted goals.

CMS Response

The CMS will continue to provide technical assistance to States on the development of directional performance goals with a target. CMS modified the SCHIP Annual Report Template (SARTs) in FY 2006 to provide additional guidance to States on development and reporting of State-specific performance goals. The template lists categories of strategic objectives and prompts States to report on appropriate goals supporting the strategic objective. The reporting fields ask for data sources, definition of the population included in the measure, and performance measurement data (numerator, denominator, rate). These questions provide a framework of what CMS expects-- measurable performance goals supporting the strategic objectives of the State SCHIP program. CMS will further refine the template in FY 2007 to guide States in developing and reporting on directional goals. We will also continue to work closely with the National Academy for State Health Policy (NASHP) to provide guidance to States on the Annual Report template, specifically enhancing the collection of State performance data.

This year SCHIP project officers conducted a targeted review of the State Annual Report submissions, Section II-Program Performance Measurement and Progress, in addition to their routine review of the entire Annual Report. That review resulted in findings similar in nature

to the results of the OIG review--many States presented performance goals that were not directional and lacked a target. As a result, CMS directed project officers to include a targeted review of State performance goals as part of every SCHIP monitoring visit protocol. Three State monitoring visits (Colorado, Minnesota and, Georgia) have been conducted since completion of the targeted review and CMS will provide more State-specific technical assistance to the States identified as not presenting directional performance goals with a target. CMS requested the OIG's worksheets during the exit interview as a check in identifying those States, but has not yet received them. Once again, CMS is requesting a copy of the worksheets developed by the OIG during this review.

In 2005, CMS created a Division of Quality, Evaluation and Health Outcomes (DQEHO) in the Center for Medicaid and State Operations (CMSO). DQEHO has assumed many of the responsibilities previously completed by CMS' contractors, Mathematical Policy Research, Inc. (MPR). DQEHO will continue with the provision of technical assistance to States. Also, CMS will continue to take advantage of any opportunities to discuss performance measurement with States and to offer technical assistance. We will promote inclusion of the topic during Regional Conferences with States.

Additionally, in 2006, CMS released "The Guide to Quality Measures: A Compendium" which is a compendium of nationally recognized, tested, and vetted quality measures to support States' programmatic needs, including public reporting, quality improvement, and program/plan monitoring. An electronic version of the compendium can be viewed at: http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/03_evidencebasedcare.asp#TopOfPage

Recommendation

CMS should ensure that States report on all goals and measures. The CMS should ensure that States include all of their goals in their Annual Reports. The CMS should also work with States to ensure that each goal in the Annual Reports includes a report of progress.

CMS Response

The CMS appreciates the report's recognition of the progress we have made in ensuring that all States submit their Annual Reports. We note that States have shown improvement in the timeliness of reporting over the past few years. For example, in 2003, seven States submitted an Annual Report, but did not provide the required certification necessary in verifying their reported information.. As of June 2007, all States had submitted and certified their 2006 SCHIP Annual Reports (these figures do not include Tennessee, which did not have an SCHIP program until 2006). CMS takes every opportunity to promote the completion and timely submission of SCHIP Annual reports and CMS staff provide whatever assistance is needed to facilitate timely submission of the completed, certified Annual Report.

The CMS will continue to promote the inclusion of State goals in the Annual Reports, including a report of progress. Under 42 CFR §457.710, the SCHIP State Plan must identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children. CMS identified a problem a few years ago that some States were not reporting on State-specific goals. To address this problem CMS changed the Annual Report template by adding fields for each of

the five categories of strategic objectives in order to prompt States to report. This section of the Annual Report includes fields for goals and an explanation of progress in meeting the strategic objective. The FY 2006 Annual Report template included fields for 3 years of data (FYs 2004-2006) to facilitate a review and determination of whether a particular goal was on target to be met.

The OIG also recommends that CMS ensure that States 'update their State plans to accurately reflect their current goals.' We note that States may change performance measures for their SCHIP program without submitting a SPA. States are only required to submit a SPA for reasons listed in 42 CFR §457.60. SPAs are required for changes such as those reflecting changes in Federal law, regulations or policy, changes in State law, organization, or operation that affect eligibility, policies to prevent substitution of coverage, changes in benefits or cost sharing, changes in the delivery system, or screen and enroll procedures. We consider the Annual Report a "living document" which reflects the current operations in the State's SCHIP program. If a State chooses to change its goals it may do so by changing the entry in its Annual Report submission.

The CMS agrees with the recommendation that we change the Annual Report template to require States to provide an explanation when a goal is marked discontinued. We are in the process of finalizing the 2007 Annual Report and have discussed this change with the contractor responsible for the template design. If it is not possible to make this change in the 2007 Annual Report template, the change will be made in the 2008 template.

The CMS agrees that we should do whatever we can in order to ensure that States report all of their goals in their Annual Reports and we currently use every avenue available to promote timely submission of complete Annual Reports, including a section dedicated to performance measurement. SCHIP Project Officers and Regional Office SCHIP contacts review the submitted Annual Reports to determine that they are complete and if the report reflects program features and changes as shown in the current SCHIP State plan. CMS Project Officers use an Annual Report Checklist to review the reports, including the State-specific goals.

The CMS also agrees with OIG's recommendation that we work with States that have difficulty reporting on all of their goals. As noted in the report, in 2006 the CMS issued "The Guide to Quality Measures: A Compendium." CMS will work with States to select quantifiable measures based on the nationally recognized, tested, and vetted quality measures presented in the compendium. CMS also agrees with the recommendation that we facilitate interaction between States that are having difficulty measuring progress and States that have been successful in measuring progress and CMS will work in concert to promote these State partnerships. We will also direct States to the Medicaid and SCHIP Quality Practices page on the CMS Website, which offers a searchable database of promising practices in use by States for their Medicaid and SCHIP Programs.

We appreciate the OIG's efforts in assessing States' progress both in reducing the number of uninsured low-income children and in meeting performance goals related to SCHIP.

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