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Report to Congressional Committees

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CHILDREN'S HEALTH INSURANCE

Inspector General Reviews Should Be Expanded to Further Inform the Congress

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Accountability * Integrity * Reliability

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Abbreviations

BBRA	Medicare, Medicaid and SCHIP Balanced Budget Refinement Act
CMS	Centers for Medicare and Medicaid Services
CPS	Current Population Survey
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
OIG	Office of Inspector General
SCHIP	State Children's Health Insurance Program

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United States General Accounting Office
Washington, DC 20548

March 29, 2002

The Honorable Max Baucus
Chairman
The Honorable Charles E. Grassley
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable W.J. "Billy" Tauzin
Chairman
The Honorable John D. Dingell
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Congress created the State Children's Health Insurance Program (SCHIP) in 1997 to reduce the number of uninsured children in families with incomes that are too high to qualify for Medicaid.[1] For SCHIP, the Congress appropriated $40 billion over 10 years, with funds allocated annually to the 50 states, the District of Columbia,[2] and the U.S. commonwealths and territories. Financed jointly by the states and the federal government, SCHIP offers a strong incentive for states to participate by offering a higher federal matching rate—that is, the federal government pays a larger proportion of program expenditures—than the Medicaid program.[3] While this incentive encourages efforts to reduce the number of uninsured children through state participation in SCHIP, concerns existed that states might inappropriately enroll Medicaid-eligible children in SCHIP and thus obtain higher federal matching funds than

[1]Medicaid is a federal-state program that provides health care coverage to certain categories of low-income adults and children. SCHIP was established as title XXI of the Social Security Act by P.L. 105-33 and is classified to 42 U.S.C. § 1397aa *et seq*.

[2]The District of Columbia is considered a state for purposes of this report.

[3]SCHIP offers an "enhanced" federal matching rate that is derived from a state's Medicaid rate. Each state's match from SCHIP is equal to 70 percent of its Medicaid matching rate plus 30 percentage points, not to exceed a federal share of 85 percent. While the federal share of expenditures for Medicaid can range from 50 to 77 percent, federal shares of SCHIP expenditures can range from 65 to 84 percent.

allowed under Medicaid.[4] Inappropriate SCHIP enrollment also can affect what benefits are available for children because the SCHIP statute allows states to (1) expand their Medicaid programs, thus affording SCHIP-eligible children the same benefits and services that the state Medicaid program provides, (2) construct separate child health programs distinct from Medicaid that could provide more limited benefit packages and could include copayments that are generally not permitted for children in Medicaid, or (3) use a combination of both approaches. To address concerns regarding inappropriate enrollment, the SCHIP statute requires states to screen all SCHIP applicants for Medicaid eligibility and, if they are eligible, enroll them in Medicaid.

Even with the requirement for Medicaid screening in place, concerns remained that children who were eligible for Medicaid might have been inappropriately enrolled in SCHIP.[5] Additionally, there was interest in assessing the progress states had made to reduce the number of uninsured children, including the extent to which states had met objectives and goals, which they established in their SCHIP programs.[6] In the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), the Congress directed the Department of Health and Human Services (HHS) Office of Inspector General (OIG) to conduct a series of studies on these issues.[7] BBRA specified that the OIG should review states that provide SCHIP coverage separately from their Medicaid programs.

BBRA also directed that we review and report on the OIG's work. In response, we assessed the OIG's efforts to inform the Congress on (1) determining whether Medicaid-eligible children were improperly enrolled in SCHIP and (2) assessing states' progress in reducing the number of uninsured children, including the progress states have made in meeting the objectives and goals initially established in their SCHIP programs.

[4]See U.S. General Accounting Office, *Children's Health Insurance Program: State Implementation Approaches Are Evolving*, GAO/HEHS-99-65 (Washington, D.C.: May 14, 1999).

[5]See H.R. Rep. No. 106-199, at 60 (1999).

[6]The SCHIP statute includes a provision requiring states, in establishing their programs, to specify strategic objectives and performance goals for providing child health assistance under SCHIP. See 42 U.S.C. §1397gg.

[7]BBRA amended the Social Security Act to require the HHS OIG to audit a sample of states beginning in fiscal year 2000 and every third fiscal year thereafter.

To examine these issues, we reviewed the OIG's approach and methodology for selecting its sample of states for the first in its series of studies to evaluate states' performance in screening SCHIP applicants for Medicaid eligibility and to assess states' progress in reducing the number of low-income uninsured children. We examined the OIG's findings in the context of other research, including our own work.[8] In some cases, we reviewed work released after the OIG's studies were completed and published to determine the extent to which other research corroborated the OIG's findings. Finally, we examined OIG's recommendations to the Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA), which jointly oversee SCHIP.[9] Our work was conducted from December 2001 through March 2002 in accordance with generally accepted government auditing standards.

Results in Brief

In responding to the mandate, the OIG published two reports, the first addressing whether Medicaid-eligible children were enrolled in SCHIP and the second assessing states' progress in reducing the number of uninsured children.[10] The scope of the OIG studies included sampling 5 of the 13 states that only enrolled children in separate child health programs during 1999. The OIG concluded that Medicaid-eligible children were not being enrolled in SCHIP by the 13 states that administer separate child health programs. However, because of variations in the administration of state programs, generalizing from the findings in 5 states to the 13 states may not be appropriate. Furthermore, the issue of appropriate enrollment is not limited to states with completely separate child health programs, but also applies to those states with combination programs and Medicaid expansions, which also receive the higher SCHIP matching rate for state program expenditures. Because the scope of the study was limited to the 13 states with separate SCHIP programs, the experience of other states—particularly the 13 states that operated SCHIP combination programs—

[8]See the related products listed at the end of this report.

[9]In June 2001, the secretary of HHS announced that HCFA's name would be changed to the Centers for Medicare and Medicaid Services. For this report, we will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

[10]See Department of Health and Human Services, Office of Inspector General, *State Children's Health Insurance Program: Ensuring Medicaid Eligibles Are Not Enrolled in SCHIP*, OEI-05-00-00241 (Washington, D.C.: Feb. 2001), and Department of Health and Human Services, Office of Inspector General, *State Children's Health Insurance Program: Assessment of State Evaluations Reports*, OEI-05-00-00240 (Washington, D.C.: Feb. 2001).

was not addressed. Had the scope of review included the 13 additional states that offered separate child health programs under combination plans, the proportion of children represented would have increased from 16.5 percent to 65 percent of SCHIP enrollees in 1999. Future OIG reviews that consider differences in enrollment practices across states and a wider universe of states could provide more information on the effectiveness of states' efforts to ensure appropriate enrollment.

Due to limitations the OIG identified in states' SCHIP evaluations, the OIG was unable to conclude whether states were making progress in reducing the number of uninsured children and in meeting the objectives and goals they established in their SCHIP programs. For example, the OIG found that the 5 states it reviewed generally did not have sound methodologies to determine reductions in the number of uninsured children, in part because they did not always take into account other factors—such as changes in the economy or private insurance coverage—that also may affect the number of uninsured children. Furthermore, the OIG found that some states had set program goals without considering how they might be measured and that states' staffs often lacked adequate evaluation skills. Based on its findings, the OIG made recommendations to HCFA and HRSA to help improve states' ability to conduct more rigorous evaluations of their programs. Because of the limitations identified by the OIG, it may wish to look beyond states' own evaluations and analyze other sources of analysis for its next review. Over time, other federal initiatives—such as improvements in state-level estimates of the number of uninsured—may help states to improve their measurement of progress under SCHIP.

We are recommending that the HHS inspector general expand the scope of analysis to include a broader array of states to further inform the Congress on states' progress in ensuring appropriate SCHIP enrollment. The OIG concurred with our recommendations, and provided general comments regarding approaches to designing future reviews.

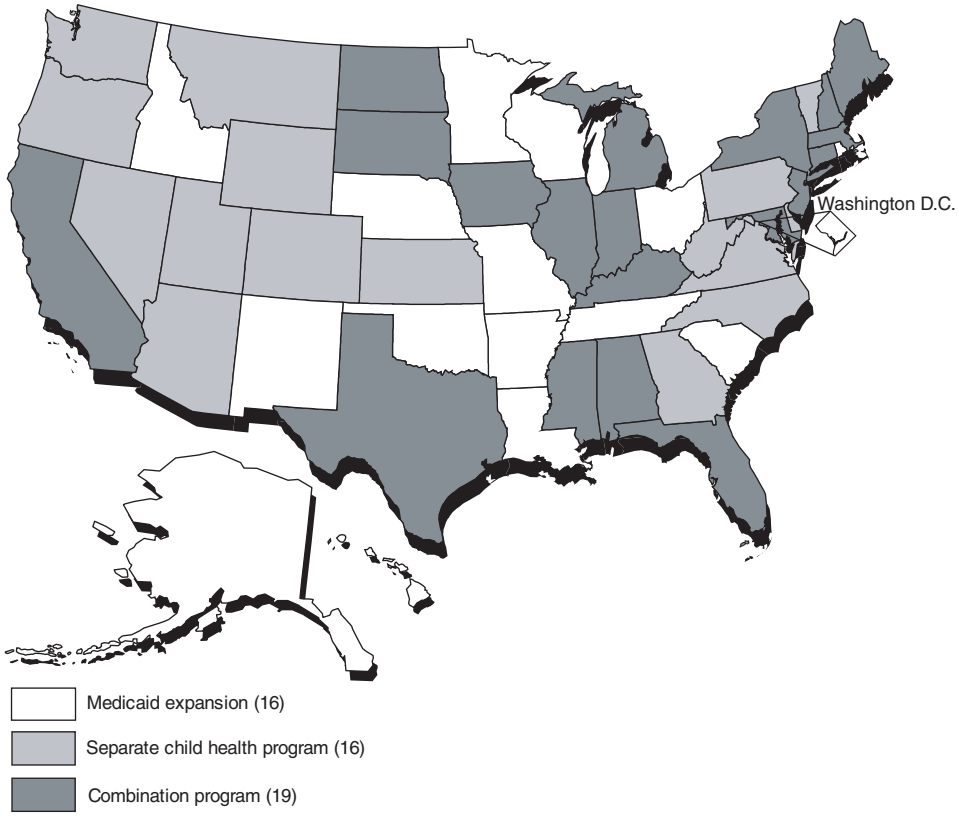
Background

States provide health care coverage to low-income uninsured children largely through two federal-state programs—Medicaid and SCHIP. Since 1965, Medicaid has financed health care coverage for certain categories of low-income individuals—over half of whom are children. To expand health coverage for children, the Congress created SCHIP in 1997 for children living in families whose incomes exceed the eligibility limits for

Medicaid. Although SCHIP is generally targeted at families with incomes at or below 200 percent of the federal poverty level, each state may set its own income eligibility limits within certain guidelines.[11] As of February 2002, 16 states have created Medicaid expansion programs, 16 states have separate child health programs, and 19 states have combination Medicaid expansions and separate child health components. (See figure 1.)

[11]In general, the SCHIP statute targets children in families with incomes at or below 200 percent of the poverty level, which equates to $36,200 for a family of four in 2002. The statute allows a state to expand eligibility up to 50 percentage points above its Medicaid income eligibility standard in 1997. See 42 U.S.C. § 1397jj(b)(1)(B)(ii)(I).

Figure 1: States' Design Choices Under SCHIP, as of February 2002



Note: Since the period reviewed by the OIG (1999), 8 states have altered their design choices under SCHIP. Seven states—Illinois, Indiana, Maryland, Mississippi, North Dakota, South Dakota, and Texas—have changed from Medicaid expansions to combination programs. West Virginia changed from a combination program to a separate child health program.

Source: Centers for Medicare and Medicaid Services (CMS).

SCHIP offers significant flexibility in program design and benefits provided by allowing states to use existing Medicaid structures or create child health programs that are separate from Medicaid. Medicaid expansions must follow Medicaid eligibility rules and cost-sharing requirements, which are generally not allowed for children. A Medicaid expansion also creates an entitlement by requiring a state to continue providing services to eligible children even when its SCHIP allotment is

exhausted.[12] In contrast, a state that chooses a separate child health program approach may introduce limited cost-sharing. Additionally, a state with a separate child health program under SCHIP may limit its own annual contribution, create waiting lists, or stop enrollment once the funds it budgeted for SCHIP are exhausted. States choosing combination programs take both approaches. For example, Connecticut's combination SCHIP program has a limited Medicaid expansion—increasing eligibility for 17 to 18 year olds up to 185 percent of the federal poverty level. Additionally, the state created a separate child health program, which covers all children in families with incomes over 185 percent, up to 300 percent of the federal poverty level.

With regard to program benefits, the choices states make in designing SCHIP have important implications. For example, a state opting for a Medicaid expansion under SCHIP must provide the same benefits offered under its Medicaid program. These benefits are quite broad and include Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for most children.[13] EPSDT services are designed to target health conditions and problems for which children are at risk, including iron deficiency, obesity, lead poisoning, and dental disease. These services are also intended to detect and correct conditions that can hinder a child's learning and development, such as vision and hearing problems.[14] In contrast, states opting for separate child health programs may depart from Medicaid requirements and provide benefits based on coverage standards

[12]However, states that expend their available SCHIP funds may then claim Medicaid matching rates for benefits and services provided under Medicaid expansions.

[13]EPSDT is optional for the medically needy population, a category of individuals who generally have too much income to qualify for Medicaid but have "spent down" their income by incurring medical and/or remedial care expenses. See 42 U.S.C. § 1396 (a)(10)(C).

[14]For additional information on EPSDT, see U.S. General Accounting Office, *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, GAO-01-749 (Washington, D.C.: July 13, 2001).

in the SCHIP legislation.[15] SCHIP separate child health programs generally cover basic benefits, such as physician services, inpatient and outpatient hospital services, and laboratory and radiological services. Other benefits, such as prescription drugs and hearing, mental health, dental, and vision services, may be provided at the states' discretion. States also may place limits on services provided and require cost-sharing, while Medicaid generally does not permit cost-sharing for children.

In addition to having flexibility in program design and benefits offered, states participating in SCHIP have a larger proportion of their program expenditures paid by the federal government than for Medicaid. A state's Medicaid program expenditures are matched by the federal government using a formula that is based on a state's per capita income in relationship to the national average. Federal matching rates for SCHIP are "enhanced"—they are established under a formula that takes 70 percent of a state's Medicaid matching rate and adds 30 percentage points, with an overall federal share that may not exceed 85 percent.[16] For 2001, federal shares of SCHIP expenditures ranged from 65 to 84 percent, with the national average federal share equaling about 72 percent. In contrast, 2001 federal shares for Medicaid ranged from 50 to 77 percent of expenditures, with the national average at about 57 percent. The SCHIP statute requires states to screen all SCHIP applicants for Medicaid eligibility and, if they are eligible, enroll them in Medicaid.[17]

[15]In prescribing a package of benefits, states with separate child health programs choose among four coverage standards. First, the benchmark standard provides coverage equivalent to that received by federal employees, state employees, or those enrolled in a state's health maintenance organization with the largest insured commercial non-Medicaid enrollment. Second, the benchmark equivalent standard provides basic coverage for inpatient and outpatient hospital care; physicians' surgical and medical services; laboratory and x-ray services; and well-baby and well-child care, including age-appropriate immunizations. Third, existing comprehensive state coverage includes benefit packages for state-operated children's health insurance programs in Florida, New York, and Pennsylvania. Fourth, states may receive approval from the secretary of health and human services for benefit packages that provide appropriate coverage for low-income children but do not match the first three standards.

[16]For example, a state with the minimum 50-percent Medicaid match receives a 65-percent match under SCHIP.

[17]See 42 U.S.C. § 1397bb(b)(3).

OIG Studies

BBRA included a mandate that the OIG conduct a study every 3 years, beginning in fiscal year 2000, to (1) determine the number, if any, of enrollees in SCHIP who are eligible for Medicaid and (2) assess states' progress in reducing the number of uninsured low-income children, including progress in achieving the strategic objectives and performance goals in their SCHIP plans, which set forth how states intend to use their SCHIP funds to provide child health assistance.[18]

BBRA directed the OIG to review states with approved SCHIP programs that do not provide health benefits under Medicaid;[19] consequently, the OIG focused on the 15 states that in 1999 operated separate child health programs under SCHIP.[20] Of these 15 states, the OIG excluded 2 states—Washington and Wyoming—because the delayed start-up of their programs resulted in no enrollees in fiscal year 1999, the year that the OIG reviewed. From the remaining 13 states, the OIG used a two-stage sampling plan to select 5 states for review. The OIG first divided the 13 states into two strata, selecting Pennsylvania separately as stratum I because it had a large number of children—81,758—enrolled in its program in fiscal year 1999. Enrollment across the remaining 12 states ranged from 1,019 in Montana to 57,300 in North Carolina. The OIG randomly selected 4 of the 12 states (North Carolina, Oregon, Utah, and Vermont) for inclusion in its study. (See table 1.)

[18]The OIG is charged with protecting the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections, and other mission-related functions. The OIG informs the secretary and the Congress of program and management problems and recommends legislative, regulatory, and operational approaches to correct them. The OIG may conduct its own evaluations or those mandated by the Congress.

[19]The BBRA mandate provides that "A state described in this [mandate] is a state with an approved state child health plan…that does not, as part of such plan, provide health benefits coverage under the State's Medicaid program." 42 U.S.C. § 1397hh(d)(2).

[20]The 15 states were Arizona, Colorado, Delaware, Georgia, Kansas, Montana, Nevada, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington, and Wyoming.

Table 1: OIG Sampling Framework for SCHIP Analysis, Fiscal Year 1999

Stratum	State	SCHIP enrollment
I (Selected by OIG)	Pennsylvania	81,758
II (Universe of states for purposes of random selection)	Arizona	26,807
	Colorado	24,116
	Delaware	2,433
	Georgia	47,581
	Kansas	14,443
	Montana	1,019
	Nevada	7,802
	North Carolina[a]	57,300
	Oregon[a]	27,285
	Utah[a]	13,040
	Vermont[a]	2,055
	Virginia	16,895

[a]State was randomly selected for the OIG's review.

Source: CMS enrollment figures for 1999.

For the 5 sample states, the OIG reviewed a variety of documents the states submitted to HCFA, such as their SCHIP plans and SCHIP evaluation reports, which are states' assessments of the effectiveness of their programs.[21] OIG staff conducted site visits and met with officials responsible for administering SCHIP in all 5 states. The OIG also randomly selected 100 active SCHIP case files from each of the 5 states in order to evaluate whether Medicaid-eligible children were incorrectly enrolled in SCHIP. The OIG did not verify accuracy and completeness of the state case files; rather, it focused on whether the information in each file supported the conclusion reached by the state.

[21]A state's SCHIP evaluation was required to address several areas of analysis, including (1) the quality of health coverage provided, (2) its choices of health benefits coverage, (3) activities in coordinating SCHIP with other public and private programs, (4) changes in trends in the states that affect the provision of health insurance, and (5) recommendations for improving SCHIP.

OIG's Assessment of Appropriate Enrollment Would Benefit From an Expanded Selection of States

In determining whether Medicaid-eligible children were improperly enrolled in SCHIP, the OIG reported that, based on a sample of 5 states, SCHIP enrollees in the 13 states with separate child health programs were generally appropriately enrolled. However, because of variations in the administration of state programs, generalizing from the 5 states to the 13 states may not be appropriate. In addition, focusing on only those states with separate SCHIP programs does not capture the experience of the majority of states or the majority of SCHIP-enrolled children. Ensuring appropriate enrollment in SCHIP is important regardless of a state's SCHIP design, because any child eligible for Medicaid that is incorrectly enrolled in SCHIP results in a state receiving a higher federal matching rate. Reviewing states, for example, that operate separate child health programs as part of a combination program would have increased the proportion of children under consideration from 16.5 percent to 65 percent of all SCHIP children enrolled in 1999, and thus provided more comprehensive information regarding states' enrollment practices.

Alternative Sampling Methodologies May More Fully Account for Variation among States

To determine whether states were improperly enrolling Medicaid-eligible children in SCHIP, the OIG separated the 13 states with separate child health programs into two strata. The first stratum was the state of Pennsylvania, which the OIG intentionally selected because it had the most children enrolled in SCHIP among the 13 states. Four states were then randomly selected from the remaining 12 states. Among the 5 states it reviewed, the OIG identified only a few cases in which Medicaid-eligible children were inappropriately enrolled.[22] For example, it reported that 1 state had a single case in which a Medicaid-eligible child was enrolled in SCHIP, while 2 other states had three and five such cases. The report also found that 2 states did not have any Medicaid-eligible children enrolled in SCHIP. The OIG concluded from these findings that most SCHIP enrollees were correctly enrolled in the 13 states administering separate child health programs.

Variations in states' enrollment practices, however, raise questions about the extent to which results from a sample of 5 states can be generalized to 13 states. Had the OIG drawn its random sample of active SCHIP cases across the 13 states in its sampling universe, it would have been better

[22]Based on a two-stage stratified-cluster sample, the OIG estimated that, at a 90-percent confidence level, from 97.6 to 99.6 percent of SCHIP enrollees were correctly enrolled in the 13 states administering separate child health programs in fiscal year 1999.

able to generalize its results. An OIG official told us that the office chose to analyze a sample of 5 states rather than all 13 states because of time and resource constraints. Recognizing that analyzing a pure random sample of cases across a large number of states may be too resource intensive, choosing a stratified sample of states may provide more information on the extent to which accurate enrollment may vary with different states' practices. Even with a stratified sample, however, generalization to all states may be problematic.

The OIG did select a stratified sample and chose one characteristic—size of a state's SCHIP program—to develop two strata. While dividing states in terms of size is potentially useful, additional distinctions may be important because program characteristics vary considerably from state to state. For example, states with differing administrative structures (New York uses health plans to determine eligibility and enroll eligible individuals, Colorado uses an enrollment contractor, and Oregon uses its Medicaid staff to determine SCHIP eligibility) could be grouped by certain characteristics for review. This could help determine whether such differences in administrative structures have a bearing on appropriate enrollment in SCHIP.

To examine whether the OIG's sampling approach reflected variations in states' administrative structures, we categorized the 12 states in the second stratum based on whether they had the same program staff determine eligibility for both the SCHIP and Medicaid programs, which can help achieve consistency in eligibility decisions. We found that the random sample of 4 states did not include any states where different employees were responsible for determining SCHIP and Medicaid eligibility, thus raising concerns as to whether conclusions could be generalized. (See table 2.)

Table 2: Enrollment Practice of 12 States from Which the Random Sample Was Drawn

OIG stratum II	State	Who determines SCHIP and Medicaid eligibility—same staff or different staff?
Randomly selected	North Carolina	Same
	Oregon	Same
	Utah	Same
	Vermont	Same
States not selected	Arizona	Different
	Colorado	Different
	Delaware	Same
	Georgia	Different
	Kansas	Same
	Montana	Different[a]
	Nevada	Different
	Virginia	Same

[a]Montana generally uses a different staff to determine eligibility for each program; however, the state's annual report notes that when children lose Medicaid coverage due to increases in family income, the Medicaid eligibility staff can enroll the children in SCHIP. In these circumstances, the same staff members would enroll children in both Medicaid and SCHIP.

Source: SCHIP annual reports and state evaluations, 1999, 2000 and 2001.

Increasing the Number of States under Consideration Would Better Inform the Congress

Because the scope of the study was limited to the 13 states with separate child health programs, the OIG examined 322,534, or 16.5 percent, of the approximately 2 million children enrolled in SCHIP in fiscal year 1999. A review that also included separate SCHIP programs in states that opted for a combination approach under SCHIP would have expanded the available universe to 26 states and to 65 percent of all SCHIP children enrolled in 1999.[23] Moreover, using the OIG's general audit authority, the scope of future reviews could include states with SCHIP Medicaid expansions, which would provide the Congress with more complete information on the extent to which states are enrolling low-income children in the appropriate programs.[24] If this approach had been used in 1999, 23 states

[23]Some states have altered their design choices under SCHIP since 1999, which has resulted in more combination and separate child health programs in SCHIP (19 states and 16 states, respectively, as of February 2002). If the OIG were to include in its scope the experience of states with combination programs for the 2001 SCHIP enrollment of 4.6 million, it would have selected a sample from 35 states, or 74 percent of all children enrolled.

[24]See 5 U.S.C. Appendix 3, § 4(a)(1).

and almost one-fourth of all children enrolled in SCHIP would have been added. (See table 3.)

Table 3: States' Design Choices and Percentage of Nationwide SCHIP Enrollment, Fiscal Year 1999

SCHIP design choices	States	Percentage of total SCHIP enrollment
Separate child health program (15 states)	Arizona, Colorado, Delaware, Georgia, Kansas, Montana, Nevada, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington, and Wyoming.	16.5
Combination (13 states)	Alabama, California, Connecticut, Florida, Iowa, Kentucky, Maine, Massachusetts, Michigan, New Hampshire, New Jersey, New York, and West Virginia.	48.7[a]
Medicaid expansion (23 states)	Alaska, Arkansas, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, and Wisconsin.	23.3

[a]States with SCHIP combination programs have both a separate child health program and a Medicaid expansion component. The 48.7 percent cited in the table does not include the 11.1 percent of children who are enrolled in SCHIP Medicaid expansion components in these states.

Source: CMS.

While States' Evaluations Offered Limited Results, Future OIG Reviews May Benefit from Improved Data Sources

The OIG identified important limitations to states' evaluations that made it unable to conclude whether states were making progress in reducing the number of uninsured children and in meeting the objectives and goals that they established under SCHIP. For example, the OIG found that states made inappropriate assumptions in reporting data about the relationship of SCHIP enrollment to the rates of uninsured, which undermined the credibility of states' results, and that states often had poor baseline data against which to measure progress. The OIG also found that states set goals without considering how to evaluate progress, and that little emphasis was placed on evaluation by the states. As a result, the OIG made recommendations to both HCFA and HRSA on ways that the federal government could assist and guide states in making improvements in their analyses. While the initial OIG reviews were inconclusive due to weaknesses in states' evaluations, future efforts may benefit from federal initiatives under way aimed at improving state-level data and analyses of SCHIP. These initiatives, however, may not have been in place long enough to benefit the OIG's next review, since results are due in 2003. As a

result, the OIG may wish to select a different approach—such as identifying states with more rigorous practices in evaluation, or augmenting its review with other sources beyond those provided by the states.

Weaknesses in States' SCHIP Evaluations Limited the OIG's Ability to Measure Progress

The OIG identified limitations to the 5 states' SCHIP evaluations and thus was unable to draw conclusions about states' progress in reducing the number of uninsured children or meeting their stated objectives and goals. For example, the OIG cited concerns regarding the reliability of states' reports of reductions in the number of uninsured, including inadequate data and evaluation practices. In cases in which states were unable to measure objectives that were established at the beginning of their SCHIP programs, their evaluations generally provided descriptive information on activities but did not assess the effect that such activities had on achieving specific goals. (See table 4.) For example, the OIG reported that none of the 5 states it reviewed attempted evaluations of their outreach programs or offered explanations of how such programs affected their measurable progress in enrollment or the number of uninsured children.

Table 4: Limitations to Five States' SCHIP Evaluations Identified by the OIG, February 2001

Limitation	Description
Data problems and evaluation practices impaired evaluations	• State-collected data were deficient or outdated. • State-level estimates based on national survey data were unreliable, particularly for smaller states. • States assumed that increased SCHIP enrollment meant reductions in uninsured.
State reports were descriptive, not evaluative	• Evaluations described activities without determining whether the activities were effective. • Information provided was qualitative and subjective.
Goals were set without evaluation in mind	• Goals could not be measured. • Evaluation practices were not established.
Evaluation was not considered a priority	• Administrators were focused on implementing programs rather than evaluating their success.
Staff members lacked evaluation skills and training	• SCHIP staff members were trained program administrators, but generally lacked thorough understanding of evaluation concepts and practices. • SCHIP staffs were small, making it unlikely that additional evaluation staff members would be hired.

Source: HHS OIG, *State Children's Health Insurance Program: Assessment of State Evaluations Reports*, OEI-05-00-00240 (Washington, D.C.: Feb. 2001).

Of particular concern were limitations in measuring how well states are meeting the primary objective of the SCHIP program—reducing the

number of uninsured. As noted by the OIG, states—and other researchers—have been hampered by limited reliable state-level data regarding children's insurance status. When SCHIP was enacted, estimates of the number of low-income uninsured children were derived from the annual health insurance supplement to the Current Population Survey (CPS), the only nationwide source of information on uninsured children by state. CPS is based on a nationally representative sample and is considered adequate to produce national estimates.[25] However, CPS data have well-recognized shortcomings, particularly with regard to state-level estimates, which can be unreliable and exhibit volatility from year to year because of small samples of uninsured low-income children, particularly in states with smaller populations. For example, using the 1994 through 1996 CPS data, estimates of the number of uninsured children in Delaware ranged from 12,000 to 32,000. In part because of these data limitations, some states—including 3 of the states sampled by the OIG—moved to special surveys or studies that were conducted locally in an effort to develop more precise estimates of the number of uninsured children.

Despite efforts by states to better estimate the number of uninsured children, the OIG cited concerns regarding states' analyses. For example, the OIG reported that some states estimated reductions in the number of uninsured children by subtracting the number of SCHIP enrollees from their original baseline estimates. However, such an approach does not ensure that increases in SCHIP lead to reductions in the number of uninsured because increases in SCHIP enrollment can result from children moving from private insurance coverage to public insurance under SCHIP, an effect known as "crowd-out." Additionally, changing economic factors can further complicate assessments of a state's progress in reducing the number of uninsured children. For example, a state may significantly increase enrollment in SCHIP but—because of declines in the economy and increased unemployment—continue to see an increase in the number of uninsured. Under these circumstances, "progress" in reducing the number of uninsured may be more difficult to identify.

Based on its findings, the OIG recommended that HCFA identify a core set of evaluation measures that will enable all SCHIP states to provide useful

[25]CPS is a monthly survey of about 50,000 households. It is the primary source of information on the labor force characteristics of the U.S. population, and estimates obtained from CPS include employment, unemployment, earnings, and hours of work.

information.[26] It further recommended that HCFA and HRSA provide guidance and assistance to states in conducting useful evaluations of their programs. The OIG noted that SCHIP staffs would benefit from assistance and training regarding the type of data to collect and how to conduct evaluations. HCFA concurred with these recommendations and cited efforts under way to improve states' evaluations of their SCHIP programs.[27]

Subsequent OIG Reviews May Benefit from Efforts to Improve Data Sources

Several federal efforts are under way that should help improve states' data sources and their evaluations of the extent to which their SCHIP programs are reducing the number of uninsured children. If implemented on a timely basis, efforts such as the following should help inform the OIG's subsequent evaluations.

- The Congress appropriated $10 million each year beginning in fiscal year 2000 to increase the sample size of CPS. Beginning in 2001, larger sample sizes are being phased into CPS, which should help improve the accuracy of state-level CPS estimates of uninsured children.[28]
- CMS is working with states to develop consistent performance measures for SCHIP, with a focus on ensuring appropriate methodology and consistency of data.
- As a condition of their state SCHIP plans, some states are required to assess whether the SCHIP program is "crowding out" private health insurance in their states. These studies could help assess the extent to which SCHIP is drawing its enrollment from uninsured children—or from children who were previously insured.
- BBRA requires HHS to conduct an evaluation of SCHIP to determine the effectiveness of the program and to provide information to guide future federal and state policy. To comply with BBRA, HHS plans a series of reports addressing a variety of major topic areas, ranging from program design to access and utilization; the first report is expected in spring 2002. HHS plans to use multiple research strategies, including case studies, surveys, and focus groups, to address questions of interest.

[26]HHS OIG, *State Children's Health Insurance Program: Assessment of State Evaluation Reports*, OEI-05-00-00240 (Washington, D.C.: Feb. 2001).

[27]HRSA did not comment on the recommendations made by the OIG.

[28]Data from the expanded sample are expected to appear in all CPS-based reports beginning in 2002.

As the OIG continues to analyze states' progress in SCHIP, its future reviews are likely to benefit from improvements in state-level estimates of the number of uninsured children and evaluations of program implementation. Moreover, improvements in states' analyses and available data should help the OIG identify and address areas in need of additional review. However, to the extent that these improvements are not in place by the time the OIG undertakes its second analysis due in 2003, it may benefit from expanding its scope of work to identify and assess states with more rigorous analyses. The OIG may also wish to review other sources that have assisted states in making evaluation improvements. For example, while some states have received private grant funds to help with SCHIP enrollment, they have also received technical assistance for the purpose of conducting evaluations on the success of their enrollment strategies.[29] Other states have paired with universities or research organizations to improve their information on the uninsured. By also drawing on the experience of states with strong evaluations or data sources, the OIG will be better able to identify approaches that could further strengthen federal and states' approaches and inform the Congress on progress in implementing SCHIP.

Conclusions

Through its periodic evaluations of states' efforts to ensure appropriate SCHIP enrollment and to reduce the number of uninsured children, the OIG is in a position to provide objective information to the Congress and others about the program's operation and success. To better capture the experience of all states, regardless of the design of their SCHIP programs, the OIG should expand its scope beyond the 13 states in its first review to also include states that operate separate child health programs within SCHIP combination programs and consider including Medicaid expansion programs as well. This would provide a broader base for understanding how well states are screening for Medicaid eligibility and identifying issues related to reducing the number of uninsured children. Such an expansion of scope may also help identify states with more rigorous evaluations of their SCHIP programs, and thus provide information on effective approaches to SCHIP evaluation as well as more complete information for the Congress.

[29]For example, the Robert Wood Johnson Foundation funds initiatives that assist states and others to expand health insurance coverage. Among other things, the foundation has published an evaluation tool to guide policymakers throughout the evaluation process.

Recommendations to the HHS Inspector General

In order to better inform the Congress on states' efforts to implement SCHIP, we recommend that the HHS inspector general

- expand the scope of the statutorily required periodic reviews to include all states with separate child health programs, including those with combination programs, and
- consider using its general audit authority to explore whether issues of appropriate SCHIP enrollment also exist among states that have opted for Medicaid expansions under SCHIP, and should therefore be included in future OIG reviews.

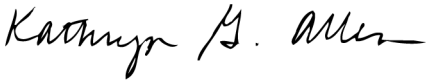
Agency Comments and Our Evaluation

We provided the inspector general of HHS an opportunity to comment on a draft of this report. In its comments, the OIG concurred with our recommendations, and agreed that expanding the scope of its inspections to include combination programs that include separate child health programs would give a greater breadth of information. It also agreed that including SCHIP Medicaid expansions would broaden the perspective and present more conclusive information regarding the status of states' SCHIP programs.

The OIG also provided general comments regarding its approach and possible approaches to designing future reviews. For example, the OIG stated that it would consider including differing state processes as a factor in its next sample design. The OIG also noted the importance of focusing on states' measurement of their own program performance. We agree with the OIG that properly conducted state evaluations serve a vital function and we believe that continued review of these efforts by the OIG is an important contribution to better understanding states' progress under SCHIP. In response to the OIG's oral and written comments, we revised the report to better clarify the scope of the BBRA mandate. The full text of the OIG's written comments is reprinted in appendix I.

We are sending copies of this report to the inspector general of the Department of Health and Human Services and other interested parties.

We will also make copies available to others on request. If you or your staffs have questions about this report, please contact me on (202) 512-7118 or Carolyn Yocom at (202) 512-4931. JoAnn Martinez-Shriver and Behn Miller also made contributions to this report.



Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

Appendix I: Comments from the Department of Health and Human Services' Office of Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 2 6 2002

Ms. Kathryn G. Allen
Director, Health Care - Medicaid and
Private Health Insurance Issues
United States General Accounting Office
Washington, D.C. 20548

Dear Ms. Allen:

Enclosed are the Office of Inspector General's comments on your draft report, "Children's Health Insurance: Inspector General Reviews Should be Expanded to Further Inform Congress," (GAO-02-512). The comments represent the tentative position of the Office of Inspector General and are subject to reevaluation when the final version of this report is received.

The Office of Inspector General appreciates the opportunity to comment on this exposure draft report before its publication.

Sincerely,

Janet Rehnquist
Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE U.S. GENERAL ACCOUNTING OFFICE'S DRAFT REPORT, "CHILDREN'S HEALTH INSURANCE: INSPECTOR GENERAL REVIEWS SHOULD BE EXPANDED TO FURTHER INFORM CONGRESS"

The Office of Inspector General (OIG) for Health and Human Services (HHS) appreciates the opportunity to review GAO's draft report *Children's Health Insurance: Inspector General Reviews Should Be Expanded To Further Inform Congress,* GAO-02-512. This report offers salient observations regarding two studies issued by the OIG in February 2001. The OIG reports, *State Children's Health Insurance Program - Ensuring Medicaid Eligibles are not Enrolled in SCHIP,* OEI-05-00-00241 and *State Children's Health Insurance Program - Assessment of State Evaluations Reports* OEI-05-00-00240 were produced to meet the mandate specified in the Balance Budget Refinement Act of 1999 (BBRA) for the OIG to prepare such reports and to offer States, the Center for Medicare and Medicaid, and Congress information regarding certain facets of the SCHIP program. We concur with GAO's recommendations.

General Comments

As pointed out by GAO, the sample for the 2001 reports was stratified by size. GAO has noted that other sampling methods could have been used and suggested that a more effective technique would have been to stratify the sample based upon administrative features used by the States, such as the separation of SCHIP and Medicaid staffs for making eligibility determinations. No sampling method guarantees unbiased results. We believe that our sampling method was appropriate. It is possible that the differences in enrollment processes between the various States could affect the results of this study but we cannot be certain of this. Nevertheless there may be merit in GAO's suggestion. When we select the sample for the 2003 studies, we will consider the State processes as a factor in the sample design.

The GAO suggested that we consider data sources other than those available from States in our future reviews. The OIG will bear in mind the suggestions made regarding our future measurement of the reliability and validity of States' evaluation efforts. However, we utilized the most complete and accurate data available at the time of our review. As GAO pointed out, it is unlikely that the Federal efforts to improve States' data sources will be completed and States may still be experiencing problems with the reliability and validity of the baseline data utilized as part of their evaluations.

While we will consider the other data sources available to measure State performance, the OIG maintains that it will remain important to continue focusing on what States are doing to measure their own program performance. We believe that future reports should evaluate what progress has been made by States related to establishing measurable goals and training staff so that they can perform the evaluation process. Properly conducted State evaluations serve a vital function. They not only inform the Secretary of Health and Human Services of the progress being made to meet the States' performance goals but they also serve as program management tools for the States.

GAO Recommendation

We recommend that the HHS Inspector General expand the scope of the statutorily required periodic reviews to include all States with separate child health programs, including those with combination programs.

Department Comment

We agree that expanding the scope of our inspections to include combination programs would give a greater breadth of information. The OIG is presently in the process of developing the FY 2003 Work Plan, and will consider expanding the scope of our work to include combination programs in our future work and data analysis.

GAO Recommendation

We recommend that the HHS Inspector General consider using its general audit authority to explore whether issues of appropriate SCHIP enrollment also exist among States that have opted for a Medicaid expansion under SCHIP, and should therefore be included in future OIG reviews.

Department Comment

As with the previous recommendation, the OIG agrees that the inclusion of such programs in our analysis would broaden our perspective and present more conclusive information regarding the status of SCHIP programs. Inclusion of these programs will be considered in our future work.

Related GAO Products

Medicaid and SCHIP: States' Enrollment and Payment Policies Can Affect Children's Access to Care. GAO-01-883. Washington, D.C.: Sept. 10, 2001.

Children's Health Insurance: SCHIP Enrollment and Expenditure Information. GAO-01-993R. Washington, D.C.: July 25, 2001.

Medicaid and SCHIP: Comparisons of Outreach, Enrollment Practices, and Benefits. GAO/HEHS-00-86. Washington, D.C.: April 14, 2000.

Children's Health Insurance Program: State Implementation Approaches are Evolving. GAO/HEHS-99-65. Washington, D.C.: May 14, 1999.

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