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April 5, 2011

The Honorable Max Baucus
Chairman
The Honorable Orrin Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

Subject: *Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement*

Medicaid and the Children's Health Insurance Program (CHIP)—two joint federal-state health care programs for low-income families and children—play a critical role in addressing the health care needs of children.¹ In 2008, more than 36 million children in the United States received health care coverage through Medicaid or CHIP. Like all children, children covered by Medicaid and CHIP may have health care conditions that could warrant care from primary care or specialist providers. At the same time, a significant number of children in Medicaid and CHIP may not be receiving basic preventive care, which these programs generally cover. For example, we reported in 2009 that, on the basis of parents' reports in national surveys, about 40 percent of children in Medicaid and CHIP had not had a well-child checkup over a 2-year period.²

Many state Medicaid and CHIP programs and other health care purchasers have started initiatives to improve care coordination for children and provide children with access to networks of care. For the purposes of this report, care coordination is broadly defined as a process in which an individual or group helps to arrange a patient's primary and specialty

¹State Medicaid programs generally cover children under 21 years of age; however, state CHIP programs generally cover children 18 years of age and younger.

²For the 2009 report, we examined national surveys conducted by the Department of Health and Human Services from 2003 through 2006. The surveys included information from parents, or other adults in the household, of children in Medicaid and CHIP about the receipt of well-child checkups. See GAO, *Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services*, [GAO-09-578](#) (Washington, D.C.: Aug. 14, 2009). See the list of related GAO products at the end of this report.

health care services.³ Care coordination can be provided by primary care providers or through other individuals such as social workers or case managers. Care coordination activities can include communication—sharing information among participants in a patient’s care—and linking patients to community resources. Care coordination can help children gain access to a network of care, that is, a set of providers who are available to help address the primary and specialty health care needs of a patient.

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), oversees state Medicaid and CHIP programs at the federal level and collects annual reports. States are required, under federal law, to annually report to CMS on the provision of a range of preventive, diagnostic, and treatment services for eligible children, known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.⁴ Under federal law, the EPSDT benefit generally entitles children in Medicaid to receive coverage of periodic screening services—often termed well-child checkups—that include a comprehensive health and developmental history, a comprehensive physical exam, appropriate immunizations, laboratory tests, and health education.⁵ Under federal law, states are also required to annually assess the operations of their CHIP programs and report to CMS on the results of those assessments.⁶ These reports are important in part because they are designed to collect a standard set of information about children’s health in Medicaid and CHIP from all states, and thus serve as a resource for CMS and other stakeholders to monitor children’s utilization of health care services.⁷ For Medicaid, CMS requires states to submit EPSDT reports (also known as CMS 416 reports), which include information on the number of children receiving well-child checkups and the number of children referred for treatment services for conditions discovered through well-child checkups. The CMS 416 reports are used by CMS to monitor states’ progress in meeting the agency’s annual goal that states provide a well-child checkup to at least 80 percent of the children eligible to receive one.⁸ CMS, for example, has used CMS 416 reports to identify states with low reported rates of service provision for purposes of conducting reviews of state EPSDT programs to identify needed improvements. For CHIP, CMS requires states to submit a CHIP annual report. This report provides a wide range of information about state CHIP programs, including states’ performance in four areas related to services provided to children: receipt of well-child visits during the first 15 months of life; receipt of well-child visits in the third, fourth, fifth, and sixth years of life; use of appropriate medications for children with asthma; and access to primary care providers.

³There are also other definitions of care coordination. See GAO, *Health Care Delivery: Features of Integrated Systems Support Patient Care Strategies and Access to Care, but Systems Face Challenges*, [GAO-11-49](#) (Washington, D.C.: Nov. 16, 2010).

⁴See 42 U.S.C. § 1396a(a)(43).

⁵For this report, we refer to the EPSDT periodic screening services as well-child checkups. Under the EPSDT benefit, children also must receive coverage of treatment and other services necessary to correct or ameliorate health conditions discovered through well-child checkups. 42 U.S.C. §§ 1396a(a)(10), 1396d(4)(A).

⁶See 42 U.S.C. § 1397hh(a).

⁷We have long recommended that agencies collect information for overseeing the programs they administer. Internal control standards specify that agencies should collect information to monitor program objectives in order to determine whether the agencies are meeting their strategic goals. See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

⁸Under federal law, CMS must develop and set annual goals for each state for the participation of eligible children in EPSDT services. 42 U.S.C. § 1396d(r)(5).

States generally provide Medicaid and CHIP services through two service delivery and financing models—fee-for-service and managed care. Under a fee-for-service model, states pay providers for each covered service for which the providers bill the state. Under a managed care model, states contract with managed care plans, such as health maintenance organizations, to provide or arrange for medical services, and prospectively pay the plans a fixed monthly fee per enrollee.⁹ Concerns have been raised about delivery model incentives and health care service utilization; for example, one concern is that the fixed payment in managed care models may create an incentive to underserve or deny access to needed care. In contrast, because providers are paid for each covered service provided in fee-for-service models, there may be an incentive to provide more services to beneficiaries than necessary. As a result, interest in understanding access to, and use of, services by delivery model in Medicaid and CHIP has been long-standing.

In the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Congress required that we study Medicaid and CHIP children’s access to primary and specialty care, including the extent to which care coordination is provided for children’s care in Medicaid and CHIP and information on children’s access to networks of care. In addition, Congress required that we study, as appropriate, information on the degree of availability of services for children in Medicaid and CHIP.¹⁰ This report examines

1. the extent to which children in Medicaid and CHIP receive care coordination and have access to networks of care,
2. how selected states are coordinating care for children in Medicaid and CHIP, and
3. the extent to which required state reports collected by CMS provide information on the provision of services to children in Medicaid and CHIP.

We provided a briefing for your staff on the information contained in this report on February 3, 2011. (See enc. I.) As discussed at that time, we agreed to issue this report, which transmits and updates the information provided at the briefing.

To examine the extent to which children in Medicaid and CHIP receive care coordination and have access to networks of care, we analyzed two nationally representative surveys administered by HHS agencies. One survey—the National Survey of Children’s Health (NSCH)—provides information on children’s access to care coordination.¹¹ The NSCH includes a measure to identify the extent that children needing care coordination received

⁹In some cases, children may receive care through a Primary Care Case Management (PCCM) model. Under a PCCM model, primary care providers are prepaid a small amount for each enrollee to manage and coordinate the enrollee’s health care. Providers are paid on a fee-for-service basis for care that they provide.

¹⁰Pub. L. No. 111-3, § 402(d), 123 Stat. 84. In conjunction with this study, we are also separately examining primary care and specialty care physicians’ willingness to serve children in Medicaid and CHIP, which was also required under CHIPRA. As we agreed with your staff, we plan to issue a separate report in 2011.

¹¹The NSCH is administered by HHS’s National Center for Health Statistics, which collects data from parents and guardians on their children’s health and use of medical services. The NSCH collects information about children 17 years of age and younger. We analyzed the NSCH’s measure of effective care coordination from 2007 (the most recent data available) for children 17 years of age and younger.

effective care coordination.¹² The second survey—the Medical Expenditure Panel Survey (MEPS)—provides information on children’s use of, and access to, health services and specialists, which we used as a proxy for children’s access to networks of care.¹³ To assess the reliability of these data, we reviewed relevant documentation and interviewed agency officials knowledgeable about the data; we determined that the data were sufficiently reliable for the purposes of this report. (See enc. II for additional information on our analyses of NSCH and MEPS survey data.) To examine how selected states are coordinating care for Medicaid and CHIP children, we selected 5 of the 21 states identified in literature and by experts as having implemented initiatives in their Medicaid and CHIP programs to improve the coordination of children’s care.¹⁴ We interviewed state officials and others involved in these initiatives, such as physician associations and advocacy groups that assisted in the implementation of the initiatives. The 5 states we selected were Colorado, Illinois, New York, North Carolina, and Oklahoma. This judgmental, nongeneralizable sample was chosen to (1) include geographic diversity, (2) represent a mix of small and large Medicaid and CHIP programs, and (3) represent a mix of Medicaid and CHIP programs with and without a large proportion of children enrolled in managed care. To examine the extent to which annual state reports collected by CMS provide information on the provision of services to children in Medicaid and CHIP, we assessed federal fiscal year 2008 information from the two key summary reports that states are required to submit to CMS: the CMS 416 reports and the state CHIP annual reports.

We conducted this performance audit from September 2009 to April 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹²The NSCH identifies children needing care coordination and assesses whether or not these children received effective care coordination. The NSCH classifies children as needing care coordination if the child received services from two or more different categories of care (preventive medical, preventive dental, mental health care, or specialist services), and the family received any help or needed extra help coordinating the child’s care. The NSCH classifies these children as receiving effective care coordination if they usually received extra help coordinating care when it was needed, and were very satisfied with communication between doctors, and communication between doctors and other entities when such communication was needed. For the purposes of our report, we classified children as not receiving care coordination if the NSCH indicated that they did not receive effective care coordination when needed.

¹³The MEPS is administered by HHS’s Agency for Health Care Research and Quality, which collects data from individuals and their medical providers on, among other things, health status, use of medical care services, and access to care. For consistency with NSCH, we analyzed MEPS survey results for children 17 years of age and younger. We analyzed data related to access to networks of care for children 17 years of age and younger from the 2005, 2006, and 2007 surveys: (a) the proportion of children who had problems receiving needed care, tests, or treatments, and (b) the proportion who experienced problems accessing needed specialists. Although 2008 MEPS survey data were available, the questions we examined related to access to networks of care were no longer included. As a result, we were unable to compare the 2008 data to the data for 2005, 2006, and 2007.

¹⁴The Patient Protection and Affordable Care Act, enacted on March 23, 2010, provides states with a new option for offering health homes (i.e., a designated provider, a team of health care professionals operating with such a provider, or a health team) for Medicaid beneficiaries with chronic conditions beginning in January 2011. Subject to CMS approval, states may make Medicaid payments for health home services, including comprehensive care management, care coordination, and comprehensive transitional care, provided by a team of health care professionals. Pub. L. No. 111-148, § 2703, 124 Stat. 119, 319 (Mar. 23, 2010). CMS provided state Medicaid and health officials with preliminary guidance on the implementation of health homes in November 2010. We did not assess the implementation of this option by states in this review.

Results in Brief

Two nationally representative surveys from 2007 suggest that many children in Medicaid and CHIP needing care coordination did not receive it, and many needing access to networks of care had a problem with accessing the needed services, as the following specifics illustrate.

- Care coordination: NSCH survey data from 2007 reveal that 45 percent of children in Medicaid and CHIP needed care coordination services, and of this group, 37 percent did not receive it.
- Access to networks of care: The 2007 MEPS data reveal that 34 percent of children in Medicaid and CHIP needed care, tests, or treatments, and of this group, 12 percent of the children's families had problems accessing the needed services. In addition, based on the MEPS data, 15 percent of children in Medicaid and CHIP needed to see specialists, and of these children, 24 percent had problems seeing the specialists they needed to see. MEPS data from 2007 also suggest that a greater proportion of children in Medicaid and CHIP and uninsured children experienced a problem accessing needed care and needed specialists than privately insured children. For example, 12 percent of children in Medicaid and CHIP reported problems accessing needed care, tests, or treatments, compared to 16 percent of uninsured children and 6 percent of privately insured children.

The five states we examined had initiatives designed to improve care coordination for children in Medicaid and CHIP by having a process in place for beneficiaries to choose or be assigned to a medical home—typically a primary care provider—and by providing enhanced payments to providers of care coordination services.¹⁵ Four of the five states provided monthly payments—per member per month—to providers for each patient covered by the initiative who was enrolled with the provider. Other approaches used by the states included increased payment rates for certain services, such as office-based checkups, and performance-based bonuses or incentive payments for meeting or exceeding quality standards. The standards that participating providers were required to meet varied among states, but included requirements such as having a system in place for patients to contact their provider 24 hours a day and 7 days a week, tracking referrals to other physicians, and designing care management plans for patients. States had various methods for monitoring participating providers. For example, North Carolina compiled quality of care indicators from claims data and annual chart reviews and shared these indicators with all providers in the state. State officials reported challenges to improving care coordination for children in Medicaid and CHIP. For example, most state representatives we spoke with said that because specialists are in shorter supply in rural areas, obtaining referrals to specialists was still an issue. Other challenges identified by states included ensuring timely payments to providers and adequate reimbursement for specialists. As of December 2010, only one state—North Carolina—had formally evaluated its initiative. These evaluations projected Medicaid cost savings from the initiative due to a reduction in the use of certain services, such as emergency room visits for enrolled patients. (See enc. III for additional information on care coordination initiatives in the five selected states.)

¹⁵We did not identify a commonly accepted definition of a medical home. For purposes of this report, a medical home is generally a provider who is able to both provide and coordinate comprehensive health care services for patients.

The two required summary reports that states provide annually to CMS are of limited use for monitoring the provision of services to children in Medicaid and CHIP due to reporting errors, missing information, and lack of detail. Our review of fiscal year 2008 CMS 416 reports found that 12 states made reporting errors on their reports, and in 10 of these states errors were large enough to result in overstatement of the extent to which children received well-child checkups. For both the CMS 416 and the CHIP annual reports, we found missing information, such as states not reporting required information on the number of children in Medicaid referred for additional services, which resulted in gaps in information on children's access. Both annual reports lack the detail necessary to assess children's access to care by delivery model, that is, the information needed to monitor services provided to children in managed care versus services provided in fee-for-service systems. Further, although the CMS 416 captures, for some states, information on the number of children referred to other providers for treatment services, it does not identify whether those children actually received the needed services. More detailed information could be helpful to CMS and others for identifying state Medicaid or CHIP programs for further review and monitoring. In 2010, HHS reported on the information available to monitor children's access to services in Medicaid and CHIP. In its report, HHS recognized that the information reported in CMS 416 and CHIP annual reports, and other data sources used for management of the Medicaid and CHIP programs, was not always accurate and complete. HHS committed to improving the quality of information available on children's access to care in these programs. CMS has efforts under way to improve state reporting on the CMS 416 and CHIP annual reports, including training CMS staff who work with states on reporting CMS 416 information, convening a national workgroup that will provide input on improving technical assistance and guidance to states on reporting on EPSDT services, and plans to provide technical assistance to states on the CHIP annual report measures.^{16,17} As of December 2010, these efforts did not include planning for separate reporting on the provision of services by managed care and fee-for-service delivery models.

Conclusions

Although some states are expanding initiatives to help improve children's access to care coordination services, almost one-quarter of families with Medicaid and CHIP children who needed specialty care reported problems accessing that care. Monitoring is important for ensuring access to specialty care for Medicaid and CHIP children, including the collection of information on whether needed specialty care services for which children have been referred were received. To appropriately inform oversight efforts and the public on the provision of services in the Medicaid and CHIP programs, accurate and complete reporting is needed. Ensuring the accuracy and completeness of information collected on the provision of services to children in Medicaid and CHIP has been a challenge for CMS despite federal requirements for annual reports from states and a long-standing CMS goal for states to routinely provide well-child checkups for eligible children. CMS's recent efforts are positive steps toward helping to ensure the usefulness of the information collected to better monitor

¹⁶Under CHIPRA, HHS must publish a set of core measures for evaluating the quality of care provided to children in Medicaid and CHIP, which states may choose to use for reporting to HHS. Pub. L. No. 111-3, § 401(a), 123 Stat. 72. HHS published a set of 24 measures on December 29, 2010, which include three performance measures from the CHIP annual report.

¹⁷CHIPRA requires states to expand the information included in CHIP annual reports. Pub. L. No. 111-3, § 402(a), 123 Stat. 82. In accordance with this mandate, beginning in 2013, CMS will require states to report additional information for their CHIP beneficiaries through satisfaction surveys, including information on access to primary and specialty services, access to networks of care, and care coordination for beneficiaries.

the provision of services. However, information is lacking on whether those referred for treatment services ever received those services. Continued steps to improve the accuracy and completeness of state reports and to identify options for improving their usefulness are warranted.

Recommendations

In light of the need for accurate and complete information on children's access to health services under Medicaid and CHIP, the requirement that states report information to CMS on certain aspects of their Medicaid and CHIP programs, and problems with accuracy and completeness in this state reporting, we recommend that the Administrator of CMS

- establish a plan, with goals and time frames, to review the accuracy and completeness of information reported on the CMS 416 and CHIP annual reports and ensure that identified problems are corrected, and
- work with states to identify additional improvements that could be made to the CMS 416 and CHIP annual reports, including options for reporting on the receipt of services separately for children in managed care and fee-for-service delivery models, while minimizing reporting burden, and for capturing information on the CMS 416 relating to children's receipt of treatment services for which they are referred.

Agency Comments

We provided a draft of this report to HHS for comment. Responding for HHS, CMS agreed with our recommendations. The full text of CMS's comments is reprinted in enclosure IV. CMS also provided technical comments, which we incorporated as appropriate.

In its comments, CMS noted efforts it is planning or has under way that begin to address our recommendations that we believe are positive steps. These include working with states to improve EPSDT data reporting requirements, identifying options to improve the value of the CMS 416 and CHIP annual reports, and drafting regulatory guidance for states for consistent reporting of managed care encounter data. However, we note that some of CMS's efforts are toward improving data that are voluntarily reported by states, as opposed to improving data that are required, such as the CMS 416 and CHIP annual reports and their underlying data. CMS's ability to monitor children's access to services is dependent on consistent, reliable, complete, and sufficiently detailed data from each state.

We are sending copies of this report to the Secretary of HHS and appropriate congressional committees. The report also is available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions or need additional information, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in enclosure V.

A handwritten signature in black ink that reads "Katherine Iritani". The signature is written in a cursive, flowing style.

Katherine Iritani
Acting Director, Health Care

Enclosures – 5



**Medicaid and CHIP: Information on Children's Access to
Care Coordination and Networks of Care, and on States'
Reports to CMS on the Provision of Services**

Briefing for staff of the

Committee on Finance, United States Senate

Committee on Energy and Commerce, House of
Representatives

Updated



Introduction

- In 2008, more than 36 million children in the United States received health care coverage through Medicaid or the Children's Health Insurance Program (CHIP).
 - About 29.3 million low-income children received coverage through Medicaid.¹
 - About 7.4 million received coverage through CHIP.
- Like all children, children in Medicaid and CHIP may have health care conditions that could warrant primary care providers' or specialists' care.

¹State Medicaid programs generally cover children under 21 years of age; however, state CHIP programs generally cover children 18 years of age and younger.



Introduction (cont.)

- A significant number of children in Medicaid and CHIP do not receive basic preventive care, which all state Medicaid and CHIP programs generally cover.
 - For example, in 2009 we estimated that 40 percent of children in Medicaid and CHIP had not had a well-child checkup over a 2-year period.²
- State Medicaid and CHIP programs and other payers have begun implementing initiatives to improve care coordination for children and provide access to networks of care.³
 - Care coordination can help children access a network of care (i.e., a set of providers who are available to help address a child's primary and specialty health care needs).

²GAO, *Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services*, GAO-09-578 (Washington, D.C.: Aug. 14, 2009).

³For purposes of this briefing, care coordination is broadly defined as a process in which an individual or group helps arrange primary and specialty health care services. Care coordination can be provided by primary care providers or through other individuals, such as social workers or case managers.



Introduction (cont.)

- The Centers for Medicare & Medicaid Services (CMS) oversees state Medicaid and CHIP programs at the federal level and collects annual reports. States are required under federal law
 - to annually report to CMS on the provision of a range of preventive, diagnostic, and treatment services for eligible children, known as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services,⁴ and
 - to assess the operations of their CHIP programs and report to CMS on the results of those assessments annually.

⁴The EPSDT benefit generally entitles eligible children to receive coverage of periodic screening services that include a comprehensive health and developmental history, a comprehensive physical examination, appropriate immunizations, laboratory tests, and health education. For the purposes of this briefing, we also refer to EPSDT screening services as well-child checkups. States are also required to cover other EPSDT services, such as vision, dental, and hearing services, and further diagnostic or treatment services necessary to correct or ameliorate health conditions discovered through well-child checkups.



Objectives

- The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) required GAO to study and report on certain aspects of the access of children in Medicaid and CHIP to primary and specialty services.⁵ This briefing provides information on:
 1. The extent to which children in Medicaid and CHIP receive care coordination and have access to networks of care.
 2. How selected states are coordinating care for children in Medicaid and CHIP.
 3. The extent to which the required state reports collected by CMS provide information on the provision of services to children in Medicaid and CHIP.

⁵Pub. L. No. 111-3, § 402(d), 123 Stat. 8, 84 (2009).



Scope and Methodology

1: Care Coordination and Access to Networks of Care

- To examine the extent to which children in Medicaid and CHIP receive care coordination and have access to networks of care, we analyzed two nationally representative surveys administered by Department of Health and Human Services (HHS) agencies.
 - **The National Survey of Children’s Health (NSCH), administered by the National Center for Health Statistics (2007 survey, most recent available).** The NSCH collected data from 91,000 parents and guardians on health questions, including questions related to care coordination for their children. For Medicaid- and CHIP-covered children 17 years of age and younger, we examined children’s need for care coordination services and whether their families reported having a problem accessing services. The NSCH only includes information for children 17 years of age and younger.



Scope and Methodology

1: Care Coordination and Access to Networks of Care (cont.)

- **The Medical Expenditure Panel Survey (MEPS), administered by the Agency for Health Care Research and Quality (2005, 2006, and 2007 surveys).**⁶ The MEPS collected data on more than 30,000 persons, including information from families, individuals, and their medical providers, on use of, and access to, health services. For Medicaid- and CHIP-covered children 17 years of age and younger, we assessed access to networks of care by examining questions related to children’s need for care, tests, and treatment and for access to needed specialists, and whether their families reported having a problem accessing needed services or specialists.
 - For consistency with the NSCH, we analyzed MEPS survey results for children 17 years of age and younger.
 - We also compared Medicaid- and CHIP-covered children to uninsured and privately insured children.

⁶Although 2008 MEPS data were available, the questions we examined related to access to networks of care were no longer included. As a result, we were unable to compare the 2008 data to the data for 2005, 2006, and 2007.



Scope and Methodology

2: State Care Coordination Initiatives

- To examine how selected states are coordinating care for Medicaid- and CHIP-covered children, we obtained information on initiatives in five selected states: Colorado, Illinois, New York, North Carolina, and Oklahoma.
 - The states in our nongeneralizable sample were identified in literature and by experts as having implemented initiatives to improve care coordination for Medicaid- and CHIP-covered children.
 - The five states were selected from 21 that experts identified to provide (1) geographic diversity, (2) a mix of small and large Medicaid and CHIP programs, and (3) a mix of programs with and without a large proportion of children enrolled in managed care.⁷

⁷Under managed care, states provide a set payment amount in advance to managed care organizations to provide services to beneficiaries.



Scope and Methodology

3: Information States Report to CMS

- To examine the extent to which state reports collected by CMS provide information on the provision of services to Medicaid- and CHIP-covered children, we assessed federal fiscal year 2008 information from the two key summary reports required by federal law:⁸
 - **CMS 416 reports:** required for state Medicaid programs, CMS 416 reports are due April 1 after the end of the federal fiscal year.
 - **State CHIP annual reports:** required for state CHIP programs, CHIP annual reports are due January 1 after the end of each federal fiscal year.
- We conducted this performance audit from September 2009 to April 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁸Fiscal year 2008 is the most recent year for which there was reporting from all states.



Background

Medicaid

- States operate their Medicaid programs within broad federal requirements.
 - State Medicaid programs are generally required to cover EPSDT services.
 - States may operate their Medicaid programs through various models—for example, they may pay providers directly for services (fee-for-service) or they may contract with managed care organizations to provide benefits.



Background

CHIP

- As for Medicaid, states operate their CHIP programs within broad federal requirements.
 - In 2010, states administered their CHIP programs in three ways:
 - 7 states administered CHIP as an expansion of their Medicaid programs,⁹
 - 18 states administered separate, stand-alone CHIP programs, and
 - 26 states had a combined program, with both a Medicaid expansion and a separate CHIP program.
- States may operate their CHIP programs through a fee-for-service delivery model, or they may contract with managed care organizations to provide benefits.
- States are required to cover certain benefits for CHIP-covered children:
 - For example, CHIP-covered children covered under Medicaid expansion programs must receive the same benefits, including EPSDT benefits, as Medicaid-covered children.

⁹This includes the District of Columbia.



Background

State Medicaid Reports

- **Medicaid:** Since 1990, CMS has required states to submit CMS 416 reports to the agency that contain information on the provision of EPSDT services, such as well-child checkups, to children enrolled in Medicaid.
 - States collect information from fee-for-service providers and managed care plans to complete the reports.
 - As we have reported, states face challenges in collecting complete and accurate information for CMS 416 reports, particularly from managed care plans that are not reimbursed on the basis of providing individual services.¹⁰

¹⁰See GAO, *Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services*, GAO-07-826T (Washington, D.C.: May 2, 2007).



Background

State Medicaid Reports (cont.)

- CMS uses these reports to monitor states' progress in meeting the agency's annual goal that states provide a well-child checkup to at least 80 percent of children eligible to receive one.¹¹ CMS makes the state reports available on the agency's Web site.
- Many states have reported using the CMS 416 to monitor Medicaid children's utilization of preventive services.¹²

¹¹Since 1990, CMS has been required under federal law to develop and set annual participation goals for each state for participation of eligible children in EPSDT services.

¹²See GAO-09-578.



Background

State CHIP Reports

- **CHIP:** Since 2002, CMS has required states to submit CHIP annual reports. Since 2003, CMS has asked that these reports include information on four performance measures used to assess states' provision of services to children in CHIP:
 - receipt of well-child visits during the first 15 months of life;
 - receipt of well-child visits in the third, fourth, fifth, and sixth years of life;
 - use of appropriate medications in children with asthma; and
 - children's access to primary care providers.
- States have flexibility in the data they use to report these measures; for example, they may use claims data, a mixture of claims data and medical records, or survey data.
- CMS uses these reports to produce and publish a summary of state CHIP programs and also makes them available on CMS's Web site.



1: Care Coordination and Networks of Care

Overview of Finding 1

- Two nationally representative surveys from 2007 suggest that many Medicaid- and CHIP-covered children needing care coordination did not receive it, and many needing access to networks of care had difficulty accessing the needed services.¹³
 - **Care Coordination**
 - NSCH data from 2007 suggest that 45 percent of Medicaid- and CHIP-covered children needed care coordination, and 37 percent of those did not receive it.
 - **Access to Networks of Care**
 - *Access to care, tests, or treatment:* MEPS data from 2007 suggest that 34 percent of Medicaid- and CHIP-covered children needed care, tests, or treatments, and 12 percent of those had problems accessing the needed services.
 - *Access to specialists:* MEPS data from 2007 suggest that 15 percent of Medicaid- and CHIP-covered children needed to see specialists, and 24 percent of those had problems seeing specialists.¹⁴

¹³All percentage estimates from MEPS and NSCH data have a margin of error of plus or minus 5 percent or less at the 95 percent confidence level, unless otherwise noted.

¹⁴The confidence interval for this estimate is plus or minus 6 percent at the 95 percent confidence level.



1: Care Coordination and Networks of Care

NSCH Care Coordination Data

- NSCH data from 2007 suggest that 45 percent of Medicaid- and CHIP-covered children needed care coordination, and 37 percent of those children did not receive it.
- The NSCH measures care coordination for children who received two or more services in the prior 12 months. For these children, the NSCH examines survey responses related to getting help coordinating care when needed, satisfaction with communication between health care providers, and satisfaction with communication between health care providers and other entities (such as schools).¹⁵

¹⁵The NSCH measures whether children needing care coordination received effective care coordination. The NSCH classifies children as needing care coordination if the child received services from two or more different categories of care (preventive medical, preventive dental, mental health care, or specialist services), and the family received any help or needed extra help coordinating the child's care. The NSCH classifies these children as receiving effective care coordination if they usually received extra help coordinating care when it was needed, and were very satisfied with communication between doctors, and communication between doctors and other entities when such communication was needed. For the purposes of this briefing, we classified children as not receiving care coordination if the NSCH indicated that they did not receive effective care coordination when needed.



1: Care Coordination and Networks of Care NSCH Care Coordination Data (cont.)

- On the basis of NSCH families' reports in the 2007 survey, 45 percent of Medicaid- and CHIP-covered children 17 years of age and younger needed care coordination services. Projected nationally, this represents an estimated 9.4 million children.¹⁶
- Of those Medicaid- and CHIP-covered children 17 years of age and younger whose families reported needing care coordination services, 37 percent did not receive the needed services. Projected nationally, this represents an estimated 3.5 million children.¹⁷

¹⁶For privately insured children, the 2007 NSCH survey suggests that 41 percent of children 17 years of age and younger, or an estimated 18 million, needed care coordination services.

¹⁷For privately insured children 17 years of age and younger whose families reported needing care coordination services, the 2007 NSCH survey suggests that 26 percent, or an estimated 5 million, did not receive the needed services.



1: Care Coordination and Networks of Care

MEPS Data on Needed Care, Tests, or Treatment

- MEPS data from 2007 suggest that 34 percent of Medicaid- and CHIP-covered children needed care, tests, or treatments, and 12 percent of those had problems accessing the needed services.
 - The MEPS asks families if their child needed any care, tests, or treatment in the last 12 months. The MEPS also asks families how much of a problem, if any, it was to get the care, tests, or treatments the family or a doctor believed were necessary for the child. On the basis of MEPS families' reports in the 2007 survey, 34 percent of Medicaid- and CHIP-covered children 17 years of age and younger needed care, tests, or treatments. Projected nationally, this represents an estimated 7.3 million children.
 - Of those Medicaid- and CHIP-covered children 17 years of age and younger whose families reported that they needed care, tests, or treatments, 12 percent of families reported problems accessing the needed services. Projected nationally, this represents an estimated 844,000 children.
- MEPS data from 2005 and 2006 concerning access to networks of care are consistent with the data from 2007 reported here.



1: Care Coordination and Networks of Care

MEPS Data on Access to Specialists

- MEPS data from 2007 suggest that 15 percent of Medicaid- and CHIP-covered children needed to see specialists, and 24 percent of those had problems seeing specialists.
 - The MEPS asks families if their child needed to see a specialist in the past 12 months and how much of a problem, if any, it was to see a specialist that the child needed to see.
 - On the basis of MEPS families' reports in the 2007 survey, 15 percent of Medicaid- and CHIP-covered children 17 years of age and younger needed to see a specialist. Projected nationally, this represents an estimated 3.2 million children.
 - Of those Medicaid- and CHIP-covered children 17 years of age and younger whose families reported that they needed to see a specialist, 24 percent of families reported problems accessing the specialist.¹⁸ Projected nationally, this represents an estimated 769,000 children.
- MEPS data from 2005 and 2006 concerning access to specialists are consistent with the data from 2007 reported here.

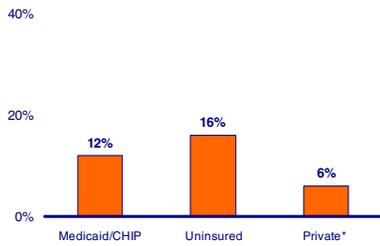
¹⁸The confidence interval for this estimate is plus or minus 6 percent at the 95 percent confidence level.



1: Care Coordination and Networks of Care

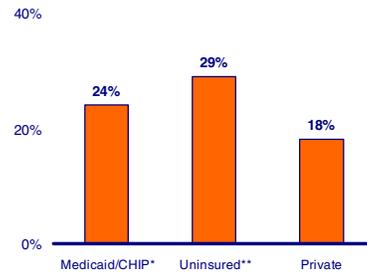
Comparing Medicaid- and CHIP-covered children with uninsured and privately insured children, MEPS data from 2007 show that a greater proportion of Medicaid- and CHIP-covered children and uninsured children experienced problems accessing needed care and needed specialists than privately insured children.

Reported a problem accessing needed care, tests, or treatment, 2007



Source: GAO analysis of 2007 MEPS data.
 *There is a significant difference at the 95 percent confidence level for this insurance type when compared to other insurance types.

Reported a problem accessing needed specialists, 2007



Source: GAO analysis of 2007 MEPS data.
 *The confidence interval for this estimate is plus or minus 6 percent at the 95 percent confidence level.
 **The confidence interval for this estimate is plus or minus 9 percent at the 95 percent confidence level.



2: Care Coordination Initiatives

Overview of Finding 2

- Initiatives in the five selected states were designed to improve care coordination by assigning children to medical homes and increasing payments to providers.
 - Care coordination initiatives in the states we examined varied in the populations covered and in the delivery model, but shared common elements:
 - States had processes for assigning children to a medical home.¹⁹ States provided enhanced payments to providers who were approved to participate in the states' care coordination initiatives and provide services.
 - States provided support to providers and monitored their initiatives.
 - States identified challenges to improving care coordination, and only one of the five states has conducted a formal, independent evaluation of its program.

¹⁹For purposes of this briefing, a medical home is generally defined as a provider who is able to both provide and coordinate comprehensive health care services for patients.



2: Care Coordination Initiatives

Characteristics of State Initiatives

- Care coordination initiatives in the five states varied in the populations covered and in the delivery models used.

State initiative	Year started	Population covered		Delivery model	
		Medicaid	CHIP	Medicaid	CHIP
Colorado—Medical Home Initiative	2007	Children	Children	FFS	MC
Illinois—Health Connect	2007	Children and adults	Children	FFS (PCCM)	FFS (PCCM)
New York—Patient Centered Medical Home	2009	Children and adults		FFS and MC	
North Carolina—Community Care of North Carolina	1998	Children and adults	Children*	FFS (PCCM)	FFS (PCCM)*
Oklahoma—Sooner Care Choice	2009	Children and adults	Children	FFS (PCCM)	FFS (PCCM)

Source: GAO analysis.

Legend: FFS = fee-for-service; MC = managed care; PCCM = primary care case management

*In October 2009, North Carolina temporarily discontinued care coordination payments for CHIP-covered children.



2: Care Coordination Initiatives

Assigning Children to Medical Homes

- All five states' initiatives have processes for assigning children to a medical home.
- Examples of these processes included the following:
 - In Illinois, once a potential enrollee becomes eligible for the initiative, a contractor employed by the state has 5 days to issue an initial enrollment packet to the eligible individual or family. Within 60 days of receiving this packet, the potential enrollee must choose a primary care provider as a medical home, or be automatically assigned to one.
 - In North Carolina, it is mandatory for infants eligible for Medicaid and children ages 1 through 18 to be enrolled in the state's initiative. Once they are enrolled, the local county department of social services assists each family in choosing a provider to be the child's medical home.



2: Care Coordination Initiatives

Methods to Approve Providers for Participation

- States used three types of methods to approve providers for participation:
 - Illinois and North Carolina used provider agreements as a condition of approval for providers. Providers agreeing to meet certain basic standards could participate in the initiative. For example, in Illinois, participating providers agreed to provide preventive services and to coordinate care for specialty services.
 - In Oklahoma and Colorado, providers were approved by the state after the state conducted a review and determined that the providers met certain standards, such as being available 24 hours a day, 7 days a week, by expanding their normal office hours or arranging for an alternate provider.
 - New York required its providers to be reviewed and approved as a medical home by a nationally recognized organization—the National Committee for Quality Assurance—in order to participate in the state’s medical home initiative.
- In addition, two of the states (Oklahoma and New York) used a tiered approach for approval, where providers were approved to a specific tier based on their ability to provide designated levels of care coordination services through tools they used in their practices.



2: Care Coordination Initiatives

Standards Approved Providers Must Meet

- The standards that participating providers were required to meet varied among states, but included requirements such as
 - having a system in place for patients to contact their provider 24 hours a day, 7 days a week (Colorado, Illinois, North Carolina, Oklahoma);
 - tracking referrals to other physicians or identifying the number of patients with certain chronic conditions (Illinois, New York);
 - designing care management plans that can include items such as the patient's condition, a list of medications and instructions for use, a list of symptoms for which they need to contact their providers, and patient communication preference (Illinois, New York);
 - having cultural competency, for example, providing cultural training to staff in the practice (Colorado);
 - implementing evidence-based guidelines for certain conditions (New York); and
 - submitting quality improvement plans or performance reports (Colorado, New York, North Carolina).



2: Care Coordination Initiatives

Types of Enhanced Payments to Providers

- States used one or more of the following three approaches to provide enhanced payments for the care coordination services provided through medical homes:
 - **per member per month** payments to providers for each patient covered by the initiative who was enrolled with the provider;
 - **increased payment rates** for the provision of certain services, such as EPSDT services; and
 - **performance-based bonuses or incentive payments** to providers who achieved goals such as increasing well-child screenings to a certain percentage of children.
- In addition, in the two states with tiered approvals (Oklahoma and New York), larger payments were made to providers approved at the higher levels.



2: Care Coordination Initiatives

Methods and Amounts for Enhanced Payments

State	Enhanced payment method			Amount of enhanced payment
	Per member per month	Increased payment rate	Performance bonus or incentive	
Colorado			•	For Medicaid, pay for performance includes \$10 per well-child visit for ages under 5 and \$40 for age 5 and older, and for CHIP, up to \$21 per child.
Illinois	•	•	•	Providers are paid a case management fee of \$2 per child (under age 21) per month and can receive increased payments by billing separately for services that are normally bundled. Providers can also receive up to \$25 per patient bonus payments for meeting or exceeding certain quality measures.
New York	•	•		Providers in the state's fee-for-service program can receive from about \$5 to \$21 (based on tier) in extra payments for certain types of office visits, and providers in managed care can receive \$2 to \$6 extra per member per month.
North Carolina	•			Providers can receive about \$5 per member per month for patients who are blind or disabled and \$2.50 for other patients.
Oklahoma	•		•	Providers can receive per member per month payments of about \$3.50 to \$7.50 based on certification tier and patient type. In addition, bonus payments are given based on performance goals set by the practice and on the practice's meeting national quality indicators for certain childhood screenings.

Source: GAO analysis of documentation from five selected states.



2: Care Coordination Initiatives

State Activities to Support Providers and Monitor Initiatives

- States had several processes to **support** participating providers in providing care coordination services.
 - Four states had toll-free numbers providers could call to find specialists who were accepting Medicaid- or CHIP-covered patients.
 - Four states had staff who could come to the offices of participating providers to provide support or answer questions related to the program.
- States also had various methods for **monitoring** participating providers.
 - For example, North Carolina compiled quality of care indicators from claims data and annual chart reviews and shared these indicators with all providers in the state. These indicators included
 - number of patients admitted to emergency rooms,
 - percentage of preventable readmissions to the hospital,
 - number of administered diabetes examinations, and
 - number of asthma-related emergency room visits.
- State officials reported that sharing the quality of care indicators has instilled competition among the providers to improve their performance.



2: Care Coordination Initiatives

Challenges and Formal Evaluations

- States identified some **challenges** to improving care coordination for Medicaid- and CHIP-covered children. For example:
 - Most state representatives we spoke with said that obtaining referrals to specialists was still an issue in rural areas. Because specialists for the most part are in shorter supply in rural areas, it was hard for some providers to find specialists for their patients.
 - Colorado found that some providers had not yet joined the initiative because they believed the compensation for Medicaid- and CHIP-covered patients was too low. Other challenges identified by states included ensuring timely payments to providers and adequate reimbursement for specialists.
- Only one state had conducted an independent **formal evaluation** of its care coordination initiative:
 - North Carolina hired a contractor to evaluate the effect of its initiative. The evaluation compared the actual cost for participants in the initiative with an estimated cost for participants had they not been enrolled in the initiative. The contractor estimated that the initiative saved the state \$190 million in 2009 by reducing the cost of certain services, including inpatient, outpatient, and emergency room services.



3: Information States Report to CMS

Overview of Finding 3

- Information states report to CMS has weaknesses that limit its usefulness for measuring and monitoring children’s access to care.
 - **Reporting errors:** States report data that fall outside of permissible ranges or that are contrary to instructions provided by CMS (CMS 416).
 - **Missing information:** States do not report certain categories of data (CMS 416 and CHIP annual report).
 - **Lack of detail:** States report summary information that lacks detail on services children receive by delivery model (CMS 416 and CHIP annual report) and whether children actually receive the services they need (CMS 416).
- Internal control standards specify that agencies should collect information to monitor program objectives in order to determine whether the agencies are meeting their strategic goals.²⁰

²⁰See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).



3: Information States Report to CMS

Reporting Errors

- Several states made reporting errors on their CMS 416 reports in fiscal year 2008, resulting in overstatement of the extent to which children received well-child checkups.
 - States are required to report the percentage of eligible children who received at least one well-child checkup, known as the participant ratio.
 - Valid participant ratios cannot be larger than 100, as this would mean more children received a checkup than were eligible to receive one.
 - In fiscal year 2008, 12 states reported participant ratios over 100 for at least one age group.
 - Ten of the 12 states had errors large enough to affect their overall participant ratios, with the amount of overstatement ranging from 1 to 14 percent.
 - Even with overstated overall participant ratios, few states met or exceeded CMS's 80 percent goal. In fiscal year 2008, only 2 states met or exceeded CMS's goal, and the nationwide participant ratio was 63 percent.



3: Information States Report to CMS

Missing Information

- Several states provided reports with missing information in fiscal year 2008, which resulted in gaps in information on children’s access to care.
 - On the CMS 416, states are required to report the number of children who are referred for additional services as a result of health problems identified during well-child checkups.
 - In fiscal year 2008, 42 states reported information on referrals made, and 9 states did not report any information on the number of referrals made.
- On the CHIP annual report, CMS specifies that states are required to report on the four performance measures only to the extent that information is available to the state.
 - In fiscal year 2008, 18 states did not report all measures to CMS—10 states reported on three measures, 6 states reported on two measures, and 2 states reported on one measure.



3: Information States Report to CMS

Lack of Detail

- CMS 416 and CHIP annual reports lack detail necessary to assess access by delivery model. Specifically, these reports do not distinguish between children in fee-for-service and those in managed care delivery models, and so potential access problems unique to a particular delivery model cannot be assessed.²¹
 - Different delivery models may provide different incentives that have unintended, negative effects. For example, in managed care models, when states provide a set payment amount in advance to provide services to beneficiaries, it may create an incentive to underserve or deny access to needed care.
 - For example, in a 2010 report examining children's access to dental services, we compared CMS 416 information from states using only fee-for-service with CMS 416 information from states using predominately managed care. This comparison suggested that children in managed care received fewer dental services, although comprehensive and reliable information to more thoroughly examine this difference was not available.²²
- In addition, although the CMS 416 captures, for some states, information on the number of children referred to other providers for treatment services, it does not identify whether those children actually received the needed services.

²¹Although the CMS 416 collects the number of children enrolled in managed care, it does not collect separate information on receipt of services for these children. As with the CMS 416, performance measures are not reported separately by delivery model on the CHIP annual report. States are allowed to only report performance measures for the delivery model with the largest number of enrollees.

²²See GAO, *Oral Health: Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns*, GAO-11-96 (Washington, D.C.: Nov. 30, 2010).



3: Information States Report to CMS HHS Recognizes Weaknesses

- HHS has recognized the weaknesses in available Medicaid and CHIP information.
 - In September 2010, HHS published a report in which it reviewed available information on the quality of care for children in Medicaid and CHIP, including information on children’s access to care.²³
 - HHS concluded that
 - wide variation exists in the accuracy and completeness of state information on the quality of care received by children enrolled in Medicaid and CHIP, and
 - Medicaid and CHIP information submitted to CMS by the states, including the CMS 416, CHIP annual report, and other information used to manage the programs, is not sufficiently complete, accurate, or timely to meet objectives of evaluating program performance or the quality of care beneficiaries receive.

²³Under CHIPRA, HHS is required to collect information on the quality of care provided to Medicaid- and CHIP-enrolled children from states and analyze and report these data beginning in September 2010 and annually thereafter.



3: Information States Report to CMS

CMS Efforts to Improve Medicaid and CHIP Reporting

- CMS officials reported that they have recently taken positive steps to improve Medicaid and CHIP data reporting.
 - In October 2010, CMS provided training for CMS EPSDT coordinators and other staff who work with states on reporting information on the CMS 416.
 - In December 2010, CMS convened the first meeting of the National EPSDT Workgroup, which will provide input on reporting on EPSDT services and ways to improve technical assistance and guidance to states, among other items.
 - CMS has also formed an internal work group to improve the Medicaid Statistical Information System (MSIS), which collects data from states on enrollment and service utilization.²⁴ These data could be useful to CMS and others to examine provision of services for children.

²⁴MSIS is a CMS system that collects eligibility and claims data from states. CMS uses this system to produce eligibility and program characteristics.



3: Information States Report to CMS

CMS Efforts to Improve Medicaid and CHIP Reporting (cont.)

- Starting in 2011, CMS will provide technical assistance to states on three of the four performance measures on the CHIP annual report with the goal of improving consistent collection and uniform reporting of these measures in conjunction with a CHIPRA-mandated quality measures initiative.²⁵
- Starting in 2013 for CHIP annual reports, CMS will require states to report additional information collected through satisfaction surveys of beneficiaries, including information on access to primary and specialty services, access to networks of care, and care coordination, as required under federal law.

²⁵Under CHIPRA, HHS must publish a core set of measures for evaluating the quality of care provided to Medicaid- and CHIP-covered children, which states may choose to use for reporting to HHS. HHS published a set of 24 measures on December 29, 2010, which include three performance measures from the CHIP annual report: receipt of well-child visits during the first 15 months of life; receipt of well-child visits in the third, fourth, fifth, and sixth years of life; and children's access to primary care providers.



3: Information States Report to CMS

CMS Efforts to Improve Medicaid and CHIP Reporting (cont.)

- However, CMS officials have indicated that they do not plan to require states to report on the provision of services to Medicaid- and CHIP-covered children by delivery model; that is, to report information on children in managed care separately from information on children in fee-for-service. Officials said that reporting separately by delivery model would be an additional burden on the states.
- As a result, it will still not be possible to assess access to care for Medicaid- and CHIP-covered children by delivery model.

Scope and Methodology for NSCH and MEPS Analyses

To examine the extent to which Medicaid- and CHIP-covered children receive care coordination and have access to networks of care, we analyzed two nationally representative surveys conducted by the Department of Health and Human Services (HHS). We analyzed the National Survey of Children's Health (NSCH) to examine the extent to which Medicaid- and CHIP-covered children receive care coordination. We examined the Medical Expenditure Panel Survey (MEPS) to examine the extent to which Medicaid- and CHIP-covered children have access to networks of care.

To assess the reliability of the NSCH and MEPS data, we spoke with knowledgeable agency officials and reviewed related documentation and compared our results to published data. We determined that the NSCH and MEPS data were sufficiently reliable for the purposes of our engagement.

National Survey of Children's Health (NSCH)

The NSCH is a nationally representative survey conducted by HHS's Centers for Disease Control and Prevention (CDC). The NSCH includes a variety of health indicators developed by the Maternal and Child Health Bureau in collaboration with CDC's National Center for Health Statistics and a national technical expert panel.¹ Our analysis was based on the 2007 NSCH, the most recent data available. Data in the NSCH are compiled through a random-digit-dialed sample of households with children 17 years of age or younger from each of the 50 states and the District of Columbia.² One child was randomly selected from all children in each identified household to be the subject of the survey, and the respondent was a parent or guardian who knew about the child's health and health care. We analyzed NSCH's measure of effective care coordination to estimate the extent to which Medicaid- and CHIP-covered children 17 years of age and younger needed care coordination and the extent to which those needing care coordination received it.

The NSCH care coordination measure classifies children as needing care coordination if their parent or guardian responded that

1. during the prior 12 months the child used services in two or more of the following categories: preventive medical, preventive dental, mental health care, or specialist services; **and**
2. the family received help coordinating the child's care among the different doctors or services used, **or** could have used extra help coordinating the child's care among the different providers and services.

¹The expert panel includes representatives from other federal agencies, state Title V leaders, family organizations, and child health researchers.

²The NSCH only includes information for children 17 years of age or younger.

Enclosure II

The NSCH measure classifies children as receiving effective care coordination if they needed care coordination and their parent or guardian responded that³

1. they received help coordinating care, did not need extra help coordinating, or usually received the extra help in coordinating their child's care when extra help was needed; **and**
2. they were very satisfied with the doctor's communication with other health care providers, when such communication was needed; **and**
3. they were very satisfied with the doctor's communication with other entities (such as schools, child care providers, and special educational programs), when such communication was needed.

Medical Expenditure Panel Survey

The MEPS is a nationally representative survey administered by HHS's Agency for Healthcare Research and Quality (AHRQ) that provides information on children's use of, and access to, health services. Our analysis of MEPS was based on data from the 2005, 2006, and 2007 surveys.⁴ We obtained data from the MEPS household component. The household component of MEPS collects data from a sample of families and individuals in selected communities across the United States. The sample is drawn from a nationally representative subsample of households that participated in the prior year's National Health Interview Survey (NHIS), a survey conducted by the National Center for Health Statistics at CDC. The MEPS household survey uses several rounds of interviewing covering 2 full calendar years. The MEPS is continuously fielded; each year a new sample of households is introduced into the study. The MEPS collects information for each person in the household based on information provided by one adult member of the household. This information includes demographic characteristics, self-reported health conditions, reasons for medical visits, use of medical services including preventive services, and health insurance coverage.

We analyzed data for several different MEPS questions as proxies for whether children 17 years of age and younger had access to networks of care, specifically:

- In the last 12 months, did you or a doctor believe [your child] needed any care, tests, or treatment?
- If yes, in the last 12 months, how much of a problem, if any, was it to get the care, tests, or treatments you or a doctor believed necessary [for your child]?
- In the last 12 months, did you or a doctor think [your child] needed to see a specialist?

³For purposes of our report, we classified children as not receiving care coordination if the NSCH indicated that they did not receive effective care coordination when needed.

⁴Although 2008 MEPS survey data were available, the questions we examined related to access to networks of care were no longer included. As result, we were unable to compare the 2008 data to the data for 2005, 2006, and 2007.

Enclosure II

- If yes, in the last 12 months, how much of a problem, if any, was it to see a specialist that [your child] needed to see?

We analyzed MEPS questions for children 17 years of age and younger to be consistent with the ages analyzed in the NSCH.

Summary of Care Coordination Initiatives in Five Selected States

To examine how selected states are coordinating care for Medicaid- and CHIP-covered children, we reviewed literature and spoke with experts and stakeholders about state efforts to improve care coordination. We identified 21 states that were developing or had implemented care coordination programs for Medicaid- and CHIP-covered children. We selected 5 of the 21 states for a more detailed review: Colorado, Illinois, New York, North Carolina, and Oklahoma. This judgmental sample was chosen to (1) include geographic diversity, (2) represent a mix of small and large Medicaid and CHIP programs, and (3) include states with a large share of Medicaid- and CHIP-covered children enrolled in managed care, as well as states with few or no children enrolled in managed care. In each state, we interviewed state officials and obtained information about the state care coordination initiative. We also interviewed officials from other groups involved in the state initiatives, such as physician associations and child advocacy groups.

All five state initiatives were designed to improve care coordination by assigning children to medical homes and increasing payments to providers approved to participate in the initiative. Each state implemented its own version of a medical home with varying requirements for the care coordination services provided through the medical home. Tables 1 through 5 provide an overview and a description of some key characteristics about each state's care coordination initiative. Specifically, for each state we provide information on the populations covered, provider participation requirements, provider payment methods, the type of state monitoring and support of providers, and the findings of any formal evaluations.¹ The following tables provide information on similarities and differences across the five states' initiatives. For example, while three methods were used for paying providers, the extent to which they were used varied across the states. The three payment methods are (1) per member per month payments, where providers receive a nominal monthly payment for each patient covered by the initiative and enrolled with the provider; (2) increased payment rates for certain services, such as well-child visits, provided to patients enrolled in the initiative; and (3) performance-based bonus payments or incentive payments to providers who meet state-established quality goals.

¹For the purposes of this report, a formal evaluation is a study or assessment of the care coordination initiative that is conducted by an external research entity. Some states completed internal reviews and studies as part of the process of overseeing their initiatives. While we provide information on the findings of internal state studies, we do not report them as formal evaluations.

Table 1: Description of Colorado’s Care Coordination Initiative, Colorado Medical Homes for Children

<p>Initiative overview</p>	<p>Colorado started its initiative in 2007 to increase Medicaid- and CHIP-covered children’s access to a medical home. In addition, Colorado uses the initiative to ensure that Medicaid children receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.</p> <ul style="list-style-type: none"> • In 2009, 236,000 Medicaid-covered and 67,000 CHIP-covered children participated in the program. Adults are not included in the program. • Medicaid-covered children receive care through a fee-for-service delivery model, and CHIP-covered children receive care through a managed care delivery model. • Primary care and specialty care providers can participate in the initiative once they are approved as a medical home.
<p>Provider participation requirements</p>	<p>Providers are approved to participate in the state’s medical home initiative by completing several steps. For example, providers must</p> <ul style="list-style-type: none"> • complete a Medical Home Index, which rates providers in areas such as cultural competencies, management of chronic conditions, preparation of a care plan that involves family members, and coordination with community agencies and schools as appropriate. • submit a quality improvement plan. • meet or be working toward meeting the state’s medical home standards, such as being available to patients 24 hours a day, 7 days a week; being culturally competent; and respecting the role of the family in a patient’s health care.
<p>Provider payment</p>	<p>Colorado providers participating in the initiative receive a performance payment for providing well-child visits. The state has different rates for Medicaid and CHIP.</p> <ul style="list-style-type: none"> • For Medicaid, providers receive an additional \$10 per well-child visit for children under the age of 5, and \$40 per well-child visit for children 5 and over. • For CHIP, primary care and obstetrics and gynecology providers receive up to an additional \$21 for well-child visits.
<p>Monitoring, support, and evaluation</p>	<p>Colorado uses various methods to monitor and support providers.</p> <ul style="list-style-type: none"> • State officials visit providers who have applied to become a medical home to assess their capacity to function as a medical home. • The state helps providers participating in the program refer patients to other providers by compiling, verifying, and sharing lists of providers who are eligible and participating in Medicaid and CHIP. • The state helps providers become medical homes by paying a nonprofit health advocacy group to train providers in medical home standards and to inform them of incentive payments.^a <p>Although the state has not conducted a formal (external) evaluation of its initiative, it has, in collaboration with a nonprofit organization, compared services and outcomes of children enrolled in medical homes with children not enrolled in medical homes. The study found that children in medical homes had lower emergency room admissions and more well-child visits than children not in medical homes</p>

Source: GAO analysis of state data.

^aIn addition to funds and support from the state, Colorado’s providers also receive assistance from a nonprofit organization that supports practices that are becoming medical homes.

Table 2: Description of Illinois’s Care Coordination Initiative, Illinois Health Connect

Initiative overview	<p>Illinois started its initiative in 2007 to establish a medical home and care coordination services for Medicaid and CHIP beneficiaries not enrolled in a Medicaid managed care plan. It is available to beneficiaries statewide.</p> <ul style="list-style-type: none"> • Illinois’s initiative is available to Medicaid- and CHIP-covered children. The initiative is also available to adults with Medicaid coverage. • As of June 2009, about 1 million Medicaid- and CHIP-covered children were enrolled with providers participating in the state’s initiative. • Care is delivered through a fee-for-service delivery model. • Only primary care providers can participate in the program.
Provider participation requirements	<p>Primary care physicians are approved to participate in the state’s medical home initiative by signing an agreement with the state to meet certain care coordination standards. For example, providers agree to</p> <ul style="list-style-type: none"> • maintain routine, urgent, and as-needed appointment standards, including: <ul style="list-style-type: none"> • routine preventive care available within 5 weeks of the date request, including within 2 weeks of the date request for infants less than 6 months; • urgent care appointments for those not determined to be emergency should be provided within 24 hours; • appointments for enrollee problems or complaints not deemed serious available within 3 weeks of the date of request; • initial prenatal appointments without expressed problems: 1st trimester within 2 weeks, 2nd trimester within 1 week, 3rd trimester within 3 days; and • upon notification of a hospitalization or emergency room visit; follow-up appointment available within 7 days of discharge from the hospital. • maintain hospital admitting and/or delivery privileges or make arrangements for such privileges, and • establish a care plan for individuals with chronic diseases that includes a list of medicines the patient is taking with dosages and when to take them, and a list of symptoms so patients know when to contact their provider.
Provider payment	<p>Illinois providers participating in the initiative are paid in three ways.^a They receive</p> <ul style="list-style-type: none"> • a \$2 per member per month payment for each child under the age of 21 for whom the provider serves as the medical home;^b • enhanced reimbursement rates for a number of selected office-based services; and • bonus payments when they meet or exceed certain quality goals or outcomes.
Monitoring, support, and evaluation	<p>The state works in conjunction with a contractor that administers the day-to-day operations of the initiative to monitor and support providers that participate in the initiative. For example, the state</p> <ul style="list-style-type: none"> • monitors practices by conducting routine visits to providers’ offices, as well as visits to investigate complaints received from patients and other providers; • monitors the frequency with which beneficiaries switch providers and the reasons cited for switching; • recently identified specific clinical areas that it will monitor using claims data, such as asthma management, diabetes management, immunizations, and developmental screenings; • monitors the availability of providers on a statewide, regional, county, city, and zip code level; and • established an electronic data portal to support improvements and care coordination by allowing providers to access claims-based reports, including patient lists, patient conditions, and histories of services provided.

Enclosure III

Although the state had not conducted a formal (external) evaluation, state officials internally analyzed claims data for fiscal years 2007 through 2009 by analyzing changes in per member per month costs since the implementation of the initiative, and they estimated savings of \$217 million.

Source: GAO analysis of state data.

^aIn addition to the three payment types, providers receive one-time funding from the state for their first year as a participant in the initiative.

^bPayments for other patients are slightly higher: \$3 per adult, and \$4 per disabled or elderly patient.

Table 3: Description of New York’s Care Coordination Initiative, Patient-Centered Medical Home

Initiative overview	<p>New York started its initiative in 2009 to provide financial incentives for providers to become medical homes for Medicaid patients.</p> <ul style="list-style-type: none"> • New York’s initiative is available to Medicaid-covered children and adults. CHIP-covered children are not covered by the initiative. • The initiative is available to those that receive care in a fee-for-service delivery model as well as those receiving care in a managed care delivery model. • Only primary care providers participate in the program.
Provider participation requirements	<p>Providers are approved to participate in the state’s medical home initiative once they have been officially recognized by the Patient-Centered Medical Home program of the National Committee for Quality Assurance (NCQA).^a Providers can be recognized at one of three different medical home tiers, depending on the amount and level of services the practice offers. Areas in which physician practices are evaluated and scored include</p> <ul style="list-style-type: none"> • using written standards on patient access and communication with patients; • using electronic health information to track patients’ medical conditions and important diagnoses; • implementing evidence-based guidelines for at least three medical conditions; • tracking referrals to other physicians; and • conducting performance reports for the practice or by provider.
Provider payment	<p>Providers recognized as a medical home receive two types of enhanced payments. The type of payment is based on the delivery model in which their Medicaid and CHIP patients are enrolled, and the amount of the payment increase is based on the provider’s medical home tier.</p> <ul style="list-style-type: none"> • For children served under a managed care model, an additional per member per month payment is made, with larger payment increases for physicians recognized at higher medical home tiers. Tier 1 providers are paid a \$2 per member per month, tier 2 providers are paid an additional \$4 per member per month, and tier 3 providers are paid an additional \$6 per member per month. • For children served under fee-for-service model, payment amounts are increased for certain office-based services. The amount of the payment increase can range from about \$5 to \$21, depending on the medical home tier of the practice, with the higher tiers receiving larger payment increases.
Monitoring, support, and evaluation	<p>New York officials told us in 2010 that because the program was so new that they had not yet established a process to monitor or evaluate outcomes of the initiative. They added that since the initiative began the number of physicians and practices that had been recognized as a medical home had dramatically increased.^b</p>

Source: GAO analysis of state data.

^aNCQA is a nationally recognized not-for-profit organization that develops health care quality and performance standards and accredits health plans, physicians, and other health care providers. NCQA assesses and scores physician practices using standards that emphasize the use of systematic, patient-centered, and coordinated care management processes.

^bAccording to a state official, prior to the state’s implementation of the initiative the number of physicians with NCQA recognition was about 300, but has increased three-fold since implementation of the state’s initiative.

Table 4: Description of North Carolina’s Care Coordination Initiative, Community Care of North Carolina

Initiative overview	<p>In 1998, North Carolina expanded an existing care coordination initiative that focused on certain populations, and introduced Community Care of North Carolina, a system of health and community networks across the state, to implement care coordination statewide.^a</p> <ul style="list-style-type: none"> • North Carolina’s initiative is available to Medicaid-covered children.^b The initiative is also available to adults with Medicaid coverage. • Enrollment in the initiative is mandatory for Medicaid-covered children ages 1-18. • As of March 2010, nearly 800,000 Medicaid-covered children were enrolled in Community Care of North Carolina. • Care is provided through a fee-for-service delivery model. • Most of the providers participating in the initiative are primary care providers, because specialists do not typically meet some of the requirements for approval.
Provider participation requirements	<p>Providers are approved to participate in the initiative by signing an agreement with the state.^c Services they agree to provide include</p> <ul style="list-style-type: none"> • being available for medical consultation 24 hours a day, 7 days a week, • offering preventive services, • arranging referrals as needed, • providing translation services, • referring and coordinating care, • implementing quality improvement and disease management initiatives, • conducting medical chart audits, and • reducing inappropriate utilization of services.
Provider payment	<p>North Carolina pays providers a per member per month payment. This payment is based on the number of aged, blind, or disabled beneficiaries for whom a provider serves as a medical home. The following rates are paid monthly:</p> <ul style="list-style-type: none"> • \$5 for each aged, blind, or disabled patient, and \$2.50 for other patients
Monitoring, support, and evaluation	<p>North Carolina monitors several health care measures that are collected from claims data and annual chart reviews. Measures that are monitored include</p> <ul style="list-style-type: none"> • preventable hospital readmissions as a percentage of total hospital admissions, • percentage of providers who use electronic prescribing, and • rates of emergency room visits for asthma patients. <p>The state has funded two external evaluations of the Community Care of North Carolina:</p> <ul style="list-style-type: none"> • A study by Mercer Consulting Group estimated that for state fiscal year 2009 savings from the program were between \$187 and \$195 million. Estimated savings were determined by comparing state costs under Community Care of North Carolina to projections of what state costs would have been under the previous program using historical data. • An earlier study of the program’s initial disease management initiatives conducted by the University of North Carolina’s Cecil G. Sheps Center estimated Medicaid savings of \$3.3 million for people with asthma and \$2.1 million for diabetes patients between 2000 and 2002. Much of these cost savings came from a reduction in hospital and emergency room admissions. Estimated savings were determined by comparing the average per member per month costs for these patients under the Community Care of North Carolina program with costs prior to the implementation of the program.^d

Source: GAO analysis of state data.

^aThe state’s existing care coordination initiative focused on patients with diabetes and asthma.

^bAccording to a North Carolina official, in October 2009, North Carolina temporarily discontinued care coordination payments for CHIP-covered children because the state lacked data needed to determine the program’s effect on CHIP costs. The state plans to resume these payments after they have implemented a system to collect the needed data.

^cBy signing the agreement with the state, providers become a member in 1 of the 14 geographic networks established across the state. Each network has a clinical director who provides leadership and is a leader in the local medical community. The providers govern their local network and hold regular medical management meetings, where they look at data related to their local network and compare their outcomes to those of other networks in the state.

^dT.C Ricketts, et al., “Evaluation of Community Care of North Carolina Asthma and Diabetes Management Initiatives: January 2000-December 2002,” The Cecil G. Sheps Center for Health Services Research, Chapel Hill, NC (Apr. 15, 2004), available at <http://www.communitycarenc.com/PDFDocs/Sheps%20Eval.pdf>.

Table 5: Description of Oklahoma’s Care Coordination Initiative, SoonerCare Choice

<p>Initiative overview</p>	<p>In 2009, Oklahoma transitioned its Medicaid program from a managed care delivery model to a fee-for-service model called SoonerCare Choice that utilizes a primary care case management system to provide a medical home.^a</p> <ul style="list-style-type: none"> • Oklahoma’s initiative is available to Medicaid- and CHIP-covered children. The initiative is also available to adults with Medicaid coverage. • In state fiscal year 2009, approximately 438,000 children participated in the initiative. • Specialists cannot serve as a medical home.
<p>Provider participation requirements</p>	<p>Providers are approved to participate in the initiative by signing an agreement with the state. The state requirements include a minimum and maximum number of patients per provider. At a minimum, all participating providers must serve at least 50 Medicaid- and CHIP-covered patients. The maximum number of patients is 2,500 for physicians and 1,250 for mid-level providers, such as nurse practitioners.</p> <p>Practices can be approved at one of three tiers based on their ability to meet the different requirements at each tier.</p>
<p>Tier 1: Entry-level medical home</p>	
<p>Providers must</p> <ul style="list-style-type: none"> • provide or coordinate all medically necessary primary and preventive services; • organize clinical data in paper or electronic format; • review all medications a patient is taking and maintain a medication list; maintain a system to track, test, and follow-up on results; • maintain a system to track referrals including self-reported referrals; • provide care coordination including family participation; and • provide patient education and support. 	
<p>Tier 2: Advanced-level medical home</p>	
<p>In addition to Tier 1 requirements, providers must accept electronic communications from the state’s Medicaid office;</p> <ul style="list-style-type: none"> • provide 24 hours a day, 7 days a week availability; • make after-hours care available to patients (provider must be available at least 30 hours per week and have open scheduling and walk-ins to provide continuity of care); • use mental health and substance abuse screening and referral; • use data from state Medicaid office to identify and track patients inside and outside of their practice; • coordinate care for patients who receive care outside the primary care provider location; and • promote access and communication with patients. 	
<p>Tier 3: Optimal-level medical home</p>	
<p>In addition to Tier 1 and 2 requirements, providers must</p> <ul style="list-style-type: none"> • organize and train staff in roles for care management, and create and maintain a prepared and proactive care team; • provide timely call-back to patients; • use health assessments to characterize patient needs and risks; • document patient self-management plan for those with chronic disease; • develop a primary care provider-led health care team;. • provide after-visit follow-up for patients; • adopt specific evidence-based clinical practice guidelines on preventive and chronic care; and • use medication reconciliation to avoid adverse interactions. 	

Enclosure III

Provider payment	<p>Oklahoma pays providers participating in the initiative in two ways: per member per month coordination payment and performance-based payments.</p> <ul style="list-style-type: none"> Per member per month care coordination payments differ by patient type and provider tier: <table border="1" data-bbox="552 294 1104 430"> <thead> <tr> <th>Type of practice</th> <th>Tier 1</th> <th>Tier 2</th> <th>Tier 3</th> </tr> </thead> <tbody> <tr> <td>Children only</td> <td>\$3.58</td> <td>\$4.65</td> <td>\$6.12</td> </tr> <tr> <td>Children and adults</td> <td>\$4.33</td> <td>\$5.64</td> <td>\$7.50</td> </tr> <tr> <td>Adults only</td> <td>\$5.02</td> <td>\$6.53</td> <td>\$8.69</td> </tr> </tbody> </table> Performance payments are paid quarterly to providers that achieve different quality goals, related to providing well-child health examinations and reduction of emergency room visits. 	Type of practice	Tier 1	Tier 2	Tier 3	Children only	\$3.58	\$4.65	\$6.12	Children and adults	\$4.33	\$5.64	\$7.50	Adults only	\$5.02	\$6.53	\$8.69
Type of practice	Tier 1	Tier 2	Tier 3														
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Monitoring, support, and evaluation	<p>The state monitors and supports providers in numerous ways. For example, the state</p> <ul style="list-style-type: none"> maintains a database to monitor participating providers and practices, and uses the database to help medical homes identify specialists for patient referrals, and monitor the number of patients served by providers; has developed a medical home review tool and is conducting educational reviews of providers and practices participating in the state initiative to identify the extent to which providers are providing the medical home services required for their respective tier; and maintains a log of calls, which are categorized and tracked from year to year, that the state agency has received on access-related issues. <p>The state has not conducted a formal (external) evaluation of this care coordination program.</p>																

Source: GAO analysis of state data.

^aThe state also has two smaller care coordination initiatives for high-risk patients.

Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

Katherine Iritani
Acting Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

MAR 18 2011

Dear Ms. Iritani:

Attached are comments on the U.S. Government Accountability Office's (GAO) correspondence entitled: "Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement" (GAO-11-293R).

The Department appreciates the opportunity to review this correspondence before its publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT CORRESPONDENCE ENTITLED, "MEDICAID AND CHIP: REPORTS FOR MONITORING CHILDREN'S HEALTH CARE SERVICES NEED IMPROVEMENT" (GAO-11-293R)

Thank you for the opportunity to review and comment on this draft report.

GAO issued two recommendations to the Department. We concur with both recommendations and offer comments below, particularly regarding the second recommendation as written.

GAO Recommendation

The Administrator of CMS should establish a plan, with goals and time frames, to review the accuracy and completeness of information reported on the CMS-416 and CHIP Annual Reports and ensure identified problems are corrected.

Centers for Medicare & Medicaid Services (CMS) Response

We agree with this recommendation and are already engaged in efforts with States to improve the accuracy and completeness of information collected by the CMS-416 and CHIP Annual Reports. As stated, these efforts could benefit from establishing precise goals and concrete timeframes.

The CMS is currently undertaking the following steps to address this concern:

- 1) Over the past 18 months, the Center for Medicaid, CHIP and Survey & Certification (CMCS) within CMS has been working closely with States to improve their understanding of EPSDT and the data reporting requirements. CMS held two "EPSDT Listening Sessions" in late 2009 to obtain input from State Medicaid Programs and national organizations on recommendations for improving service delivery, and monitoring and assessment of health outcomes related to EPSDT. In addition, CMS has held three EPSDT training sessions for CMS staff in both the Central Office and Regional Offices. One of these training sessions, held in October 2010, focused solely on the new data collection requirements for the CMS-416. CMS issued a revised form CMS-416 and instructions in late December 2010 that included changes as required by CHIPRA as well as requested by the Oral Health Technical Advisory Group (an advisory group made up of state Medicaid dental directors). The changes will provide CMS and States with a more complete profile of dental services provided to children. CMCS also currently serves on the National Academy for State Health Policy EPSDT Advisory Committee, a group that includes State EPSDT staff and provides guidance to State Medicaid staff administering the EPSDT benefit.
- 2) Additionally, in December 2010, CMS established a National EPSDT Improvement Workgroup which includes several sub-workgroups including a Data Improvement Sub-Workgroup. The workgroup members represent a wide range of perspectives, experience with and knowledge of EPSDT. The members also have experience with the challenges

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States have faced in collecting and reporting useful Medicaid and CHIP performance data. The members of the Data Improvement Sub-Workgroup will lend their expertise to inform CMS' development of a plan for improving the quality and usefulness of the data reported on the CMS-416.

- 3) In an effort to reduce variation in the accuracy and completeness of data submitted to CMS via the CMS-416, an internal EPSDT workgroup at CMS has begun developing a set of data validation methods, including instituting a number of data integrity checks and procedures for monitoring and flagging questionable data or substantial year-to-year variation. Until more automated processes are in place, the workgroup is discussing how to implement a process for conducting regular internal audits of all changes made to EPSDT databases to reduce and prevent the possibility of data reporting errors by CMS. CMS also recently developed a crosswalk and additional guidance to assist States in collecting and reporting CMS-416 data that is more complete, accurate, and user-friendly. The crosswalk is a two-page instructional resource that defines each line of the CMS-416 using more simplified and straightforward terms, provides examples of potential responses, and provides edit checks in a notes column. The document will be issued to States in the coming months.
- 4) Major efforts are also underway to improve information on access and quality of care provided through the CHIP annual reports. CHIPRA gives CMS new authority and resources to monitor the services provided to children enrolled in Medicaid and CHIP. These provisions are helping CMS build an infrastructure for Medicaid/CHIP to measure and report on health care access and quality for children using a uniform set of tools across the States. This infrastructure has included indentifying an initial core set of child health quality measures for voluntary use by States, \$100 million in grant funding to States to develop quality and performance measurement tools and strategies, and developing a Pediatric Quality Measures Program to refine the core quality measures and assist States in analyzing the data yielded from these efforts for use in quality improvement efforts. In February 2011, CMS issued technical specifications for the standardized reporting of the CHIPRA core set of measures and CMS is now developing plans for providing States with technical assistance on collecting the data and using the information for quality improvement purposes. (See: <http://www.cms.gov/MedicaidCHIPQualPrac/Downloads/CHIPRACoreSetTechManual.pdf>)

GAO Recommendation

The Administrator of CMS should work with States to identify additional improvements that could be made to the CMS-416 and CHIP Annual Reports, including options for reporting on the receipt of services separately for children in managed care and fee-for-service delivery models, while minimizing reporting burden, and for capturing information on the CMS-416 relating to children's receipt of treatment services for which they are referred.

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CMS Response

We agree with this recommendation. Over the past year CMS has been working to identify options for improving the value of the CMS-416 as well as the CHIP Annual Reports. CMS is striving to strike a balance between targeting resources to upgrade existing data collection tools and investing in new tools that can ultimately reduce the duplication of efforts. CMS is also striving to enhance CMS and the States' collective capacity to address the complex challenge of ensuring access to care for the diverse population groups that Medicaid and CHIP serve. CMS' goal is to work together with States to determine the data reporting elements that will be most effective in measuring quality and performance of these programs. In general, CMS is interested in working with States and stakeholders to develop data and a set of measures that will achieve consistency across States and ensure a higher quality of valued information.

CMCS Data Strategy

The CMS is currently working with States through its CHIPRA quality demonstration grantees and its Technical Advisory Groups, (which are state workgroups that focus on policy areas such as quality, oral health, mental health, managed care, and coverage) to strengthen systems for measuring and collecting data on access and quality. In addition, efforts are now underway under the leadership of our Data and Systems Group to develop a larger strategy to meet the data and information exchange needs of CMS and the States. Two such efforts to improve the timeliness and accuracy of data reported deserve note. CMS is investing considerable resources in improving the Medicaid Statistical Information System and expanding the use of electronic health records (EHRs). Both of these information sources have efficiencies and capacities to collect more detailed information than either the CMS-416 or CHIP Annual Reports. Though widespread adoption of EHRs is not expected until 2014, leveraging EHRs where possible today, and working toward a future in which data are electronically collected and shared, is an investment that CMS expects will have a great value over time in not only improving the quality of care, but also in improving CMS's capacity to monitor services provided to beneficiaries.

It is our aim that with the help of the National EPSDT Workgroup, which will be discussing, among other things, the use of EHRs to collect information on children's use of services as required by EPSDT, there may be additional enhancements to the CMS-416 that enlighten the way we collect data now and in the future, and help improve upon the quality of information available to States and CMS.

Information Sources for Monitoring Access and Quality

Starting in 2013, CHIPRA requires CHIP programs and CHIP Medicaid Expansion programs to include in their CHIP Annual Report data from a monitoring tool, the Consumer Assessment of Healthcare Providers and Systems (CAHPS).¹ The CAHPS survey tool is also a component of

¹ Currently, 33 States are either CHIP combination or Medicaid Expansion programs.

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the CHIPRA initial core set of quality measures for voluntary use by State Medicaid/CHIP programs. It includes a number of questions about beneficiaries' satisfaction in accessing primary and specialty care, including questions about the ease of receiving needed care. While the CMS-416 could be expanded to collect more detailed information on children's receipt of needed services, it would duplicate information now being requested of States through CAHPS. As we work to make modifications to the CMS-416 to improve the accuracy of the information it captures, we believe the use of CAHPS in the future will prove to capture beneficiaries' experiences in accessing EPSDT benefits in an even more useful manner.

Several surveys conducted by the Department of Health and Human Services analyzed for this GAO report (the National Survey of Children's Health and the Medical Expenditure Panel Survey) are also excellent tools to answer questions about the extent to which children in Medicaid and CHIP nationwide have access to networks of care and coordinated care. Although the surveys are not State-specific, they offer insights into services provided to children enrolled in Medicaid/CHIP and collect individual data that can be stratified by demographic and health characteristics that are useful for monitoring access to quality care.

Managed Care Improvement Initiative

The CMS also has a number of tools and a new initiative underway for monitoring access and quality of care in managed care arrangements. With respect to the CMS-416, current instructions specify that data reported on the form must include services delivered to individuals in both fee-for-service or managed care arrangements. While CMS recognizes the challenges States face in collecting service use data from plans that use a capitated payment system, we are committed to working with States to identify the most critical data elements that will enable both the Federal government and the States to more effectively monitor and oversee access to care provided through managed care delivery systems. In particular, we are working to improve collection and reporting of encounter data. CMS is in the process of drafting regulatory guidance on reporting of encounter data to CMS in a consistent format across programs. Ultimately, programs will be required to report data more frequently to ensure an ongoing flow of accurate and timely information, thus improving CMS' oversight capabilities.

In addition, Medicaid and now CHIP programs that contract with prepaid managed care organizations are required to conduct annual external quality reviews (EQR). The EQRs are required by Congress, and CHIPRA requires that CMS report on an annual basis the lessons learned from the EQRs. CMS is now in the process of updating its protocols for EQRs and will issue new guidance to States to strengthen the collection and validation of encounter data on services provided by managed care organizations.

Improving the quality of information available on children's access to care in Medicaid and CHIP is one of CMS's key priorities, and the onus of improving the data collected rests both on the States and CMS. It is our view that the collection of data reported on the CMS-416 and CHIP Annual Reports will benefit from these targeted efforts, as well as CMS-wide efforts

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underway to improve the collection and reporting of data on quality of care measures more broadly. We appreciate the efforts that went into this report and look forward to working with the GAO on this and other issues.

GAO Contact and Staff Acknowledgments

GAO Contact

Katherine Iritani, Acting Director, (202) 512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, Catina Bradley, Assistant Director; Tim Bushfield; Sean DeBlieck; Alison Goestch; Laura Henry; Shirin Hormozi; Hannah Locke; Roseanne Price; and Hemi Tewarson made key contributions to this report. Martha Kelly and Suzanne Worth, Assistant Directors, provided technical assistance.

Related GAO Products

Oral Health: Efforts Under Way to Improve Children's Access to Dental Services, but Sustained Attention Needed to Address Ongoing Concerns. [GAO-11-96](#). Washington, D.C.: November 30, 2010.

Health Care Delivery: Features of Integrated Systems Support Patient Care Strategies and Access to Care, but Systems Face Challenges. [GAO-11-49](#). Washington, D.C.: November 16, 2010.

Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement. [GAO-10-810](#). Washington, D.C.: August 4, 2010.

Medicaid Preventive Services: Concerted Efforts Needed to Ensure Beneficiaries Receive Services. [GAO-09-578](#). Washington, D.C.: August 14, 2009.

Medicaid: Concerns Remain about Sufficiency of Data for Oversight of Children's Dental Services. [GAO-07-826T](#). Washington, D.C.: May 2, 2007.

Medicaid Managed Care: Access and Quality Requirements Specific to Low-Income and Other Special Needs Enrollees. [GAO-05-44R](#). Washington, D.C.: December 8, 2004.

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

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

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