DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

OCT 2 0 2006

Report Number: A-07-03-02011

Mr. Kevin W. Concannon, Director
Iowa Department of Human Services
Hoover State Office Building, 5th Floor
Des Moines, Iowa 50319-0114

Dear Mr. Concannon:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General final report entitled "Review of Premium Payments for Iowa's Separate State Children's Health Insurance Program for the Period July 1, 2000 Through June 30, 2002." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make the final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determinations.

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If you have any questions regarding this report, please contact Greg Tambke, Audit Manager, at (573) 893-8338, extension 30. Please refer to report number A-07-03-02011 in all correspondence.

Sincerely,

for Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Thomas Lenz
Regional Administrator, Region VII
Centers for Medicare & Medicaid Services
Richard Bolling Federal Building, Room 235
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Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PREMIUM PAYMENTS FOR IOWA'S SEPARATE STATE CHILDREN'S HEALTH INSURANCE PROGRAM FOR THE PERIOD JULY 1, 2000 THROUGH JUNE 30, 2002

Daniel R. Levinson
Inspector General

October 2006
A-07-03-02011

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Title XXI of the Social Security Act authorized the State Children's Health Insurance Program (SCHIP) to provide uninsured low-income children with health care coverage. Each State administers SCHIP in accordance with a State child health plan approved by the Centers for Medicare & Medicaid Services (CMS). The State child health plan is a comprehensive written statement describing the nature and scope of the State's program. While the State has considerable flexibility in designing its plan and operating its program, it must comply with Federal requirements specified in Title XXI and applicable regulations.

States have three options for covering uninsured children in SCHIP. They may design a separate children's health insurance program, expand Medicaid eligibility, or develop a combination of the two strategies. Iowa developed a combination of the strategies. It expanded Medicaid for children with family income up to 133 percent of the Federal poverty level. It also created a separate children's health insurance program, called Healthy and Well Kids in Iowa (HAWK-I), for children whose family income does not exceed 200 percent of the Federal poverty level and who are not eligible for Medicaid.

The Iowa Department of Human Services (the State agency) is responsible for administering SCHIP in Iowa. The State agency contracts with an administrator to perform the administrative functions of the HAWK-I program, including determining eligibility and enrolling eligible children in the program. Under the HAWK-I program, eligible children are enrolled in commercial health insurance plans and the administrator pays the monthly per child premiums to the insurance companies on behalf of the State agency. The State agency initially contracted with Eligibility Services, Inc., to administer the HAWK-I program. In June 2000, the State agency contracted with Maximus, Inc., to administer the program.

OBJECTIVE

Our objective was to determine whether HAWK-I premium payments complied with Federal and State requirements and the approved State child health plan.

SUMMARY OF FINDINGS

Not all HAWK-I premium payments complied with Federal and State requirements and the approved State child health plan during the 2-year period that ended June 30, 2002. In 42 of 114 cases in our statistically valid sample, the applicants' records did not support the eligibility determinations or the administrator made duplicate premium payments to commercial insurers on behalf of HAWK-I eligible children. Some cases had multiple errors. Specifically, the errors included:

- income exceeding maximum limits for HAWK-I eligibility (10 cases),
- unverified or missing eligibility documentation (10 cases),
- no documentation that children were uninsured (12 cases),

- HAWK-I not canceled upon Medicaid eligibility determination (17 cases),
- coverage during the waiting period (5 cases),
- coverage beyond the 12-month eligibility period (4 cases), and
- duplicate premium payments (2 cases).

Additionally, in 12 cases, the SCHIP administrator and the State agency's Medicaid eligibility staff erroneously determined that family income exceeded the Medicaid eligibility limits. As a result, the State agency enrolled the children in the HAWK-I program and never completed the Medicaid eligibility process. We were unable to determine whether the families were eligible for Medicaid because the Medicaid eligibility process was incomplete.

These errors occurred because the administrator's quality control reviews were ineffective and because the State agency's oversight of the administrator was limited. The duplicate premium payments resulted from insufficient edits in the administrator's payment system.

Based on the results of our sample, we estimate that the administrator made improper premium payments totaling $4,766,525 ($3,521,032 Federal share) for the 2-year period that ended June 30, 2002. We also set aside, for CMS adjudication, estimated payments totaling $2,036,557 ($1,504,405 Federal share) for cases in which the only error was family income that fell within Medicaid eligibility guidelines.

RECOMMENDATIONS

We recommend that the State agency:

- refund $3,521,032 to the Federal Government for HAWK-I overpayments,
- work with CMS to resolve $1,504,405 in payments for set-aside cases,
- amend the contract with the administrator to include quality control requirements and incorporate similar provisions in Iowa's State child health plan,
- strengthen the administrator's quality control requirements to ensure that HAWK-I applications and the supporting documentation adequately substantiate eligibility,
- strengthen controls to ensure appropriate oversight of the administrator, and
- direct the administrator to improve its computer edits to prevent duplicate premium payments.

STATE AGENCY'S COMMENTS

In written comments to our draft report, the State agency disagreed with many of our findings that HAWK-I premium payments did not comply with Federal and State requirements. The State agency provided an explanation and, in some cases, additional documentation supporting

its position. However, the State agency did agree with some of the findings and indicated that it has already implemented a number of changes to address issues raised by the OIG in this audit. The State agency's written response, excluding 4 attachments totaling 77 pages, is included in Appendix D.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

After reviewing the State agency's comments and the additional documentation, we removed several of the items cited as errors in the draft report. After considering the additional documentation and comments, we continue to believe that the remaining findings and recommendations are valid.

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INTRODUCTION

BACKGROUND

State Children's Health Insurance Program

Title XXI of the Social Security Act (the Act) authorized the State Children's Health Insurance Program (SCHIP) to provide uninsured low-income children with health care coverage. The Balanced Budget Act of 1997 (Public Law 105-33) created Title XXI and appropriated nearly $40 billion over 10 years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, but not enough to afford private insurance.

SCHIP is a State and Federal partnership. Each State administers SCHIP in accordance with a State child health plan approved by the Centers for Medicare & Medicaid Services (CMS). The State child health plan is a comprehensive written statement describing the nature and scope of the State's program. While the State has considerable flexibility in designing its plan and operating its program, it must comply with Federal requirements specified in Title XXI and applicable regulations.

States have three options for covering uninsured children in SCHIP. They may design a separate children's health insurance program, expand Medicaid eligibility, or develop a combination of the two strategies. Iowa developed a combination of the strategies. It expanded Medicaid for children with family income up to 133 percent of the Federal poverty level. It also created a separate children's health insurance program, called Healthy and Well Kids in Iowa (HAWK-I), for children whose family income does not exceed 200 percent of the Federal poverty level and who are not eligible for Medicaid. The Iowa Department of Human Services (the State agency) administers SCHIP in Iowa.

Healthy and Well Kids in Iowa Administrator

The State agency contracts with an administrator to perform the administrative functions of the HAWK-I program, including determining eligibility and enrolling eligible children in the program. Under the HAWK-I program, eligible children are enrolled in health insurance plans and the administrator pays the monthly per child premiums to commercial insurance companies on behalf of the State agency. The administrator is responsible for maintaining the original documentation used to determine a child's eligibility. If the administrator determines that the family income is above 150 percent of the Federal poverty level, the administrator is to collect a small monthly premium from the family and remit these funds to the State agency.

The State agency initially contracted with Eligibility Services, Inc. (ESI), to administer the HAWK-I program. Although ESI administered the HAWK-I program prior to the audit period, ESI made eligibility determinations that resulted in HAWK-I coverage for certain children included in our review. In June 2000, the State agency contracted with Maximus, Inc. (Maximus), to administer the program. Under the terms of the contract, payments to Maximus were not directly tied to the number of children enrolled in the HAWK-I program.

Iowa Expenditures

For the 2-year period that ended June 30, 2002, the State agency reported SCHIP expenditures of $67.3 million, which consisted of $31.5 million for the Medicaid expansion program and $30.9 million for HAWK-I. The Federal share of expenditures for SCHIP was 74.14, 73.87, and 74.00 percent for Federal fiscal years 2000, 2001, and 2002, respectively. The Federal match for Medicaid expenditures was 63.06, 62.67, and 62.86 percent for these respective periods.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether HAWK-I premium payments complied with Federal and State requirements and the approved State child health plan.

Scope

Our audit covered the 2-year period that ended June 30, 2002. During this period, Iowa reported to CMS HAWK-I expenditures totaling $30,864,608. Our audit included expenditures totaling $30,029,570 ($22,204,976 Federal share) in health insurance coverage for children in 13,681 families. The difference of $835,038 was due primarily to our exclusion of HAWK-I premiums paid during the 2-year period that applied to insurance coverage prior to July 1, 2000, or subsequent to June 30, 2002. In addition, we did not reduce HAWK-I expenditures by the cost-sharing premiums that families paid because the administrator was unable to provide an itemized list of these premiums, by family, for the respective coverage periods.

We limited our internal control review to the controls related to the eligibility determinations that Maximus performed, Maximus's controls to prevent duplicate premium payments, and the State agency's oversight of eligibility determinations.

We conducted our fieldwork at the State agency in Des Moines, IA, and at Maximus in West Des Moines, IA.

Methodology

To accomplish our objective, we reviewed SCHIP laws and regulations, program guidance, and Iowa's State child health plan. We obtained the monthly HAWK-I invoices and a detailed list of HAWK-I beneficiaries with their respective premium payments, which we reconciled to the amounts reported to CMS on the Form CMS 21 Summary Sheet.[1]

We interviewed officials at Maximus to understand its internal controls for eligibility determinations. We interviewed State agency officials to understand their oversight of the administrator's eligibility determinations. We then examined the adequacy and effectiveness of the quality control reviews that the State agency and Maximus performed.

[1]The Form CMS 21 Summary Sheet is the certified quarterly SCHIP statement of expenditures.

We randomly selected a sample of 114 cases with premiums totaling $696,673 ($515,094 Federal share) to determine the adequacy of the eligibility determinations. (See Appendix A for the sampling methodology.) We collected HAWK-I case files; correspondence sent to the applicants; case notes; child support payment histories; historical wage information; unemployment data; and, if applicable, the Medicaid case files, Social Security wages, and Supplemental Security Income for the selected cases. Additionally, we obtained from the State agency a list of Medicaid participants to determine whether HAWK-I applicants were enrolled in Medicaid.

We determined whether HAWK-I premium payments were appropriate by:

- reviewing applicant records to determine whether the records included the documents necessary to support the eligibility determinations,

- recalculating the administrator's computation of the annual family income used to determine whether the beneficiary was eligible for the HAWK-I program, and

- determining whether the HAWK-I and Medicaid programs provided duplicate coverage.

We also determined whether the administrator made duplicate HAWK-I premium payments to insurance companies on behalf of the same beneficiary.

Based on our sample results, we projected the total improper premium payments to our universe. We separately projected the premium payments for the sampled cases in which the only error was family income that fell within Medicaid eligibility guidelines.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

IMPROPER AND POTENTIALLY UNALLOWABLE PREMIUM PAYMENTS

Not all HAWK-I premium payments complied with Federal and State requirements and the approved State child health plan during the 2-year period that ended June 30, 2002. In 42 of 114 cases in our statistically valid sample, the applicants' records did not support the eligibility determinations or the administrator made duplicate premium payments to commercial insurers on behalf of HAWK-I eligible children. Some cases had multiple errors. Specifically, the errors included:

- income exceeding maximum limits for HAWK-I eligibility (10 cases),

- unverified or missing eligibility documentation (10 cases),

- no documentation that children were uninsured (12 cases),

- HAWK-I not canceled upon Medicaid eligibility determination (17 cases),

- coverage during the waiting period (5 cases),
- coverage beyond the 12-month eligibility period (4 cases), and
- duplicate premium payments (2 cases).

Additionally, in 12 cases, the SCHIP administrator and the State agency's Medicaid eligibility staff erroneously determined that family income exceeded Medicaid eligibility limits. As a result, the State enrolled the children in the HAWK-I program and never completed the Medicaid eligibility process. We were unable to determine whether the families were eligible for Medicaid because the Medicaid eligibility process was incomplete.

These errors occurred because the administrator's quality control reviews were ineffective and because the State agency's oversight of the administrator was limited. The duplicate premium payments resulted from insufficient edits in the administrator's payment system.

Based on the results of our sample, we estimate that the administrator made improper premium payments totaling $4,766,525 ($3,521,032 Federal share) for the 2-year period that ended June 30, 2002. We also set aside, for CMS adjudication, estimated payments totaling $2,036,557 ($1,504,405 Federal share) for cases in which the only error was family income that fell within Medicaid eligibility guidelines.

Income Exceeding Maximum Limits for HAWK-I Eligibility

Pursuant to section 4 of the fourth amendment to the State child health plan, income limits for the HAWK-I program are based upon countable gross earned[2] and unearned income and may not exceed 200 percent of the Federal poverty level.

In 10 of the 114 cases reviewed, the administrator enrolled children in HAWK-I even though their family income exceeded the program's upper limit. These cases contained errors in calculating the family income. Such errors included projecting income based on an incorrect frequency of pay and incorrectly determining total income. For example, the administrator projected one family's income assuming that wages were received monthly rather than biweekly as indicated on the applicant's documentation. If the administrator had projected income correctly, it would have determined that the family income exceeded the upper limit and that the children were ineligible for the program.

Unverified or Missing Eligibility Documentation

Pursuant to 42 CFR § 457.965, "The State must include in each applicant's record, facts to support the State's determination of the applicant's eligibility for SCHIP." Additionally, section 4 of the first amendment to the State child health plan mandates that applications be screened for

[2]Effective October 1, 1999, the second amendment to the State child health plan allowed for a 20-percent deduction to earned income in determining eligibility for the HAWK-I program.

verification of income. It also states that a child will not be reenrolled if the family fails to return the required income verification during the renewal process.

Of the 114 cases reviewed, 10 cases[3] were approved and determined eligible for HAWK-I even though the administrator had not documented facts in the case files to substantiate the eligibility determinations. In these cases, one or more of the following errors occurred:

- In four cases, the administrator relied on income amounts written on the application without obtaining supporting documentation. The State child health plan does not provide for self-certification of income; applicants are required to submit proof of their income, such as pay stubs, tip records, and statements from their employers. For self-employed applicants, the administrator requires business records or income tax returns.

- In three cases, the administrator improperly computed family income because the administrator did not obtain the expenditures needed to determine the income for self-employed parents. In these cases, the administrator did not properly establish HAWK-I eligibility because it could not accurately determine whether family income was within Medicaid income guidelines.

  To illustrate one case, a self-employed parent provided documentation that showed receipt of amounts billed to his clients for a 1-week period (gross income) but excluded a deduction of expenditures from gross income (net income).

- In five cases, the administrator accepted applications with critical questions unanswered. Federal regulations (42 CFR § 457.965) require States to include in each applicant's record facts to support the State's determination of the applicant's eligibility. During our review of these application files, we did not observe any documentation that addressed the unanswered application questions. The section of the application that was unanswered required the parent to answer questions regarding his or her children's private health insurance coverage. These questions are critical in determining eligibility. Depending on the answers to these questions, these children may have been ineligible. However, the administrator did not determine why the questions were left unanswered, even though section 4 of the first amendment of the State child health plan requires applications to be "screened for completeness of information."

No Documentation That Children Were Uninsured

Title XXI of the Act, section 2101 (42 U.S.C. 1397aa), states: "The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children . . . ." Further, section 4 of the first amendment to the State child health plan states that: "A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program."

[3]Two cases had two documentation errors. Accordingly, these 10 cases had a total of 12 documentation errors.

In 12 of the 114 cases, we were unable to determine whether insurance coverage that the applicant identified had been canceled. The applications generally indicated that the children were insured or that the applicants would drop existing coverage if the children were approved for the HAWK-I program. However, the administrator did not request any verification that the children's health insurance coverage had ended; the only documentation retained in the case file indicated that coverage existed.

HAWK-I Not Canceled Upon Medicaid Eligibility Determination

Section 4 of the first amendment to the State child health plan states that: "The child shall be disenrolled from the plan and cancelled from the program as of the first day of the month following the month in which Medicaid eligibility is attained."

In 17 of the 114 cases, the administrator did not remove children from HAWK-I once Medicaid eligibility was determined. For these cases that may have resulted in dual coverage because of a retroactive enrollment in Medicaid, we used the notices of decision received from Medicaid to determine the earliest date that HAWK-I officials would have been aware of Medicaid coverage and questioned only the subsequent months.

Coverage During the Waiting Period

To ensure that HAWK-I coverage does not substitute for coverage under group health plans, Iowa imposes a 6-month waiting period when employer-related group health insurance coverage has been dropped unless certain exclusions apply.[4] Pursuant to section 4 of the first amendment of the State child health plan, these exclusions include (1) "Employment was lost for a reason other than voluntary termination," (2) "There was a change in employment to an employer who does not provide an option for dependent coverage," or (3) "Dependent coverage was terminated due to an extreme economic hardship on the part of the employee or employer." The Iowa Administrative Code, section 441-86.2(4), states: "Extreme economic hardship for employees shall mean that the employee's share of the premium for providing employer-sponsored dependent coverage exceeded 5 percent of the family's gross annual income."

The administrator approved 5 of the 114 cases for HAWK-I when the 6-month waiting period should have been imposed. For example, an applicant asserted that she could not afford the increase in her family's group health insurance premium. After the increase, the family's premium was approximately $75 per month, which was 3 percent of its gross income. Pursuant to section 4 of the first amendment of the State child health plan, the applicant's child should have been subject to a waiting period because the premium did not exceed 5 percent of the family's gross annual income. However, the administrator approved the application and immediately enrolled the child.

[4]This requirement was subsequently changed in section 4 of the seventh amendment to the State child health plan, which states: "Effective July 1, 2003, the State no longer imposes a 6-month waiting period for children who have been insured through an employer group health plan in the six months prior to the month of application."

Coverage Beyond the 12-Month Eligibility Period

Pursuant to section 4 of the first amendment of the State child health plan, "Eligibility for HAWK-I is granted in 12-month enrollment periods." In addition, the Iowa Administrative Code, section 441-86.9, states that: "All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program."

In 4 of the 114 cases reviewed, children were insured beyond the 12-month eligibility period without a redetermination demonstrating that the children continued to be eligible for HAWK-I. For example, a family with six children reapplied for HAWK-I coverage in August 2001, prior to the end of their eligibility on September 30, 2001. During the redetermination process, the administrator determined that the family was not eligible; however, the administrator continued to pay premiums on behalf of the family through October 31, 2001, and three of the children remained enrolled until January 31, 2002.

Duplicate Premium Payments

In accordance with Office of Management and Budget (OMB) Circular A-87, section C(1)(a), to be allowable under Federal awards, costs must be "necessary and reasonable for proper and efficient performance and administration of Federal awards." Additionally, OMB Circular A-87, section C(2)(a), states that in determining reasonableness of a given cost, consideration shall be given to whether the cost is of a type generally recognized as ordinary and necessary for the operation of the Federal unit or the performance of the Federal award.

In 2 of the 114 cases reviewed, the administrator made 2 premium payments for the same months of coverage for the same children. For example, in one of the cases, four children were enrolled in one SCHIP insurance plan effective May 1, 2001. However, these children were already enrolled in another SCHIP insurance plan, and they were not disenrolled from this initial SCHIP insurance plan until the end of July 2001. Accordingly, the administrator made duplicate payments on behalf of these four children for 3 months.

Income Falling Within Medicaid Eligibility Guidelines

Pursuant to section 2102(b)(3)(B) of the Act, the State must include a provision in the State child health plan requiring that children be enrolled in Medicaid if they are found through the SCHIP application process to be eligible for Medicaid. The State child health plan, section 1, provides that children with family income below 133 percent of the Federal poverty level are eligible for Medicaid. Additionally, section 2 of the fourth amendment to the State child health plan states that the HAWK-I program covers children who are not eligible for Medicaid.

In 12 cases, the administrator enrolled children in HAWK-I even though family income fell within Medicaid eligibility guidelines. In these cases, the administrator did not properly establish HAWK-I eligibility because the SCHIP administrator and the State agency's Medicaid eligibility staff erroneously determined that family income exceeded Medicaid eligibility limits. However, we could not determine whether these families were qualified for Medicaid because the Medicaid eligibility process was incomplete.

CAUSES OF IMPROPER AND POTENTIALLY UNALLOWABLE PAYMENTS

The administrator's documentation of the applicants' records did not substantiate the eligibility determinations as required because the administrator's quality control reviews were ineffective and because the State agency's oversight was inadequate. Duplicate premium payments occurred because the administrator did not have adequate computer edits to prevent them.

The administrator was not contractually required to implement a quality control process. Also, the administrator provided no documentation of its quality control reviews until approximately 2 years after it began administering the program. The administrator indicated that it had performed quality control reviews during the initial 2 years of its administration; however, these reviews were not documented. We believe that the deficiencies in eligibility determinations show that the quality control process needs to be improved.

The State agency's oversight was inconsistent and limited. The State agency assigned one staff member to review eligibility determinations as time permitted, and the findings identified were sometimes not reviewed with the administrator for more than a year.

IMPROPER AND POTENTIALLY UNALLOWABLE PAYMENT AMOUNTS

Our statistically valid sample found $110,336 ($81,505 Federal share) in inappropriate premium payments. Based on the sample results, we estimated that the administrator made improper premium payments totaling $4,766,525 ($3,521,032 Federal share) because of eligibility determination errors and duplicate premium payments for the 2-year period that ended June 30, 2002.

Additionally, our statistically valid sample found $37,443 ($27,659 Federal share) in premium payments for 12[5] cases with family income that met Medicaid eligibility guidelines. However, because the Medicaid eligibility process was incomplete, we could not determine whether these families were qualified for Medicaid. As such, we set aside these premiums for CMS adjudication. Based on the sample results, CMS and the State need to resolve an estimated $2,036,557 ($1,504,405 Federal share) in potentially unallowable premium payments by determining whether the families in these cases meet all Medicaid eligibility criteria. (See Appendix B for the sample results and projections.)

[5]In 12 cases, the administrator enrolled children in HAWK-I even though family income fell within Medicaid eligibility guidelines. Some of the cases included multiple HAWK-I applications submitted during the audit period. Because we questioned the premium payments for 1 of the 12 cases due to other errors, we did not include this case in the set-aside projection. Of the remaining 11 cases, 5 had questioned premium payments associated with a different application. For these five cases, we included part of the premiums in the questioned costs and part of the premiums in the set-aside. For the remaining six cases, the only error found was that family income fell within Medicaid eligibility guidelines.

RECOMMENDATIONS

We recommend that the State agency:

- refund $3,521,032 to the Federal Government for HAWK-I overpayments,[6]
- work with CMS to resolve $1,504,405 in payments for set-aside cases,
- amend the contract with the administrator to include quality control requirements and incorporate similar provisions in Iowa's State child health plan,
- strengthen the administrator's quality control requirements to ensure that HAWK-I applications and the supporting documentation adequately substantiate eligibility,
- strengthen controls to ensure appropriate oversight of the administrator, and
- direct the administrator to improve its computer edits to prevent duplicate premium payments.

STATE AGENCY'S COMMENTS AND OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State agency did not concur with all of our findings and recommendations. However, the State agency did agree with some of the findings and indicated that it has implemented corrective action regarding the issues being reported. The State agency's comments, excluding 4 attachments totaling 77 pages, are presented in Appendix D. We have forwarded these exhibits in their entirety to CMS.

The State agency's initial comments to our draft report addressed issues that were not included in our report. We requested that the State agency resubmit its comments based only upon the issues reported. Additionally, we provided the State agency with a spreadsheet outlining by case and application the issues identified. Subsequently, the State agency submitted revised comments and additional documentation supporting its position. The State agency's comments continued to address issues that were never included in our draft report. As such, these comments have been redacted. The State agency also provided us with its attachment A, which contained its detailed analysis of the issues on a case by case basis. However, the letter containing the State agency's comments was not always consistent with the detail provided in its attachment A. Because of these inconsistencies, we utilized the detailed information found in attachment A to determine the State agency's position on the issues.

[6]Our projections did not account for the premiums paid by the families enrolled because the administrator was unable to provide an itemized list of these premiums by coverage period. If the State agency provides the itemized premiums for each of the 114 cases in our sample, the projected questioned costs could be adjusted to account for the cost-sharing premiums. Based upon amounts reported to CMS, the amount that the State agency received from families for these cost-sharing premiums was approximately 3.24 percent of the total premiums paid for the 2-year period that ended June 30, 2002.

After reviewing the State agency's comments and the additional documentation, we removed several of the items cited as errors in the draft report. After considering the additional documentation and comments, we continue to believe that the remaining findings and recommendations are valid.

APPENDIXES

SAMPLING METHODOLOGY

POPULATION

We drew the sample from 13,681 cases with children enrolled in the Healthy and Well Kids in Iowa (HAWK-I) program from July 1, 2000, to June 30, 2002. Iowa reimbursed premium payments for these cases between July 1, 2000, and November 30, 2002, and reported them to the Centers for Medicare & Medicaid Services (CMS) on the Form CMS 21 Summary Sheet for the quarters that ended September 30, 2000, through December 31, 2002.

SAMPLING FRAME

The sampling frame consisted of two computer files obtained from the Iowa Department of Human Services that delineated the monthly capitation payments for HAWK-I enrollment for the period July 1, 2000, to June 30, 2002. The payments included retroactive payments made through November 30, 2002. We reconciled these data to the State Children's Health Insurance Program expenditures reported for Federal financial participation on the Form CMS 21 Summary Sheet. During this reconciliation, we noted that Iowa made $7,664 in HAWK-I payments that were not included on the capitation reports. We adjusted the reports to include these payments.

We combined these files, incorporated the reconciling adjustments into a single file, and ensured that there were no duplicate case numbers. We determined that there were 13,681 separate HAWK-I case numbers. For the period July 1, 2000, to June 30, 2002, Iowa made HAWK-I premium payments of $30,029,570; the Federal share was $22,204,976.

Over the period of our audit, the Federal Government reimbursed Iowa in several different Federal fiscal years. We calculated the total improper Federal share of the reimbursements resulting from this review using the lowest percentage applicable, which was 73.87 percent.

SAMPLE UNIT

The sample unit was the case number for cases in which premiums had been reimbursed through Federal financial participation. The case numbers refer to an eligible group or family.

SAMPLE DESIGN

We used a stratified sample to evaluate the population of eligible cases. To accomplish this, we separated the sampling frame into three strata based on the total amount of the premiums paid for each case during the audit period:

- stratum 1: less than $3,000 (10,438 cases),
- stratum 2: $3,000 to $11,000 (3,205 cases), and
- stratum 3: greater than $11,000 (38 cases).

SAMPLE SIZE

We reviewed a total of 114 cases, 38 from each stratum.

SOURCE OF RANDOM NUMBERS

The random numbers were generated from the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS statistical software package. The package has been validated using National Bureau of Standards methodology.

METHOD OF SELECTING SAMPLE ITEMS

We combined the files obtained from the Iowa Department of Human Services that delineated Iowa's payments for HAWK-I coverage. The resulting list separated the payments by beneficiary and period of coverage. Additionally, we incorporated the adjustments determined as a result of our reconciliation between the CMS reports and the files. The information was combined into a single database, sorted, and grouped by case number. We then sorted the data in ascending order, without consideration of the Federal share, by the total premium costs that Iowa paid. We then segregated the data into the three strata—less than $3,000, $3,000 to $11,000, and greater than $11,000—and gave each case number a sequential number. We randomly selected 38 cases from strata 1 and 2; we reviewed all 38 cases in stratum 3.

ESTIMATION METHODOLOGY

We used the RAT-STATS variables appraisal program to evaluate the sample results. We used the lower limit at the 90-percent confidence level to estimate the total unallowable premium payments and the point estimate to estimate the premiums to be set aside for CMS adjudication.

STRATIFIED RANDOM SAMPLE RESULTS AND PROJECTIONS

Sample Results and Questioned Costs

Stratum Number	Stratum Range	Population (Number of Cases)	Population (Total Dollars Claimed)	Sample (Number of Cases)	Sample (Total Dollars Claimed)	Sample Errors (Number of Cases)	Sample Errors (Total Dollars)
1	Less than $3,000	10,438	$14,201,639	38	$53,578	14	$17,622
2	$3,000 to $11,000	3,205	15,359,050	38	174,214	15	25,291
3	Greater than $11,000	38	468,881	38	468,881	13	67,423
Total		**13,681**	**$30,029,570**	**114**	**$696,673**	**42**	**$110,336**

Projection of Sample Results
(Precision at the 90-Percent Confidence Level)

Upper Limit	$9,315,483
Point Estimate	$7,041,004
Lower Limit	$4,766,525
Precision Percent	32.30%

Sample Results and Set-Aside Costs

Stratum Number	Stratum Range	Population (Number of Cases)	Population (Total Dollars Claimed)	Sample (Number of Cases)	Sample (Total Dollars Claimed)	Sample Errors (Number of Cases)	Sample Errors (Total Dollars)
1	Less than $3,000	10,438	$14,201,639	38	$53,578	2	$3,561
2	$3,000 to $11,000	3,205	15,359,050	38	174,214	5	12,293
3	Greater than $11,000	38	468,881	38	468,881	4	21,589
Total		**13,681**	**$30,029,570**	**114**	**$696,673**	**11**	**$37,443**

Projection of Sample Results
(Precision at the 90-Percent Confidence Level)

Upper Limit	$3,440,572
Point Estimate	$2,036,557
Lower Limit	$632,542
Precision Percent	68.94%

SUMMARY OF ERRORS BY CASE

Claim Sample Number	Income Exceeding Maximum Limits for HAWK-I Eligibility	Unverified or Missing Eligibility Documentation	No Documentation That Children Were Uninsured	HAWK-I Not Canceled Upon Medicaid Eligibility Determination	Coverage During the Waiting Period	Coverage Beyond 12-Month Eligibility Period	Duplicate Premium Payments	Income Falling Within Medicaid Guidelines
1		X						
2				X	X			
3								
4								
5				X				
6								
7				X				
8	X	X				X		
9								
10								
11			X					
12								
13								X
14					X			
15				X				
16								
17				X				
18								
19				X				
20	X			X				
21								
22								
23								
24								
25								
26								X
27		X						
28								
29								
30								
31								
32								
33								
34	X		X					
35	X							
36								
37								
38								
39				X				
40								

Claim Sample Number	Income Exceeding Maximum Limits for HAWK-I Eligibility	Unverified or Missing Eligibility Documentation	No Documentation That Children Were Uninsured	HAWK-I Not Canceled Upon Medicaid Eligibility Determination	Coverage During the Waiting Period	Coverage Beyond 12-Month Eligibility Period	Duplicate Premium Payments	Income Falling Within Medicaid Guidelines
41								
42	X							
43								
44								
45								
46								
47	X				X			X
48								
49								
50				X		X		
51								
52	X	X		X		X		
53	X	X						
54				X				
55			X					
56							X	
57								
58								
59				X				X
60				X				X
61								
62								
63			X	X	X			
64								X
65			X					X
66								
67								
68			X					
69								
70								
71								
72								
73			X					
74								
75								
76								
77		X						X
78								
79				X				
80								
81								
82	X							
83								

Claim Sample Number	Income Exceeding Maximum Limits for HAWK-I Eligibility	Unverified or Missing Eligibility Documentation	No Documentation That Children Were Uninsured	HAWK-I Not Canceled Upon Medicaid Eligibility Determination	Coverage During the Waiting Period	Coverage Beyond 12-Month Eligibility Period	Duplicate Premium Payments	Income Falling Within Medicaid Guidelines
84								
85								
86							X	
87								
88								
89			X					
90		X		X				X
91				X				
92								
93								
94								
95		X	X					
96								
97								
98								
99								
100		X	X					
101	X		X					
102								
103								X
104								X
105								
106								
107								
108								X
109			X					
110								
111					X	X		
112								
113								
114		X						
Total	**10**	**10**	**12**	**17**	**5**	**4**	**2**	**12**

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

APR 2 7 2006

Patrick Cogley,
Regional Inspector General for Audit Services
Office of Inspector General
Offices of Audit Services
Region VII
601 East 12th Street
Room 284A
Kansas City, MO 64106

RE: REVIEW OF PREMIUM PAYMENT FOR IOWA'S SEPARATE STATE CHILDREN'S HEALTH INSURANCE PROGRAM – REPORT NUMBER: A-07-03-02011

Dear Mr. Cogley:

Enclosed please find comments from the Iowa Department of Human Services (DHS) to the March 15, 2006 unofficial response to Iowa's comments of February 24, 2006 concerning the Office of Inspector General's (OIG) audit of Iowa's SCHIP program, known as the Healthy and Well Kids in Iowa (***hawk-i***) program.

The enclosed response addresses each of the unofficial responses, indicating Iowa's original response, the unofficial OIG response, and a new state response indicating whether DHS agrees or disagrees with the finding. The general comments reflect much of the original DHS comments but have been revised based on the OIG unofficial response. DHS appreciates the effort of the OIG in answering questions raised by DHS during this process and for the opportunity to provide these additional comments that will be included in the final report.

Questions about the attached response can be addressed to:

Bob Krebs
Iowa Department of Human Services
Division of Financial, Health and Work Supports
Hoover State Office Building, 5th Floor
Des Moines, IA 50319
Phone: (515) 281-5334 Fax: (515) 281-7791 Email: rkrebs@DHS.state.ia.us

Sincerely,

Kevin W Concannon

Kevin W. Concannon
Director

AUDIT OF PREMIUM PAYMENT FOR IOWA'S SEPARATE STATE CHILDREN'S HEALTH INSURANCE PROGRAM FOR THE PERIOD JULY 1, 2000 THROUGH JUNE 30, 2002
AUDIT REPORT CIN: A-07-03-02011
Comments from Iowa Department of Human Services (Revised April 27, 2006)

GENERAL COMMENTS

On December 6, 2005, the Office of Inspector General (OIG) provided the state with a draft report of its audit findings. The state responded to the draft report on February 24, 2006. Then, on March 15, 2006, the OIG provided the state with an unofficial response to the state's February 24, 2006 response. The comments in the remainder of this document are the original comments made in the February 24, 2006 response with some revisions based on the March 15, 2006 unofficial response from the OIG.

This audit covers the period of July 1, 2000 through June 30, 2002. During this time, the Center for Medicare and Medicaid Services (CMS) conducted a site visit of the Medicaid and ***hawk-i*** programs. The final report on the site visit, issued in February 2002, states, "The Iowa Medicaid and ***hawk-i*** programs were reviewed and found to be in compliance with Federal and State requirements." The OIG findings are thus inconsistent with the findings of CMS for this same audit period. A copy of the full report is included as Attachment B.

Program Improvements Already Made

The Iowa Department of Human Services (DHS) and the SCHIP third-party administrator have already implemented a number of changes that address some of the issues raised by the OIG in this audit. These changes include:

- a re-designed application form that helps ensure questions are not overlooked by the applicant or the eligibility worker,
- a new contract with the SCHIP third-party administrator that includes performance measures related, in part, to the correctness of SCHIP eligibility determinations specifically dealing with quality control and oversight of the SCHIP third-party administrator, (see Attachment C for more information)
- implementation of a renewal form that contains all of the information previously provided by the family except for income information, which again helps ensure questions are not overlooked by the applicant or the eligibility worker,
- a re-designed automated match with children newly approved for Medicaid to ensure SCHIP eligibility is canceled at the earliest possible date,
- obtained legislative authority to conduct a match of children enrolled in commercial health insurance plans with the SCHIP enrollment file to identify any children who are insured,
- implementation in October 2001 of system edits to prevent duplicate payments to health plans,

AUDIT OF PREMIUM PAYMENT FOR IOWA'S SEPARATE STATE CHILDREN'S HEALTH INSURANCE PROGRAM FOR THE PERIOD JULY 1, 2000 THROUGH JUNE 30, 2002
AUDIT REPORT CIN: A-07-03-02011

Comments from Iowa Department of Human Services (Revised April 27, 2006)

- implementation in July 2004 of an automated referral process which allows Medicaid eligibility workers to electronically refer to ***hawk-i*** children who are denied Medicaid due to excess family income or canceled from Medicaid due to excess family income, and

- implementation in January 2004 of an online application which allows families to complete and file a ***hawk-i*** application via the ***hawk-i*** website and which does not permit applications to be submitted with unanswered questions.

Iowa has several areas of concern regarding the findings of the OIG. Those areas are addressed below.

OIG Interpretation of State Requirements

It is the position of DHS that the OIG misinterpreted or too narrowly interpreted certain administrative rules, policies, and procedures pertaining to eligibility determinations. This misinterpretation resulted in error findings in over 51% of the 68 sampled cases having an error. The primary misinterpretation of administrative rules surrounded the rule found at 441—IAC 86.2(c) that states, in part, "Income shall be verified using the best information available. For example, earnings from the 30 days prior to the date of application **may** (emphasis added) be used to verify earned income if it is representative of the income expected in future months." This rule provides DHS with the discretion to determine what constitutes the "best information available."

Data Redacted by OIG/OAS Auditors

The OIG also found cases in error because families did not provide copies of a Schedule C or Schedule F form documenting the expenses of their self-employment enterprise. What the OIG failed to recognize is that, beginning in February 2000, the ***hawk-i*** program allows the same expenses as allowed by the Internal Revenue Service (IRS). So, the copy of the 1040 form was sufficient proof.

In addition, the OIG cited errors in cases where questions on the application were left unanswered.

Data Redacted by OIG/OAS Auditors

In other cases cited by the OIG as in error, the question on the application left unanswered asks if each child is receiving SSI (Supplemental Security Income). This question is asked to help identify children receiving Medicaid during the SCHIP application process, prior to the automated Medicaid match. Under section 1634 of the Social Security Act, Iowa is a state in which receipt of SSI results in automatic eligibility for Medicaid with rare exceptions. So, even if the question is left unanswered, Medicaid eligibility will likely be discovered before SCHIP eligibility would be incorrectly approved. There are situations where Medicaid is denied to an SSI recipient because the person does not cooperate in supplying third-party liability information, has a trust that creates Medicaid ineligibility, or does not meet residency requirements. First, both state and federal laws do not allow children to be determined ineligible for Medicaid due to the failure of a parent or guardian to provide third-party liability information. In addition, it is extremely unlikely that Iowa would be notified of a new SSI approval of a child who is considered to be living in another state. And, in each of the cases where the question was left unanswered, the child was not receiving SSI. These cases should not be found in error since, despite the

unanswered questions, the information was known to the agency and the cases were eligible. No dollars were misspent.

Case File Documentation

It is the position of DHS that the OIG overlooked or misinterpreted documentation in case files that supported the eligibility determination. This oversight or misinterpretation by the OIG resulted in error findings in over 45% of the 68 sampled cases having an error. In all cases, the documentation the OIG claimed was missing was found in the case file and in numerous cases, the documentation was supplied to the OIG as part of the Department's response to a preliminary report of error findings. However, the OIG retained these error findings in the draft report. In addition, the OIG failed to consider verified information found on computer systems available to Income Maintenance staff for the purposes of eligibility determinations. Specifically, the OIG stated in numerous findings that "Support used to verify the accuracy of Iowa's eligibility determinations came only from the Hawk-I administrator's case files. Unless the documentation verifying income was retained in the Hawk-I case file, we did not use it as support for income." In nine cases cited in error by the OIG due to missing income verification, the verified income information was found on the state's Iowa Collection and Reporting (ICAR) system for child support or on the state's interface with the federal Income and Eligibility Verification System (IEVS). This information is both known to the agency and in the possession of the state and supports the original eligibility determination. In another six cases cited as in error by the OIG due to missing documentation, the verified information was contained in the Medicaid case file. Again, this information was known to the agency and in the possession of the state and supports the original eligibility determination.

OIG Calculation of Income

It is the position of DHS that in several cases the OIG made errors in math calculations in determining if the family met SCHIP income limits or was eligible to have the 6-month waiting period waived. These miscalculations resulted in error findings in over 13% of the 68 sampled cases having an error. In some cases, the SCHIP third-party administrator incorrectly included a reimbursement as income, but, even with the reimbursement excluded, eligibility existed. In addition, in some cases, the OIG calculated the amount of the family's health insurance premium to be less than 5% of their gross income which would result in a 6-month waiting period after canceling the coverage for the children. But, in fact the health insurance premium was as much as 11% of the family's gross income, resulting in no waiting period.

Failure to Reduce Expenditures by Cost-Sharing Premiums

The OIG states that the expenditures it found in error were not reduced by the cost-sharing premiums because "the administrator was unable to provide an itemized list of these premiums, by family, for the respective coverage period." This statement is inaccurate. The SCHIP third-party administrator regularly collects and, had they been asked, would have been easily able to provide this information. The state is providing the information under separate cover to the local OIG office.

Procedural Errors Not Resulting in Ineligibility

In several cases cited by the OIG as in error, the error was only procedural and did not result in the child being ineligible. It is the position of DHS that these errors should not be included in any disallowances. For example, in one case, the third-party administrator did not obtain an application form prior to adding an eligible child to an already eligible family. In another case, the third-party administrator failed to obtain verification of the date health insurance was canceled. But, subsequently provided verification shows that ***hawk-i*** coverage did not begin prior to the effective date of the health insurance cancellation.

FINDINGS

General Comments

DHS disagrees with all of the findings in 25 of the 68 cases cited as having errors. These 25 cases represent $98,552 or 42.3% of the $232,740 in premium payments determined by the OIG to be inappropriate, and $14,270 or 38.7% of the $36,897 in premium payments for people the OIG claims meet Medicaid guidelines. DHS also partially disagrees with the error findings in another 25 cases. DHS agrees with all of the findings in seven cases.

In cases where DHS partially disagrees with the OIG findings, we request that the disallowance be adjusted to cover only the months applicable to the findings with which DHS agrees and any extrapolation be adjusted accordingly.

Further, where DHS agreed with the OIG findings on a case with duplicate premium payments, the case was corrected and any misspent dollars were recouped. And, the state worked to identify any similar cases and recoup any misspent dollars on those cases. Therefore, the state disputes the extrapolation of any disallowance resulting from this error finding to the entire SCHIP budget for Iowa.

The DHS response to the case-specific findings can be found in Attachment A.

Income Exceeding Maximum Limits for *hawk-i* Eligibility

OIG Finding

Pursuant to section 4 of the fourth amendment to the State child health plan, income limits for the HAWK-I program are based upon countable gross earned and unearned income and may not exceed 200 percent of the Federal poverty level.

In 11 of the 114 cases reviewed, the administrator enrolled children in HAWK-I even though their family income exceeded the program's upper limit. These cases contained errors in calculating the family income. Such errors included projecting income based on an incorrect frequency of pay and incorrectly determining total income. For example, the administrator

projected one family's income assuming that wages were received monthly rather than biweekly as indicated on the applicant's documentation. If the administrator had projected income correctly, it would have determined that the family income exceeded the upper limit and that the children were ineligible for the program.

DHS Response

DHS concurs with the findings in 8 of the 11 cases cited with this error finding. DHS partially agrees with the finding in one case. DHS disagrees with the finding in the remaining 2 cases.

In both of these cases DHS disagrees with, the OIG miscalculated the countable family income or misinterpreted Medicaid income policies.

DHS disagrees with the finding in 1 case where this error was the only finding. This case represents $355 of the $232,740 in premium payments the OIG determined were inappropriate. DHS requests the disallowance and any extrapolation be adjusted accordingly.

Details supporting the position of DHS can be found in Attachment A.

Unverified or Missing Eligibility Documentation

OIG Finding

Pursuant to 42 CFR § 457.965, "The State must include in each applicant's record, facts to support the State's determination of the applicant's eligibility for SCHIP." Additionally, section 4 of the first amendment to the State child health plan mandates that applications be screened for verification of income. It also states that a child will not be reenrolled if the family fails to return the required income verification during the renewal process.

Of the 114 cases reviewed, 36 cases were approved and determined eligible for HAWK-I even though the administrator had not documented facts in the case files to substantiate the eligibility determinations. In these cases, one or more of the following errors occurred:

- In 15 cases, the administrator relied on income amounts written on the application without obtaining supporting documentation. The State child health plan does not provide for self-certification of income; applicants are required to submit proof of their income, such as pay stubs, tip records, and statements from their employers. For self-employed applicants, the administrator requires business records or income tax returns.

- In five cases, the administrator improperly computed family income because the administrator did not obtain the expenditures needed to determine the income for self-employed parents. In these cases, the administrator did not properly establish HAWK-I eligibility because it could not accurately determine whether family income was within Medicaid income guidelines.

To illustrate one case, a self-employed parent provided documentation that showed receipt of amounts billed to his clients for a 1-week period (gross income) but excluded a deduction of expenditures from gross income (net income).

- In five cases, the administrator's eligibility determinations were based on incomplete income records. The administrator used Medicaid's calculation of family income received from the State agency's Medicaid eligibility staff prior to March 1, 2001. Because the definition for family income in HAWK-I and Medicaid is different when determining countable income, the HAWK-I eligibility determination was based on incomplete income records.

- In 15 cases, the administrator accepted applications with critical questions unanswered. Federal regulations (42 CFR § 457.965) require States to include in each applicant's record facts to support the State's determination of the applicant's eligibility. During our review of these application files, we did not observe any documentation that addressed the unanswered application questions. The sections of the application that were unanswered required the parent to indicate whether his or her children were covered through private health insurance, were institutionalized, or received Supplemental Security Income. These sections are critical in determining eligibility. If the parent affirmatively answered any of the questions, his or her children may have been ineligible. However, the administrator did not determine why the questions were left unanswered, even though section 4 of the first amendment of the State child health plan requires applications to be "screened for completeness of information."

- In one case, the administrator did not require an application to enroll the child. Pursuant to the Iowa Administrative Code, section 441-86.3(6), an application is required unless Medicaid refers the case. However, in this case, the administrator stated that it enrolled the child in HAWK-I on the basis of a phone call from the family. The administrator did not retain any documentation regarding this enrollment.

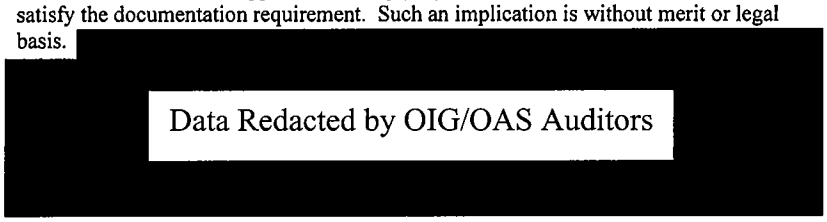
DHS Response

DHS concurs with the findings in 2 of the 36 cases cited with this error finding. DHS partially agrees with the findings in another 5 cases. DHS disagrees with all of the findings in the remaining 29 cases cited with this error finding.

It is the position of DHS that, in 29 of these cases, documentation in the case file or documentation known to the agency and in the possession of the state supports the eligibility determination.

There is no administrative rule and no federal requirement that every question on the application and review forms must be answered before eligibility can be granted. As the OIG stated in its finding, the case file must include "facts to support the State's determination of the applicant's eligibility for SCHIP." In these 29 cases, DHS argues that verified information or information known to the Department supports the state's eligibility determination.

- Documentation supporting the eligibility determination was known to the agency and in the possession of the state in 16 cases cited for relying on income amounts written on the application without obtaining supporting documentation. In 10 of the 16 cases, the verified information was contained in computer systems maintained or interfaced by the state. In the other six cases, the verified information was contained in the Medicaid case file. Contrary to the findings, the SCHIP third-party administrator did not rely on "self-certification of income." Many states are exploring methods to go to "paperless" case files. However the OIG appears to be implying that only paper documents in a case file satisfy the documentation requirement. Such an implication is without merit or legal basis.



- In 2 of the cases the OIG cites for lacking documentation of self-employment expenses, documentation of the expenses was in the case file. The ***hawk-i*** program allows as self-employment expenses, the same expenses as those allowed by the IRS. So, the 1040 form in the case file was sufficient. It lists the net adjusted income after expenses allowed by the IRS were deducted from the gross income of the self-employment. In a third case, the case specifically cited in the finding above, the state agrees that the expenses were not provided. However, when proof of expenses is not provided, the expense is not allowed. And, in this case, the expense was not allowed in determining net profit. But, even without using the expense, the family's countable annual income was within limits.

- In 7 of the cases the OIG cites for having incomplete income records, the documentation of income, separate from the Medicaid Notice of Decision, was found in the case file or on computer systems maintained and made available to the Department for the purposes of income verification. In the other two cases, documentation of income was found in the Medicaid case file and supported the determination of ***hawk-i*** eligibility.

- In the 15 cases the OIG cited for having applications with questions unanswered, 11 had not answered the question about whether the child was receiving SSI. However, Iowa is a 1634 state or one in which receipt of SSI results in automatic Medicaid eligibility. So, had these children been receiving SSI, they would have been identified in the Medicaid match that occurs between the Medicaid and ***hawk-i*** programs. And, none of these children were actually receiving SSI, so no federal funds were misspent. In another case, the question about whether the child is institutionalized was not answered. However, the applicant had already answered another question that all the children lived with the applicant. In three cases, the OIG cited an error for the applicant not answering whether the children were insured. However, the family's pay stubs show no deduction for health insurance. [redacted]

[redacted] Data Redacted by OIG/OAS Auditors

DHS disagrees with the findings in 15 cases where this error was the only finding. These cases represent $72,315 or 31.1% of the $232,740 in premium payments the OIG determined were inappropriate. DHS requests the disallowance and any extrapolation be adjusted accordingly.

Details supporting the position of DHS can be found in Attachment A.

No Documentation That Children Were Uninsured

OIG Finding

Title XXI of the Act, section 2101 (42 U.S.C. 1397aa), states: "The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children . . . ." Further, section 4 of the first amendment to the State child health plan states that: "A child who is currently enrolled in an individual or group health plan is not eligible to participate in the HAWK-I program."

In 14 of the 114 cases, we were unable to determine whether insurance coverage that the applicant identified had been canceled. The applications generally indicated that the children were insured or that the applicants would drop existing coverage if the children were approved for the HAWK-I program. However, the administrator did not request any verification that the children's health insurance coverage had ended; the only documentation retained in the case file indicated that coverage existed.

DHS Response

DHS concurs with the findings in 6 of the 14 cases cited with this error finding. DHS partially agrees with the findings in another 6 cases. DHS disagrees with all of the findings in the remaining 2 cases cited with this error finding.

It is the position of DHS that the OIG misinterpreted or overlooked information in the case file. In four of the 14 cases cited with this error finding, the applicant attested on the application that the children were uninsured. In another three cases, documentation that the insurance coverage had ended was in the case file at the time of the audit. [redacted]

[redacted] Data Redacted by OIG/OAS Auditors

Data Redacted by OIG/OAS Auditors In another two cases in which the state disagrees with the finding the documentation was not present at the time of the eligibility determination. However, subsequent verification establishes that the children were uninsured at the time eligibility was established. Therefore, there were no federal funds misspent.

DHS disagrees with the findings in 1 cases where this error was the only finding. This case represents $1,917 of the $232,740 in premium payments the OIG determined were inappropriate. DHS requests the disallowance and any extrapolation be adjusted accordingly.

Details supporting the position of DHS can be found in Attachment A.

***hawk-i* Not Canceled Upon Medicaid Eligibility Determination**

OIG Finding

Section 4 of the first amendment to the State child health plan states that: "The child shall be disenrolled from the plan and cancelled from the program as of the first day of the month following the month in which Medicaid eligibility is attained."

In 18 of the 114 cases, the administrator did not remove children from HAWK-I once Medicaid eligibility was determined. For these cases that may have resulted in dual coverage because of a retroactive enrollment in Medicaid, we used the notices of decision received from Medicaid to determine the earliest date that HAWK-I officials would have been aware of Medicaid coverage and questioned only the subsequent months.

DHS Response

DHS concurs with the findings in 17 of the 18 cases cited with this error finding. DHS partially disagrees with the findings in one case. DHS disagrees with all of the findings in the remaining case cited with this error finding.

In both cases where the state disagrees with the finding, the requirement to provide a 10-day advance notice of adverse action would have prevented the state from canceling ***hawk-i*** coverage until a month later than the OIG asserts should have happened.

DHS requested and received guidance from CMS (formerly HCFA) regarding the handling of children enrolled in SCHIP who are retroactively approved for Medicaid. A copy of that guidance is found in Attachment D. The cases cited by the OIG where Medicaid was approved retroactively were handled correctly and according to the CMS guidance.

DHS disagrees with the findings in one case where this error was the only finding. This case represent $132 of the $232,740 in premium payments the OIG determined were inappropriate. DHS requests the disallowance and any extrapolation be adjusted accordingly.

Details supporting the position of DHS can be found in Attachment A.

Coverage During the Waiting Period

OIG Finding

To ensure that HAWK-I coverage does not substitute for coverage under group health plans, Iowa imposes a 6-month waiting period when employer-related group health insurance coverage has been dropped unless certain exclusions apply. Pursuant to section 4 of the first amendment of the State child health plan, these exclusions include (1) "Employment was lost for a reason other than voluntary termination," (2) "There was a change in employment to an employer who does not provide an option for dependent coverage," or (3) "Dependent coverage was terminated due to an extreme economic hardship on the part of the employee or employer." The Iowa Administrative Code, section 441-86.2(4), states: "Extreme economic hardship for employees shall mean that the employee's share of the premium for providing employer-sponsored dependent coverage exceeded 5 percent of the family's gross annual income."

The administrator approved 8 of the 114 cases for HAWK-I when the 6-month waiting period should have been imposed. For example, an applicant asserted that she could not afford the increase in her family's group health insurance premium. After the increase, the family's premium was approximately $75 per month, which was 3 percent of its gross income. Pursuant to section 4 of the first amendment of the State child health plan, the applicant's child should have been subject to a waiting period because the premium did not exceed 5 percent of the family's gross annual income. However, the administrator approved the application and immediately enrolled the child

DHS Response

DHS concurs with the findings in 5 of the 8 cases cited with this error finding. DHS disagrees with all of the findings in the remaining 3 cases cited with this error finding.

In one of the cases with which DHS disagrees, it is the position of DHS that using the cafeteria income to offset the cost of the health insurance results in a "double count" of the income. In this case, the parent receives the cafeteria income as part of their gross income which is used to determine eligibility. In determining the cost of the family's health insurance, the OIG asserts that the state must offset the cost with the cafeteria income. The family has the discretion on how to spend the income. The state disagrees with the finding. In the other case, both parents are employed. One parent had enrolled himself, his spouse, and children in an employer related health plan. Deductions were being taken from his paychecks. His spouse received the cash value of a health plan for her only as part of her gross income. Again, the OIG asserts that this cash value must be used to offset the cost of health insurance when determining if the family's health care costs exceeded 5% of their gross income. And, again, the state disagrees with the finding. The family has the choice on how to apply the income. The state cannot assume that it will be applied to health care. A second case in which the state disagrees with the finding, the circumstances are similar except that the amount received by the parent as part of their regular pay is not classified as "cafeteria income." But the state takes the same position in this case as in the case with cafeteria income. In the third case, the OIG asserts that a waiting period should

have been imposed because the parent voluntarily terminated their employment. However, prior to the termination of employment, the family was paying more than 5% of their gross income for health insurance premiums. So, the reason the insurance coverage ended would be moot.

DHS disagrees with the findings in 2 cases where this error was the only finding. These cases represent $1,855 of the $232,740 in premium payments the OIG determined were inappropriate. DHS requests the disallowance and any extrapolation be adjusted accordingly.

Details supporting the position of DHS can be found in Attachment A.

Failure of Applicants to Cooperate During Medicaid Eligibility Process

OIG Finding

Applicants must cooperate in the eligibility determination process if they appear eligible for Medicaid; otherwise, they may not be considered for HAWK-I. The Iowa Administrative Code, section 441-86.2(5), states that: "A child who would be eligible for Medicaid except for the parent's failure or refusal to cooperate . . . shall not be eligible for coverage under the HAWK-I program."

The administrator approved 2 of the 114 cases for HAWK-I after Medicaid denied the applications because the families did not cooperate during the eligibility verification process. For example, one case involved a family whose infant was enrolled in Medicaid, but whose other children were enrolled in HAWK-I. When the State agency's Medicaid eligibility staff wanted to redetermine the family's income and possibly enroll all of the children in Medicaid, the parents refused to provide further information. As a result, the State agency removed the infant from Medicaid. Two months later, the administrator enrolled the infant in HAWK-I even though it received a Medicaid notice of decision stating that the infant was being denied Medicaid coverage because of the applicant's failure to provide necessary documentation. Pursuant to the Iowa Administrative Code, section 441-86.2(5), the children should not have been eligible for HAWK-I because of the parents' refusal to provide documentation necessary to make a proper eligibility determination.

DHS Response

DHS disagrees with all of the findings in both of the cases cited with this error finding.

It is the position of DHS that the OIG overlooked documentary evidence in the case file for both of these cases. The Medicaid Notice of Decision establishing the reason for the cancellation of Medicaid was in both of the case records cited for this error finding at the time of the audit. And, both Notices of Decision establish the fact that the family's Medicaid was canceled due to income exceeding the Medicaid limits, not for failing to cooperate with a Medicaid requirement.

Both of the cases with this error finding also had other error findings.

Details supporting the position of DHS can be found in Attachment A.

Coverage Beyond the 12-Month Eligibility Period

OIG Finding

Pursuant to section 4 of the first amendment of the State child health plan, "Eligibility for HAWK-I is granted in 12-month enrollment periods." In addition, the Iowa Administrative Code, section 441-86.9, states that: " All eligibility factors shall be reviewed at least every 12 months to establish ongoing eligibility for the program."

In 5 of the 114 cases reviewed, children were insured beyond the 12-month eligibility period without a redetermination demonstrating that the children continued to be eligible for HAWK-I. For example, a family with six children reapplied for HAWK-I coverage in August 2001, prior to the end of their eligibility on September 30, 2001. During the redetermination process, the administrator determined that the family was not eligible; however, the administrator continued to pay premiums on behalf of the family through October 31, 2001, and three of the children remained enrolled until January 31, 2002.

DHS Response

DHS concurs with the findings in 4 of the 5 cases cited with this error finding. DHS disagrees with all of the findings in the remaining case cited with this error finding.

While the state agrees with the findings in four of the cases, the OIG incorrectly cited an error in one case. The enrollment period ran from March 2001 through February 2002. The case file contains a copy of the notice informing the family that the enrollment period expired on February 28, 2002. No capitation payment was made for the family for months after February 2002.

The case with this error finding with which DHS disagrees also had other error findings.

Details supporting the position of DHS can be found in Attachment A.

Duplicate Premium Payments

OIG Finding

In accordance with Office of Management and Budget (OMB) Circular A-87, section C(1)(a), to be allowable under Federal awards, costs must be "necessary and reasonable for proper and efficient performance and administration of Federal awards." Additionally, OMB Circular A-87, section C(2)(a), states that in determining reasonableness of a given cost, consideration shall be given to whether the cost is of a type generally recognized as ordinary and necessary for the operation of the Federal unit or the performance of the Federal award.

In 2 of the 114 cases reviewed, the administrator made 2 premium payments for the same months of coverage for the same children. For example, in one of the cases, four children were enrolled

in one SCHIP insurance plan effective May 1, 2001. However, these children were already enrolled in another SCHIP insurance plan, and they were not disenrolled from this initial SCHIP insurance plan until the end of July 2001. Accordingly, the administrator made duplicate payments on behalf of these four children for 3 months.

DHS Response

The state agrees with this error finding in both of these cases.

Income Falling Within Medicaid Eligibility Guidelines

OIG Finding

Pursuant to section 2102(b)(3)(B) of the Act, the State must include a provision in the State child health plan requiring that children be enrolled in Medicaid if they are found through the SCHIP application process to be eligible for Medicaid. The State child health plan, section 1, provides that children with family income below 133 percent of the Federal poverty level are eligible for Medicaid. Additionally, section 2 of the fourth amendment to the State child health plan states that the HAWK-I program covers children who are not eligible for Medicaid.

In 14 cases, the administrator enrolled children in HAWK-I even though family income fell within Medicaid eligibility guidelines. In these cases, the administrator did not properly establish HAWK-I eligibility because the SCHIP administrator and the State agency's Medicaid eligibility staff erroneously determined that family income exceeded Medicaid eligibility limits. However, we could not determine whether these families were qualified for Medicaid because the Medicaid eligibility process was incomplete.

DHS Response

DHS concurs with the findings in 7 of the 14 cases cited with this error finding. DHS partially disagrees with the finding in one cases. .DHS disagrees with all of the findings in the remaining 6 cases cited with this error finding.

It is the position of DHS that the OIG miscalculated income, overlooked documentary evidence, or misinterpreted program policy in nearly 43% of the cases with this error finding. In three cases, the family's income clearly still exceeded Medicaid limits but fell within ***hawk-i*** limits. In one case, the OIG cited the state for not using the same deductions as the Medicaid program when screening for potential Medicaid eligibility. In fact, states were provided with guidance at the time of SCHIP implementation that tells states that they do not need to include in the screening process any processes, "that are more extensive than those required to ensure eligibility under Title XXI." In another case, the OIG correctly asserts that a reimbursement should not have been counted as income in the eligibility determination. However, even without the reimbursement, the countable income is within ***hawk-i*** limits.

DHS disagrees with the findings in 2 cases where this error was the only finding. These cases represent $3,561 of the $36,897 in premium payments for people the OIG claims meet Medicaid

guidelines. DHS requests the disallowance and any extrapolation be adjusted accordingly. In addition, DHS requests that before any disallowance is established, a determination be made as to whether the children in the seven cases in which the state agrees with the finding would have been eligible for Medicaid under the Medicaid expansion group which is funded with Title XXI funds.

Details supporting the position of DHS can be found in Attachment A.

RECOMMENDATIONS

OIG Recommendation

Refund $5,902,872 to the federal government for ***hawk-i*** overpayments.

DHS Response

As stated previously, DHS disagrees with all of the findings in 25 of the 68 cases cited as having errors. These 25 cases represent $98,552 or 42.3% of the $232,740 in premium payments determined by the OIG to be inappropriate, and $14,270 or 38.7% of the $36,897 in premium payments for people the OIG claims meet Medicaid guidelines. DHS also partially disagrees with the error findings in another 17 cases. DHS agrees with all of the findings in 16 cases. Based on these findings, DHS requests that the disallowance and any extrapolation be adjusted accordingly.

DHS invites the OIG to review the documentation supporting our position on the individual cases in order to resolve any areas of disagreement.

OIG Recommendation

Work with CMS to resolve $420,882 in payments for set-aside cases.

DHS Response

As stated in the above recommendation response, the state disagrees with findings representing over 38.7% of the premium payments for people the findings claimed were within Medicaid guidelines. Based on these findings, DHS requests that the disallowance and any extrapolation be adjusted accordingly. For the cases with which we agree, DHS will work with CMS to resolve the payments.

OIG Recommendation

Amend the contract with the administrator to include quality control requirements and incorporate similar provisions in Iowa's State child health plan.

DHS Response

On July 1, 2005, a new performance-based contract was entered into with the SCHIP third-party administrator. It contains provisions that include numerous quality control processes. These processes are conducted, in part, by the SCHIP third-party administrator, by staff of the Department's Quality Control unit, and by the Department's SCHIP unit. These processes examine not only the eligibility determinations made by the SCHIP third-party administrator, but also premium collection, health plan enrollment and disenrollment, and payment of capitation fees. This part of the contract is found in Attachment C.

Also, as previously stated, site visits by CMS have stated that our quality control activities are adequate. Refer to Attachment B for more information.

OIG Recommendation

Strengthen the administrator's quality control requirements to ensure that ***hawk-i*** applications and the supporting documentation adequately substantiate eligibility.

DHS Response

The current contract with the SCHIP third-party administrator strengthens their quality control requirements. Staff of the SCHIP third-party administrator will conduct quality control readings on a minimum of 30 cases per month. In addition, the contract contains performance standards for providing an efficient and responsive telephone system, a dedicated fax line, as well as maintaining an eligibility decision error rate of three percent or less, processing applications within prescribed timeframes, and maintaining an operational computer system. The contract also requires that the integrity of the computer system be certified annually through an independent audit. The parameters for the first SAS 70 audit are currently being developed. The SCHIP third-party administrator reports monthly on these areas to demonstrate their ability to meet the performance measures. Failure to meet the prescribed standards will result in financial penalties. In addition, the SCHIP third-party administrator is responsible for any erroneous payments made by the administrator.

OIG Recommendation

Strengthen controls to ensure appropriate oversight of the administrator.

DHS Response

The current contract with the SCHIP third-party administrator strengthens DHS's oversight. DHS will conduct quality control readings on a minimum of 70 cases per month. In addition, DHS has provided the SCHIP third-party administrator with written clarifications of eligibility policies and procedures when the need is identified by either party. These written clarifications are used by the SCHIP third-party administrator as a tool for training or re-training of their eligibility staff.

OIG Recommendation

Direct the administrator to improve its computer edits to prevent duplicate premium payments.

DHS Response

Even during the audit time period, the SCHIP third-party administrator was aggressively working to identify and fix any computer system problems. That process continues today. Additionally, the new contract requires that the integrity of the computer system be validated annually through an independent auditor. The parameters for the first SAS 70 audit are currently being developed.