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MEDICAID

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

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Highlights

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

Why GAO Did This Study

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

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

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

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

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

What GAO Found

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

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