May 2, 2007

MEDICAID

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

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.