Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FRAUD AND ABUSE SAFEGUARDS IN SEPARATE STATE CHILDREN'S HEALTH INSURANCE PROGRAMS

Daniel R. Levinson
Inspector General

March 2007
OEI-06-04-00380

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

OBJECTIVES

1. To assess the extent to which six selected States with separate State Children's Health Insurance Programs (SCHIP) have established methods and procedures to meet Federal requirements regarding SCHIP fraud and abuse prevention, detection, and investigation; and

2. To assess these States' oversight of SCHIP contractors and Centers for Medicare & Medicaid Services' (CMS) oversight of States regarding SCHIP fraud and abuse prevention, detection, and investigation in the six selected States.

BACKGROUND

Federal and State governments jointly fund SCHIPs to provide health care assistance to low-income children who do not qualify for Medicaid. States may structure SCHIP as an expansion of Medicaid, as a program separate from Medicaid, or as some combination of these. Thirty-nine States have all or some part of their SCHIP separate from Medicaid. To protect the integrity of these separate SCHIPs, Federal regulations require States to establish safeguards against fraud and abuse. However, little is known about the arrangements these States have made to establish fraud and abuse safeguards.

To determine the extent to which States have met requirements to establish fraud and abuse safeguards, we examined documentation and interviewed staff from 6 States with separate SCHIPs and 17 health plans contracted by these selected States. Using this material, we also assessed State oversight of separate SCHIP contractors regarding fraud and abuse issues. Finally, we assessed CMS oversight by interviewing staff of CMS central and regional offices and by reviewing documentation regarding CMS's onsite compliance reviews of the selected SCHIPs and other oversight mechanisms.

FINDINGS

The six selected States met requirements for prevention and detection of fraud and abuse by assigning responsibility to SCHIP contractors that have established such procedures. Each of these States has assigned to SCHIP health plans or administrative contractors responsibility for establishing safeguards through which fraud and abuse might be prevented or detected, including safeguards associated with beneficiary eligibility and enrollment, provider enrollment, and detection of fraud and abuse. In each of the six States selected, these contractors have established safeguards that meet the Federal requirements in these areas.

One of the six States has not met Federal requirements for investigating suspected SCHIP fraud and abuse cases and referring cases to law enforcement. Five of the six States have established procedures to meet Federal investigation and referral requirements, and one State has not. In this State, SCHIP staff reported that the State has not identified a State law enforcement entity that will accept SCHIP-only fraud and abuse cases. State staff would not investigate such cases because they would not be prosecuted even if fraud were substantiated.

Although oversight mechanisms in the six States address Federal requirements, they do not always enable States to know how well health plans are performing safeguard activities. All six States in our review require SCHIP health plans to establish and submit written plans for the prevention, detection, and investigation of fraud and abuse; to attest to the accuracy of claims for payment; and to provide the State access to relevant SCHIP data. All of these States also have procedures to conduct audits of beneficiary eligibility processes and enrollment data. However, the current level of these States' oversight of SCHIP contractors does not always provide States with the means to know how well health plans are performing on some critical fraud and abuse matters, including provider enrollment, detection of fraud and abuse, investigation and referral to law enforcement, service delivery to beneficiaries, and execution of fraud and abuse plans. Further, it appears that dispersal of SCHIP oversight responsibilities within States and State staff perceptions about limited exposure to fraud and abuse may inhibit State oversight of SCHIP health plans regarding fraud and abuse safeguards.

CMS relies primarily on States for oversight of SCHIP fraud and abuse safeguards, although it has completed some onsite reviews of States. The SCHIP statute allows CMS discretion regarding Federal oversight of separate SCHIP fraud and abuse safeguards, neither prescribing nor prohibiting particular oversight activities. In interviews, CMS officials expressed that, rather than being prescriptive regarding oversight of fraud and abuse activities, SCHIP's statute and regulations focus on "programmatic oversight at the Federal level." According to CMS officials, SCHIP has limited exposure to fraud and abuse because Federal allotments are capped and managed care arrangements provide protections against fraud and abuse.

Despite its reliance on States for oversight, CMS has used its authority to conduct onsite reviews of separate SCHIP fraud and abuse safeguards. Since SCHIPs were established in 1997, CMS has conducted at least one onsite review that included some aspect of fraud and abuse safeguards for five of the six States we reviewed. However, these onsite reviews typically examined only a few fraud and abuse issues. Further, although CMS cited five of these States during these onsite reviews for having insufficient fraud and abuse safeguard procedures reviews, CMS staff reported requiring execution of a corrective action plan for only one of the five States. CMS used less formal follow-up methods, such as telephone conversations, in the other four States in which problems were noted.

RECOMMENDATIONS

To address the noncompliance by one State identified in this report, as well as other potential areas of improvement, CMS should:

- Ensure that the noncompliant State institutes procedures to meet Federal requirements for investigating cases of suspected SCHIP fraud and abuse and referring cases to law enforcement, and
- Take steps to strengthen Federal and State oversight of separate SCHIPs' fraud and abuse safeguards.

AGENCY COMMENTS

In its comments to the draft report, CMS stated that it does not dispute the findings in the report and suggested clarifying language to emphasize that the SCHIP statute is not prescriptive in describing Federal oversight of fraud and abuse. CMS also noted its recent efforts to assist States in strengthening fraud and abuse efforts.

OFFICE OF INSPECTOR GENERAL RESPONSE

We made changes to the final report to clarify that the SCHIP statute allows CMS discretion regarding its oversight of SCHIP fraud and abuse activities, neither prescribing nor prohibiting particular oversight activities.

TABLE OF CONTENTS

OBJECTIVES

1. To assess the extent to which six selected States with separate State Children's Health Insurance Programs (SCHIP) have established methods and procedures to meet Federal requirements regarding SCHIP fraud and abuse prevention, detection, and investigation; and

2. To assess these States' oversight of SCHIP contractors and Centers for Medicare & Medicaid Services' (CMS) oversight of States, regarding SCHIP fraud and abuse prevention, detection, and investigation in the six selected States.

BACKGROUND

The Balanced Budget Act of 1997 established SCHIP under Title XXI of the Social Security Act.[1] To implement SCHIP, Congress appropriated nearly $40 billion over 10 years to help States provide health care assistance to uninsured, low-income children whose family income is too high to qualify for Medicaid. The Federal and State governments jointly finance the program and States are provided a capped allotment of Federal funds each year. States administer their SCHIPs and CMS provides Federal oversight.

Title XXI allows States to design their SCHIPs using one of three program options: a Medicaid expansion program, a separate SCHIP program, or a combination of both. Medicaid expansion programs, which relax the financial rules of existing Medicaid eligibility categories, are subject to Federal and State Medicaid requirements. In contrast, Federal requirements that govern separate SCHIPs allow States more flexibility in eligibility criteria; cost sharing; and type, amount, and scope of services covered. In 39 States, all or some part of SCHIP is separate from Medicaid.

Federal Fraud and Abuse Safeguard Requirements

Federal regulations regarding fraud and abuse safeguards differ among the Medicaid program and separate SCHIPs. Medicaid expansion programs are subject to the program integrity rules and requirements specified under Title XIX.[2] Safeguards for Medicaid are more structured. They include Medicaid Eligibility Quality Control reviews of beneficiary enrollment processes;[3] tools for detecting fraud and abuse in provider billing, e.g., Medicare-Medicaid data match[4] and State Surveillance Utilization Review Subsystems;[5] Medicaid Fraud Control

Units to investigate and prosecute cases of suspected fraud and abuse;[6] External Quality Reviews of Medicaid managed care entities;[7] and the recently created Medicaid Integrity Program.[8]

By contrast, Federal regulations for separate SCHIPs allow States considerable flexibility in how they safeguard their programs against fraud and abuse. Separate SCHIPs are not required to have equivalent Medicaid structures. Rather, as a general Federal requirement, States "must establish procedures for ensuring program integrity and detecting fraudulent or abusive activity" in separate SCHIPs.[9] Further, Federal regulations contain a number of standards related to safeguarding SCHIPs from fraud and abuse, but these regulations typically do not specify the procedures States should use to meet the requirements. States are allowed, but not required, to establish a program integrity unit for monitoring and maintaining the integrity of separate SCHIPs.[10]

Federal regulations relevant to safeguarding against fraud and abuse in separate SCHIPs include provisions regarding criteria for beneficiary eligibility and enrollment in SCHIP,[11] rules regarding provider participation in SCHIP,[12] and requirements for States and their health plan contractors to have structures to detect potential fraud and abuse.[13] Federal regulations also address investigation of suspected SCHIP fraud and abuse cases and their referral to law enforcement.[14] Additionally, Federal regulations address program oversight, including States' oversight of SCHIP contractors[15] and CMS's oversight of States regarding SCHIP.[16]

Oversight of Separate SCHIPs

By Federal law and regulations, States and CMS share responsibility for oversight of SCHIP fraud and abuse prevention, detection, and investigation.

States must ensure that SCHIP health plans have arrangements or procedures designed to safeguard against fraud and abuse and to verify the accuracy of health plan claims for payment. In this report, the term "health plans" refers to a variety of entities that these six States have contracted with to provide health care services to SCHIP beneficiaries, including fee-for-service insurance plans and managed care plans. States must also safeguard against potential fraud and abuse by SCHIP health plans themselves.[17] Federal regulations also contain a number of provisions regarding State contracts with health plans.[18] Federal regulations provide States flexibility to design procedures for ensuring program integrity and detecting fraud and abuse that are based upon the needs of their unique SCHIP programs.[19] This flexibility allows States to use a variety of methods in establishing their procedures, including contractually assigning certain responsibilities to SCHIP health plans or other contractors.

Federal regulations provide CMS with three tools for oversight of SCHIPs' fraud and abuse prevention, detection, and investigation. First, Federal regulations specify that "CMS reviews State and local administration of the SCHIP plan through analysis of the State's policies and procedures, on-site reviews of selected aspects of agency operation, and examination of samples of individual case records."[20] Second, CMS receives from States annual SCHIP reports which contain prescribed program information that CMS can use for monitoring.[21] Third, the Payment Error Rate Measurement program, which became effective November 4, 2005, and was preceded by a series of CMS pilot projects, is designed to measure improper SCHIP payments.[22] In part to facilitate CMS's use of these tools for oversight of SCHIPs, Federal law requires States to collect, maintain, and furnish program information to enable CMS "to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans . . ."[23]

METHODOLOGY

Scope

To meet the study objectives, we examined fraud and abuse safeguards in 6 of the 39 States that have all or part of their SCHIPs separate from Medicaid.[24] Within these 6 States, we examined fraud and abuse safeguards established by 17 selected SCHIP health plans and other contractors. Although States may use many of the methods and procedures we examined to oversee additional issues related to program integrity, our review focused primarily on the prevention, detection, and investigation of suspected fraud and abuse cases. We also assessed these States' oversight of SCHIP contractors and CMS's oversight of the six selected SCHIPs regarding fraud and abuse.

Selection of States

We purposively selected six States with separate SCHIPs. Factors considered for State selection included diversity in program design (fully separate from Medicaid or a combination of separate and Medicaid expansion programs), number of program enrollees, primary type of service delivery (managed care or fee-for-service), geographic location, and States' locations within CMS regions. The six selected States are Iowa, Massachusetts, Michigan, New York, Pennsylvania, and Texas. Within each of these States, we selected the 3 health plans with the largest SCHIP enrollment (except Iowa, which contracts with only 2 health plans), for a total of 17 health plans. The selected States accounted for 31 percent of national enrollment in separate SCHIPs as of December 2004.[25] Appendix A contains a detailed description of the six States and additional information about our study methodology.

Data Collection and Analysis

From each selected State and selected health plan, we requested documents demonstrating their methods and procedures for safeguarding the separate SCHIPs against fraud and abuse. We also inquired about States' use of SCHIP contractors to prevent, detect, and investigate fraud and abuse, including States' oversight of contractors, and safeguards against fraud and abuse by health plans themselves. From CMS, we requested copies of reports for compliance reviews it had conducted of these six States since the inception of SCHIP, associated review protocols, and State annual reports.

We received initial responses and documentation from the 6 States and 17 health plans from May to July 2005. We also received documentation after interviews and other follow-up activities from July to January 2006. Most data collection from CMS occurred in August and September 2005.

We interviewed staff from the six States, from selected health plans, from the CMS central office, and from each CMS regional office responsible for oversight of these States. We conducted these telephone interviews to clarify any questions about previously submitted documents, to request additional documents when needed, and to discuss the experiences and perceptions of staff regarding fraud and abuse in separate SCHIPs. We also discussed preliminary findings and an early draft of the report with CMS SCHIP officials during a meeting in July 2006.

We reviewed documents and other information provided by respondents to determine what safeguards and oversight mechanisms had been established. For purposes of this report, the term "established" means that we obtained documentation that, in our best judgment, demonstrated that the mechanism was in place and available for use.

Based on our review of documentation and interviews of key personnel, we completed the following analyses:

- To assess State compliance with Federal requirements to establish separate SCHIP fraud and abuse safeguards, we determined what safeguards the six States and their SCHIP contractors had established and assessed whether these safeguards met applicable Federal requirements.
- To assess States' oversight of separate SCHIP contractors regarding fraud and abuse safeguards, we determined what methods and procedures States had established for oversight, whether State procedures met Federal requirements for State oversight, and whether potential program vulnerabilities existed.
- To assess CMS oversight of States' separate SCHIPs, we determined how frequently and to what extent CMS compliance reviews and other CMS oversight mechanisms addressed fraud and abuse issues.

Limitations

Because the 6 States and 17 SCHIP health plans were purposively selected for review, findings and conclusions cannot be generalized beyond these entities. Additionally, because measuring outcomes of established procedures was beyond of the scope of the study, the report does not draw conclusions regarding the effectiveness of these separate SCHIPs' fraud and abuse safeguards. Finally, although we made every effort to obtain all relevant information and documentation for our analysis, it is possible that States have established additional procedures for which they did not provide documentation.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

The six selected States met requirements for prevention and detection of fraud and abuse by assigning responsibility to SCHIP contractors that have established such procedures

Each of these States has met Federal requirements for preventing and detecting fraud and abuse in separate SCHIPs, largely by assigning responsibility for establishing most fraud and abuse safeguards to SCHIP health plans or administrative contractors. Federal requirements governing program activities through which fraud and abuse might be prevented and detected include beneficiary eligibility and enrollment, provider enrollment, and detection of fraud and abuse. State contractors have established safeguards that met the Federal requirements in these areas.

Entities responsible for eligibility determinations have established procedures to obtain required applicant information

Federal regulations require an SCHIP eligibility determination based on criteria such as financial need, eligibility for Medicaid (which takes precedence over SCHIP), and the existence of other health coverage.[26] The six States have assigned responsibility for SCHIP enrollment activities to administrative contractors (three), health plans (two), and State staff (one). Regulations also require eligibility redetermination at least every 12 months.[27] Each entity responsible for determining SCHIP eligibility in these States has established procedures that meet State and Federal requirements. The responsible entities use self-reported information from a standardized application (a combined Medicaid/SCHIP application in five of these States)[28] plus any supporting documentation required by the State to meet eligibility requirements. Entities in five of the States have procedures to redetermine beneficiary eligibility every 12 months, and in the sixth State, every 6 months.

Health plans in our review have established procedures to verify that network providers meet criteria for participating in SCHIP

All six States rely on the SCHIP health plans to determine whether providers in their networks meet standards for SCHIP participation.[29] Federal regulations provide a number of criteria that physicians and other providers must meet to participate in SCHIP and prohibit States from making payments to providers who have been excluded from participating in the Medicare and Medicaid programs.[30] To meet these requirements, the SCHIP health plans we reviewed have established a variety of procedures, most commonly a formal enrollment process through which they verify State licensure and check for certain criminal convictions[31] and exclusions (see Table 1). The 17 health plans that we reviewed reenroll providers in their networks every 2 years (3 health plans) or every 3 years (14 health plans).

Table 1. Provider Enrollment Activities of SCHIP Heath Plans We Reviewed

Procedure To Check:	Health Plans With Procedure
State Licensure Boards	17
State Adverse Action Lists	17
OIG Exclusions	17
National Practitioner Data Bank	15
Certain Criminal Convictions	14
Provider Address [Onsite]	12
Healthcare Integrity Practitioner Data Bank	10

Source: OIG analysis of documentation from 17 SCHIP health plans in 6 States, 2006.

Health plans have a variety of techniques, data analysis tools, and informational tips to satisfy requirements for fraud and abuse detection

The 6 States pay these 17 health plans on a capitated basis, i.e., a predetermined amount for each SCHIP beneficiary. These health plans, in turn, pay health care providers for SCHIP services. Although Federal regulations require States to have methods and criteria for identifying suspected fraud and abuse cases, the regulations do not specify the procedures States should establish.[32] Five of the six States largely leave it to their health plans to determine the procedures to establish for detection of fraud and abuse. One State was a notable exception because its contract specifies a number of activities that SCHIP health plans should establish to ensure that provider payments are appropriate and to detect potential fraud and abuse.

The health plans that we reviewed have established a core set of techniques for detecting fraud and abuse (see Table 2). Not all of these health plans have established all detection procedures, but most have multiple procedures, and a few other procedures were reported to be under development during our study.

Table 2: Fraud and Abuse Detection Procedures and Safeguards of SCHIP Heath Plans We Reviewed (N = 17)

Procedure or Safeguard	Health Plans With Procedure	Health Plans Developing Procedure
Targeted Claims Reviews	17	0
Telephone Hotline	16	0
Provider Verification of Beneficiary Eligibility	15	1
Automated Prepayment Edits	15	0
Utilization Review Staff	13	1
Random Sampling	13	0
Aberrant Billing Detection	11	3
Error Rate Measurement	11	1
Fraud Reporting Information on Internet	10	0

Source: OIG analysis of documentation from 17 SCHIP health plans in 6 States, 2006

Although all SCHIP health plans we reviewed appear to have a variety of data analysis tools that can be used for detecting fraud and abuse, 5 of the 17 health plans had software systems specifically designed for fraud detection. Health plan staff explained that these fraud detection software systems often use automated processes to analyze several years' worth of billing data and to identify the areas of greatest vulnerabilities.

One of the six States has not met Federal requirements for investigating suspected SCHIP fraud and abuse cases and referring cases to law enforcement

When cases of suspected fraud and abuse are detected, Federal regulations require States to conduct a preliminary investigation or take other action to determine whether a full investigation is warranted.[33] For cases that warrant more than preliminary investigation, Federal regulations require States to establish procedures for conducting full investigations, including referral of cases to the appropriate law enforcement agencies if necessary.[34]

Five of the six States have established procedures to meet Federal investigation and referral requirements and one State has not.[35] In the State that is not in compliance with Federal requirements, SCHIP staff reported that the State has not identified a State law enforcement entity that will prosecute SCHIP-only fraud and abuse cases. SCHIP staff in this State explained that, although there is a State unit designated for investigating and referring SCHIP fraud and abuse cases, this unit would not investigate cases involving only SCHIPs because of the lack of a State entity to prosecute if fraud were substantiated. Both State SCHIP staff and CMS regional office staff were aware of this situation and the State's noncompliance with Federal regulations.

SCHIP health plans typically task designated staff to conduct preliminary investigations, including identifying and developing suspicious cases

All six States assign responsibility for conducting preliminary investigations to the separate SCHIP health plans and require health plans to have written policies and procedures for detecting and investigating fraud and abuse. Beyond the basic requirement to investigate suspicious cases, additional requirements among these States included that health plans designate specific staff to investigate fraud and abuse cases (four States), periodically report their investigation activities to SCHIP agencies (four States), and train staff regarding fraud and abuse (two States).

Staff from health plans we reviewed reported that most fraud and abuse investigation leads come from tips from employees, such as utilization review staff, and tips from telephone hotlines. To investigate these leads, 14 of the 17 health plans we reviewed assign preliminary investigations to a special fraud unit or other designated health plan personnel. Investigation procedures for these staffs typically involved a general review of the case facts and analysis of relevant claims and services. Of the three remaining health plans, two subcontract for investigation services and one was in the process of obtaining these services from a subcontractor at the time of our study.[36]

Staff assigned to other State agencies or departments are usually responsible for full investigations of suspected SCHIP fraud and abuse

Staff in five of the six States clearly identified State agencies or departments responsible for handling full investigations.[37] However, as previously mentioned, the responsible entity in one of these five States does not investigate SCHIP-only cases. The sixth State listed entities to which fraud and abuse reports are to be made but did not specify which State entity is responsible for investigating cases.

In three of the States, a Memorandum of Understanding (MOU) or an Interagency Agreement governs the relationship between SCHIPs and entities responsible for conducting investigations. These MOUs and agreements typically specify responsibilities regarding investigations, referrals to law enforcement, prosecution, and reporting between parties. Three States do not have MOUs or agreements to govern the relationship between the separate SCHIPs and the entity responsible for conducting investigations. State staff in two of these States report relying on health plans to conduct both preliminary and full investigations for some cases of suspected fraud and abuse and to work with local law enforcement.

Although oversight mechanisms in the six States address Federal requirements, they do not always enable States to know how well health plans are performing safeguard activities

As mentioned, the six States have assigned many responsibilities for prevention, detection, and investigation of fraud and abuse to SCHIP health plans and other contractors. In these States, oversight mechanisms do not always allow these States to know the extent to which SCHIP health plans are performing safeguard activities. Further, State staff responsible for investigating fraud and abuse in the six States report receiving few, if any, referrals of such cases from their health plans. This is a possible indication that safeguard responsibilities assigned to health plans are not carried out as well as they need to be. For example, one State reported having investigated 13 cases of suspected fraud and abuse by separate SCHIP providers from 2001 to mid-2005, none of which had been referred to State investigators by separate SCHIP health plans.

The most common State oversight mechanisms address areas specifically required by Federal regulations

All six States have established mechanisms for conducting oversight of SCHIP health plans and contractors (see Table 3). To ensure that SCHIP health plans have administrative and management arrangements or procedures that meet Federal requirements, all of these States contractually require their SCHIP health plans to have written fraud and abuse plans.[38] All six States also include in their contracts federally mandated requirements that SCHIP health plans attest to the accuracy of payment or claims data and provide Government officials with access to these data.[39]

Table 3: Common Oversight Mechanisms Established by Six States	
State Oversight Method	**States With Method**
Health Plans Required To Have Written Fraud and Abuse Plans	6 [40]
Contracts Require Claims Accuracy Attestation and Access to Data	6
Monitoring of Summary Data Supplied by Health Plans	6
State Hotlines for Complaints and Fraud Tips	5
Periodic Audits of SCHIP Beneficiary Eligibility and Enrollment*	5
Required Reporting of Health Plan Investigation Activities	4 [41]
Verification of Provider Address [Onsite]	6
* One State does not assign beneficiary enrollment to contractors. Another State reported it had not completed these audits for two of the three health plans we reviewed.	

Source: OIG analysis of documentation from 6 States, 2006.

To meet Federal requirements that States have methods to identify, report, and verify the accuracy of claims for beneficiaries enrolled in a separate SCHIP, the five States that assign beneficiary enrollment to health plans or administrative contractors have procedures to periodically conduct audits to verify appropriate enrollment.[42] The one State that enrolls beneficiaries itself has procedures to routinely compare health plan enrollment data with its own records to identify any discrepancies. Because SCHIP health plans are typically paid by the six States based on the number of beneficiaries enrolled in the plans, these beneficiary enrollment audits also serve as one of the primary oversight mechanisms these States have established to meet the Federal requirement to safeguard against fraud or abuse by health plans themselves.

Current oversight does not always allow States to know how well SCHIP health plans are performing safeguard activities in some critical program areas

Our assessment of the primary oversight approaches these six States use for the critical areas of fraud and abuse safeguard activities with health plans identified the following concerns.

One State had not conducted all beneficiary eligibility audits. Although this is generally one of the stronger areas for State oversight in these six States, one State reported that, despite having procedures in place for periodic beneficiary eligibility audits, it has never conducted such an audit for two of its three SCHIP health plans included in our study. This State relies on its health plans to enroll SCHIP beneficiaries. Considering that these audits are a primary oversight mechanism reported by this State to verify appropriate enrollment and accuracy of payments to its health plans, failure to conduct beneficiary enrollment audits leaves this State vulnerable to fraud and abuse.

States have few methods to verify provider enrollment procedures performed by health plans. Although all six States rely on health plans to ensure that providers enrolled in SCHIP meet participation rules, State oversight mechanisms typically do not involve States' verifying health plan performance in this area. Two States had established protocols for verifying health plan provider enrollment processes, but one had used its procedures only for health plans that also participated in the Medicaid program at the time of our study. Other common oversight mechanisms established by these States include relying on health plan accreditation by national organizations and sharing information with other States about adverse actions taken against providers.

States have few mechanisms for oversight of health plans' procedures for detection of fraud and abuse in improper billing by providers. Although the six States rely heavily on SCHIP health plans to detect potential fraud and abuse by providers, these States have generally not established oversight mechanisms to monitor this aspect of health plan performance. State SCHIP staff in these States often expressed their perceptions that potential fraud and abuse by providers is more the concern of health plans than of the State. However, States also reported that SCHIP health plans have referred very few cases of suspected fraud and abuse by providers, suggesting that greater oversight is needed.

States rely on self-reported information for oversight of health plan investigations and referral activities. The six States rely to varying degrees on SCHIP health plans to investigate and refer cases of suspected fraud and abuse. The primary oversight mechanism established by five of the States is to require health plans to periodically report their investigation and referral activities, including such items as the number and types of cases and referrals, amounts of overpayments and recoveries, and other penalties.

Reliance on self-reported information does not allow States to know whether, or how well, health plan staff are investigating cases of suspected fraud and abuse.

States commonly use self-reported, aggregated data for monitoring health plan services. The most common oversight mechanism for monitoring SCHIP health plan service delivery, established by the six States, relies on aggregated data self-reported by health plans. These data vary across the States and include information about beneficiary complaints, utilization of services, and/or beneficiary health data. Although four States report requiring or receiving actual encounter data from SCHIP health plans, only one State had established procedures for using such data to monitor the services provided by health plans. Additionally, one State sends an explanation-of-benefits notice to a random sample of beneficiaries. Although these oversight mechanisms allow these States to monitor some aspects of SCHIP health plan service delivery, few include means to verify service delivery.

States have not implemented onsite reviews of the health plan fraud and abuse plans. As previously mentioned, all six States require separate SCHIP health plans to have written policies and procedures for preventing, detecting, and investigating fraud and abuse.[43] Four of the six States had not adopted onsite reviews regarding fraud and abuse safeguards for their separate SCHIPs. Two States reported developing protocols for onsite reviews of health plans to verify implementation of their fraud and abuse plans. However, none of these States had formally conducted such a review at the time of our study.[44]

State oversight regarding fraud and abuse safeguards may be inhibited by dispersal of SCHIP oversight responsibilities within States and certain perceptions expressed by State staff

Placement of State oversight functions with several agencies seems to create confusion and possible gaps. In all six States, responsibility for oversight of separate SCHIP fraud and abuse safeguards is dispersed among several agencies. Across the six States, the SCHIP agencies are most commonly responsible for oversight of beneficiary eligibility and enrollment, whereas oversight of provider enrollment, detection of fraud and abuse, and investigation and referrals are often the responsibility of other State entities. Consequently, no single unit within each of the six States had complete information about State oversight of SCHIP contractors.

Coordination and communication among agencies that share SCHIP oversight responsibilities in these States also appeared problematic. To the extent that these problems are persistent or typical, successful oversight will likely be affected. Coordination difficulties in one State resulted in the submission of separate responses to our data collection request from two different agencies, which sometimes provided conflicting answers. Within two other States, different agencies pointed to each other as the responsible entity for ensuring contractor compliance with a particular Federal SCHIP requirement, suggesting that neither group was conducting oversight. Indeed, in one of these States, SCHIP staff were unaware that a contract compliance review of their largest SCHIP health plan had never been conducted.

State staff indicate that their SCHIP has limited exposure to fraud and abuse. State staff commonly expressed the belief that the capitated nature of contracts with SCHIP health plans protects States from exposure to fraud and abuse in provider billing, placing the risk instead on health plans. Although capitated contracts may insulate States from the costs of improper billing by providers during the current contract period, health plans may increase capitated rates under subsequent SCHIP contracts to account for any losses due to fraud and abuse.

State staff indicate that oversight of Medicaid health plans benefits the separate SCHIP. Some SCHIP staff in these States noted that the separate SCHIPs likely benefited from the more stringent standards and oversight in the Medicaid program regarding fraud and abuse. For example, States subject all Medicaid health plans to an annual External Quality Review, including those health plans that participate in both the Medicaid program and separate SCHIPs. However, Medicaid oversight would seem to have minimal effect on separate SCHIP health plans that do not also participate in Medicaid, which was true for 4 of the 17 SCHIP health plans we examined. Further, potential benefits for SCHIPs from Medicaid oversight of health plans that participate in both programs would be dependent upon the extent and quality of the Medicaid oversight itself.

CMS relies primarily on States for oversight of SCHIP fraud and abuse safeguards, although it has completed some onsite reviews of States

The SCHIP statute allows CMS discretion regarding Federal oversight of separate SCHIP fraud and abuse safeguards, neither prescribing nor prohibiting particular oversight activities. In interviews, CMS officials expressed that, rather than being prescriptive regarding oversight of fraud and abuse activities, the SCHIP's statute and regulations focus on "programmatic oversight at the Federal level." According to CMS officials, SCHIP has limited exposure to fraud and abuse because Federal allotments are capped and managed care arrangements provide protections against fraud and abuse. Therefore, CMS officials report that CMS relies primarily on States for oversight of separate SCHIP fraud and safeguards.

Despite CMS's reliance on States for oversight, it has conducted onsite reviews for monitoring separate SCHIP fraud and abuse safeguards. In 2002, CMS produced and distributed to its regional offices guidance for conducting these onsite reviews. In this document, we identified 14 topics related to fraud and abuse that could be reviewed during onsite reviews of SCHIPs.[45]

From 1997, when SCHIP started, to August 2005, CMS conducted a total of 11 onsite reviews of 5 of our 6 States that examined at least 1 fraud and abuse-related topic. Ten of the eleven CMS onsite reviews of these States examined four or fewer issues related to SCHIP fraud and abuse, most often those involving beneficiary eligibility and enrollment processes.

CMS does not always require that corrective action plans be developed to address problems noted during onsite SCHIP reviews. CMS cited four of the five reviewed States for having insufficient procedures in at least one of the fraud and abuse-related issues. For three of these States, CMS staff reported using informal means, such as telephone conversations or e-mails, to follow up on concerns raised by the reviews. CMS staff reported requiring the one remaining State to execute a corrective action plan to address the issues with 10 fraud and abuse-related Federal regulations with which CMS found the State to be noncompliant. Although CMS's onsite review occurred in 2003, our study found that as of 2005 this State remained noncompliant with Federal requirements for full investigation and referral of suspected SCHIP fraud and abuse cases. State SCHIP staff provided documents indicating that, although its corrective action plan did address many issues of noncompliance cited by CMS, it did not fully address the investigation and referral issue.

CMS has not always followed up on the problems in subsequent reviews. For the four States with more than one onsite review, the CMS reviewers typically did not reevaluate problems identified in prior reviews, even when prior review reports did not indicate that States had corrected the problems. CMS staff responsible for determining the onsite review topics reported that they typically base decisions about onsite review topics on their familiarity with State programs, discussions with State staff, CMS initiatives, and annual report data, but not necessarily on reevaluating past problems.

With one exception, the six States we reviewed comply with Federal requirements regarding the establishment of fraud and abuse prevention, detection, and investigation safeguards in their separate SCHIPs. One of the six States does not meet Federal requirements for investigating cases of suspected fraud and abuse and referring cases to law enforcement.

These States rely extensively on their SCHIP contractors to prevent, detect, and investigate fraud and abuse. However, the current level of State oversight of SCHIP contractors does not always provide States with the means to know how well contractors are performing on some critical fraud and abuse matters, including provider enrollment, detection of fraud and abuse, investigation and referral to law enforcement, service delivery to beneficiaries, and execution of contractor fraud and abuse plans. It appears that a number of factors may inhibit State oversight of SCHIP contractors regarding fraud and abuse safeguards.

CMS reports that it relies primarily on States for oversight of SCHIP fraud and abuse safeguards. CMS has conducted onsite compliance reviews of separate SCHIPs in five of the six States we reviewed. However, CMS's reviews typically examined only a few of the areas we identified in CMS guidance documents as related to fraud and abuse safeguards. Additionally, CMS has not typically required States to develop formal corrective action plans in response to problems noted in its reviews.

To address the one instance of noncompliance found in this report, as well as other potential areas of improvement, CMS should:

Ensure That the Noncompliant State Institutes Procedures To Meet Federal Requirements for Investigating Cases of Suspected SCHIP Fraud and Abuse and Referring Cases to Law Enforcement

Staff in one State reported that it has not identified a law enforcement entity that will accept fraud cases involving only SCHIP. Therefore, that State's designated investigation unit does not investigate such cases or refer them to law enforcement, as required. CMS should work with State officials to bring the State into compliance with Federal regulations on this issue. Options may include additional efforts to identify a State law enforcement entity to accept SCHIP fraud cases or development of procedures for the State to refer cases to Federal law enforcement entities, such as OIG or the Department of Justice, when necessary. Although this issue of noncompliance affected only one of the six States, CMS should determine whether all States with separate SCHIPs have appropriate investigation and referral procedures.

Take Steps To Strengthen Federal and State Oversight of Separate SCHIPs' Fraud and Abuse Safeguards

CMS relies heavily on States for oversight of fraud and abuse safeguards for separate SCHIPs. In turn, these six States rely on SCHIP contractors to prevent, detect, and investigate potential fraud and abuse. However, our findings indicate that the current Federal and State oversight approaches have vulnerabilities.

Options CMS should consider to strengthen its oversight of separate SCHIPs include:

- Establishing a specific frequency for onsite reviews and a basic set of required review elements to ensure that SCHIP fraud and abuse safeguards are routinely examined;
- Requiring States to submit corrective action plans in response to problems noted during reviews that involve noncompliance with Federal regulations or other serious fraud and abuse-related vulnerabilities to better support problem resolution; and
- Requiring States to submit, in their annual SCHIP reports, data about separate SCHIP fraud and abuse activities, e.g., the number of cases investigated and/or referred.

Options CMS should consider to strengthen States' oversight of SCHIP contractors include:

- Providing training and written guidance to States on fraud and abuse oversight, including identifying what a full State oversight effort might encompass;
- Providing technical assistance to States on how to implement more direct methods for assessing contractor performance; and
- Facilitating forums for sharing information among States, including sharing practices that States find effective.

AGENCY COMMENTS

In its comments to the draft report, CMS stated that it does not dispute the findings in the report. However, CMS suggested clarifying language to emphasize that the SCHIP statute is not prescriptive in describing Federal oversight of fraud and abuse. CMS expressed that the SCHIP "statute and regulations focus on programmatic oversight at the Federal level." CMS also noted its recent efforts completed or underway to assist States in strengthening fraud and abuse efforts. The efforts described are consistent with our second recommendation. In its comments, CMS did not specifically respond to our first recommendation.

OFFICE OF INSPECTOR GENERAL RESPONSE

We made changes to the final report to clarify that the SCHIP statute allows CMS discretion regarding its oversight of SCHIP fraud and abuse activities, neither prescribing nor prohibiting particular oversight activities. We also included the full text of CMS comments in Appendix B, which includes CMS's descriptions of its recent efforts to assist States in strengthening fraud and abuse efforts.

ENDNOTES

[1] 42 U.S.C. §§ 1397aa–1397jj; Social Security Act, §§ 2101–2110; Pub. Law. No. 105-33, Subtitle J.

[2] 42 CFR § 457.900(c).

[3] 42 CFR § 431.800.

[4] 42 U.S.C. § 1395ddd(g); Social Security Act, § 1893(g); Pub. Law No. 109-171, Title VI, Subtitle A, Ch. 3 § 6034(d)(1).

[5] 42 CFR § 456.3.

[6] 42 CFR § 1007.11.

[7] 42 CFR § 438.310.

[8] 42 U.S.C. § 1396u-6; Social Security Act, § 1936; Pub. Law No. 109-171, Title VI, Subtitle A, Ch. 3 § 6034(a)(2).

[9] 42 CFR § 457.915(a).

[10] 42 CFR § 457.915(b).

[11] 42 CFR §§ 457.350(a)(1) and (2); 42 CFR 457.310; 42 CFR 457.320.

[12] 42 CFR § 457.935.

[13] 42 CFR § 457.915(a)(1); 42 CFR § 457.955(a).

[14] 42 CFR § 457.915(c); 42 CFR § 457.925; 42 CFR 457.930.

[15] 42 CFR § 457.353; 42 CFR § 457.950; 42 CFR § 457.955; 42 CFR § 457.980.

[16] 42 CFR § 457.200; 42 CFR § 457.720; 42 CFR § 457.750(a) and (b).

[17] 42 CFR § 457.955; 42 CFR § 457.915; 42 CFR § 457.980.

[18] 42 CFR § 457.950; 42 CFR § 457.955.

[19] 42 CFR § 457.915.

[20] 42 CFR § 457.200(a).

[21] 42 CFR § 457.750.

[22] 42 CFR § 431.970; 42 CFR § 457.720

[23] 42 U.S.C. § 1397gg(b)(1); Social Security Act, § 2107(b)(1).

[24] Based on the most recent information from the CMS Web site, 39 States have either fully separate SCHIPs or combination SCHIP/Medicaid programs. CMS, "State Children's Health Insurance Program Plan Activity as of August 9, 2005." Available online at http://www.cms.hhs.gov/LowCostHealthInsFamChild/downloads/SCHIPStatePlanActivityMap.zip. Accessed April 13, 2006.

[25] Based on OIG's analysis of health plan enrollment information obtained from States and SCHIP enrollment data from the 2004 annual SCHIP report.

[26] 42 CFR §§ 457.350(a)(1) and (2); 42 CFR § 457.310; 42 CFR § 457.320.

[27] 42 CFR § 457.320(e)(2).

[28] The sixth State does not use a combined application, but has established procedures for periodic data matches between SCHIP and Medicaid enrollment files. Two other States also established procedures for SCHIP/Medicaid matches, in addition to their procedures for combined applications.

[29] Additionally, State staff in one of the six States are responsible for screening providers participating in the Primary Care Case Management portion of the SCHIP. Procedures established for this staff are similar to those of the selected SCHIP health plans discussed in this section.

[30] 42 CFR §§ 457.935(a) and (b).

[31] Health plans we reviewed used a variety of methods to check for criminal convictions, such as checks of various databases that contain criminal conviction data, reliance on State licensure boards that check for criminal convictions, and/or law enforcement checks for criminal convictions.

[32] 42 CFR § 457.915(a)(1).

[33] 42 CFR § 457.925.

[34] 42 CFR § 457.930.

[35] At the time of our review, one of these five States had recently drafted procedures for investigating cases of potential fraud and abuse by beneficiaries, and investigative staff reported that they had not yet investigated such a case. By contrast, procedures for investigating cases of potential fraud and abuse by providers appeared to have been long in place, and staff reported conducting several investigations in recent years.

[36] This health plan had not yet finalized the contract for these services. Staff from this small SCHIP health plan reported that, in the meantime, staff were “doing the best we can” to investigate cases.

[37] These entities include law enforcement agencies (attorneys general, inspectors general), Medicaid Fraud Control Units, and investigative branches of the State insurance and health agencies.

[38] 42 CFR § 457.955; according to minimum Federal requirements, these arrangements must: (1) enforce compliance with all applicable Federal and State standards, (2) prohibit unsolicited personal contact with potential enrollees, and (3) include a mechanism for reporting information on known violations of law to appropriate Government officials. In one State, fraud and abuse plans became required of separate SCHIP health plans with fewer than 60,000 beneficiaries during our study period in January 2006. Previously, this was a State requirement only for separate SCHIP health plans with 60,000 beneficiaries or more.

[39] 42 CFR § 457.950.

[40] One State had recently begun to require development and submission of fraud and abuse plans by separate SCHIP health plans with fewer than 60,000 beneficiaries effective in January 2006 during our study period.

[41] One State had recently begun to require reporting investigation activities by separate SCHIP health plans with fewer than 60,000 beneficiaries effective in January 2006 during our study period.

[42] 42 CFR § 457.980.

[43] One State had recently begun to require development and submission of fraud and abuse plans by separate SCHIP health plans with fewer than 60,000 beneficiaries effective in January 2006 during our study period.

[44] One State reported that it had conducted an onsite review of Medicaid fraud and abuse plan implementation at two health plans we reviewed in our selection of States. These two health plans had participated in both the State Medicaid program and the separate SCHIP program.

[45] CMS, “Title XXI, State Children’s Health Insurance Program Regional Office Monitoring Handbook,” 2002. The handbook uses the term “program integrity” to refer to the issues we examined and groups them into five areas: beneficiary eligibility, provider enrollment, claims validity, use of managed care entities, and case referral and investigation. Each of these areas has subissues, for a total of the following 14 potential issues:

General: Ensuring State Processes for Detecting Program Fraud and Abuse

1. Procedures for detecting fraudulent or abusive activity
2. Assignment of program integrity responsibilities to staff

Beneficiary Eligibility: Ensuring the Integrity of the Eligibility Determination Process

3. Eligibility standards
4. Procedures for screening applicant children
5. Policies for verifying eligibility
6. Procedures for discouraging substitution of SCHIP for private coverage
7. Requirements for reporting changes in circumstance that affect eligibility
8. Policies for redetermining eligibility

Provider Enrollment: Ensuring the Legitimacy of Healthcare Providers [Practitioners]

9. Procedures to ensure that providers excluded from Medicare/Medicaid program participation do not receive payment
10. Application of Title XIX [Medicaid] provider enrollment provisions

Program Claims: Ensuring the Accuracy of Claims

11. Systems to identify, report, and verify the accuracy of claims

Case Referral and Investigation: State Management of Suspected Cases of Fraud and Abuse

12. Procedures for conducting preliminary case investigations
13. Procedures for referring cases to State program integrity staff
14. Procedures for State program integrity staff for conducting a full investigation or referring suspected cases to law enforcement

APPENDIX A

Expanded Methodology

Scope. Thirty-nine States had some part of their State Children's Health Insurance Program (SCHIP) separate from Medicaid as of January 2005. We examined fraud and abuse safeguards in 6 of these 39 States. While many of the methods and procedures examined may be used by States for additional types of program integrity activities, our review focused primarily on the prevention, detection, and investigation of suspected fraud and abuse. Within each State, we examined safeguards established by States and by their SCHIP health plans and other contractors. We also assessed States' oversight of these contractors, and Centers for Medicare & Medicaid Services' (CMS) oversight of the six SCHIPs.

Selection of States. We purposively selected 6 of the 39 States with separate SCHIPs. Factors considered for State selection included diversity in program design (fully separate from Medicaid or combination programs), number of program enrollees, primary type of service delivery (managed care or fee-for-service), geographic location, and States' locations within CMS regions. To prepare for the possibility of nonresponse, we selected a seventh State. Subsequently, one State could not provide all requested information and was eliminated, leaving six selected States.

The six selected States are Iowa, Massachusetts, Michigan, New York, Pennsylvania, and Texas (see Table A1).

Within each of the six States, we selected the 3 health plans with the largest separate SCHIP enrollment (except Iowa, which contracts with only 2 SCHIP health plans), for a total of 17 health plans. Size of reviewed health plans ranged from 622 to 85,229 SCHIP beneficiaries at the time of our study.

Table A1. Provider Enrollment Activities of SCHIP Heath Plans We Reviewed			
Selected States	Program Type[1]	Separate SCHIP Enrollment[1]	Total FY 2005 Federal SCHIP Funds (millions)[2]
Iowa	Combined	18,873	$ 28
Massachusetts	Combined	21,382	$ 59
Michigan	Separate	37,350	$ 111
New York	Combined	332,464	$ 270
Pennsylvania	Separate	127,259	$ 131
Texas	Separate	335,751	$ 450
Totals		**873,079**	**$ 1,049**
Percentage of national separate SCHIP enrollment			31%
Percentage of Federal SCHIP funds in the six States			26%

[1] As of Fiscal Year 2005 (first quarter), http://www.cms.hhs.gov.

[2] CMS Web site http://www.cms.hhs.gov/schip/about-SCHIP.asp, accessed 10/5/2005.

Source: OIG analysis of documentation from 17 SCHIP health plans in 6 States, 2006.

Data Collection. Because little was previously known about separate SCHIP fraud and abuse safeguards, we reviewed the following literature to identify safeguards used in the Medicaid program:

- CMS, "Review of State Medicaid Program Integrity Procedures: National Report," 2002;
- CMS, "Resource Guide of State Fraud and Abuse Systems," 2001;
- CMS, "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care," 2000;
- CMS, "Guidance and Best Practices Relating to the States' Surveillance and Utilization Review Functions," undated;
- U.S. Government Accountability Office (GAO), "Medicaid Program Integrity: State and Federal Efforts To Prevent and Detect Improper Payments," GAO-04-707, July 2004;
- GAO, "Medicaid: State Efforts To Control Improper Payments Vary," GAO-01-662, June 2001; and

- U.S. Department of Health & Human Services, Office of Inspector General, "State Medicaid Fraud Control Units: Annual Report," 2003.

Identifying safeguards used in the Medicaid program was useful because, although SCHIP and Medicaid are different programs, they both provide health care coverage to low-income populations through a Federal/State partnership. Further, because Medicaid is a more mature program than SCHIP, States have more experience in safeguarding Medicaid against fraud and abuse. We used information gained from the literature review to develop the data collection instruments and interview protocols, and to follow up with respondents regarding separate SCHIP fraud and abuse safeguards.

We used a structured data collection instrument to request State and health plan documentation for the methods and procedures established to safeguard the separate SCHIPs against fraud and abuse. Specifically, we asked for information and documentation from States and health plans about safeguards for beneficiary eligibility and enrollment, provider enrollment, detection of fraud and abuse in provider billing, and investigation and referral of suspected fraud and abuse cases. We also inquired about States' use of SCHIP contractors to prevent and detect fraud and abuse, including States' oversight of contractors and safeguards against fraud and abuse by managed care organizations themselves.

We received initial responses and documentation from the 6 selected States and 17 health plans from May to July 2005. We also received documentation after interviews and other followup from July to January 2006.

Data collection from CMS occurred from August to September 2005. We obtained copies of CMS reports related to onsite compliance reviews that had been conducted in the six States since the inception of SCHIP, associated review protocols, and SCHIP annual reports.

Document Reviews, Interviews, and Analyses. We reviewed documents by States and health plans to identify what safeguards and oversight mechanisms had been established, when they were established, and what entity was responsible for them. Where applicable, we determined whether the established safeguards and oversight mechanisms met Federal requirements for separate SCHIPs.

For purposes of this report, the term "established" means that we obtained documents that, in our best judgment, demonstrated that the method or procedure was set up and available for use. To judge whether documents demonstrated that safeguards and oversight mechanisms had been established, we looked for documents that would indicate a level of readiness beyond initial development, including such items as corporate or departmental procedures. For States, we also asked for documentation demonstrating whether oversight mechanisms had been put into use. For example, if a State reported methods for conducting onsite reviews of contractor fraud or abuse plans, we asked for copies of the review protocols and reports associated with the latest reviews of each health plan we examined.

We considered respondents to have established safeguards or oversight mechanisms—as long as documentation supported that the method was available for use—even if documents did not demonstrate that the methods were actually used. Whenever we learned that respondents were still developing processes, or had not fully implemented procedures, we noted those conditions in the report as well.

Whenever the safeguards or oversight mechanisms reportedly established by the six States or health plans were not readily apparent in the documents submitted, we followed up on the items during interviews with staff from the States and health plans we reviewed, often requesting additional documentation. In addition, we interviewed CMS central and regional office staffs responsible for oversight of these States. Interviews allowed verification and clarification of document review findings. Interviews of all respondents used standardized questions to inquire about additional topics not included in data collection instruments, such as inquiries about staff perceptions and experiences with fraud and abuse in their separate SCHIPs.

As mentioned, we examined published reports about fraud and abuse safeguards in the Medicaid program to inform our data collection instruments. We specifically asked States and health plans about several of the techniques identified in these reports, along with more general inquiries about all their fraud and abuse safeguards. Our analysis considered all the safeguards and oversight mechanisms documented by States and health plans including, but not limited to, techniques listed in the initial data collection instruments.

In some cases, our analysis used more inclusive definitions of techniques than those identified during our literature review and contained in the survey instruments. For example, the initial data collection instrument specifically asked about "criminal background checks" as a provider enrollment safeguard. One report we reviewed described this safeguard as requiring physicians and other providers to supply their fingerprints for a law enforcement agency to conduct a check of criminal history.[1] Federal regulations require exclusion of individuals who have been convicted of certain crimes, but do not specify what methods States must use to meet this requirement.[2] To determine whether a respondent had met the separate SCHIP Federal requirement regarding certain crimes, our analysis also considered safeguards such as checks of various databases that contain criminal conviction data, e.g., the Healthcare Integrity and Protection Data Bank, and databases maintained by some of the State licensure boards.

In another example, we asked respondents about "routinely scheduled programs that identify aberrant claims or billing practices." Our analysis considered all documented aberrant billing detection techniques, whether routinely scheduled or otherwise.

Based on our review of documentation and interview results, we completed the following analyses:

- To determine the extent to which States have established methods and procedures to meet Federal requirements regarding fraud and abuse, we determined what safeguards the six States (and their SCHIP contractors when these responsibilities were delegated) had established, and assessed whether these safeguards met applicable Federal requirements.
- To assess States' oversight of separate SCHIP contractors regarding fraud and abuse, we determined the methods and procedures States had established for oversight, whether State procedures met Federal requirements for State oversight, and whether gaps or potential program vulnerabilities existed.
- To assess CMS oversight of separate SCHIPs regarding fraud and abuse, we determined how frequently and to what extent CMS compliance reviews and other CMS oversight mechanisms covered fraud and abuse issues.

---

[1] CMS, "Review of State Medicaid Program Integrity Procedures: National Report," 2002, p. 8.

[2] 42 CFR § 457.935(b).

Limitations. Because the 6 States and 17 SCHIP health plans were purposively selected for review, findings and conclusions cannot be generalized beyond these entities. Additionally, because measuring outcomes of established procedures was beyond of the scope of the study, the report does not draw conclusions regarding the effectiveness of separate SCHIP fraud and abuse safeguards. Finally, while we made every effort to obtain all relevant information and documentation for our analysis, it is possible that States have established additional procedures for which they did not provide documentation.

A P P E N D I X B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC 21 2006

TO: Daniel R. Levinson
Inspector General

FROM: Leslie V. Norwalk, Esq.
Acting Administrator

SUBJECT: Office of Inspector General's (OIG) Draft Report: "Fraud and Abuse Safeguards in Separate State Children's Health Insurance Programs" (OEI-06-04-00380)

We appreciate the opportunity to review and comment on the above referenced OIG draft report, "Fraud and Abuse Safeguards in Separate State Children's Health Insurance Programs." On July 13, 2006, the Centers for Medicare and Medicaid Services (CMS) held an exit conference with the OIG, in which we discussed the working draft report. During the exit conference, it was conveyed that CMS, overall, does not dispute the specific findings of the working draft report. However, CMS did express concern that the report did not mention, and take into account, several inherent characteristics of the State Children's Health Insurance Program (SCHIP) that would put the report's findings into perspective. The OIG has since invited CMS to summarize, in writing, our concerns, in advance of a second meeting with OIG representatives.

We subsequently provided written comments on our concerns. We requested that the report explicitly describe how the structure of the SCHIP program makes it less vulnerable to fraud and abuse than other Federal and Federal/State programs, such as Medicaid. Specifically, we asked the OIG to stress that SCHIP is different from Medicaid and that allotments and managed care arrangements make SCHIP fraud and abuse less of a concern in comparison to Medicaid.

We appreciate the additional language the OIG added to the report, as follows: "In interviews, CMS officials reported that, after weighing program risks against limited resources, CMS has chosen to rely primarily on States to monitor SCHIP fraud and abuse prevention, detection and investigation activities. According to CMS officials, SCHIP has limited exposure to fraud and abuse because Federal allotments are capped and managed care arrangements provide protections against fraud and abuse." (See page ii, under the heading, "CMS relies primarily on States for oversight of SCHIP fraud and abuse safeguards, although it has completed some onsite reviews of States.").

However, the above language suggests that CMS made a choice to rely primarily on States to monitor SCHIP fraud and abuse. The reality is that CMS has historically relied

Page 2 – Daniel R. Levinson

on States to oversee SCHIP fraud and abuse in response to SCHIP statute and regulations. We propose that the language is replaced with the following: "In interviews, CMS officials reported that SCHIP statute is not prescriptive in describing Federal oversight of fraud and abuse activities. Rather, SCHIP's statute and regulations focus on programmatic oversight at the Federal level. According to CMS officials, SCHIP has limited exposure to fraud and abuse because Federal allotments are capped and managed care arrangements provide protections against fraud and abuse."

In addition, on pages 17 and 18, OIG Recommendations and Options for CMS to Strengthen Oversight of Fraud and Abuse, we would like to add the following sentences:

"The CMS recognizes that it is important to monitor the potential for inappropriate use of expenditures at the State level and to assist States in strengthening its fraud and abuse efforts. As such, CMS is assessing the existing mechanisms States have in place to address fraud and abuse issues. We have revised the SCHIP annual report template to collect information from States about the fraud and abuse processes and safeguards they have in place. We are also revising the SCHIP site visit Monitoring Guide to ensure that all site visits include a component for reviewing fraud and abuse mechanisms and efforts that States have in place, as well as to provide technical assistance to States."

Again, we appreciate the opportunity to review and comment on the draft report.

ACKNOWLEDGEMENTS

This report was prepared under the direction of Kevin G. Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office. Other principal Office of Evaluation and Inspections staff who contributed include:

Blaine Collins, *Team Leader*

Deborah McGurk, *Project Leader*

Deborah Cosimo, *Program Analyst*

Ruth Ann Dorrill, *Program Analyst*

Alan Levine, *Program Specialist*

Elise Stein, *Director, Public Health and Human Services Branch*

Barbara Tedesco, *Mathematical Statistician*