United States Government Accountability Office

Report to Congressional Requesters

August 2019

# MEDICAID

# Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings

GAO-19-481

GAO Highlights

Highlights of GAO-19-481, a report to congressional requesters

## Why GAO Did This Study

The EPSDT benefit is key to ensuring that Medicaid beneficiaries aged 20 and under receive periodic screening services, such as well-child screenings, and diagnostic and treatment services, such as physical therapy and eyeglasses, to correct or ameliorate conditions discovered during a screening.

GAO was asked to examine the extent to which Medicaid beneficiaries aged 20 and under receive health care services under the EPSDT benefit. Among other things, GAO examined (1) what is known about the provision of EPSDT services based on CMS-required annual state reporting, and (2) CMS oversight of the EPSDT benefit. To do this, GAO analyzed annual state reporting data from fiscal years 2010 through 2017, the most current year data were available; CMS documentation; and federal internal control standards. GAO also interviewed CMS officials and Medicaid officials from 16 states selected, in part, on the variation in number of beneficiaries and geographic diversity.

## What GAO Recommends

GAO is making six recommendations to CMS regarding its oversight of the EPSDT benefit, including collecting appropriate blood lead screening data; taking action, if needed, after assessing the appropriateness of performance measures and targets for EPSDT; and evaluating states' performance in meeting CMS's EPSDT targets. CMS agreed with three recommendations, but disagreed with three others regarding performance measures and targets. GAO maintains that these recommendations are valid, as discussed in this report.

View GAO-19-481. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

August 2019

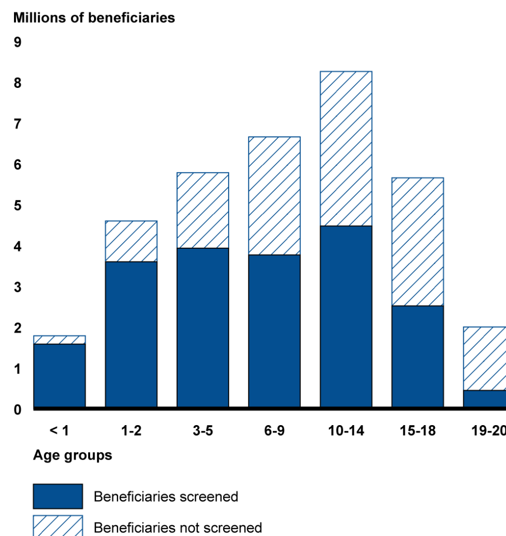
# MEDICAID

## Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings

## What GAO Found

Approximately half of all Medicaid beneficiaries aged 20 and under received screenings and services recommended under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in fiscal year 2017, but nearly as many did not. For example, GAO's analysis of state-reported data found that about 59 percent of all beneficiaries (20.2 million) who should have received at least one recommended well-child screening received one. About 48 percent of beneficiaries aged 1 to 20 (18.3 million) received a preventive dental service in fiscal year 2017. Older beneficiaries tended to have lower rates of screening.

**Number of Medicaid Beneficiaries Receiving and Not Receiving Well-Child Screenings in Fiscal Year 2017, by Age Group**




Source: GAO analysis of Centers for Medicare & Medicaid Services Early and Periodic Screening, Diagnostic, and Treatment data for fiscal year 2017. | GAO-19-481

The Centers for Medicare & Medicaid Services (CMS), the agency that oversees Medicaid, including EPSDT, has taken steps to improve the quality of information that states report about the provision of EPSDT services. CMS has also set some EPSDT performance measure targets for states; yet, the agency has not taken other steps to oversee the EPSDT benefit, such as

- collecting the data necessary to evaluate whether states are complying with CMS's policy for beneficiaries to receive a blood lead screening;
- taking action, as needed, based on assessments of the appropriateness of some performance measures, such as well-child screening measures; and
- using state-reported information to regularly evaluate states against CMS's EPSDT targets, or assisting states in planning improvements to meet the targets.

Absent these steps, CMS's oversight is limited and beneficiaries may not be receiving appropriate EPSDT services when they need them.

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## Abbreviations

| | |
|---|---|
| CHIP | Children's Health Insurance Program |
| CMS | Centers for Medicare & Medicaid Services |
| EPSDT | Early and Periodic Screening, Diagnostic, and Treatment |
| HHS | Department of Health and Human Services |
| T-MSIS | Transformed Medicaid Statistical Information System |

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

**441 G St. N.W.**
**Washington, DC 20548**

August 16, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Joseph P. Kennedy, III
House of Representatives

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is key to ensuring that eligible beneficiaries aged 20 and under receive appropriate services under Medicaid, a joint federal-state health care program for low-income and medically needy individuals. The EPSDT benefit is a comprehensive set of covered services for Medicaid's youngest beneficiaries that includes periodic screening services, such as physical exams, and diagnostic and treatment services, such as physical therapy and eyeglasses, among other services.[1] In fiscal year 2017, approximately 40 million Medicaid beneficiaries were entitled to receive ESPDT services. However, we and the Department of Health and Human Services (HHS) Office of Inspector General have previously found that millions of beneficiaries had not received the services to which they were entitled.[2]

The Centers for Medicare & Medicaid Services (CMS), an agency within HHS, is responsible for overseeing Medicaid at the federal level, including the EPSDT benefit. To help inform its oversight of the EPSDT benefit, CMS relies, in part, on several data sets submitted by states.[3] States are required to report annually on the provision of certain EPSDT services

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[1]The EPSDT benefit is defined in federal law to include screening, vision, dental, and hearing services, as well as other necessary services identified in section 1905(a) of the Social Security Act to correct or ameliorate any condition discovered through screening, regardless of whether such service is covered under the state Medicaid plan. 42 U.S.C. § 1396d(r).

[2]See GAO, *Medicaid and CHIP: Reports for Monitoring Children's Health Care Services Need Improvement*, GAO-11-293R (Washington, D.C.: April 5, 2011); and HHS Office of Inspector General, *Most Medicaid Children in Nine States Are Not Receiving All Required Preventive Screening Services*, OEI-05-08-00520 (Washington, D.C.: May 2010).

[3]For the purpose of our report, "states" refers to the 50 states and the District of Columbia.

through the Form CMS-416.[4] States may also voluntarily report information to CMS annually on health care services provided to EPSDT beneficiaries, as well as individuals covered under the Children's Health Insurance Program (CHIP) through the Child Core Set.[5] According to CMS, the agency will increasingly rely on the Child Core Set to measure health care outcomes for Medicaid and CHIP beneficiaries, rather than the CMS-416. Finally, as part of a separate effort conducted jointly with states, CMS has sought to improve the quality and usefulness of state-reported Medicaid data through its Transformed Medicaid Statistical Information System (T-MSIS). CMS intends for T-MSIS to provide more information to improve Medicaid oversight and to reduce the number of reports CMS requires states to submit, including the CMS-416 and the Child Core Set.

You asked us to review the extent to which Medicaid beneficiaries aged 20 and under receive health care services under the EPSDT benefit. In this report, we examine

1. what is known about the provision of EPSDT services in all states according to what states report on the CMS-416;
2. CMS oversight of the EPSDT benefit; and
3. what is known about the capabilities of T-MSIS data to replace states' CMS-416 and Child Core Set reporting.

Our report also describes state practices to promote and facilitate the delivery of EPSDT services. (See app. I.)

To examine what is known about the provision of EPSDT services in all states according to what states report on the CMS-416, we analyzed data states reported to CMS through the CMS-416 from fiscal year 2010, the year in which the current reporting template was implemented, through 2017, the most recent year of data available at the time of our reporting. Specifically, we analyzed data on the three primary ESPDT services reported on the CMS-416: (1) well-child screenings, (2) preventive dental

[4]Guam and Puerto Rico also submitted CMS-416 data in some years from fiscal year 2010 through 2017, but we did not include them in our analysis.

[5]CMS also oversees CHIP, a joint federal-state health care program for uninsured low-income individuals aged 18 and under, whose household income exceeds the limits for Medicaid eligibility.

services, and (3) blood lead screenings.[6] For our analysis, we calculated the following, both nationally and for each state, using the fiscal years and age groups that CMS uses for oversight:[7]

- the number and percent of beneficiaries recommended to receive at least one well-child screening who received at least one screening from fiscal years 2010 through 2017, both overall and for each of the seven age groups reported on the CMS-416;[8]
- the number and percent of beneficiaries aged 1 to 20 who received preventive dental services from fiscal years 2011 through 2017; and
- the number of screenings conducted for blood lead levels for beneficiaries aged 12 through 24 months in fiscal year 2017 using the 1 to 2 age group on the CMS-416.[9]

We did not independently verify the accuracy of state-reported CMS-416 data; however, we checked those data for obvious errors and omissions, compared analysis results with CMS's publicly reported data about EPSDT services, and communicated with CMS officials to resolve any identified discrepancies. We also reviewed written guidance and documents from CMS and interviewed CMS officials about the collection and reliability of CMS-416 data. On this basis, we determined that these data were sufficiently reliable for the purpose of our reporting objective.

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[6]At a minimum, well-child screenings include a comprehensive health and developmental history, including both physical and mental health development assessments; physical exams; age-appropriate immunizations; appropriate vision and hearing tests; dental exams; laboratory tests, including blood lead level assessments at certain ages; and health education, including anticipatory guidance.

The CMS-416 also includes information on the provision of dental treatment, dental diagnostic, and oral health services. The CMS-416 does not include information on provision of other EPSDT services, such as hearing and vision services.

[7]CMS focuses on certain age groups based on its policy and guidance, as well as clinical guidelines from nationally recognized medical organizations. For example, CMS focuses on preventive dental services to beneficiaries aged 1 year and older based on American Academy of Pediatric Dentistry guidelines, which state that beneficiaries should begin to receive dental care no later than age 1. We used fiscal year 2011 for our analysis of CMS-416 data on dental services to align with a CMS initiative to improve EPSDT beneficiaries' access to dental services, the Oral Health Initiative.

[8]The age groups reported in CMS-416 are younger than age 1, ages 1 to 2, ages 3 to 5, ages 6 to 9, ages 10 to 14, ages 15 to 18, and ages 19 to 20. For the purposes of our analyses, we rounded percentages to the nearest percentage point.

[9]We also calculated the number of screenings conducted for blood lead levels for beneficiaries aged 3 through 5 in fiscal year 2017 as reported on the CMS-416.

To examine CMS oversight of the EPSDT benefit, we reviewed guidance from CMS to states on the EPSDT benefit, CMS's process for reviewing EPSDT data on the CMS-416 and Child Core Set, and CMS summary reports about EPSDT performance measures.[10] We also interviewed CMS officials about their oversight activities, including reviewing data, setting and monitoring EPSDT-related performance measure targets, and assisting states with meeting EPSDT targets. We compared these efforts to best practices for results-oriented management as identified in previous GAO work, and assessed them against federal standards for internal control.[11] We also selected a non-generalizable sample of 16 states and interviewed Medicaid officials in these states to obtain information on data reporting and reliability, communications with CMS about EPSDT oversight, and leading practices officials identified for providing EPSDT services in their states.[12] To obtain state variation, the 16 states were selected on the basis of (1) the high and low number of Medicaid beneficiaries aged 20 and under, (2) the high and low number of and percent of beneficiaries recommended to receive at least one well-child screening who receive at least one screening, (3) variation in the way they deliver EPSDT services, (4) variation in whether they participated in a program with CMS to report EPSDT information through T-MSIS, and (5) their geographic diversity.[13]

[10]CMS officials said that activities that the agency has undertaken to improve health care services for children in Medicaid generally are efforts to improve states' delivery of EPSDT services. For the purposes of our report, we focused on CMS's activities related to select EPSDT services reported through the CMS-416 and Child Core Set.

[11]GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, GAO/GGD-96-118 (Washington, D.C.: June 1, 1996); *Veterans Justice Outreach Program: VA Could Improve Management by Establishing Performance Measures and Fully Assessing Risks*, GAO-16-393 (Washington, D.C.: Apr. 28, 2016); *Performance Measurement and Evaluation: Definitions and Relationships*, GAO-11-646SP (Washington, D.C.: May 2, 2011); and *Managing for Results: Enhancing Agency Use of Performance Information for Management Decision Making*, GAO-05-927 (Washington, D.C.: Sept. 9, 2005).

See GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 10, 2014). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

[12]The 16 states we selected are California, Delaware, Hawaii, Illinois, Iowa, Louisiana, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, Pennsylvania, Rhode Island, Tennessee, Texas, and Virginia.

[13]States provide EPSDT services through various delivery models, such as fee-for-service and managed care.

To examine what is known about the capabilities of T-MSIS data to replace states' CMS-416 and Child Core Set reporting, we interviewed CMS officials about T-MSIS data accuracy and completeness, and CMS's plans for using T-MSIS data to replace state reporting of the CMS-416 and the Child Core Set. We also reviewed the results of two sets of pilot studies CMS conducted to assess the extent to which T-MSIS could be used to replicate certain parts of the CMS-416 and the Child Core Set.[14] In addition, we interviewed knowledgeable Medicaid officials in our selected states regarding T-MSIS data quality and their interactions with CMS about T-MSIS. We assessed CMS's efforts to develop a timeline with interim milestones for when T-MSIS will replace state reporting of the CMS-416 or Child Core Set against federal standards for internal control.

We conducted this performance audit from March 2018 to August 2019 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.

# Background

## EPSDT Benefit

Federal law specifies that the EPSDT benefit covers screening, vision, dental, and hearing services, as well as other Medicaid coverable services that are necessary to correct or ameliorate any conditions discovered through screening.[15] The EPSDT benefit generally entitles beneficiaries to these services regardless of whether such services are covered in a state's Medicaid state plan and regardless of any restrictions that the state may impose on coverage for adult services.[16] The EPSDT screening component includes a wide range of preventive services, such

[14]The two sets of pilot studies included three studies on the CMS-416, which included 11 sample states, and one study on the Child Core Set, which included 6 sample states.

[15]See 42 U.S.C. § 1396d(r).

[16]The EPSDT benefit is a mandatory benefit for all categorically eligible individuals aged 20 and under covered under the state plan and may be provided at state option to other individuals eligible for Medicaid or CHIP. See 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B).

as comprehensive child health assessments known as well-child screenings and age-appropriate blood lead screenings. Because EPSDT covers any medically necessary service that could be covered for adults in addition to the specified preventive screenings, the EPSDT benefit is generally more comprehensive than the benefits provided for adult beneficiaries.

The federal government and states jointly share responsibility for implementing the EPSDT benefit. CMS, as part of its Medicaid oversight responsibilities, approves state Medicaid plans, which describe how the state administers its Medicaid program, including components related to the provision of EPSDT services. CMS also develops and issues general guidance to states about the EPSDT benefit, such as explanations of covered services and strategies for providing those services.[17]

Additionally, CMS has developed a goal for EPSDT, which is to assure that beneficiaries get the health care they need when they need it: the right care to the right child at the right time in the right setting.[18] Further, CMS established performance measures, some with associated targets, to guide states' implementation of EPSDT.[19] For example, CMS set performance measures and performance measure targets as part of its Oral Health Initiative.[20] CMS developed the performance measure targets to carry out statutory requirements, quality improvement efforts, and

[17]In addition, agency officials cited working with affinity groups that bring officials and experts together to address such topics as school based health and antipsychotic drug use in children; quality demonstration grants to states; and technical advisory groups, webinars, and publications on various topics, such as improving immunization rates.

[18]See CMS, *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (Washington, D.C.: June 2014).

[19]Performance measurement is the ongoing monitoring and reporting of program accomplishments, particularly progress toward pre-established goals. It involves identifying performance goals and measures, including establishing performance baselines by tracking performance over time; identifying quantifiable, numerical targets for improving performance; and measuring progress against those targets.

[20]CMS began the Oral Health Initiative in April 2010 to improve Medicaid beneficiaries' aged 1 to 20 access to dental services under the EPSDT benefit, with an emphasis on prevention. These services included preventive dental services and sealants on permanent molar teeth for beneficiaries aged 6 to 9. CMS set performance measure targets for both services, but CMS officials reported that in March 2016 they informed states that CMS no longer planned to use the target for measuring states' performance on the sealant performance measure. The officials said the performance measure and target were removed when the agency identified issues with calculating the measure.

agency policy. (See table 1 for EPSDT performance measures that have associated targets.)

**Table 1: CMS Performance Measures that have Associated Targets to Guide State Implementation of the EPSDT Benefit**

| EPSDT service | Performance measure | Performance measure target | Year established |
|---|---|---|---|
| Well-child screening[a] | Participant ratio: Percentage of beneficiaries recommended to receive at least one well-child screening—based on the state's periodicity schedule[b]—who receive at least one screening. | Eighty percent of beneficiaries receive screening. | 1990 |
| | Screening ratio: Ratio of the total number of screenings provided to the expected number of screenings, based on the state's periodicity schedule. | Eighty percent of screenings are provided. | 1990 |
| Dental services[c] | Percentage of beneficiaries aged 1 to 20 who receive a preventive dental service. | (1) At least 10 percentage point improvement over a 5-year period in each state.[d]<br>(2) 52 percent nationally in fiscal year 2015. | 2010 |
| Blood lead screening[e] | Percentage of beneficiaries who receive a blood lead test. | All beneficiaries (100 percent) are required to receive a test at 12 months and 24 months of age. Beneficiaries between 24 and 72 months of age must receive a blood lead screening if they have not been previously screened for lead.[f] | 1998 |

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS). | GAO-19-481

Note: CMS developed the performance measure targets to carry out statutory requirements, quality improvement efforts, and agency policy.

[a]The Omnibus Budget Reconciliation Act of 1989 required the Secretary of Health and Human Services to establish Early and Periodic Screening, Diagnostic, and Testing (EPSDT) participation goals for each state. See Pub. L. No. 101-239, § 6403(c), 103 Stat. 2106, 2263 (codified as amended at 42 U.S.C. § 1396d(r)). Participant and screening ratios are defined in section 5360 of CMS's State Medicaid Manual.

[b]A periodicity schedule sets the frequency by which certain services should be provided and will be covered.

[c]Dental services performance measures and performance measure targets were set as part of CMS's Oral Health Initiative. CMS began the Oral Health Initiative to improve access to dental services under the EPSDT benefit for Medicaid beneficiaries' aged 1 to 20, with an emphasis on prevention. These services included preventive dental services and sealants on permanent molar teeth for beneficiaries aged 6 to 9. CMS officials reported that in March 2016 they informed states that CMS no longer planned to use the target for measuring states' performance on the sealant performance measure.

[d]Though CMS originally set a 5-year time frame (fiscal years 2011 through 2015) for meeting the 10 percentage point improvement targets for the dental service performance measures set as part of the Oral Health Initiative, agency officials said in March 2019 that the time frame is now open-ended.

[e]See CMS, State Medicaid Manual, Section 5123.2.D.1.

[f]In 2012, CMS announced an option for states to request approval from CMS to implement a targeted lead screening program. According to CMS officials as of 2019, one state has an approved targeted lead screening policy, and all other states are subject to the universal screening policy.

States have flexibility, within federal parameters, to determine how EPSDT services are provided. For example, states are required to ensure that Medicaid-eligible beneficiaries and their families are aware of the EPSDT benefit and have access to required services, but states can choose whether to administer the benefit themselves or to oversee managed care organizations that are contracted to provide the benefit. States may also determine the frequency of screening services and communicate them through periodicity schedules that meet federal requirements.[21]

## EPSDT Reporting

CMS uses various sources of information to oversee the EPSDT benefit, such as the CMS-416, the Child Core Set, and the Medicaid and CHIP Scorecard.

### CMS-416 and Child Core Set

States report information about the provision of select ESPDT services to CMS annually through the CMS-416 and measures on the Child Core Set.[22] The CMS-416 provides CMS with basic information about EPSDT services, such as the participant ratio and number of beneficiaries receiving a preventive dental service.[23] It includes the information necessary for CMS to assess states' performance on the participant ratio and the screening ratio, among other things.[24] The agency then can compare performance on the two ratios with the agency's ESPDT performance measure targets. The Child Core Set provides CMS with information about the quality of health care provided to Medicaid and CHIP beneficiaries, and supports state efforts to improve health care

[21]States must establish reasonable standards, known as periodicity schedules, for medical, vision, hearing, and dental screening services in consultation with recognized medical and dental child health organizations. Periodicity schedules set the frequency by which certain services should be provided and will be covered.

[22]States are required by law to report annually to HHS the number of children provided child health screening services, the number of children referred for corrective treatment, the number of children receiving dental services, and states' results in attaining EPSDT participation goals established by the department. States must submit data to CMS by April 1 for the prior fiscal year's reporting. See 42 U.S.C. § 1396a(a)(43)(D).

[23]The participant ratio is the percentage of Medicaid beneficiaries aged 20 and under who received at least one recommended well-child screening, based on the state's periodicity schedule.

[24]In April 2011, we recommended that the Administrator of CMS work with states to identify additional improvements that could be made to reporting about the provision of EPSDT services. See GAO-11-293R. CMS agreed with our recommendation; however, as of March 2019, we consider the recommendation open.

quality and health outcomes.[25] Child Core Set reporting becomes mandatory on an annual basis beginning with the state reports on fiscal year 2024. As of 2019, the Child Core Set included performance measures related to the provision of EPSDT services, such as well-child visits in the first 15 months of life. Because reporting is currently voluntary, states vary in the number of performance measures they choose to report. In fiscal year 2017, for example, 50 states and the District of Columbia voluntarily reported on at least one of the 27 Child Core Set performance measures, with states reporting a median of 18 Child Core Set performance measures.[26] (See app. II for the information reported in the CMS-416 and Child Core Set.) As shown in table 2, there are both similarities and differences between the CMS-416 and Child Core Set.

[25]The CHIP Reauthorization Act of 2009 required HHS to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs. See Pub. L. No. 111-3, § 401, 123 Stat. 8, 72 (codified as amended at 42 U.S.C. § 1320b-9a).

[26]We used fiscal year 2017 data, because it is the most recent year for which data were available.

**Table 2: Selected Features of the Form CMS-416 and Child Core Set**

| Characteristic | CMS-416 | Child Core Set |
| --- | --- | --- |
| Population reported | Medicaid beneficiaries aged 20 and under | Medicaid beneficiaries aged 20 and under<br>Children's Health Insurance Program (CHIP) beneficiaries aged 18 and under[a] |
| Enrollment requirements for inclusion in population | Beneficiaries enrolled in Medicaid for 90 continuous days[b] | Varies by measure |
| Year reporting began | 1990 | 2011 |
| Reporting required or voluntary | Required | Voluntary[c] |
| Information reported | Basic information regarding the number of eligible beneficiaries<br>Primary care access and preventive care<br>Dental and oral health services | Basic information regarding the number of eligible beneficiaries, by measure<br>Primary care access and preventive care<br>Maternal and perinatal health<br>Care of acute and chronic conditions<br>Behavioral health care<br>Dental and oral health services<br>Experience of care |
| Comparability of state information | Not comparable, data affected by states' periodicity schedules[d] | Comparable |

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS) CMS-416 and Child Core Set. | GAO-19-481

[a]CMS prefers that states combine reporting of Child Core Set performance measures for beneficiaries enrolled in Medicaid and CHIP, whenever possible.

[b]States also report the total number of beneficiaries eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services at any point during the fiscal year. However, this is not used in calculating any of the other information reported on the CMS-416.

[c]Child Core Set reporting is mandatory beginning with the annual state report for fiscal year 2024. Because reporting is voluntary until then, states vary in the number of performance measures they choose to report. In fiscal year 2017, for example, 50 states and the District of Columbia voluntarily reported on at least one of the 27 Child Core Set performance measures, with states reporting a median of 18 Child Core Set performance measures. We used fiscal year 2017 data, because it is the most recent year for which data were available.

[d]A periodicity schedule sets the frequency by which certain services should be provided and will be covered.

Since the Child Core Set performance measures include CHIP beneficiaries who may not be entitled to the EPSDT benefit, data from the Child Core Set are not directly comparable with reporting on the CMS-416.[27] In addition, CMS-416 data cover a longer period of time, as they are available from 1995, while Child Core Set data are available from 2011. CMS officials said that having more years of CMS-416 data helps identify trends in the provision of EPSDT services over a longer period of time than possible with the Child Core Set. On the other hand, CMS officials said it is difficult to compare states' performance using the CMS-416, because some performance measures are based on periodicity schedules, which vary state-to-state and over time. In contrast, the Child Core Set allows for more consistency in comparing data across states, because each state is expected to calculate performance measures in the same way.

## Medicaid and CHIP Scorecard

In June 2018, CMS published the first Medicaid and CHIP Scorecard, which includes performance measures about the provision of services to Medicaid and CHIP beneficiaries.[28] The scorecard includes 17 performance measures related to the provision of EPSDT services, six of which are performance measures from the Child Core Set—and one of these six measures is derived from the CMS-416.[29] In January 2019, CMS officials reported that the scorecard will be used to provide increased transparency about state Medicaid program administration and beneficiary health outcomes, and drive health care quality improvement across states.

According to CMS officials, CMS envisions that the scorecard will be strengthened as state reporting of data through T-MSIS becomes more timely, accurate, and complete. CMS has been working since 2011 to

[27]States can administer CHIP through a separate CHIP program, an expanded Medicaid program, or a combination of the two. CMS-416 captures data for beneficiaries enrolled in CHIP through Medicaid expansion, because they are entitled to ESPDT coverage, but does not capture data for beneficiaries enrolled in separate CHIP programs. States may, but are not required to, provide EPSDT coverage to beneficiaries in separate CHIP programs.

[28]The scorecard also includes performance measures about how states and the federal government work together to administer Medicaid and CHIP.

[29]The remaining performance measures come from the Adult Core Set and a nationwide adult Medicaid Consumer Assessment of Healthcare Providers and Systems survey. The preventive dental service performance measure on the Child Core Set is derived from the CMS-416.

implement T-MSIS as a replacement for some current reporting to improve and increase states' reporting of Medicaid and CHIP data.[30] CMS intends for T-MSIS to provide a national data repository to support federal and state Medicaid and CHIP program management, among other things. T-MSIS includes data not previously reported by states and is intended to improve Medicaid and CHIP program efficiency, in part, by allowing states to compare their data with other states' data.[31] T-MSIS includes data that can measure the provision of EPSDT services. According to CMS officials, T-MSIS also includes aspects designed to improve the accuracy of available state data. For example, states' T-MSIS submissions undergo approximately 2,800 automated quality checks, which provide states with feedback on data format and consistency. As of January 2019, all 50 states and the District of Columbia were submitting data monthly, according to CMS, but T-MSIS data were not being used to create the CMS-416, Child Core Set, or the scorecard. Agency officials said research-ready files are in development and T-MSIS data are improving in quality over time with historical state resubmissions.

[30]We and others have reported insufficiencies in available Medicaid data, including Medicaid Statistical Information System data. See GAO, *Medicaid: Program Oversight Hampered by Data Challenges, Underscoring Need for Continued Improvements*, GAO-17-173 (Washington, D.C.: Jan. 6, 2017). See also HHS, Office of Inspector General, *Office of Inspector General's FY 2015 Top Management and Performance Challenges Facing the Department of Health and Human Services*, accessed October 3, 2017, https://oig.hhs.gov/reports-and-publications/top-challenges/2015/challenge01.asp. CMS has acknowledged the need for improved Medicaid data, and T-MSIS is CMS's primary effort, conducted jointly with states, to improve the collection of Medicaid data and replace the current Medicaid Statistical Information System.

[31]We have previously recommended that CMS expedite efforts to obtain complete information from all states on unreported T-MSIS data elements and use such data for program oversight. See GAO, *Medicaid: Further Action Needed to Expedite Use of National Data for Program Oversight*, GAO-18-70 (Washington, D.C.: Dec. 8, 2017).

## CMS Reports Indicate that Approximately Half of Beneficiaries Received Recommended Screenings and Services in 2017, but Nearly as Many Did Not

According to our analysis of CMS-416 data for fiscal year 2017, millions of Medicaid beneficiaries received recommended EPSDT well-child screenings and preventive dental services. However, nearly as many eligible beneficiaries did not receive the various recommended screenings and services, and few states met CMS's performance measure targets for EPSDT services. Additionally, while available data show that millions of blood lead screenings were performed, the total number of beneficiaries receiving blood lead screenings is unknown, because the data are incomplete.

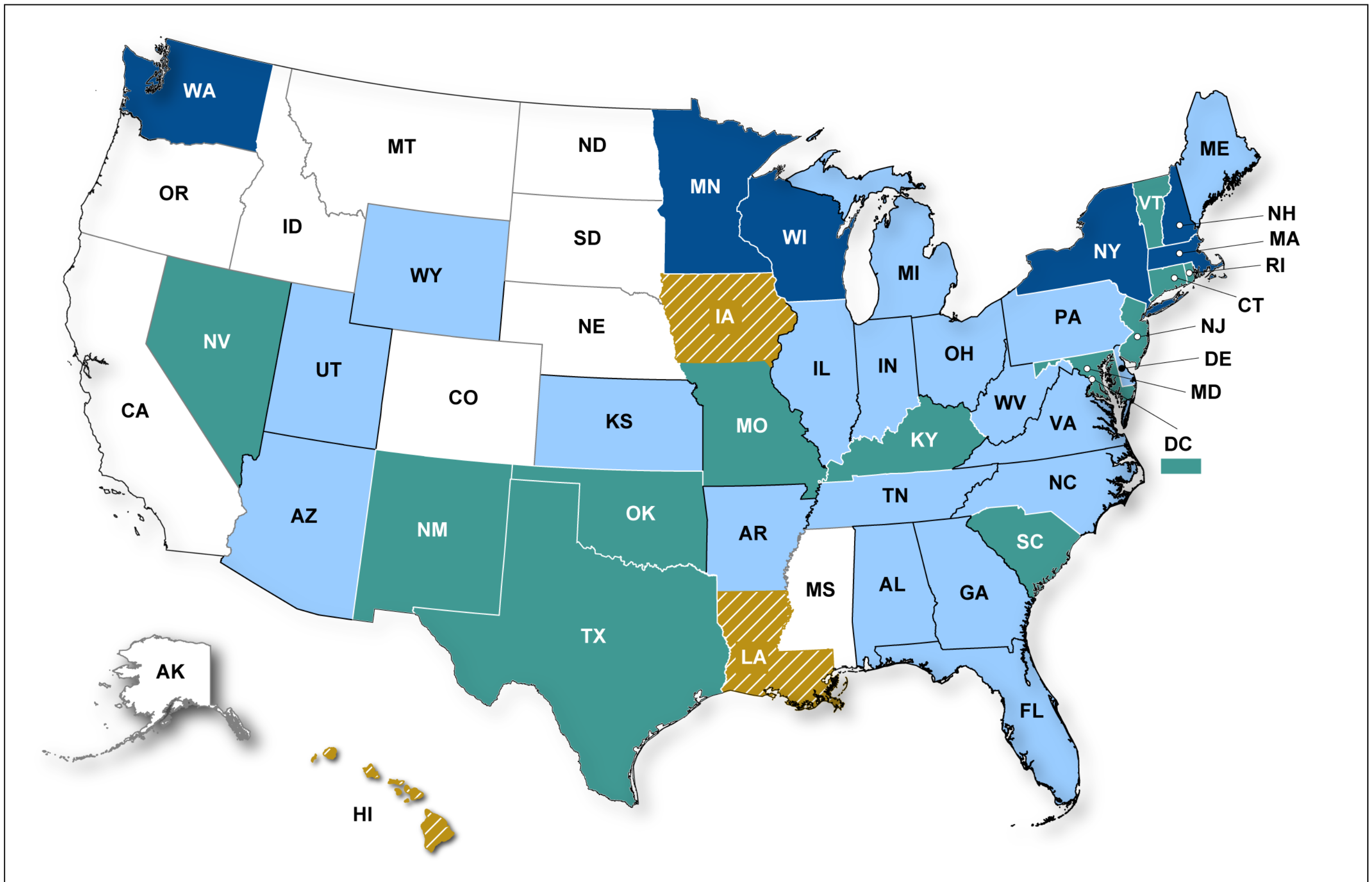
### Well-Child Screenings

In fiscal year 2017, 20.2 million (59 percent) of the 34.2 million beneficiaries who should have received at least one recommended well-child screening received that screening, known as the participant ratio, according to our analysis of state-reported CMS-416 data.[32] Additionally, our analysis indicates that the national participant ratio has declined 5 percentage points since fiscal year 2010.

Three states met CMS's participant ratio target of 80 percent in fiscal year 2017, as shown in figure 1. Our analysis also indicates that no more than four states met CMS's participant ratio target in any one fiscal year from 2010 through 2017. (See app. III, table 6, for participant ratios in each state and nationally from fiscal years 2010 through 2017.)

[32]The number of beneficiaries recommended to receive a screening (34.2 million) is less than the total number of beneficiaries (40.1 million), because of differences in states' periodicity schedules, which set the frequency of screening services. For example, some older beneficiaries are not recommended to receive screenings every year.

**Figure 1: Participant Ratios for Medicaid Well-Child Screenings in Fiscal Year 2017, By State**




| Participant ratio[a] | Number of states |
|---|---|
| Less than 50 percent | 10 |
| 50-59 percent | 19 |
| 60-69 percent | 13 |
| 70-79 percent | 6 |
| 80 percent or greater[b] | 3 |

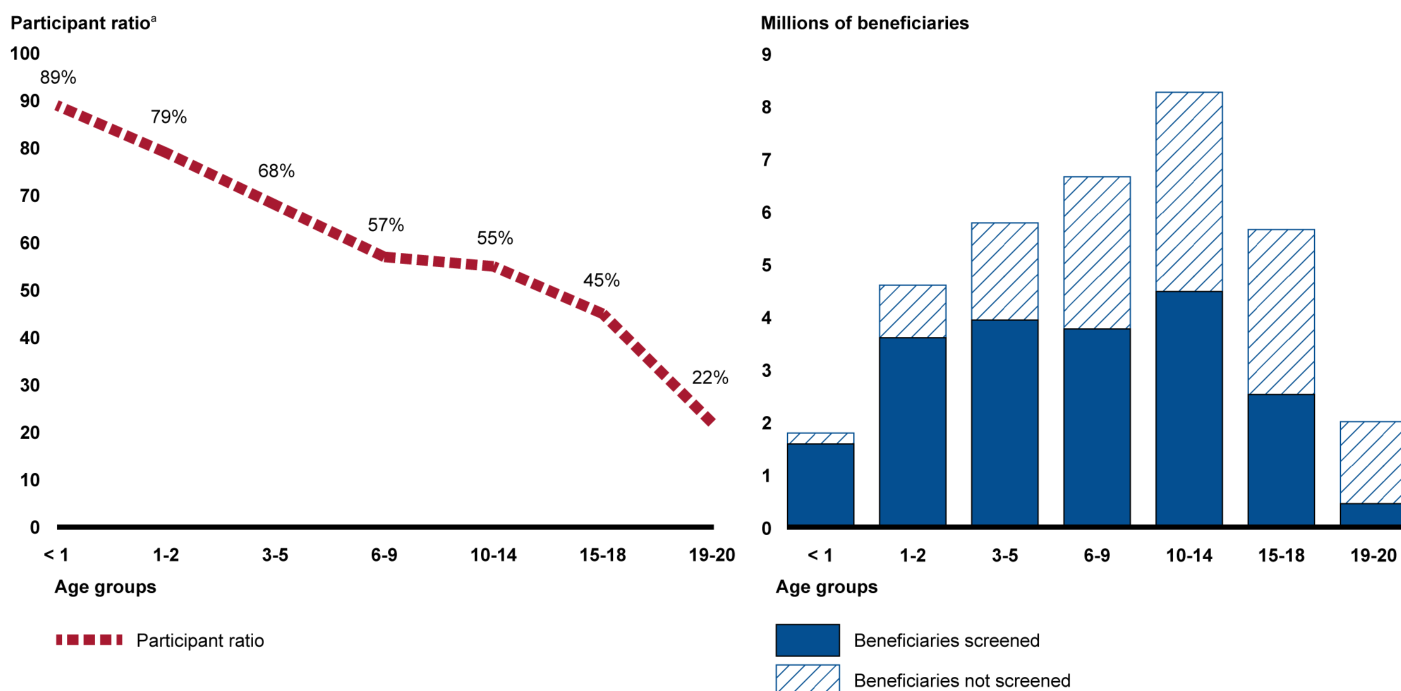
Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Form CMS-416 data for fiscal year 2017; Map Resources (map). | GAO-19-481

[a]The participant ratio is the percentage of Medicaid beneficiaries aged 20 and under who received at least one recommended well-child screening, based on the state's periodicity schedule, which sets the frequency of screening services.

[b]State met CMS's participant ratio target of 80 percent.

Our analysis also indicates that as beneficiaries age, they tend to receive fewer recommended well-child screenings, which results in lower participant ratios. (See fig. 2 for participant ratios and numbers of beneficiaries receiving and not receiving well-child screenings for each CMS-416 age group in fiscal year 2017.) CMS has issued a guide on serving older eligible beneficiaries, stating that regular preventive care visits can lead to early identification of health issues. CMS officials said the agency included measures focusing on these beneficiaries on the Child Core Set and Medicaid and CHIP Scorecard to recognize the importance of addressing these beneficiaries and to encourage states to focus on this population. CMS officials noted that some states have already taken steps to increase the number of well-child screenings that older eligible beneficiaries receive, for example, by partnering with schools.

**Figure 2: Participant Ratio and the Number of Medicaid Beneficiaries Who Did and Did Not Receive Well-Child Screenings in Fiscal Year 2017, by Age Group**




Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Form CMS-416 data for fiscal year 2017. | GAO-19-481

Note: Includes data for 50 states and the District of Columbia. Age groups are based on those reported in CMS-416 data.

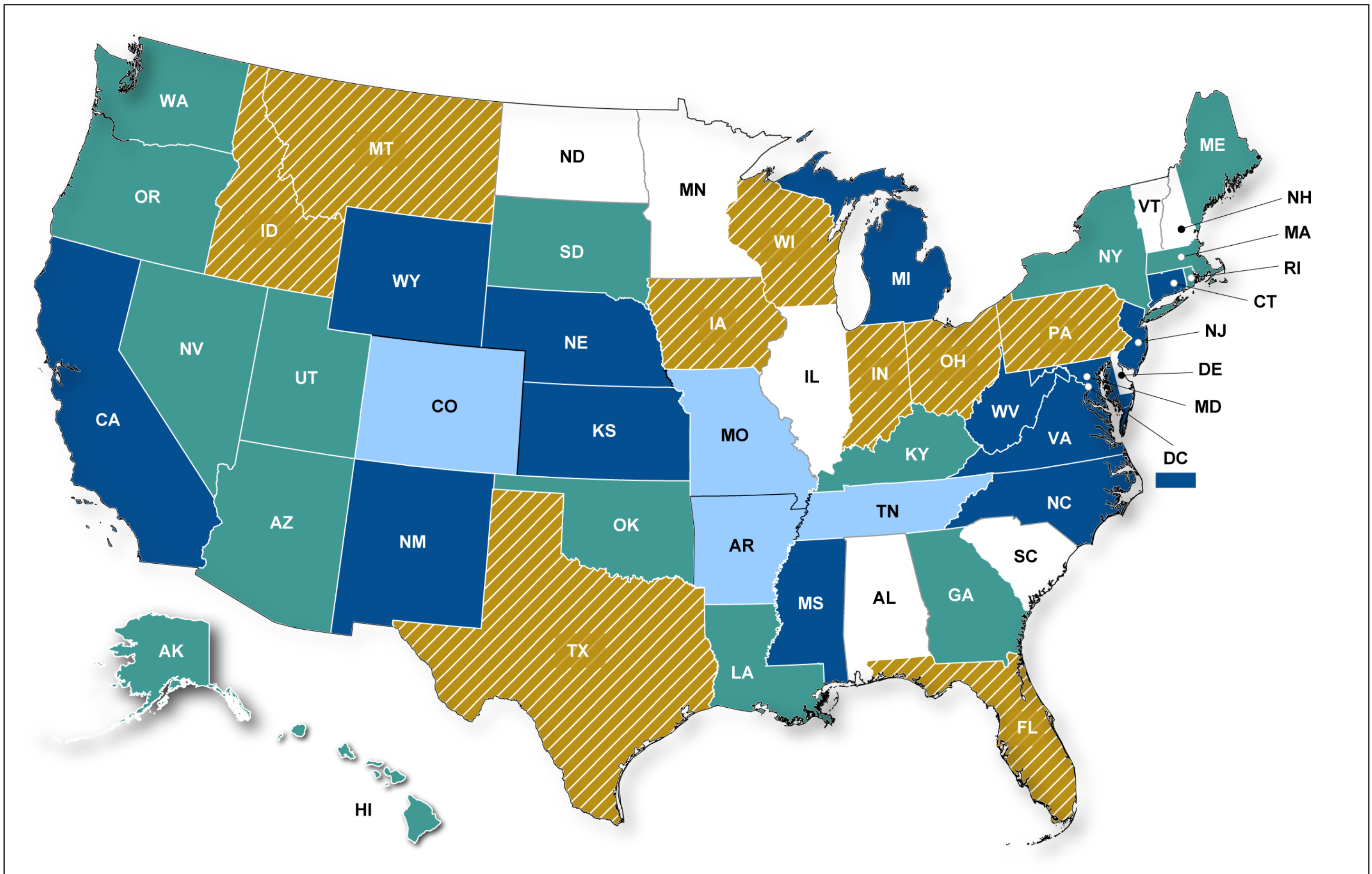
[a]The participant ratio is the percentage of Medicaid beneficiaries aged 20 and under who received at least one recommended well-child screening, based on the state's periodicity schedule, which sets the frequency of screening services.

## Dental Services

In fiscal year 2017, 18.3 million (48 percent) of the 38.3 million Medicaid beneficiaries aged 1 to 20 received a preventive dental service, according to our analysis of CMS-416 data. This is an increase from the 42 percent of beneficiaries receiving preventive dental services in 2011—the baseline year for measuring state progress toward CMS's Oral Health Initiative targets—but less than CMS's 52 percent national performance measure target. Our analysis also shows that from fiscal years 2011 through 2017, nine states met CMS's performance measure target of a 10 percentage point increase in each state's percentage of beneficiaries aged 1 to 20 receiving a preventive dental service.[33] (See fig. 3 and table 8 in app. III for the percentage of beneficiaries aged 1 to 20 that received preventive dental services in each state and nationally from fiscal years 2011 through 2017.)

[33]Though CMS originally set a 5-year time frame (fiscal years 2011 through 2015) for meeting the 10 percentage point improvement targets for the dental service performance measures set as part of the Oral Health Initiative, agency officials said in March 2019 that the time frame is now open-ended for the preventive dental service performance measure. Therefore, we analyzed data through fiscal year 2017—the most recent year of data available at the time of our reporting.

Figure 3: Changes in Percentage of Medicaid Beneficiaries Aged 1 to 20 Receiving Preventive Dental Services from Fiscal Year 2011 through Fiscal Year 2017, By State




| Percentage point change | Number of states |
|---|---|
| Percentage point reduction | 8 |
| No percentage point change | 4 |
| 1 to 4 percentage point increase | 16 |
| 5 to 9 percentage point increase | 14 |
| 10 percentage point increase or greater[a] | 9 |

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) Form CMS-416 data for fiscal years 2011 and 2017; Map Resources (map). | GAO-19-481

Note: CMS set a 5-year time frame (fiscal years 2011 through 2015) for states to meet the 10 percentage point improvement targets for the dental service performance measures set as part of the Oral Health Initiative. CMS officials said in March 2019 that the time frame is now open-ended for the preventive dental service performance measure.

[a]State met CMS's performance measure target for preventive dental services.

## Blood Lead Screenings

Available data on blood lead screenings in the CMS-416 are incomplete and, as a result, do not provide information necessary to determine how many beneficiaries received the screenings. According to CMS's November 2016 guidance, CMS-416 data do not accurately represent the number of beneficiaries receiving blood lead screenings.

- The CMS-416 data capture screenings paid for by Medicaid, but not those performed using funding from other sources, such as the Centers for Disease Control and Prevention. This could under-count the number of screenings performed.
- In addition, the blood lead screening data reported on the CMS-416 show how many screenings were performed, but do not identify the number of beneficiaries who received a blood lead screening.

Our analysis of available CMS-416 data shows that in fiscal year 2017 states reported 2.0 million blood lead screenings for beneficiaries aged 12 through 24 months, and there were 4.6 million beneficiaries aged 12 through 24 months.[34]

[34]Beneficiaries are required to receive a blood lead screening at 12 months and 24 months of age. States reported these blood lead screenings in the 1 to 2 age group on the CMS-416. Additionally, beneficiaries between 24 and 72 months of age must receive a blood lead screening if they have not been previously screened for lead. In fiscal year 2017, states reported 0.9 million blood lead screenings for these beneficiaries. States reported these blood lead screenings in the 3 to 5 age group on the CMS-416.

# CMS Has Improved EPSDT Data Quality; Additional Actions Are Needed to Improve Oversight of EPSDT Services, Particularly Blood Lead Screening Data

## CMS Is Improving EPSDT Data, yet Does Not Regularly Take Action Based on Assessing the Appropriateness of the CMS-416 for Oversight

CMS has regularly taken actions to use both the CMS-416 and the Child Core Set to improve the quality of information about the provision of EPSDT services. These actions have made the data reported about EPSDT services more complete and reliable. For example, CMS collects data annually from states on performance measures for both the CMS-416 and the Child Core Set. (See table 3.) Additionally, CMS annually reviews the Child Core Set measures to determine whether measures need to be added, deleted, or revised. CMS also regularly provides technical assistance to states about data reliability, such as through its monthly Quality Technical Advisory Group.[35] For example, during one group meeting, states shared challenges with reporting information about developmental screenings on the Child Core Set and suggestions for how to overcome these challenges. These actions are generally consistent with federal internal control standards regarding information and communication, which specify that management should use quality information to achieve the entity's objectives.[36]

[35]The Quality Technical Advisory Group involves monthly meetings between CMS and representatives from state Medicaid agencies where states can share information with CMS and with other states on Medicaid quality issues.

[36]See GAO-14-704G.

**Table 3: Examples of CMS Actions to Collect and Improve Information about the Provision of EPSDT Services Using the Form CMS-416 and Child Core Set**

| Oversight activity standard | | CMS-416 | Child Core Set |
|---|---|---|---|
| Establish performance measures for ESPDT services, regularly assess performance measures and ensure their relevance, and communicate performance measures to the states | Actions taken | • Established well-child performance measures in 1990.<br>• Established performance measures for dental services in 2010 as part of its Oral Health Initiative.[a]<br>• Provides publicly available instructions to help states complete the CMS-416.<br>• Issued guidance to states in November 2016 communicating the blood lead screening policy.<br>• Assesses whether the information it collects on the CMS-416 is appropriate and useful for EPSDT oversight | • Established performance measures on a range of services, including well-child screenings and dental services, in 2011.<br>• Reviews the Child Core Set annually and identifies ways to improve it.[b]<br>• Issues annual federal notice with changes to the Child Core Set for states. |
| | Actions not taken | • No actions based on assessments of whether the information it is gathering is appropriate or useful for EPSDT oversight. For example, no additions, removals, or amendments of any performance measures on the CMS-416 since 2010, despite acknowledged limitations. | — |
| Collect performance measure data from states | Actions taken | • Collects performance data annually from states. | • Collects performance data annually from states.[c] |
| | Actions not taken | — | — |
| Ensure data reliability | Actions taken | • Reviews states' CMS-416 submissions and performs logical validation checks before accepting and publishing final yearly data.<br>• Convenes affinity groups that bring officials and experts together to address different topics, such as school-based health, and technical advisory groups, and provides technical assistance upon request, such as issuing guidance in November 2016 about how to improve reporting of blood lead screenings. | • Works with states to increase number of performance measures reported and the number of states reporting each measure, as well as the accuracy of the performance measures.<br>• Provides technical assistance to improve the extent of reporting on Child Core Set measures. |
| | Actions not taken | — | — |

Source: GAO comparison of federal internal control standards for information and communication to Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-481

NOTE: A dash (—) reflects no significant deficiencies in actions taken under a given oversight activity for a given data set.

[a]CMS began the Oral Health Initiative to improve Medicaid beneficiaries' aged 1 to 20 access to dental services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, with an emphasis on prevention. These services include preventive dental services and sealants on permanent molar teeth for beneficiaries aged 6 to 9. CMS officials reported that in March 2016 they informed states that CMS no longer planned to use the target for measuring states' performance on the sealant performance measure.

[b]The CHIP Reauthorization Act of 2009 directed the Secretary of Health and Human Services to establish a pediatric quality measures program to improve core set measures on an ongoing basis, among other things. The Secretary is required to recommend updates to the core measures annually, which CMS carries out in partnership with the National Quality Forum, which is a nonprofit

organization that fosters agreement on national standards for measurement and public reporting of health care performance data. See Pub. L. No. 111-3, § 401, 123 Stat. 8, 72 (codified as amended at 42 U.S.C. § 1320b-9a).

[c]State reporting on the Child Core Set is voluntary until reports on fiscal year 2024, so not all states report all measures.

While CMS has taken actions to improve the quality of information about EPSDT, and agency officials said they regularly assess whether the information CMS collects on the CMS-416 is appropriate and useful for EPSDT oversight, CMS has not taken action, as needed, based on such assessments. For example, CMS has not added, removed, or amended any performance measures on the CMS-416 since 2010, even though officials acknowledge limitations in these measures.[37]

- The participant ratio, for example, is dependent, in part, on a state's chosen periodicity schedule, which means that the measure is not consistently defined across states.
- The screening ratio reflects the extent to which beneficiaries received the recommended number of well-child screenings during the year, but this information is aggregated and therefore cannot be used to determine whether individual beneficiaries received the recommended number of well-child screenings.

Although federal law requires collecting certain information about the provision of EPSDT services, it provides the agency with flexibility to determine the form and manner in which data are collected and to set performance measures.[38] For example, CMS could change the way states are required to calculate the participant ratio or the screening ratio, and could examine ways to do so to address the limitations that the agency has identified and improve the quality of information about the provision of EPSDT services.

[37]In the 2010 reporting year, the CMS-416 was revised to provide more information on dental sealants and oral health services provided by clinicians other than dentists. CMS officials said that the agency has not prioritized any further substantive changes to the CMS-416 in order to allow states to focus their resources on reporting of T-MSIS data and Child Core Set measures.

[38]Beginning in 1990, the Omnibus Budget Reconciliation Act of 1989 required state Medicaid programs to annually report to HHS information on EPSDT services including the number of children provided child health screening services, the number of children referred for corrective treatment, the number of children receiving dental services, and states' results in attaining EPSDT participation goals established by the department. Pub. L. No. 101-239, § 6403, 103 Stat. 2106, 2262-64 (codified as amended at 42 U.S.C. § 1396a(a)(43) (D)).

Because CMS has not taken action, as needed, based on assessments of the appropriateness of its CMS-416 performance measures, the agency cannot be sure that it has the information it needs to oversee state implementation of EPSDT. This is inconsistent with federal internal control standards regarding information and communication, which specify that management should identify information requirements in an iterative and ongoing manner and ensure information remains relevant.[39] We have previously reported that results-oriented organizations set performance goals to define desired program outcomes and develop performance measures that are clearly linked to these performance goals and outcomes.[40]

## CMS Has Set Some Performance Measure Targets, yet Does Not Consistently Evaluate States' Performance against These Targets

CMS has taken steps to develop, assess, and use CMS-416 information to improve states' performance in providing EPSDT services. For example, CMS has set performance measure targets for participant and screening ratios reported on the CMS-416, and CMS publishes state-level results of the participant and screening ratios. In addition, after identifying issues with calculating the performance measure and target for the permanent molar sealants, CMS removed them from the Oral Health Initiative. CMS also convenes affinity groups and technical advisory groups to provide assistance to states in improving performance, often centered on specific services, such as dental services.

However, CMS and state Medicaid officials told us that CMS does not consistently (1) communicate CMS-416 performance measure targets to states, (2) evaluate state performance against performance measure targets, or (3) provide states with assistance in reaching performance measure targets. While it has not done so across all performance measure targets, CMS did take these actions regarding targets for preventive dental services as part of its Oral Health Initiative. For example, CMS

- communicated with states about the preventive dental service performance measure target after it developed the Oral Health Initiative;

[39] See GAO-14-704G.

[40] See GAO-05-927.

- disseminated a national oral health strategy and published a review of eight states identifying innovative approaches in providing preventive dental services; and
- provided targeted outreach to states with the lowest performance on the preventive dental service performance measure.

Improvements in the provision of dental services occurred in many states. For example, in 2013, CMS met with state Medicaid officials in Florida about improving the provision of preventive dental services. Five years later, the percentage of beneficiaries receiving preventive dental services had increased 18 percentage points.

CMS has not taken action in other areas. For example:

- CMS does not communicate the participant and screening ratio targets. Officials from CMS and from each of our 16 selected states told us that CMS does not mention these targets in communications with states, including discussions related to performance improvement.
- CMS has not evaluated state performance in meeting the participant and screening ratio targets, nor has it provided focused assistance to states to resolve gaps in states' performance in reaching these targets comparable to the assistance provided for the preventive dental screening performance measure as part of the Oral Health Initiative.
- CMS did not provide formal written notification to states when in March 2016 the agency informed participants in two meetings that CMS no longer planned to use the target for measuring states' performance on the permanent molar sealants performance measure.[41] The notification was not provided through an official policy document, such as an agency informational bulletin distributed to all states. Despite removing the target, CMS issued a technical assistance brief in March 2018 that referenced it, which could have led to confusion among state officials.

With regard to the Child Core Set, CMS has not established any performance measure targets and agency officials were not able to provide information about plans for setting targets. CMS officials said that

[41]CMS officials said that they clarified to states through presentations at the National Association of Medicaid Directors and the Oral Health Technical Advisory Group in 2016 that due to issues with the performance measure, the agency had dropped that performance measure and target from the Oral Health Initiative.

the CMS-416 will remain a part of its EPSDT oversight. However, because its information is not standardized across states, CMS plans to increasingly rely on the standardized Child Core Set data to assess and improve states' performance on the provision of EPSDT services. CMS officials noted that it publishes median, top quartile, and bottom quartile information for each state for all the Child Core Set measures that are publicly reported. Officials further reported in June 2019 that CMS and states use these as performance benchmarks, with an aim of reaching the national median on these measures if not the top quartile. Reporting these data is an important step in ensuring better oversight of EPSDT. However, CMS has not developed fixed targets that explicitly track states' progress in increasing beneficiaries' receipt of EPSDT screenings and services. Using a median to assess states' performance ensures that half the states will not meet this target, regardless of their individual performance. Further, CMS officials have not provided plans or timelines for when the Child Core Set would be used to help states achieve performance measure targets.

CMS's inaction regarding using the CMS-416 and Child Core Set to improve performance on the provision of EPSDT services limits the agency's oversight and is inconsistent with federal internal control standards for monitoring, and practices of leading organizations. Federal internal control standards specify that management should (1) set performance measure targets in measureable, numeric terms; (2) communicate necessary information to achieve performance targets; (3) evaluate progress toward desired targets; and (4) take action to resolve identified issues.[42] Without regularly using the CMS-416 and Child Core Set to improve the provision of EPSDT services, CMS is unable to identify whether state or federal efforts and policies are increasing the number of beneficiaries receiving EPSDT services. As a result, CMS's oversight is limited and beneficiaries may not be receiving appropriate EPSDT services when they need them—CMS's stated goal for EPSDT. (See table 4 for examples of actions CMS has and has not taken regarding using the CMS-416 and Child Core Set for improving the provision of EPSDT services.)

[42]See GAO-14-704G; and GAO, *Military Bands: Military Services Should Enhance Efforts to Measure Performance,* GAO-17-657 (Washington, D.C.: Aug. 10, 2017).

**Table 4: Examples of CMS Actions to Improve Performance on Provision of EPSDT Services Using Form CMS-416 and Child Core Set**

| Oversight activity standard | | CMS-416 | Child Core Set[a] |
|---|---|---|---|
| Set targets for states to achieve on performance measures, regularly assess targets, and communicate those targets to the states | Actions taken | • Established participant ratio and screening ratio performance measure targets in 1990 and communicated to states through the State Medicaid Manual.<br>• Established performance measure targets for preventive dental services and permanent molar sealants as part of the Oral Health Initiative in 2010 and communicated to states through an oral health strategy document. CMS removed the permanent molar sealants performance measure and target when it identified problems with calculating the performance measure.<br>• Established performance measure targets for beneficiaries receiving blood lead screenings in 1998 and communicated to states through the State Medicaid Manual.<br>• Issued bulletin in November 2016 reminding states of targets for beneficiaries receiving blood lead screenings.<br>• In January 2019, CMS officials said that they plan to evaluate the performance measure targets developed as part of the Oral Health Initiative for preventive dental services by the end of 2019. | • None |
| | Actions not taken | • CMS does not remind states about participant and screening ratio targets.<br>• CMS officials described limitations of the participant and screening ratios in August 2018. Yet, CMS has not adjusted the participant ratio or screening ratio performance measure targets since 1990.<br>• In March 2016, CMS informed participants in two meetings that the agency no longer planned to use the target for measuring states' performance on the permanent molar sealants performance measure; however, CMS did not provide formal written notification to states. | • No performance targets set or plans for future targets available as of March 2019. |
| Conduct regular evaluations comparing states' performance to the established targets | Actions taken | • CMS issued a bulletin in July 2014 comparing states' performance with performance measure targets for preventive dental services. | • None |
| | Actions not taken | • CMS does not compare states' performance with participant ratio and screening ratio performance measure targets.<br>• Since its July 2014 bulletin, CMS has not issued subsequent bulletins comparing states' performance with performance measure targets for preventive dental services. | • No evaluations conducted directly comparing performance on Child Core Set measures with targets, nor plans to conduct such evaluations in the future, as of March 2019; no performance targets set or plans for future targets available as of March 2019. |

| Oversight activity standard | | CMS-416 | Child Core Set[a] |
|---|---|---|---|
| Assist states with planning and implementing needed improvement to address performance gaps | Actions taken | • CMS convenes affinity groups and technical advisory groups, and provides technical assistance upon request, such as its Oral Health Technical Advisory Group.<br>• CMS has provided focused technical assistance to several states to improve provision of preventive dental services.<br>• CMS issued a bulletin in July 2014 with technical support for states to improve provision of preventive dental services and permanent molar sealants. | • CMS provides technical assistance and analytic support to support states' efforts to measure and improve the quality of health care for children and adults enrolled in Medicaid and CHIP. Specific topics include: collecting, reporting, and using the Child Core Set; assessing data quality to improve completeness and accuracy of state reporting of the Child Core Set measures; and designing and implementing quality improvement initiatives focused on the Child Core Set measures.<br>• Eighteen states participated in the CHIP Reauthorization Act Quality Demonstration grant program. The goal of this grant program is to provide staff resources to states to strengthen the quality of and access to children's health care through a variety of health care delivery models, provider and patient-level interventions, and measurement approaches. |
| | Actions not taken | • CMS does not provide focused technical assistance on improving the provision of well-child screenings to meet performance measure targets.<br>• CMS has not developed affinity groups on the provision of well-child services associated with the participant ratio and screening ratio performance measure targets. | • No technical assistance provided to improve performance on provision of EPSDT services relative to performance measure targets, since no performance targets set or plans for future targets available as of March 2019. |

Source: GAO comparison of federal internal control standards for information and communication to Centers for Medicare & Medicaid Services (CMS) information. | GAO-19-481

[a]State reporting on the Child Core Set is voluntary until reports on fiscal year 2024, so not all states report all measures.

## CMS Has Taken Limited Actions to Improve Data on the Number of Blood Lead Screenings, which Are Critical to Identifying Harmful Lead Exposure

CMS is unable to determine whether all eligible EPSDT beneficiaries are receiving blood lead screenings in accordance with CMS policy. As previously noted, CMS-416 data are incomplete, because they only include blood lead screenings paid for by Medicaid, and the form reports the number of screenings performed instead of the number of beneficiaries receiving screenings.[43]

CMS has stated that screenings are important for identifying beneficiaries with elevated blood lead levels at as young an age as possible, because lead exposure can harmfully affect nearly every system of the body and cause developmental delays. According to a presidential task force on environmental health and safety risks to children, co-chaired by HHS, early identification of developmental delays allows providers and communities to intervene earlier to improve health outcomes.[44] The presidential task force issued goals in December 2018 to reduce lead exposure and associated harms, including a goal to identify lead-exposed individuals and improve their health outcomes.

**State examples of collecting blood lead screening data**

**Nebraska**. Medicaid officials said that the state has developed a database with the Nebraska Health Information Initiative containing laboratory testing data. Treating providers and managed care organizations can access the database to determine whether a Medicaid beneficiary has received a blood lead screening.

**New Jersey**. Medicaid officials said that it can be difficult to track blood lead screenings that are performed using funding from sources other than Medicaid; for example, those performed by the state health department. Officials said that they have been building a lead registry to capture data on lead screenings performed, regardless of how they are funded. New Jersey Medicaid officials said they collect data every 6 months on screenings not paid for by Medicaid and enter the data into the state's blood lead registry.

Source: GAO interviews with Medicaid officials in selected states. | GAO-19-481

Without complete information about blood lead screenings, CMS cannot identify the number of beneficiaries who have not received blood lead screenings. As a result, the agency may be unaware of beneficiaries with unidentified lead exposures. CMS issued guidance in 2016 to states on improving blood lead screening reporting, including correcting reporting errors and partnering with providers to ensure beneficiaries receive blood lead screenings. (See sidebar for examples of efforts states have taken to improve available data about blood lead screenings.) However, as of February 2019, the screening data remained incomplete, according to agency officials. CMS officials also told us they are currently in discussions with the Centers for Disease Control and Prevention about how to capture more complete information about Medicaid beneficiaries who are receiving blood lead screenings through programs funded by that agency. However, as of February 2019, CMS officials had not identified specific actions to gather this data. The lack of data is inconsistent with

[43]CMS officials said that all EPSDT services reported on the CMS-416 are limited to those paid for by Medicaid, and not just blood lead screenings. However, blood lead screenings are the only EPSDT service reported on the CMS-416 that is required for all beneficiaries, unless the state has implemented a targeted lead screening program.

[44]See President's Task Force on Environmental Health Risks and Safety Risks to Children, *The Federal Action Plan to Reduce Childhood Lead Exposures and Associated Health Impacts* (Washington, D.C.: December 2018).

federal internal control standards, which specify that management should obtain relevant data from reliable sources based on identified information requirements, and use such data for effective monitoring.[45]

## CMS Replicated Some CMS-416 and Child Core Set Information Using T-MSIS, but Lacks Time Frames and Interim Milestones for Using T-MSIS Data to Streamline State Reporting

According to CMS, the results of recent pilot studies indicate that T-MSIS data can be used to replicate some information on the CMS-416 and Child Core Set.[46] CMS officials said that the results also suggest that CMS may eventually be able to use T-MSIS data to produce the CMS-416 and Child Core Set data, thus eliminating the need for states to report this information themselves separately. As previously noted, CMS intends for T-MSIS to both reduce the number of reports CMS requires states to submit and to provide more information to improve Medicaid oversight.

CMS officials said that they were encouraged that the pilot studies to replicate portions of the CMS-416 and Child Core Set generally yielded positive results. For example, CMS was able to use T-MSIS to replicate the total number of Medicaid beneficiaries aged 20 and under eligible for EPSDT from the CMS-416 within 5 percent of state-reported values for eight of nine pilot states—which CMS officials viewed as a positive result.[47] CMS officials noted some concerns with inaccurate state Medicaid eligibility data; for example, multiple dates of birth reported through T-MSIS for the same beneficiary. However, CMS officials believe the accuracy and completeness of T-MSIS data has improved since the pilot studies, which were conducted using data from 2015 and 2016.[48] Regarding the Child Core Set, CMS was able to use T-MSIS to replicate some of the information, such as adolescent well-care visits, but not other information, such as emergency department visits.

[45]See GAO-14-704G.

[46]CMS conducted two sets of pilot studies in 2017 and 2018 in separate samples of states selected based on the agency's assessment of the completeness and quality of states' T-MSIS data. The two sets of pilot studies included three studies on the CMS-416 and one study on the Child Core Set. An 11-state sample was initially selected for the CMS-416 pilot studies, while a 6-state sample was initially selected for the Child Core Set pilot study.

[47]Eleven states were initially included in the sample. CMS identified data reliability issues in two states, which were removed from the pilot study.

[48]CMS used state-reported T-MSIS data from calendar years 2015 and 2016 to replicate portions of the sample states' CMS-416, and T-MISIS data from calendar year 2015 to replicate portions of the sample states' Child Core Set.

While CMS found generally positive results from the pilots, the agency has not developed a plan with time frames and interim milestones for when it will use state-reported T-MSIS data to produce the CMS-416 and Child Core Set data sets instead of states separately producing both T-MSIS data and the two data sets. In April 2019, CMS officials said that they were planning additional pilots beginning in fiscal year 2019 to replicate portions of the CMS-416 and the Child Core Set. However, CMS officials were unable to provide planned next steps, including time frames and interim milestones, for using T-MSIS data to replace the CMS-416 and Child Core Set. This is inconsistent with federal internal control standards related to using and communicating quality information to achieve objectives. Without a specific plan with time frames with interim milestones, CMS may miss opportunities to use T-MSIS data to streamline state reporting and better oversee states' provision of EPSDT services. This limitation is similar to one we reported in December 2017 about the initial steps CMS had taken for using T-MSIS data.[49] We found CMS was limited in using T-MSIS for its broader oversight efforts of state Medicaid programs, in part, due to the absence of an articulated plan and time frames.

## Conclusions

Under EPSDT, millions of Medicaid's youngest beneficiaries received well-child screenings and dental services in fiscal year 2017; however, nearly as many of them did not. Further, existing data on blood lead screenings are incomplete and inaccurate, leaving CMS unaware of beneficiaries with unidentified lead exposures that can cause developmental delays. The EPSDT data collected—whether via the CMS-416, Child Core Set, or T-MSIS—have the potential to improve CMS oversight of beneficiaries' receipt of necessary services and screenings. However, CMS has not taken sufficient steps to help ensure the appropriateness of its state data collection, evaluations, and assistance; and its plans for new reporting, including time frames and interim milestones, are lacking.

[49]See GAO-18-70. CMS concurred with our recommendation to articulate a specific plan and associated time frames for using T-MSIS data for oversight. As of April 2019, the recommendation remains open.

## Recommendations for Executive Action

We are making the following six recommendations to CMS:

- The Administrator of CMS should work with states and relevant federal agencies to collect accurate and complete data on blood lead screening for Medicaid beneficiaries in order to ensure that CMS is able to monitor state compliance with its blood lead screening policy, and assist states with planning improvements to address states' compliance as needed. (Recommendation 1)
- The Administrator of CMS should regularly assess the appropriateness of performance measures and targets for the EPSDT benefit, and take any necessary actions to ensure their relevance and use, including adding, changing, or removing measures, or targets, and regularly communicating performance measures and targets to states. (Recommendation 2)
- The Administrator of CMS should conduct regular evaluations of state performance by comparing states' performance measurement data with CMS's EPSDT targets to identify gaps in states' performance and areas for improvement. (Recommendation 3)
- The Administrator of CMS should assist states with planning needed improvements, including providing focused assistance, to resolve gaps in states' performance in meeting CMS's EPSDT targets. (Recommendation 4)
- The Administrator of CMS should develop a plan with time frames and interim milestones for using T-MSIS data to generate the necessary data from the CMS-416 to improve EPSDT oversight and streamline state reporting. (Recommendation 5)
- The Administrator of CMS should develop a plan with time frames and interim milestones for using T-MSIS data to generate the necessary data from the Child Core Set to improve EPSDT oversight and streamline state reporting. (Recommendation 6)

## Agency Comments and Our Evaluation

We provided a draft of this report to HHS for comment, and its comments are reprinted in appendix IV. HHS also provided us with technical comments, which we incorporated in the report as appropriate. Overall, HHS concurred with three recommendations and did not occur with three recommendations.

HHS concurred with our first recommendation that CMS should work with states and relevant federal agencies to collect accurate and complete data on blood lead screening for Medicaid beneficiaries and assist states

with planning improvements to resolve gaps in states' performance as needed. However, HHS stated that it would not be possible to obtain complete data on blood lead screenings, because some screenings are not paid for by Medicaid. In our report, we noted some state and CMS efforts to improve available data on blood lead screenings. We continue to believe CMS needs to take additional actions to collect accurate and complete data to oversee whether eligible EPSDT beneficiaries are receiving blood lead screenings in accordance with CMS policy.

HHS did not concur with our second recommendation, which stated that CMS should regularly assess the appropriateness of performance measures and targets for the EPSDT benefit, and take any necessary actions to ensure their relevance and use.

- HHS noted that it assesses the appropriateness of Child Core Set measures annually and may update existing measures based on that assessment, including measures on the CMS-416. We acknowledge CMS's actions to assess the appropriateness of Child Core Set measures annually and update those measures as appropriate, and we found these actions generally consistent with federal internal control standards regarding information and communication. However, CMS has not taken action, as needed, related to any assessments of the CMS-416 performance measures, even though officials acknowledge limitations in these measures, such as the participant and screening ratios.
- HHS also stated that it may set targets in key areas as appropriate, and has done so as part of the Oral Health Initiative, but that HHS does not believe it would be productive at this time to set targets for every measure. We are encouraged that HHS agreed that it may set targets in key areas as appropriate. This is consistent with our recommendation for CMS to regularly assess the appropriateness of its targets. Our recommendation does not assume that targets should be set for every measure—rather, that CMS needs to regularly assess the appropriateness of performance measures and targets for the EPSDT benefit and communicate them to states.

HHS did not concur with our third recommendation, which stated that CMS should conduct regular evaluations of state performance by comparing states' performance measurement data with CMS's EPSDT targets.

- HHS stated that it offers a wide range of technical assistance on quality improvement to help states address performance goals. HHS

commented that it believes this is the most effective method of helping states identify and address areas for potential improvement. We acknowledge that CMS has provided states with technical assistance and individual state snapshots of selected Child Core Set measures over time. However, regular evaluations of states' performance against appropriate EPSDT targets are necessary to help identify gaps in states' performance and areas for improvement.

- HHS noted that states recently received snapshots about their performance on publicly reported Child Core Set measures for the past 5 years, through fiscal year 2017. According to HHS, the snapshots include information about a state's performance on each measure relative to other states' performance and highlights significant changes in a state's performance for each measure. However, these snapshots include descriptions of all states' performance—using medians, and top and bottom quartiles—which are subject to change over time. Moreover, because the median is the midpoint of all states' performance, this target ensures that half of states will not meet it, regardless of their individual performance. A fixed target—or targeted improvement goal, such as the one developed as part of the Oral Health Initiative—would provide states with the opportunity to measure performance over prior years' results, which is a more meaningful measure that all states can strive to achieve.

HHS did not concur with our fourth recommendation, which stated that that CMS should assist states with planning needed improvements to resolve gaps in states' performance in meeting EPSDT targets.

- HHS stated that it has developed national and state-specific improvement goals for children enrolled in Medicaid with respect to receipt of at least one preventive dental service and provided targeted technical assistance to the lowest performing states. In this report, we noted states' progress in meeting targets once CMS developed a performance measurement target for preventive dental services, including actions to improve state performance. Developing additional targets on performance measures critical to beneficiaries' health and well-being could help improve oversight of EPSDT.
- HHS also described other examples of targeted technical assistance to remedy gaps in states' performance, which included working with states on improving their performance on certain Child Core Set measures and improving access to EPSDT services by better leveraging schools as settings for care. Such technical assistance could be valuable for CMS to provide to states after identifying gaps in

states' performance relative to EPSDT targets. Doing so would allow CMS to share additional strategies to help states plan and implement needed improvements.

HHS concurred with our fifth and sixth recommendations that CMS should develop a plan with time frames and interim milestones for using T-MSIS data to generate the necessary data from the CMS-416 and Child Core Set to improve EPSDT oversight and streamline state reporting.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix V.

Carolyn L. Yocom
Director,
Health Care

# Appendix I: Selected States' Practices for Delivering Early and Periodic Screening, Diagnostic, and Treatment Services

Selected states used several types of practices to promote and facilitate the delivery of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, according to Medicaid officials in the 16 selected states we interviewed and profiles of these states created by the American Academy of Pediatrics. The practices selected states used included outreach and education, financial incentives, collaboration in EPSDT administration, and EPSDT service delivery initiatives, as shown in figure 4.

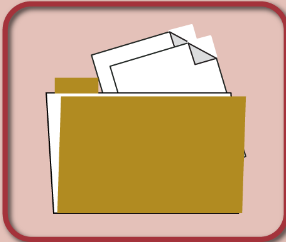
**Figure 4: Selected States' Practices for Promoting and Facilitating the Delivery of EPSDT Services, as Reported by States and the American Academy of Pediatrics**

### Outreach and education

- Mississippi: State Medicaid agency encourages EPSDT providers to perform age-appropriate EPSDT screenings when Medicaid beneficiaries present for a sports physical.
- Iowa: State Medicaid agency has a website to serve EPSDT providers, which includes links to information and archived newsletters.
- Tennessee: At the start of every school year, all public school students across the state receive a flyer encouraging them to apply for Medicaid if they are uninsured, and to get an EPSDT screening each year.

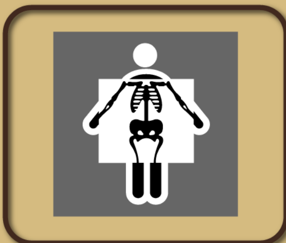
### Financial incentives

- New Hampshire: Parents or guardians of Medicaid beneficiaries enrolled with one of the state's managed care organizations receive a prepaid debit card that has funds added to it when beneficiaries receive EPSDT preventive care services.
- Texas: State Medicaid agency provides enhanced reimbursements to medical providers for oral evaluations and fluoride varnishes provided during a Texas Health Steps medical checkup and to dental providers for dental services under the First Dental Home benefit. Providers must complete training and obtain certification in order to receive the enhanced reimbursement.
- Missouri: State Medicaid agency's contracts with managed care organizations require the managed care organizations to establish member incentive programs to encourage members to receive EPSDT services.



### Collaboration in EPSDT administration

- Rhode Island: State Medicaid agency partners with the state's department of education to provide services within its programs through the EPSDT benefit.
- Illinois: State Medicaid agency collaborates with the University of Illinois-Chicago, Department of Psychiatry to provide behavioral health support through a consultation line to primary care providers serving Medicaid beneficiaries aged 20 and under in the fee-for-service and managed care delivery systems.
- Pennsylvania: Managed care organizations collaborate with community organizations to deliver health services in settings more accessible to beneficiaries.



### EPSDT service delivery initiatives

- Nebraska: State Medicaid agency has eliminated diagnostic exclusions for beneficiaries aged 20 and under with autism and developmental disabilities.
- Hawaii: State Medicaid agency has established a coordination of care effort with the state Department of Health on the Early Intervention Program, which encourages identification of beneficiaries with or at risk of developmental delays. The state Medicaid agency also ensures that managed care organizations collaborate with the Early Intervention Program to efficiently serve children with special health care needs in early childhood.
- New Jersey: State Medicaid agency incorporated changes to the state's managed care contracts to increase blood lead screenings and created a state database to identify and track beneficiaries who have not been screened.

Source: GAO analysis of interviews with Medicaid officials in 16 selected states and American Academy of Pediatrics state profiles regarding the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. | GAO-19-481

# Appendix II: Information Reported on Form CMS-416 and Child Core Set

States annually report information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to the Centers for Medicare & Medicaid Services (CMS), through the Form CMS-416 and the Child Core Set. The CMS-416 provides basic information about EPSDT for Medicaid beneficiaries aged 20 and under, such as the participant ratio and number of beneficiaries receiving a preventive dental service. The Child Core Set provides CMS with information about the quality of health care provided to Medicaid beneficiaries and individuals aged 18 and under who are covered under the Children's Health Insurance Program. In fiscal year 2024, annual reporting of the Child Core Set will become mandatory. As of 2019, the Child Core Set included performance measures related to the provision of EPSDT services, such as well-child visits in the first 15 months of life. Because Child Core Set reporting is currently voluntary, states vary in the number of performance measures they choose to report. In fiscal year 2017, for example, 50 states and the District of Columbia voluntarily reported on at least one of the 27 Child Core Set performance measures, with states reporting a median of 18 Child Core Set performance measures.[1] Some information is only reported on the CMS-416 or Child Core Set, while other information—well-child visits, preventive dental services, and dental sealants—is reported on both CMS-416 and Child Core Set. (See table 5 for information reported on the CMS-416, the Child Core Set, or both.)

**Table 5: Overview of Measures Reported on Form CMS-416 and Child Core Set**

| Category of information | Information reported | Reported on CMS-416 | Reported on Child Core Set |
|---|---|---|---|
| Participation and eligibility measures | • Total individuals eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit | ✓ | |
| | • State periodicity schedule | ✓ | |
| | • Period of EPSDT eligibility | ✓ | |
| | • Expected and total number of received screenings | ✓ | |
| | • Total individuals recommended to receive screening | ✓ | |
| | • Total individuals receiving recommended screening | ✓ | |
| | • Participant and screening ratios | ✓ | |

[1]We used fiscal year 2017 data, because it is the most recent year for which data were available.

| Category of information | Information reported | Reported on CMS-416 | Reported on Child Core Set |
|---|---|---|---|
| Primary care access and preventive care | • Well-child screenings | ✓ | ✓ |
| | • Blood lead screenings | ✓ | |
| | • Referrals for treatment | ✓ | |
| | • Weight assessments | | ✓ |
| | • Depression screenings | | ✓ |
| | • Chlamydia screenings | | ✓ |
| | • Access to primary care practitioners | | ✓ |
| | • Immunization status | | ✓ |
| Maternal and perinatal health[a] | • Prenatal and postpartum care timeliness | | ✓ |
| | • Low birth weight | | ✓ |
| | • Central line-associated bloodstream infections | | ✓ |
| | • Cesarean births | | ✓ |
| | • Audiological diagnoses | | ✓ |
| | • Contraceptive care | | ✓ |
| Care of acute and chronic conditions | • Asthma medication | | ✓ |
| | • Emergency department visits | | ✓ |
| Behavioral health care | • Attention-Deficit/Hyperactivity Disorder medication | | ✓ |
| | • Follow-ups post-hospitalization for mental illness | | ✓ |
| | • Use of psychosocial care for beneficiaries on antipsychotics | | ✓ |
| | • Use of multiple concurrent antipsychotics | | ✓ |
| Dental and oral health services | • Preventive dental services | ✓ | ✓ |
| | • Dental sealants | ✓ | ✓ |
| | • Receipt of any dental service | ✓ | |
| | • Receipt of dental treatment or diagnostic service | ✓ | |
| Experience of care | • Consumer Assessment of Healthcare Providers and Systems survey results | | ✓ |

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS) Form CMS-416 and Child Core Set. | GAO-19-481

[a]According to CMS, the health of a child is affected by a mother's health and the care she receives during pregnancy. When women access the health care system for maternity care, an opportunity is presented to promote services and behaviors to optimize their health and the health of their children.

# Appendix III: Summary of Selected Early and Periodic Screening, Diagnostic, and Treatment Data

Tables 6 through 8 present annual state-reported data from the Centers for Medicare & Medicaid Services' (CMS) Form CMS-416 on the provision of selected Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services by state and nationally. Well-child screenings are presented from fiscal year 2010, the year in which the current reporting template was implemented, through fiscal year 2017, the most recent year for which data were available at the time of our review. Preventive dental services data are presented from fiscal year 2011, the baseline year for measuring states' progress toward CMS's Oral Health Initiative targets, through fiscal year 2017, the most recent year for which data are available.[1]

**Table 6: Well-Child Screening Participant Ratio for Medicaid Beneficiaries Aged 20 and Under, Fiscal Years 2010 through 2017, by State and Nationally**

Percentage

| State | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | Percentage point change, FY 2010 to FY 2017 | Min[a] | Max[b] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | 54 | 53 | 53 | 54 | 52 | 52 | 53 | 55 | 1 | 52 | 55 |
| Alaska | 55 | 56 | 38 | 36 | 41 | 40 | 41 | 39 | (16) | 36 | 56 |
| Arizona | 65 | 64 | 64 | 61 | 54 | 52 | 48 | 50 | (15) | 48 | 65 |
| Arkansas | 46 | 47 | 48 | 48 | 48 | 45 | 48 | 50 | 4 | 45 | 50 |
| California | 91 | 88 | 100 | 100 | 52 | 51 | 42 | 49 | (42) | 42 | 100 |
| Colorado | N/A[c] | 47 | 51 | 49 | 49 | 47 | 46 | 49 | 2[d] | 46 | 51 |
| Connecticut | 53 | 52 | 64 | 65 | 67 | 66 | 69 | 68 | 15 | 52 | 69 |
| Delaware | 59 | 59 | 59 | 60 | 57 | 57 | 53 | 54 | (5) | 53 | 60 |
| District of Columbia | 81 | 81 | 69 | 63 | 63 | 63 | 64 | 66 | (15) | 63 | 81 |
| Florida | 66 | 51 | 59 | 57 | 53 | 57 | 59 | 59 | (7) | 51 | 66 |
| Georgia | 51 | 49 | 54 | 54 | 55 | 54 | 55 | 56 | 5 | 49 | 56 |
| Hawaii | 76 | 76 | 77 | 78 | 78 | 82 | 75 | 81 | 5 | 75 | 82 |
| Idaho | 46 | 51 | 51 | 52 | 48 | 47 | 47 | 47 | 1 | 46 | 52 |
| Illinois | 77 | 76 | 74 | 73 | 77 | 54 | 54 | 54 | (23) | 54 | 77 |
| Indiana | 50 | 47 | 69 | 77 | 55 | 54 | 53 | 52 | 2 | 47 | 77 |

[1]CMS began the Oral Health Initiative in April 2010 to improve Medicaid beneficiaries' aged 1 to 20 access to dental services under the EPSDT benefit, with an emphasis on prevention. These services included preventive dental services and sealants on permanent molar teeth for beneficiaries aged 6 to 9. CMS officials said that in March 2016 they informed states that CMS no longer planned to use the target for measuring states' performance on the sealant performance measure.

| State | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | Percentage point change, FY 2010 to FY 2017 | Min[a] | Max[b] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Iowa | 81 | 81 | 81 | 81 | 70 | 73 | 77 | 82 | 1 | 70 | 82 |
| Kansas | 57 | 58 | 56 | 58 | 58 | 52 | 50 | 53 | (4) | 50 | 58 |
| Kentucky | 57 | 58 | 57 | 57 | 57 | 58 | 59 | 60 | 3 | 57 | 60 |
| Louisiana | 71 | 73 | 66 | 67 | 74 | 76 | 77 | 80 | 9 | 66 | 80 |
| Maine | 38 | 51 | 53 | 54 | 93 | 62 | 56 | 53 | 15 | 38 | 93 |
| Maryland | 63 | 63 | 64 | 64 | 65 | 65 | 67 | 66 | 3 | 63 | 67 |
| Massachusetts | 75 | 71 | 71 | 71 | 70 | 69 | 71 | 70 | (5) | 69 | 75 |
| Michigan | 50 | 51 | 50 | 51 | 51 | 51 | 52 | 52 | 2 | 50 | 52 |
| Minnesota | 72 | 68 | 68 | 71 | 72 | 70 | 72 | 73 | 1 | 68 | 73 |
| Mississippi | 42 | 42 | 42 | 41 | 43 | 40 | 43 | 43 | 1 | 40 | 43 |
| Missouri | 73 | 75 | 74 | 74 | 70 | 70 | 68 | 66 | (7) | 66 | 75 |
| Montana | 56 | 56 | 59 | 44 | 42 | 38 | 43 | 44 | (12) | 38 | 59 |
| Nebraska | 92 | 51 | 47 | 46 | 35 | 43 | 44 | 46 | (46) | 35 | 92 |
| Nevada | 68 | 67 | 67 | 66 | 67 | 66 | 68 | 65 | (3) | 65 | 68 |
| New Hampshire | 73 | 71 | 62 | 67 | 66 | 65 | 67 | 71 | (2) | 62 | 73 |
| New Jersey | 62 | 63 | 63 | 64 | 62 | 61 | 62 | 63 | 1 | 61 | 64 |
| New Mexico | 71 | 60 | 60 | 62 | 63 | 62 | 61 | 60 | (11) | 60 | 71 |
| New York | 61 | 62 | 61 | 72 | 73 | 70 | 67 | 75 | 14 | 61 | 75 |
| North Carolina | 55 | 57 | 57 | 57 | 58 | 57 | 57 | 58 | 3 | 55 | 58 |
| North Dakota | 46 | 45 | 44 | 45 | 45 | 42 | N/A[e] | 42 | (4) | 42 | 46 |
| Ohio | 57 | 46 | 44 | 30 | 37 | 42 | 49 | 50 | (7) | 30 | 57 |
| Oklahoma | 56 | 55 | 56 | 56 | 60 | 60 | 63 | 61 | 5 | 55 | 63 |
| Oregon | 63 | 64 | 43 | 41 | 40 | 41 | 46 | 48 | (15) | 40 | 64 |
| Pennsylvania | 55 | 61 | 63 | 58 | 58 | 66 | 79 | 58 | 3 | 55 | 79 |
| Rhode Island | 61 | 58 | 57 | 57 | N/A[f] | 62 | 62 | 60 | (1) | 57 | 62 |
| South Carolina | 62 | 63 | 63 | 61 | 61 | 60 | 63 | 64 | 2 | 60 | 64 |
| South Dakota | 51 | 52 | 48 | 54 | 48 | 33 | 35 | 35 | (16) | 33 | 54 |
| Tennessee | 64 | 64 | 58 | 59 | 58 | 55 | 54 | 57 | (7) | 54 | 64 |
| Texas | 65 | 64 | 62 | 65 | 66 | 70 | 71 | 68 | 3 | 62 | 71 |
| Utah | 61 | 59 | 57 | 56 | 57 | 57 | 57 | 57 | (4) | 56 | 61 |
| Vermont | 52 | 56 | 57 | 51 | 54 | 53 | 58 | 60 | 8 | 51 | 60 |
| Virginia | 73 | 62 | 50 | 73 | 74 | 55 | 56 | 55 | (18) | 50 | 74 |
| Washington | 64 | 65 | 65 | 67 | 71 | 71 | 72 | 73 | 9 | 64 | 73 |
| West Virginia | 46 | 44 | 52 | 54 | 53 | 56 | 60 | 54 | 8 | 44 | 60 |
| Wisconsin | 74 | 74 | 74 | 71 | 76 | 76 | 78 | 79 | 5 | 71 | 79 |
| Wyoming | 51 | 45 | 44 | 45 | 44 | 43 | 47 | 50 | (1) | 43 | 51 |

| State | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | Percentage point change, FY 2010 to FY 2017 | Min[a] | Max[b] |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **U.S. total** | **64** | **61** | **62** | **63** | **59** | **58** | **58** | **59** | **(5)** | **58** | **64** |

Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) Form CMS-416 data for fiscal years (FY) 2010 through 2017. | GAO-19-481

Note: The participant ratio is the percentage of Medicaid beneficiaries aged 20 and under who received at least one recommended well-child screening, based on the state's periodicity schedule, which sets the frequency of screening services.

[a]The lowest participant ratio for Medicaid beneficiaries aged 20 and under from FY 2010 through FY 2017.

[b]The highest participant ratio for Medicaid beneficiaries aged 20 and under from FY 2010 through FY 2017.

[c]Colorado did not report the necessary information to calculate the participant ratio in FY 2010.

[d]Since Colorado did not report the necessary information to calculate the participant ratio in FY 2010, the percentage point change is calculated from FY 2011 to FY 2017.

[e]North Dakota did not report this information for FY 2016.

[f]Rhode Island did not report information for beneficiaries under age 1 in FY 2014.

**Table 7: Well-Child Screening Participant Ratio for Medicaid Beneficiaries Aged 20 and Under in Fiscal Year 2017, by Age Group, by State, and Nationally**

Percentage

| State | Younger than 1 | 1 to 2 | 3 to 5 | 6 to 9 | 10 to 14 | 15 to 18 | 19 to 20 |
|---|---|---|---|---|---|---|---|
| Alabama | 76 | 77 | 65 | 48 | 51 | 40 | 16 |
| Alaska | 91 | 64 | 51 | 26 | 33 | 29 | 7 |
| Arizona | 95 | 73 | 60 | 45 | 48 | 38 | 16 |
| Arkansas | 94 | 71 | 60 | 65 | 40 | 33 | 4 |
| California | 71 | 68 | 68 | 47 | 47 | 36 | 14 |
| Colorado | 94 | 78 | 62 | 43 | 45 | 34 | 13 |
| Connecticut | 96 | 88 | 82 | 64 | 67 | 58 | 34 |
| Delaware | 100 | 79 | 66 | 50 | 48 | 38 | 19 |
| District of Columbia | 91 | 80 | 73 | 66 | 66 | 57 | 33 |
| Florida | 94 | 83 | 73 | 54 | 54 | 43 | 21 |
| Georgia | 95 | 81 | 69 | 48 | 50 | 37 | 12 |
| Hawaii | 96 | 82 | 73 | 94 | 85 | 85 | 27 |
| Idaho | 96 | 75 | 56 | 38 | 40 | 28 | 17 |
| Illinois | 91 | 79 | 69 | 42 | 52 | 41 | 28 |
| Indiana | 93 | 79 | 61 | 44 | 47 | 39 | 18 |
| Iowa | 93 | 81 | 77 | 91 | 83 | 88 | 41 |
| Kansas | 93 | 75 | 67 | 44 | 46 | 37 | 18 |
| Kentucky | 96 | 80 | 68 | 81 | 49 | 35 | 26 |

| State | Younger than 1 | 1 to 2 | 3 to 5 | 6 to 9 | 10 to 14 | 15 to 18 | 19 to 20 |
|---|---|---|---|---|---|---|---|
| Louisiana | 96 | 82 | 66 | 91 | 85 | 86 | 39 |
| Maine | 34 | 84 | 60 | 55 | 53 | 42 | 21 |
| Maryland | 93 | 85 | 78 | 62 | 63 | 55 | 36 |
| Massachusetts | 75 | 83 | 81 | 72 | 70 | 64 | 44 |
| Michigan | 92 | 76 | 60 | 46 | 47 | 39 | 24 |
| Minnesota | 91 | 77 | 67 | 83 | 72 | 66 | 40 |
| Mississippi | 97 | 76 | 55 | 32 | 33 | 23 | 12 |
| Missouri | 92 | 70 | 52 | 75 | 64 | 67 | 47 |
| Montana | 98 | 76 | 56 | 32 | 39 | 29 | 8 |
| Nebraska | 93 | 74 | 58 | 30 | 39 | 31 | 12 |
| Nevada | 83 | 71 | 57 | 73 | 65 | 58 | 22 |
| New Hampshire | 92 | 86 | 76 | 100 | 61 | 50 | 26 |
| New Jersey | 93 | 84 | 74 | 59 | 61 | 54 | 32 |
| New Mexico | 93 | 74 | 66 | 87 | 60 | 35 | 15 |
| New York | 77 | 82 | 80 | 100 | 67 | 60 | 32 |
| North Carolina | 96 | 90 | 73 | 49 | 52 | 39 | 16 |
| North Dakota | 85 | 59 | 46 | 31 | 36 | 30 | 10 |
| Ohio | 92 | 76 | 65 | 41 | 43 | 39 | 17 |
| Oklahoma | 92 | 71 | 53 | 67 | 59 | 49 | 20 |
| Oregon | 95 | 77 | 59 | 41 | 42 | 34 | 17 |
| Pennsylvania | 94 | 81 | 68 | 54 | 54 | 48 | 26 |
| Rhode Island | 86 | 79 | 68 | 58 | 58 | 51 | 32 |
| South Carolina | 92 | 73 | 54 | 72 | 65 | 57 | 20 |
| South Dakota | 87 | 60 | 44 | 21 | 27 | 20 | 9 |
| Tennessee | 94 | 82 | 70 | 52 | 52 | 40 | 23 |
| Texas | 96 | 85 | 77 | 65 | 65 | 53 | 23 |
| Utah | 94 | 77 | 61 | 77 | 40 | 34 | 14 |
| Vermont | 96 | 89 | 74 | 58 | 58 | 48 | 24 |
| Virginia | 93 | 83 | 74 | 46 | 48 | 38 | 15 |
| Washington | 93 | 81 | 64 | 88 | 75 | 65 | 29 |

| State | Younger than 1 | 1 to 2 | 3 to 5 | 6 to 9 | 10 to 14 | 15 to 18 | 19 to 20 |
|---|---|---|---|---|---|---|---|
| West Virginia | 93 | 81 | 71 | 50 | 47 | 39 | 17 |
| Wisconsin | 95 | 81 | 66 | 97 | 80 | 77 | 46 |
| Wyoming | 96 | 74 | 57 | 53 | 34 | 26 | 8 |
| **U.S. total** | **89** | **79** | **68** | **57** | **55** | **45** | **22** |

Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) Form CMS-416 data for fiscal year 2017. | GAO-19-481

Note: The participant ratio is the percentage of Medicaid beneficiaries aged 20 and under who received at least one recommended well-child screening, based on the state's periodicity schedule, which sets the frequency of screening services.

**Table 8: Percentage of Medicaid Beneficiaries Aged 1 to 20 Receiving Preventive Dental Services, Fiscal Years 2011 through 2017, by State and Nationally**

Percentage

| State | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | Percentage point change, FY 2011 to FY 2017 | Min[a] | Max[b] |
|---|---|---|---|---|---|---|---|---|---|---|
| Alabama | 51 | 51 | 52 | 50 | 49 | 49 | 49 | (2) | 49 | 52 |
| Alaska | 43 | 44 | 42 | 46 | 46 | 46 | 46 | 4 | 42 | 46 |
| Arizona | 46 | 44 | 45 | 46 | 47 | 43 | 48 | 2 | 43 | 48 |
| Arkansas | 48 | 49 | 50 | 51 | 50 | 48 | 48 | 0 | 48 | 51 |
| California | 37 | 36 | 37 | 38 | 37 | 36 | 45 | 8 | 36 | 45 |
| Colorado | 51 | 51 | 50 | 51 | 49 | 51 | 51 | 0 | 49 | 51 |
| Connecticut | 57 | 59 | 60 | 60 | 59 | 63 | 63 | 6 | 57 | 63 |
| Delaware | 44 | 46 | 46 | 47 | 48 | 48 | 42 | (2) | 42 | 48 |
| District of Columbia | 50 | 48 | 50 | 53 | 54 | 53 | 56 | 6 | 48 | 56 |
| Florida | 14 | 19 | 25 | 27 | 33 | 36 | 37 | 24 | 14 | 37 |
| Georgia | 48 | 50 | 50 | 51 | 52 | 52 | 52 | 4 | 48 | 52 |
| Hawaii | 41 | 41 | 44 | 44 | 49 | 63 | 46 | 4 | 41 | 63 |
| Idaho | 49 | 53 | 56 | 50 | 47 | 59 | 65 | 17 | 47 | 65 |
| Illinois | 49 | 50 | 52 | 51 | 45 | 42 | 45 | (4) | 42 | 52 |
| Indiana | 29 | 28 | 38 | 48 | 48 | 45 | 45 | 16 | 28 | 48 |
| Iowa | 40 | 45 | 49 | 49 | 50 | 51 | 52 | 12 | 40 | 52 |
| Kansas | 41 | 42 | 46 | 48 | 47 | 46 | 46 | 5 | 41 | 48 |
| Kentucky | 44 | 38 | 43 | 43 | 45 | 47 | 48 | 4 | 38 | 48 |
| Louisiana | 47 | 48 | 48 | 48 | 47 | 47 | 49 | 2 | 47 | 49 |
| Maine | 32 | 34 | 40 | 40 | 38 | 38 | 36 | 4 | 32 | 40 |
| Maryland | 50 | 52 | 53 | 53 | 53 | 54 | 55 | 5 | 50 | 55 |
| Massachusetts | 51 | 53 | 54 | 53 | 52 | 55 | 54 | 3 | 51 | 55 |

| State | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | Percentage point change, FY 2011 to FY 2017 | Min[a] | Max[b] |
|---|---|---|---|---|---|---|---|---|---|---|
| Michigan | 36 | 37 | 40 | 40 | 40 | 42 | 43 | 6 | 36 | 43 |
| Minnesota | 38 | 30 | 38 | 38 | 37 | 37 | 37 | (2) | 30 | 38 |
| Mississippi | 45 | 47 | 48 | 50 | 47 | 50 | 51 | 6 | 45 | 51 |
| Missouri | 32 | 34 | 35 | 35 | 36 | 34 | 33 | 0 | 32 | 36 |
| Montana | 36 | 41 | 47 | 43 | 40 | 30 | 53 | 18 | 30 | 53 |
| Nebraska | 47 | 48 | 52 | 52 | 53 | 54 | 54 | 7 | 47 | 54 |
| Nevada | 40 | 38 | 45 | 37 | 38 | 43 | 43 | 3 | 37 | 45 |
| New Hampshire | 56 | 55 | 56 | 50 | 55 | 55 | 54 | (2) | 50 | 56 |
| New Jersey | 43 | 44 | 47 | 48 | 48 | 49 | 50 | 7 | 43 | 50 |
| New Mexico | 47 | 51 | 51 | 47 | 52 | 53 | 53 | 6 | 47 | 53 |
| New York | 39 | 39 | 41 | 43 | 43 | 44 | 40 | 1 | 39 | 44 |
| North Carolina | 45 | 49 | 49 | 49 | 50 | 51 | 51 | 6 | 45 | 51 |
| North Dakota | 29 | 29 | 29 | 29 | 29 | N/A[c] | 27 | (1) | 27 | 29 |
| Ohio | 25 | 37 | 21 | 33 | 34 | 35 | 35 | 10 | 21 | 37 |
| Oklahoma | 44 | 46 | 47 | 48 | 48 | 48 | 49 | 4 | 44 | 49 |
| Oregon | 39 | 40 | 40 | 35 | 37 | 39 | 41 | 2 | 35 | 41 |
| Pennsylvania | 36 | 37 | 40 | 43 | 44 | 46 | 47 | 11 | 36 | 47 |
| Rhode Island | 43 | 43 | 41 | 44 | 44 | 47 | 47 | 4 | 41 | 47 |
| South Carolina | 53 | 54 | 51 | 51 | 48 | 50 | 50 | (3) | 48 | 54 |
| South Dakota | 44 | 45 | 41 | 40 | 36 | 45 | 45 | 1 | 36 | 45 |
| Tennessee | 47 | 48 | 49 | 48 | 48 | 48 | 47 | 0 | 47 | 49 |
| Texas | 56 | 54 | 53 | 53 | 66 | 67 | 68 | 12 | 53 | 68 |
| Utah | 48 | 50 | 52 | 47 | 53 | 53 | 50 | 3 | 47 | 53 |
| Vermont | 58 | 59 | 59 | 62 | 54 | 54 | 55 | (3) | 54 | 62 |
| Virginia | 47 | 48 | 48 | 49 | 50 | 50 | 53 | 6 | 47 | 53 |
| Washington | 53 | 54 | 55 | 55 | 56 | 56 | 56 | 3 | 53 | 56 |
| West Virginia | 42 | 45 | 46 | 45 | 47 | 50 | 48 | 6 | 42 | 50 |
| Wisconsin | 25 | 26 | 25 | 26 | 27 | 30 | 39 | 15 | 25 | 39 |
| Wyoming | 40 | 40 | 41 | 43 | 42 | 47 | 49 | 9 | 40 | 49 |
| **U.S. total** | **42** | **42** | **43** | **44** | **45** | **46** | **48** | **6** | **42** | **48** |

Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) Form CMS-416 data for fiscal years (FY) 2011 through 2017. | GAO-19-481

Note: Percentages in parentheses represent a negative number. The reported percentage point change from FY 2011 to FY 2017 does not equal the difference between FY 2011 and FY 2017 percentages in some states due to rounding.

[a]The lowest percentage of Medicaid beneficiaries aged 1 through 20 receiving preventive dental services from FY 2011 through FY 2017.

[b]The highest percentage of Medicaid beneficiaries aged 1 through 20 receiving preventive dental services from FY 2011 through FY 2017.

[c]North Dakota did not report this information for FY 2016.

# Appendix IV: 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

JUN 07 2019

Carolyn Yocom
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid: Additional CMS Data and Oversight Needed to Help Ensure Children Receive Recommended Screenings*" (GAO-19-481).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Matthew D. Bassett
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL CMS DATA AND OVERSIGHT NEEDED TO HELP ENSURE CHILDREN RECEIVE RECOMMENDED SCREENINGS (GAO-19-481)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is committed to ensuring that children in Medicaid receive screening and other services they are entitled to under the Early Periodic Screening, Diagnostic, and Treatment benefit (EPSDT).

HHS currently collects information on EPSDT services through mandatory reporting on the Form CMS-416 and voluntary reporting on the Child Core Set. The Child Core Set, in particular, allows HHS to evaluate state performance using a wide array of evidence-based quality metrics which are reviewed annually through a rigorous stakeholder engagement process to ensure that they are meaningful for the Medicaid and Children's Health Insurance Program (CHIP) beneficiary populations. As GAO notes in its report, these efforts are generally consistent with federal internal control standards specifying that management should use quality information to achieve the entity's objectives.

HHS releases information on state reporting of Form CMS-416 data each year. HHS also annually releases state progress in reporting the Child Core Set quality measures and assesses state-specific performance for measures that are reported to CMS by at least 25 states and meet CMS standards for data quality. The annual reports include information on median performance for all publicly reported measures, as well as the top and bottom quartiles of performance. HHS has also developed a Medicaid and CHIP Scorecard to increase transparency about the programs' administration and outcomes. The Scorecard includes six of the Child Core Set measures as a tool to increase visibility on state health system performance and encourage performance improvement.

HHS does not have the authority to establish binding targets for states on either the Child Core Set measures or the Form CMS-416. However, when appropriate and resources allow, HHS has developed initiatives to improve performance on specific areas of concern identified through quality reporting. The Oral Health Initiative is one example of how HHS has used state-reported data to develop national and state-specific benchmarks for quality improvement using the preventive dental service measure on the Child Core Set. In Fiscal Year (FY) 2011, 42 percent of children enrolled in Medicaid received at least one preventive dental service. In response, HHS developed national and state-specific 10 percentage point improvement goals for this measure, identified states performing below the national average, and provided targeted technical assistance to the lowest performing states. As of FY 2017, 9 states have met HHS's performance targets, with 39 states demonstrating some level of improvement on this measure over that time period. As a result, the national rate of children enrolled in Medicaid who have received at least one preventive dental service in a year has climbed to 48 percent.

In addition, in late 2018, HHS sent each state an individualized trend snapshot which includes the state's performance on publicly reported Child Core Set measures through FY 2017, information about a state's performance on each measure relative to other states' performance, and highlights significant changes in a state's performance for each measure. This tool is designed to enable states to easily identify how their performance compares to their state peers and whether their performance has trended in a positive direction. HHS believes the trend

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**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL CMS DATA AND OVERSIGHT NEEDED TO HELP ENSURE CHILDREN RECEIVE RECOMMENDED SCREENINGS (GAO-19-481)**

snapshots will, spur quality improvement efforts by encouraging states to think about their Core Set measure performance over time and not simply at any given point in time.

HHS also regularly analyzes this data to identify states that are outperforming their peers and develop technical assistance resources like learning collaboratives, toolkits, and issue briefs to help disseminate the lessons they learned and share best practices with other states.

HHS believes efforts described above to improve the quality of data being reported in the Child Core Set, set targets in key areas, and provide technical assistance to states to improve their performance on key quality measures strike an appropriate balance between developing quality information, performing monitoring activities, evaluating issues, and remediating deficiencies.

HHS is also working with states to improve the quality of data in the Transformed Medicaid Statistical Information System (T-MSIS). All states, the District of Columbia, and all participating territories have begun submitting T-MSIS data. T-MSIS is a critical source of data for key eligibility, enrollment, program, utilization and expenditure data for the Medicaid and CHIP. The enhanced data available from T-MSIS will support improved program and financial management, robust evaluations of demonstration programs, improve program integrity and efficiency, and will reduce burden on states for reporting requirements. Specific analyses that will be possible with T-MSIS data include assessing beneficiary access to and quality of care, evaluating the impact of different types of delivery system models, and examining important enrollment and service utilization trends. Beginning in July 2017, HHS has identified 12 Top Priority Items (TPIs) for T-MSIS data quality. States have been focused on addressing these 12 TPIs as they are CMS's highest priority T-MSIS data issues. States have made significant progress addressing these TPIs.

In 2019, HHS is beginning to expand its TPIs to include an additional 11 focus areas in support of continuous improvement in T-MSIS data quality. Six focus areas were released in April and the next five TPIs will be released this summer. The guidance on the T-MSIS Coding Blog provides a description of all 23 TPIs.[1] Through a one-on-one state technical assistance effort, HHS reviews a state's data quality issues in these areas and works with the state on addressing them. HHS will also begin to share and use T-MSIS data publicly in 2019.

As noted by GAO, HHS has conducted pilot studies to determine the feasibility of using T-MSIS data to compute EPSDT metrics currently collected through Form CMS-416 and the Child Core Set. As T-MSIS data quality continues to improve, HHS will develop ways to use this data to improve EPSDT oversight and streamline state reporting.

GAO's recommendations and HHS' responses are below.

**GAO Recommendation**

[1] https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/tmsis-blog/?entry=51423

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**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL CMS DATA AND OVERSIGHT NEEDED TO HELP ENSURE CHILDREN RECEIVE RECOMMENDED SCREENINGS (GAO-19-481)**

Work with states and relevant federal agencies to collect accurate and complete data on blood lead screening for Medicaid beneficiaries in order to ensure that CMS is able to monitor state compliance with its blood lead screening policy and take corrective action as needed.

**HHS Response**
HHS concurs with GAO's recommendation.

However, many blood lead screening tests for Medicaid children are paid for by sources other than Medicaid. Therefore, obtaining complete data on blood lead screenings for children enrolled in Medicaid will not be possible. HHS has and will continue to provide guidance to states on the importance of blood lead screening and share best practices on approaches they can take to increase those screening rates.

**GAO Recommendation**
Regularly assess the appropriateness of performance measures and targets for the EPSDT benefit and take any necessary actions to ensure their relevant use, including adding, changing, or removing measures or targets, and regularly communicating performance measures and targets to states.

**HHS Response**
HHS does not concur with GAO's recommendation.

HHS assesses the Medicaid and CHIP Child and Adult Core Sets on an annual basis through a rigorous stakeholder engagement process. Through this annual review, HHS updates the existing measures, as appropriate, and assesses whether any measures should be added or deleted, including from the CMS Form 416.

HHS may also set targets in key areas as appropriate. As noted in the report, HHS established a non-binding target for the preventive dental quality measure in the Child Core Set as part of the Oral Health Initiative. Additionally, we provide information to states on whether their performance on publicly-reported Core Set measures is above the median or in the top or bottom quartiles, thus providing performance benchmarks for states.

In conversations with GAO following the release of the draft report, it became clear that this recommendation is requesting targets for all EPSDT measures. HHS does not believe it would be productive at this time to set targets for every measure.

**GAO Recommendation**
Conduct regular evaluations of state performance by comparing states' performance measurement data with CMS's EPSDT targets to identify gaps in states' performance and areas for improvement.

**HHS Response**
HHS does not concur with GAO's recommendation.

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**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL CMS DATA AND OVERSIGHT NEEDED TO HELP ENSURE CHILDREN RECEIVE RECOMMENDED SCREENINGS (GAO-19-481)**

HHS does not believe it would be productive at this time to set targets for every EPSDT measurement and therefore cannot evaluate states' performance against those targets. As mentioned above, HHS recently sent each state an individualized trend snapshot that provided a state-specific summary of performance on publicly reported Child Core Set measures through FY 2017. The snapshots include a state's performance on publicly reported Child Core Set measures for five years, information about a state's performance on each measure relative to other states' performance, and highlights significant changes in a state's performance for each measure. In addition, HHS offers a wide range of quality improvement technical assistance to help states address performance goals. HHS believes this is the most effective method of helping states identify and address areas for potential improvement.

**GAO Recommendation**
Assist states with planning needed improvements, including providing focused assistance, to resolve gaps in states' performance in meeting CMS's EPSDT targets.

**HHS Response**
HHS does not concur with GAO's recommendation.

As mentioned above, HHS has developed initiatives to improve specific areas of concern identified through quality reporting when appropriate and as resources allow. HHS developed national and state-specific improvement goals for children enrolled in Medicaid with respect to receipt of at least one preventive dental service and provided targeted technical assistance to the lowest performing states. Other examples of targeted technical assistance include work with states on improving their performance on the Core Set measure of inappropriate utilization of antipsychotic medication in young children and improving access to EPSDT services by better leveraging schools as settings for care. However, HHS does not believe it is productive at this time to develop similar programs for every EPSDT measurement.

**GAO Recommendation**
Develop a plan with time frames and interim milestones for using T-MSIS data to generate the necessary data from the CMS-416 to improve EPSDT oversight and streamline state reporting.

**HHS Response**
HHS concurs with GAO's recommendation.

HHS has conducted pilot studies to determine the feasibility of using T-MSIS data to compute EPSDT metrics currently collected through Form CMS-416 and the Child Core Set. However, not all of the data collected through the CMS-416 can be collected through T-MSIS (for example, state periodicity schedules).

HHS is dependent upon states improving their T-MSIS data submissions in order to generate the EPSDT measures. When the quality of state data is sufficient to reliably generate the EPSDT

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**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID: ADDITIONAL CMS DATA AND OVERSIGHT NEEDED TO HELP ENSURE CHILDREN RECEIVE RECOMMENDED SCREENINGS (GAO-19-481)**

measures, HHS will produce the applicable EPSDT measures using TMSIS data. As mentioned above, HHS is working with states to improve T-MSIS data quality.

**GAO Recommendation**
Develop a plan with time frames and interim milestones for using T-MSIS data to generate the necessary data from the Child Core Set to improve EPSDT oversight and streamline state reporting.

**HHS Response**
HHS concurs with GAO's recommendation.

As mentioned above, HHS is working with states to improve T-MSIS data quality. HHS has conducted pilot studies to determine the feasibility of using T-MSIS data to compute EPSDT metrics currently collected through Form CMS-416 and the Child Core Set. However, not all of the measures on the Child Core Set can be calculated using administrative data from T-MSIS (for example, measures that require electronic health record data).

When the quality of state data is sufficient to reliably generate the EPSDT measures, HHS will produce the applicable EPSDT measures using TMSIS data.

HHS appreciates the work GAO has done, but believes that the current efforts underway to work with states to monitor the EPSDT benefit have not been fully captured in this report. HHS looks forward to future conversations on this issue.

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# Appendix V: GAO Contact and Staff Acknowledgments

## GAO Contact

Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

## Staff Acknowledgments

In addition to the contact named above, Karen Doran (Assistant Director), Peter Mangano (Analyst-in-Charge), Matthew Green, Erika Huber, Drew Long, Jennifer Rudisill, and Kelly Turner made key contributions to this report. Also contributing were Muriel Brown, Giselle Hicks, Erika Lessien, and Madeline Ross.

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