

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE CHILDREN'S HEALTH
INSURANCE PROGRAM**

**Ensuring Medicaid Eligibles are not Enrolled in
SCHIP**



**FEBRUARY 2001
OEI-05-00-00241**

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To evaluate whether States are enrolling Medicaid eligible children in the State Children's Health Insurance Program.

BACKGROUND

Many low-income children receive health care coverage through Medicaid and the State Children's Health Insurance Program (SCHIP). The SCHIP is designed to reduce the number of uninsured children by offering health care coverage to previously uninsured children. The program targets children with family income too high for Medicaid and too low to afford private insurance.

The Balanced Budget Refinement Act of 1999 required that the Office of Inspector General (OIG) sample States in order to: (1) evaluate whether States are correctly enrolling children in SCHIP or Medicaid; and (2) assess States' progress in reducing the number of uninsured low-income children. According to the Act, the OIG was to evaluate the States' progress on performance goals. Sampled States were to be selected only from States not using SCHIP funds to expand Medicaid.

This is one of two reports focusing on five of the 15 States administering separate child health programs as of October 1, 2000. Those States are North Carolina, Oregon, Pennsylvania, Utah and Vermont. This report focuses on State efforts to ensure that Medicaid eligibles are not enrolled in SCHIP. In a companion report, we assess States' efforts to evaluate their SCHIP performance goals.

FINDINGS

SCHIP eligible children are enrolled in the proper program

We found few Medicaid eligible children enrolled in SCHIP in the 100 cases we reviewed in each of the 5 sample States. One State had a single case in which a Medicaid eligible child was enrolled in SCHIP, while two other States had three and five cases, respectively. Two States had no Medicaid eligible children enrolled in SCHIP. Three States had no over-income children in SCHIP. We found only one over-income case in one of the States and three such cases in the other. Based on our 2-stage stratified-cluster sample, we estimate that at the 90 percent confidence level, between 97.6 percent and 99.6 percent of SCHIP enrollees were correctly enrolled in the 13 States administering separate child health programs in fiscal year 1999. States attribute correct enrollments to

review of income information and staff training. All five States require proof of income to determine eligibility for some applicants.

Four sample States manually determine SCHIP eligibility, while the fifth utilizes an electronic eligibility system. One State is currently developing an electronic eligibility system. Others are interested in such systems but have no plans to implement them.

States provide a smooth transition between SCHIP and Medicaid

States have worked to streamline the process of transferring children from one program to another. Four of the 5 States permit 6 to 12 months of continuous eligibility for SCHIP. This reduces the burden of frequent income verification for States and relieves families of the need to provide frequent income updates to the State.

In an effort to encourage and simplify SCHIP re-enrollment, States have sent out re-enrollment reminder letters to families and allowed applicants to submit shorter re-application forms. Medicaid staff often determine both SCHIP and Medicaid eligibility, which increases program coordination and staff knowledge about eligibility rules.

Conclusion

We believe that Medicaid eligible children are not being enrolled in SCHIP by States who administer separate child health programs.

AGENCY COMMENTS

The Health Care Financing Administration (HCFA) and the Health Resources and Services Administration (HRSA) provided formal comments to the draft report. Both concur with the findings. The full text of their comments are included as Appendices A and B.

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	i
INTRODUCTION	1
FINDINGS	
SCHIP eligible children are enrolled in the proper program	5
States provide a smooth transition between State CHIP and Medicaid	7
APPENDICES	
A: HCFA Comments	9
B: HRSA Comments	12

INTRODUCTION

PURPOSE

To evaluate whether States are enrolling Medicaid eligible children in the State Children's Health Insurance Program.

BACKGROUND

Many low-income children receive health care coverage through Medicaid and the State Children's Health Insurance Program (SCHIP).¹ Both Medicaid and SCHIP are joint State-Federal programs that allow States administrative discretion within guidelines established by statute and the U.S. Department of Health and Human Services.

Medicaid, which was established in 1965, is the largest program providing health care services to America's poorest people. Within broad national guidelines set by the Federal Government, each State administers its own program, sets its own eligibility standards, determines the type, amount, duration and scope of services, and sets payment rates.

Total non-administrative expenditures for the Medicaid program were \$180.9 billion in 1999 (\$102.5 billion in Federal and \$78.4 billion in State funds). The Health Care Financing Administration (HCFA) reports that in 1998, 51 percent of all Medicaid recipients were children. In 1998, Medicaid paid an average of \$1,150 per child for the 20.6 million children who received services through the program.

The State Children's Health Insurance Program and uninsured children

Over 10 million children in the United States are uninsured. SCHIP is designed to help reduce the number of uninsured low-income children by providing them with health care coverage. Title XXI of the Social Security Act (SCHIP's enabling legislation) was created by the Balanced Budget Act of 1997 (P.L. 105-33). The law appropriated nearly \$40 billion over 10 years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private insurance.

Like Medicaid, SCHIP is a State and Federal partnership, but the Federal match for SCHIP expenses is greater than the match for Medicaid. States have three options for covering uninsured children under Title XXI: design a separate children's health insurance program, expand Medicaid eligibility, or a combination of the two strategies. As of October 1, 2000, 15 States administer separate child health programs, 23 run

¹The Health Care Financing Administration refers to Title XXI-funded programs as State CHIP or SCHIP.

expanded Medicaid, and 18 have combination programs.² This report focuses on the 15 States operating separate programs. These States are Arizona, Colorado, Delaware, Georgia, Kansas, Montana, Nevada, North Carolina, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington, and Wyoming.

Under Title XXI, a State must have an approved State plan for a fiscal year in order to receive an allotment that year. Each State submitted a SCHIP plan to HCFA, outlining program structures, use of funds, benefits, strategic objectives, and performance goals.

Close to 2 million children who would otherwise be without health insurance coverage were enrolled in SCHIP in fiscal year 1999. This is double the number reported enrolled in 1998, the first full year of the program. Of the 56 State and territorial children's health insurance programs to date, 53 were operational during fiscal year 1999. Of the nearly 2 million children covered as of September 30, 1999, over 1.2 million were enrolled in separate children's health insurance programs and almost 700,000 were enrolled in Medicaid expansion plans.

Ensuring correct enrollment in State CHIP and Medicaid

To encourage States to expand child health insurance eligibility, the Federal match for States' Title XXI expenditures is greater than the match for Medicaid. The average Federal match for Title XXI is 71 percent, while the average Federal match for Medicaid is 57 percent. Medicaid is an entitlement program and States are required to enroll all eligible children. SCHIP is not an entitlement program and States have the discretion to cap enrollment for SCHIP eligibles or create waiting lists. So that States do not try to maximize SCHIP reimbursements by enrolling Medicaid eligibles in SCHIP, Title XXI requires States to screen SCHIP applicants for Medicaid eligibility. Therefore it is essential that children found eligible for Medicaid must be enrolled in Medicaid rather than in the SCHIP. States receive only the Medicaid-level match for any child enrolled in Medicaid based on the eligibility standards that existed before Title XXI was enacted. Due to their effort to enroll children in new Title XXI funded programs, some States have noticed the so-called "woodwork effect"; by conducting outreach for SCHIP, they encourage greater numbers of Medicaid eligibles to apply for health care services as well.

In their SCHIP State plans, States agreed to assess all SCHIP applicants for Medicaid eligibility before checking SCHIP eligibility. Medicaid assessment techniques for some States are outlined as follows:

- North Carolina checks the Medicaid information system to see whether the applicant has existing Medicaid coverage. If the child is not currently covered by Medicaid, Medicaid eligibility is assessed before SCHIP eligibility is pursued.

² Currently, 50 States, 5 Territories and the District of Columbia administer Title XXI programs.

- Nevada checks Medicaid eligibility for all applicants reporting income up to 25 percent above the Medicaid limit before assessing eligibility for SCHIP.
- Delaware uses a common computer eligibility system for Medicaid and SCHIP.

Legislative Requirement for OIG Studies

Section 703 of the Balanced Budget Refinement Act of 1999 required that the Office of Inspector General (OIG) sample States in order to: (1) evaluate whether States are correctly enrolling children in SCHIP or Medicaid as appropriate; and (2) assess the progress made by States to reduce the number of uninsured low-income children. The Act further requires that the OIG evaluate the progress sampled States have made to achieve their strategic objectives and performance goals. Sampled States were to be selected from States not using any SCHIP funds to expand Medicaid.

This is one of two reports focusing on a sample of five States administering separate children's health programs. This report focuses on State efforts to ensure that Medicaid eligibles are not enrolled in SCHIP. In a companion report entitled "State Children's Health Insurance Plan - Assessment of State Evaluation Reports," OEI-05-00-00240, we address States' evaluations of their performance goals.

METHODOLOGY

Based on the requirements outlined in the Balanced Budget Refinement Act of 1999, we limited our universe to the 15 States utilizing their Title XXI allotments to operate separate children's health programs. Two States, Wyoming and Washington, were excluded from the population because they began administering SCHIP in December 1999 and February 2000, respectively, and thus had no enrollees in fiscal year 1999.

We used a 2-stage stratified-cluster sampling plan to select 5 States from the 13 remaining States. The remaining 13 States were divided among 2 strata. Pennsylvania was a self-representing State as illustrated in Strata 1, based on the significantly large number of children enrolled in their SCHIP. From the remaining 12 States, we randomly selected 4 States, North Carolina, Oregon, Utah, and Vermont, for Strata 2. The chart on the following page outlines the number of children enrolled in SCHIP in each of the Strata and sample States in Fiscal Year 1999.

Selected Sample States

STRATA 1

States Selected	Number of Children Enrolled in SCHIP in FY 1999	Number of Cases Selected For Review
Pennsylvania	81,758	100
Totals	81,758	100

STRATA 2

States Selected	Number of Children Enrolled in SCHIP in FY 1999	Number of Cases Selected For Review
North Carolina	57,300	100
Oregon	27,285	100
Utah	13,040	100
Vermont	2,055	100
Totals	99,680	400

We reviewed the 5 States' Title XXI plans and the SCHIP evaluation reports submitted to HCFA in March 2000. We conducted on-site visits and met with staff at the agency administering SCHIP in each of the five States.

We conducted case file reviews and discussed enrollment issues and goal attainment with State staff. We reviewed 100 randomly selected active SCHIP case files in each State in order to evaluate whether ineligible children were enrolled in SCHIP. We provided each State with randomly selected case numbers and staff pulled these cases in preparation for our visit. The results of our case file review were analyzed using a statistical analysis package that takes into account complex sample designs.

One part of our discussions with SCHIP staff focused on State efforts to appropriately enroll children and safeguards used to ensure proper enrollment. We also discussed State CHIP evaluations. We collected documentation of State eligibility and enrollment practices and of evaluation efforts.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

SCHIP eligible children are enrolled in the proper program

We found few Medicaid eligible children enrolled in SCHIP in the 100 cases we reviewed in each of the 5 sample States. One State had a single case in which a Medicaid eligible child was enrolled in SCHIP, while two other States had three and five cases, respectively. Two States had no Medicaid eligible children enrolled in SCHIP.

While the focus of our review was on children who were enrolled in SCHIP despite their eligibility for Medicaid, we also found a limited number of cases in which family income exceeded established limits for SCHIP eligibility. One State had one such case and another had three cases with over-income children. The other three States had no such cases.

All five States reported a belief that they are enrolling children in the appropriate programs. When asked, States rated how successful they believed they had been on a scale of 1 to 10, with 10 being extremely successful, the average rating was 9. States attribute their success to careful analysis of income information and timely training of their employees.

Our case file reviews confirmed the States own assessments. Using the results of our case file reviews in the 5 sampled States, we estimate that at the 90 percent confidence level, between 97.6 and 99.6 percent of the children were enrolled correctly in SCHIP in the 13 States that administered separate child health programs in fiscal year 1999.

Eligibility is primarily based on income

All SCHIP programs must evaluate children's eligibility based on family income. The five States we visited require some proof of income to determine program eligibility for most enrollees. Four States require between 1 and 3 months of current payroll information, one of which allows families to self-declare income earned through self-employment. The fifth sample State allows most families to self-declare their income but asks for proof of income, such as a recent W-2 tax form for children in families with self-employment income. States also verify some reported family income through checks of computerized data bases, such as WageMatch or Social Security Administration files.

States report they are confident that children are enrolled correctly because they have faith in families' willingness to report income changes. Several States that utilize continuous enrollment report that families contact program staff to report income changes when they happen, even though this is not required by the program. Because families

volunteer information about income changes, States believe that families are honestly reporting income and other information at enrollment.

Other eligibility factors require children to:

- be younger than 19 years old;
- not have other current health insurance;
- have been without health insurance for a period of time specified by the State (usually 1 to 6 months); and
- be U.S. citizens or legal residents.

Training helps ensure proper enrollment

SCHIP administrators reported they train eligibility staff about program rules and enrollment practices. They indicated that training helps ensure enrollment workers understand current programs and changes to SCHIP and Medicaid as they occur. One State found problems with workers enrolling children with current insurance despite SCHIP rules that prohibit this. As a result, the State retrained all enrollment workers to ensure that they understood program rules and now reports that incorrect enrollment of insured children has been stopped. Several States reported that they conduct periodic training for staff to ensure their knowledge of program rules and guidelines and to keep them informed of any changes in program operation.

Eligibility mostly determined manually

Four of the five sample States manually determine SCHIP eligibility. These States rely on enrollment workers to collect and review documentation, calculate eligibility, and ensure that applicant children are not Medicaid eligible before enrolling them in SCHIP. However, these States store this information electronically. The fifth sample State utilizes an electronic eligibility system that assesses whether the children are eligible for Medicaid. If children are found ineligible for Medicaid, the process is repeated to determine SCHIP eligibility.

One State that currently determines eligibility manually is in the process of developing a centralized computer system to electronically verify eligibility. State staff anticipate the electronic verification process will enable them to move children between SCHIP and Medicaid more easily and will make the transition between programs seamless for the recipient. It also will diminish the possibility of improper program placement. The other three States we visited would like to develop a system to determine eligibility electronically but have no immediate plans to do so.

None of the sampled States conduct systematic checks of eligibility after a child is enrolled in SCHIP. However, several States indicated that they conduct post-enrollment checks if they question information a family provides.

Public perception of Medicaid may lead to enrollment challenges

Two States report that families view SCHIP more favorably than Medicaid because people associate Medicaid with public assistance. These two States report they suspect some Medicaid eligibles are applying for SCHIP, meaning that State workers must pay close attention to income information.

In the three other States, administrators report that families have not expressed a preference for SCHIP over Medicaid. Applicants may not be aware of a difference between SCHIP and Medicaid in these States, as the two programs are similar in structure and benefits. A single agency administers both programs in these States, and the distinction between the programs is not publicized.

States provide a smooth transition between State CHIP and Medicaid

Families eligible for SCHIP and Medicaid often experience changes in income which effect program eligibility. Since income fluctuations are common, the five sample States have worked to streamline the process of transferring children from one program to the other.

States permit continuous eligibility

Four of the five sample States allow SCHIP enrollees to remain in the program for a specified period even if family income changes enough to warrant transfer to Medicaid or out of the program. The “continuous eligibility period” begins when the application has been approved and lasts between 6 and 12 months, as determined by the State. Continuous eligibility helps reduce the burden on States to repeatedly verify income information and relieves families of the need to provide frequent income documentation. Although States utilizing continuous eligibility allow children to remain on SCHIP as family income changes, there can be exceptions to this rule to ensure proper enrollment. For instance, one State automatically transfers SCHIP recipients to Medicaid when their families begin receiving Temporary Assistance for Needy Families benefits.

The only sample State that does not practice continuous eligibility requires SCHIP enrollees to notify staff of a change in income within 10 days of any change. After notification of a change, enrollees are transferred to the Medicaid program if they meet Medicaid eligibility requirements. Transferred individuals are unaware of a change in program enrollment because the transfer is done internally and enrollees see no differences in program structures or benefits.

States have simplified the re-enrollment process

In an effort to encourage and simplify SCHIP re-enrollment, sampled States have taken steps to ease the process. For example, several States send out reminder letters prior to

the re-enrollment date, no longer require new applications to be completed at re-enrollment, and allow eligibles to re-enroll by mail or phone.

Medicaid staff often determine both SCHIP and Medicaid eligibility

Four of the five States facilitate the transfer of applicants' enrollment information between Medicaid and SCHIP by having the Medicaid enrollment staff also determine SCHIP eligibility. This method of partnering the programs allows the person conducting the eligibility determinations to become familiar with both programs and reduces the likelihood of incorrect program placement. Four States also automatically refer individuals who are not eligible for SCHIP to Medicaid and vice versa. In some States, those SCHIP applicants found to be Medicaid eligible only need to fill out an addendum to their completed SCHIP applications.

Conclusion

As required by Section 703 of the Balanced Budget Refinement Act of 1999, we evaluated whether States administering separate child health programs are enrolling Medicaid eligibles in SCHIP. Based on our random sample, these five States do not appear to be doing so.

Agency Comments

The Health Care Financing Administration and the Health Resources and Services Administration provided formal comments to the draft report. They concur with the findings. The full text of their comments are included in Appendices A and B.

The HCFA provided information regarding their continued work with States to ensure that effective screening occurs, and acknowledged the importance of State developed systems to effectively ensure that children who are screened and found potentially eligible for Medicaid are enrolled in Medicaid. The HCFA also notes they have issued guidance to States encouraging simplification of the application and enrollment process to promote coordination, and are working with States to examine the redetermination process to assure that it promotes ongoing coverage of children who become ineligible for one program and eligible for the other.

The HRSA offered technical comments that included stating the specific date for our summary of SCHIP plans, and adding language to clarify that the 15 States in our universe had "accessed their 1998 SCHIP allotment" rather than utilized "their entire Title XXI allotments."



DATE: JAN - 9 2001

TO: June Gibbs Brown
Inspector General

FROM: Robert A. Berenson, M.D. *Robert A. Berenson M.D.*
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "State Children's Health Insurance Program - Assessment of State Evaluations Reports," (OEI-05-00-00240) and "State Children's Health Insurance Program - Ensuring Medicaid Eligibles are not Enrolled in SCHIP," (OEI-05-00-00241)

Thank you for the opportunity to review and comment on the above-referenced draft reports. As you know, health coverage for children continues to expand nationwide under the State Children's Health Insurance Program (SCHIP). The Health Care Financing Administration (HCFA) is releasing new national data showing that in Federal Fiscal Year 2000, over 3.3 million children received health care coverage through SCHIP, a 70 percent increase over the number of children enrolled in 1999. The Census Bureau recently released data showing a decline of 1.7 million people in the ranks of the uninsured between 1998 and 1999, two-thirds of whom were children. These numbers confirm that the Clinton Administration has made major strides in increasing enrollment in SCHIP and Medicaid.

We have carefully reviewed your two reports on the SCHIP program. We concur with the recommendations in the first report, and our detailed comments appear below.

While there were no recommendations or areas of improvement noted in the second report, we do concur with the OIG findings. The coordination policy, established by statute, requires that a child found to be potentially Medicaid eligible through the SCHIP eligibility screening process cannot be enrolled in a separate SCHIP unless there is a finding of ineligibility for Medicaid. The OIG review of five States confirms that States have been able to develop effective screening procedures. HCFA will continue to work with States to ensure that effective screening occurs. In addition, it is equally important that States develop effective systems to ensure that the children who are screened and found potentially eligible for Medicaid are enrolled in Medicaid. Otherwise, eligible children will remain uninsured.

Many States have developed effective "screen and enroll" procedures, and HCFA has issued guidance to States encouraging simplification of the application and enrollment process to promote coordination. We are also working with States to examine the redetermination process to assure that it promotes ongoing coverage of children who become ineligible for one program and eligible for the other program. Our final SCHIP regulations will provide further guidance in this area, and we will continue working with States on these issues and monitoring States'

programs through HCFA regional office onsite reviews. These reviews provide an opportunity to identify best practices, provide technical assistance to States, and assure compliance with the statute.

We appreciate the effort that went into these reports. Once again, thank you for the opportunity to review and comment on the issues raised. While we recognize the assessment that the States' March 31, 2000 evaluations lacked a significant amount of quantitative or evaluative information about progress with their SCHIP programs to date, we also feel it is important to note the States' significant level of innovation and commitment in developing, in many cases, entirely new programs in a relatively short period of time. Evaluating the success of a program within the first year of implementation can be extremely difficult. HCFA is committed to continuing to work with States on all of the areas discussed in this report and we are confident that as programs mature, more quantifiable information will become available. Our response to the recommendations in your first report follows.

OIG Recommendation

HCFA should identify a core set of evaluation measures and develop a more specific framework for the content and structure of the reports that States are required to submit.

HCFA Response

We concur. To assist States in complying with Title XXI, section 2108 of the SCHIP statute, HCFA, in partnership with the National Academy for State Health Policy, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- recognize the diversity of State approaches to Title XXI programs;
 - provide consistency across States in the structure, content, and format of the report;
 - build on data already collected by HCFA quarterly enrollment and expenditure reports; and
- enhance accessibility of information to stakeholders on the achievements under Title XXI.

The final rules include a provision that the Secretary will establish a core set of performance measures that will be reported by States in their annual reports. We will work with States to develop such measures in order to obtain comparable data across States.

OIG Recommendation

HCFA and the Health Resources and Services Administration should provide guidance and assistance to States in conducting useful evaluations of their programs.

HCFA Response

We concur. The guidance and assistance that HCFA provides the States is by way of policy letters, technical assistance visits, participation on SCHIP Technical Advisory Groups, and information exchanges at conferences.

Each State has independent responsibility to create the capacity for assembling a data collection plan and resources to implement such a plan that would support their unique SCHIP State plan evaluations. While we agree that staff resources in States may affect their ability to fully conduct useful and meaningful evaluations, certain of the recommendations would also likely

require statutory changes in States, including the need for a set-aside or increased amount of administrative funding. We note that matching funds are already available to States for evaluation activities, but these expenditures are subject to the statutory 10 percent limit on administrative costs.

HCFA concurs that the following elements, which were enumerated in the OIG recommendation, should be included in a State data collection plan: 1) what data to collect; 2) how to obtain specific data; 3) how to determine if the data is reliable; 4) how to determine what the data is yielding; and 5) how to evaluate the data.

APPENDIX B



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Health Resources and
Services Administration
Rockville MD 20857

DEC - 8 2000

TO: Deputy Inspector General for Audit Services, OS
FROM: Deputy Administrator
SUBJECT: Office of the Inspector General State Health Children's Health Insurance Program, Ensuring Medicaid Eligibles are not Enrolled in SCHIP, OEI-05-00-00241

We have reviewed the subject draft report. Attached are the Health Resources and Services Administration's comments.

Staff questions may be referred to Jeanelle Kallevang on (301) 443-5181.


Thomas G. Morford

Attachment

Comments of the Health Resources and Services Administration on the
Office of Inspector General (OIG) Final Report, "State Children's Health Insurance
Program: Ensuring Medicaid Eligibles are not Enrolled in SCHIP"
Code OEI-05-00-00241

General Comments

The Health Resources and Services Administration appreciates the opportunity to provide our comments on the Office of Inspector General (OIG) Final Report "State Children's Health Insurance Program: Ensuring Medicaid Eligibles are not Enrolled in SCHIP." The findings outlined in this report are very important in demonstrating that States are enrolling SCHIP-eligible children in the appropriate program.