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United States Government Accountability Office
Washington, DC 20548

December 5, 2012

The Honorable Max Baucus
Chairman
Committee on Finance
United States Senate

Subject: *Medicaid and CHIP: Considerations for Express Lane Eligibility*

Dear Mr. Chairman:

Each year, millions of children do not have health insurance coverage even though they are eligible for Medicaid or the Children's Health Insurance Program (CHIP), two joint federal-state programs that provide health insurance to certain low-income individuals.¹ Additionally, each year, some children lose Medicaid or CHIP coverage for which they are eligible and then, after a short coverage gap, reenroll—a process that is costly to the programs administratively, as well as burdensome for families.² The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided states with new incentives and tools to simplify eligibility determinations and increase the enrollment and retention of children in Medicaid and CHIP. One of these tools is Express Lane Eligibility (ELE), which allows states to determine eligibility for children in Medicaid or CHIP by using certain information, such as information from other public-assistance programs that enroll children.³ Specifically, within certain limits, ELE allows a state Medicaid or CHIP agency to use another

¹Medicaid finances health insurance for certain categories of individuals, including low-income children; CHIP is an insurance program for certain low-income, uninsured children whose family income is too high for Medicaid. Under Medicaid and CHIP, states pay qualified health care providers for covered services given to enrolled beneficiaries, and then seek reimbursement for the federal share of those payments.

In fiscal year 2010, 34.4 million children had health coverage through Medicaid, and 7.7 million children had health care coverage through CHIP, while approximately 8 million children were uninsured. The specific factors considered in determining eligibility for Medicaid and CHIP vary across states and generally involve income, disability status, residency, age, and citizenship.

²For example, many children who are still eligible lose coverage because the family failed to respond accurately or on time to notices to renew eligibility (children's enrollment must be renewed at least once a year). Some children disenroll from CHIP or Medicaid because they are no longer eligible or obtain private coverage.

³Pub. L. No. 111-3, § 203(a), 123 Stat. 8, 40 (2009) (codified, as amended, at 42 U.S.C. § 1396a(e)(13)). Under CHIPRA, the ELE option may only be used for Medicaid and CHIP eligibility determinations for children and cannot be used for parents or other adults. CHIPRA established new performance bonuses for states adopting at least five of eight specified policies to simplify Medicaid and CHIP enrollment and retention procedures for children; one of the specified policies was ELE. States are eligible for these performance bonuses for fiscal years 2009 through 2013. See Pub. L. No. 111-3, § 104, 123 Stat. 8, 17-23.

entity's findings—in other words, determinations of fact, such as the family's income—when evaluating a child's eligibility for Medicaid or CHIP, as long as those findings were made within a reasonable period. These other entities, called Express Lane Agencies, are defined to include public agencies that determine eligibility for certain assistance programs, such as the National School Lunch Program, the Supplemental Nutrition Assistance Program (SNAP, formerly called the Food Stamp Program), the Temporary Assistance for Needy Families program (TANF), and Head Start.⁴ Under ELE, a state Medicaid or CHIP agency may rely on an Express Lane Agency's findings even if the Express Lane Agency uses a different method than Medicaid or CHIP to derive those findings.⁵

If a state opts to implement ELE, it selects the agency from which it will obtain a finding, chooses the finding it will use (e.g., income, household size, or residency), and decides whether it will use that finding for initial eligibility determinations, renewals, or both.⁶ For example, a state may choose to evaluate a child's initial eligibility for Medicaid using the state SNAP agency's calculation of net income. Children may be found eligible for Medicaid or CHIP using ELE, however, they may not be denied eligibility using ELE. Instead, CHIPRA requires states to evaluate the eligibility of children who are found ineligible through ELE using their regular Medicaid or CHIP procedures. To implement ELE, states must obtain approval from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that is responsible for overseeing state Medicaid and CHIP programs at the federal level. To provide additional oversight of ELE, CHIPRA required that HHS conduct, by contract, grant, or interagency agreement, a comprehensive independent evaluation of ELE and report the results of this evaluation to Congress by September 30, 2012.⁷ This evaluation had not been issued as of November 29, 2012. CHIPRA also requires that states annually calculate and report on the rate of erroneous payments for children enrolled

⁴Each state Medicaid or CHIP agency must decide which other agencies are capable of making determinations for one or more of the eligibility requirements for their Medicaid or CHIP programs. Accordingly, a state's Medicaid or CHIP program may use different Express Lane Agencies and may select more than one.

⁵For example, methods for calculating income within each state may differ across programs and implementing entities. In determining program eligibility, some entities may include variables such as court-ordered child support payments or income earned by 19-year-olds as part of a family's income, while other entities do not.

⁶State Medicaid and CHIP programs using ELE, however, must verify the citizenship or nationality status of children using their regular procedures. If a state determines that children would otherwise be eligible for Medicaid or CHIP using findings from an Express Lane Agency, children must be enrolled pending the documentation of citizenship or nationality. (In addition to documentation, states have the option of establishing citizenship through a match with the Social Security Administration.)

⁷Pub. L. No. 111-3, § 203(b), 123 Stat at 46-47. HHS contracted with Mathematica Policy Research—which subcontracted with the Urban Institute and Health Management Associates—to conduct a comprehensive evaluation of ELE. This evaluation will be completed through the issuance of several reports. The first report, which was to have been issued by September 30, 2012, was to include analyses of the effects of ELE on administrative costs (such as savings in time or money) and enrollment. Two additional reports, scheduled to be released in 2013, are expected to consist of a report with recommendations for legislative or administrative changes for ELE, and a final report with analyses based on updated and expanded data.

through ELE.⁸ CHIPRA authorized ELE from 2009 through September 30, 2013. Accordingly, unless reauthorized, CMS will not approve any state plan amendments for ELE after this date.⁹ Between 2009 and November 2012, 13 states received approval to implement ELE for Medicaid, CHIP, or both. Seven of these states have been approved to use ELE for less than 2 years.

Because CHIPRA's authorization for ELE is scheduled to expire on September 30, 2013, Congress may consider whether or not to reauthorize it. You asked us to provide information about ELE, including whether ELE, if available, would be useful to states in implementing the Patient Protection and Affordable Care Act (PPACA).¹⁰ Among other things, PPACA provides for the expansion of Medicaid eligibility to certain previously ineligible adults.¹¹ This report compiles some key considerations related to the availability of ELE beyond September 30, 2013.

To compile some key considerations related to the availability of ELE beyond September 2013, we reviewed relevant federal laws, including provisions of CHIPRA and PPACA, regulations, and guidance; reviewed publicly available reports on ELE, including preliminary information from the CHIPRA-mandated evaluation of ELE; and interviewed officials from HHS, representatives of organizations that represent states, and representatives from selected stakeholder organizations.¹² We gathered information regarding outcomes of states' ELE implementations that were detailed in publicly available reports; we did not evaluate the methods or data sources used for those reports, nor did we conduct original analyses of data. We also reviewed our

⁸CHIPRA requires states to compute error rates associated with ELE by conducting full Medicaid eligibility reviews on a statistically valid sample of children enrolled using findings from an Express Lane Agency and to report the rate of erroneous excess payments to CMS annually. 42 U.S.C. § 1396a(e)(13)(E).

⁹States administer and operate their Medicaid and CHIP programs in accordance with state plans that must be approved by CMS. To implement ELE, a state must submit a state plan amendment to CMS for approval.

¹⁰Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029. For purposes of this report, references to PPACA include the amendments made by HCERA.

¹¹PPACA provides for states to expand Medicaid coverage to nonpregnant, nonelderly individuals with income at or below 133 percent of the federal poverty level beginning no later than January 1, 2014. PPACA also provides for a 5 percent income disregard when calculating modified adjusted gross income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the federal poverty level. Federal poverty levels are based on federal poverty guidelines issued by HHS on an annual basis. These guidelines provide income thresholds that vary across states and by family size.

¹²Specifically, within HHS we spoke with officials from CMS, CMS's Tribal Affairs Group, and HHS's Office of the Assistant Secretary for Planning and Evaluation. Among organizations that represent states, we spoke with representatives from the National Association of Medicaid Directors and the National Conference of State Legislatures. Representatives we spoke with from selected stakeholder organizations were those that have conducted research or issued reports or briefs on ELE and included the Center for Children & Families of the Georgetown University Health Policy Institute, the Children's Partnership, Enroll America, the Kaiser Family Foundation, Mathematica Policy Research, the National Academy for State Health Policy, and the Urban Institute. We also contacted representatives from the American Public Human Services Association and the National Governor's Association, whose representatives indicated that they did not have any information to share on ELE. To minimize overlap with other ongoing or recent evaluations of ELE, we did not interview state officials.

previous reports, including our November 2012 report on access to Medicaid.¹³ Results from any one ELE implementation cannot be generalized to other implementations because of differences between states in how ELE was implemented (e.g., whether it was for initial enrollment or for renewals) and differences between states in how they make eligibility determinations in the absence of ELE.

We conducted this performance audit from June 2012 to December 2012, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

Four key considerations related to ELE's availability beyond 2013 include (1) the potential for administrative savings; (2) effects on enrollment of eligible, but not enrolled, children; (3) states' level of interest in using ELE particularly for implementing PPACA; and (4) uncertainty regarding the potential for erroneous excess payments for children enrolled through ELE.

- Available information regarding administrative savings associated with ELE suggests that ELE could save time and reduce administrative costs. For example, a study that compared the cost of enrolling children using ELE in Louisiana with the cost of enrolling and renewing children by using the state's traditional process estimated savings of \$9.0 million to \$12.9 million during the first year of implementation.
- Available information also suggests that ELE could have beneficial effects on enrollment, but the extent to which it will do so will depend on how it is implemented. For example, South Carolina renewed 65,000 children using ELE during the first 6 months of its ELE implementation.
- Stakeholders we spoke with generally believed that states currently using ELE would be interested in continuing to do so, for example, to avoid having to change their Medicaid or CHIP enrollment or renewal processes. Although current ELE authority under CHIPRA applies only to children, stakeholders noted benefits if ELE could be used for adults—a group for which Medicaid coverage is expanded under PPACA—such as the administrative savings of enrolling children and their parents at the same time or of enrolling newly eligible adults. Stakeholders also noted that some states may not have been interested in implementing ELE because they are busy implementing changes required by PPACA, or because they may be concerned about ELE's scheduled expiration.

¹³GAO, *Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance*, [GAO-13-55](#) (Washington, D.C.: Nov. 15, 2012).

- Whether ELE may have resulted in erroneous excess payments for children enrolled through ELE is uncertain. As of November 2012, CMS had not issued guidance on how to determine ELE errors and calculate such payments, pending other agency priorities in implementing PPACA. If the ELE option is continued, it will be particularly important that CMS issue such guidance, as questions have been raised by states and others regarding how an ELE error should be defined.

Background

States have the flexibility to design ELE implementations to increase enrollment and retention in their Medicaid or CHIP programs in a way that meets their unique needs. The particular way in which a state designs its ELE implementation can reflect specific state goals or particular considerations regarding potential Express Lane Agencies. For example, a state's ELE goals could include simplifying the eligibility determinations made by the state or targeting the state's outreach to groups of eligible uninsured children served by other entities. A state's considerations in selecting an Express Lane Agency could include an assessment of the reliability of the agency's data,¹⁴ the extent to which children served by a potential Express Lane Agency are already enrolled in Medicaid or CHIP, and existing collaborations or data-sharing agreements.

States opting to implement ELE must submit a Medicaid or CHIP state plan amendment (or both) to CMS for approval.¹⁵ The state plan amendment must identify key features such as the Express Lane Agency; the finding or findings that will be used; and whether the option will be used for initial enrollment, renewals, or both. As of November 9, 2012, 13 states had received CMS approval to implement ELE in their Medicaid program (5 states), CHIP program (2 states), or both (6 states).¹⁶ These ELE implementations have been in place for different amounts of time. After CHIPRA's enactment in 2009, 2 states received approval to implement ELE in 2009, 4 states received approval in 2010, 3 states received approval in 2011, and 4 states received approval in 2012. As of November 2012, one additional state plan amendment for ELE implementation was under review, from a state that already has approval for another ELE implementation and is seeking to broaden its use of ELE.

¹⁴We have previously reported on issues related to the reliability of data from certain agencies that can be selected as Express Lane Agencies, including SNAP and the National School Lunch program. For example, in 2012 we reported that SNAP and the National School Lunch program were among the top 10 programs with the highest reported amounts of improper payment dollar estimates in fiscal year 2011. Incomplete or inaccurate reporting of income by participants was reported as one of the primary reasons for the SNAP improper payments. See GAO, *Improper Payments: Remaining Challenges and Strategies for Governmentwide Reduction Efforts*, [GAO-12-573T](#) (Washington, D.C.: Mar. 28, 2012), 7.

¹⁵State plans describe how the states will operate their Medicaid and CHIP programs and detail eligibility criteria and other key information. A state must submit any changes it wishes to make to its plan, such as revisions to eligibility criteria, to CMS for review and approval as a state plan amendment.

¹⁶The 13 states that had received CMS approval to implement ELE were Alabama, Colorado, Georgia, Iowa, Louisiana, Maryland, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, South Carolina, and Utah.

Key Considerations Include Administrative Savings, States' Level of Interest, and Uncertainty Regarding the Potential for Erroneous Excess Payments

Information Regarding Administrative Savings with ELE

As of September 2012, the available information regarding administrative savings associated with ELE was largely about two states (Louisiana and South Carolina) and suggested that ELE could save time and reduce costs. In addition, in a recent report, we noted that several states reported that ELE contributed to decreases in the average time taken to process new Medicaid applications. The CHIPRA-mandated evaluation of ELE is expected to provide more complete information about administrative savings based on analyses of data from six states that implemented ELE. Preliminary results of that evaluation suggest that ELE does have the potential to yield administrative savings, the extent to which will depend on how it is implemented.

An analysis of Louisiana's ELE implementation conducted by the Urban Institute indicated that Louisiana's Medicaid program realized between \$15 and \$22 in administrative savings for each dollar it spent to create ELE infrastructure.¹⁷ To create the infrastructure for its ELE program Louisiana spent almost \$600,000. State officials told the Urban Institute that the administrative costs for an initial determination of eligibility for Medicaid through Louisiana's traditional processes were about \$116 per application, compared to between \$12 and \$15 per application through its ELE program. The Urban Institute estimated that this differential allowed the state to save between \$1.0 million and \$1.1 million on initial enrollment costs during 2010, the first year that Louisiana implemented ELE. Administrative costs for renewal in Medicaid through Louisiana's traditional processes were \$51 to \$76 per application, but renewal was estimated to cost nothing through ELE. The Urban Institute estimated that this differential allowed the state to save between \$8.0 million and \$11.9 million on renewals during the first full year of renewals. Therefore the estimated combined savings for ELE initial enrollments and renewals range from \$9.0 million to \$12.9 million, or \$15 to \$22 in administrative savings for each dollar of initial investment.¹⁸

¹⁷Stan Dorn, Ian Hill, and Fiona Adams, *Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment through Express Lane Eligibility* (Washington, D.C.: The Urban Institute, 2012).

¹⁸The Urban Institute noted several limitations to its analysis. For example, it assumed that all ELE-enrolled children who used their Medicaid cards would, in the absence of ELE, have enrolled using the state's traditional processes. That assumption would overestimate administrative cost savings because some of these children would probably not have enrolled in the absence of ELE. In contrast, administrative costs may have been understated because some children who were enrolled through ELE might, in the absence of ELE, only have been enrolled on an expedited basis after developing an urgent medical need. Administrative costs exceed average levels in such cases.

Louisiana's Express Lane Eligibility Implementation

Louisiana uses findings from SNAP to identify and automatically enroll children in Medicaid. The SNAP application that Louisiana originally used informed parents that if their children qualify for SNAP, they may also qualify for free health insurance. If parents did not wish their information to be shared with Medicaid, they could decline this option by checking a box on the SNAP application. (In January 2011, the form was changed to allow families to opt in to information sharing and automatic enrollment.) Each month, the department that administers SNAP gave the state Medicaid program an electronic file of children receiving SNAP whose parents did not opt out of the information sharing option. Medicaid staff matched this SNAP file against Medicaid files to identify those children who were not already enrolled and against Social Security Administration (SSA) data to verify citizenship status. Then, relying on the SNAP findings and the SSA data match, the SNAP children were automatically enrolled in Medicaid. The state sent the parents enrollment cards for the children. Louisiana treated a child's first use of the Medicaid card to access care as evidence of consent to enrollment.

(From Stan Dorn, Ian Hill, and Fiona Adams, *Louisiana Breaks New Ground: The Nation's First Use of Automatic Enrollment through Express Lane Eligibility* [Washington, D.C.: The Urban Institute, 2012], and Henry J. Kaiser Family Foundation, *Optimizing Medicaid Enrollment: Spotlight on Technology* [Menlo Park, Calif.: The Henry J. Kaiser Family Foundation, 2010].)

South Carolina estimated that it would save 50,000 hours and \$1 million per year by implementing ELE.¹⁹ South Carolina uses income findings from SNAP and TANF for Medicaid renewals. Prior to implementing ELE, South Carolina officials determined that a large number of children temporarily lost coverage at renewal, which can be problematic for families and also increases the administrative costs for Medicaid because it requires staff to make new eligibility determinations when children reapply. Specifically, the officials found that 42 percent of children who lost coverage at renewal were reenrolled in Medicaid within 1 month. They also estimated that staff spent, on average, 20 minutes on each renewal determination. Since South Carolina's ELE implementation allowed for automated reviews with no staff involvement, it enabled the state to save money as well as prevented children from losing coverage.

Additionally, in our recent report on access to care through Medicaid, 6 states reported to us that ELE helped reduce the time required for processing new applications.²⁰ We surveyed the 50 states and the District of Columbia from February through May 2012 and asked whether the average processing time for new regular Medicaid applications—applications not based on disability—had changed since January 2008. Of the 8 states that had implemented ELE for initial eligibility determinations before the survey was completed, 6 reported that the average processing time had decreased—Alabama, Colorado, Iowa, Maryland, New Jersey,

¹⁹CMS, *2011 CHIPRA Annual Report: Steady Growth, New Innovation* (Washington, D.C.: 2011); and John Supra, *South Carolina's Experience Implementing Express Lane Redeterminations* (Columbia, S.C.: South Carolina Health & Human Services, Nov. 1, 2011).

²⁰For this report, we administered a survey of Medicaid officials in the 50 states, the District of Columbia, and the 5 largest U. S. territories generally asking about their experiences from 2008 to 2011 with regard to any changes in beneficiaries' access to care. Not all states were able to provide specific data in response to our survey. For example, 16 states could not report their average processing times for their Medicaid applications, of which about half noted that they do not track these data or that they track them differently than how they were requested in our survey. For additional details, see [GAO-13-55](#).

and Oregon—and each of these 6 states indicated that they believed that ELE was one of the procedures that had decreased the processing times.²¹

The CHIPRA-mandated evaluation of ELE included a plan to estimate administrative costs in 6 states that implemented ELE—Alabama, Iowa, Louisiana, Maryland, New Jersey, and Oregon.²² Preliminary results of the evaluation indicated that ELE has the potential to result in administrative savings, the extent to which will depend on how the state implements ELE. Preliminary results also indicated that administrative savings were generally greater in states that implemented highly automated ELE enrollment processes, and these states were generally ones that had built on existing relationships with their Express Lane Agencies. Furthermore, preliminary results suggested that some states' savings were partially offset by the costs of implementing ELE, including costs of identifying and conducting outreach to children who did not subsequently enroll.²³

Information Regarding ELE's Effects on Enrollment

As of September 2012, available information from several states regarding the effects of ELE on enrollment suggested that ELE could have beneficial effects on enrollment, although the magnitude of the effect varied according to how the state implemented ELE. During 2010, Louisiana identified over 20,500 children who were eligible for initial enrollment in Medicaid through its ELE implementation, and of these children, about 11,100 were enrolled and used services.²⁴ In the first full year during which Louisiana used ELE for renewals, over 156,000 children were renewed through ELE. South Carolina renewed 65,000 children using ELE during the first 6 months of its ELE implementation.²⁵ (Both states implemented ELE using automated reviews of electronic data.) New Jersey's ELE implementation resulted in enrollment of a more modest number of children.²⁶ The state used information provided on its income tax forms to identify uninsured children, and enrolled slightly over 3,800 children on the basis of the 2008 tax form and another 135 children on the basis of the 2009 tax form.²⁷

²¹Of the other two states that had implemented ELE procedures for initial Medicaid determinations before the survey was completed, Georgia reported that it did not know whether its average processing time for new regular applications had changed since January 2008, and Louisiana reported that its average processing time for new regular applications (which would include applications from most adults, not just children) had increased.

²²As of November 29, 2012, the results of this evaluation had not been issued. This evaluation used methods for estimating administrative costs that differed from the methods that the Urban Institute used in its evaluation of the Louisiana ELE implementation.

²³Margaret Colby, Adam Swinburn, and Sean Orzol, *More with Less: Express Lane Eligibility's Potential to Improve Administrative Efficiency* (abstract for a conference of the Association for Public Policy Analysis and Management, November 2012).

²⁴Stan Dorn, Ian Hill, and Fiona Adams, *Louisiana Breaks New Ground*.

²⁵CMS, *2011 CHIPRA Annual Report: Steady Growth, New Innovation*.

²⁶Families USA, *Express Lane Eligibility: Early State Experiences and Lessons for Health Reform*. (Washington, D.C.: January 2011).

²⁷Under ELE, a state may obtain and use information directly from state income tax records or returns.

In addition to increasing the number of enrolled children, ELE may help reach children who differ in age or other characteristics from those who are enrolled through other methods. For example, the Urban Institute's analysis of the Louisiana ELE implementation found that children who were enrolled through ELE included a greater proportion of children who were over the age of 7 than did children who were not enrolled through ELE.²⁸

The CHIPRA-mandated evaluation of ELE also included a plan to examine enrollment outcomes associated with ELE implementations to date. Preliminary analysis of data from 5 states that implemented ELE—Alabama, Iowa, Louisiana, Maryland, and New Jersey—indicated that enrollment gains associated with ELE varied depending on how the state implemented ELE. Preliminary results also suggested that states that used automated processes or that minimized the number of steps that were required to apply for coverage tended to have greater increases in enrollment with ELE.²⁹

States' Level of Interest in Using ELE, Including for PPACA Implementation

States' level of interest in continuing or starting to use the ELE option, including for PPACA implementation, is also a key consideration regarding the availability of ELE after September 30, 2013. Stakeholders we interviewed—including representatives of organizations that represent states, representatives of organizations that have conducted research or issued reports or briefs on ELE, and CMS officials—described reasons why states might be interested in using ELE, and why some states may not have chosen to implement ELE to date. As of November 2012, 13 states had been approved to implement ELE. Stakeholders we spoke with generally believed that states that currently use ELE would be interested in continuing to use it beyond the September 30, 2013, expiration date. For example, states that have already implemented ELE may want to continue using it to avoid having to change their Medicaid or CHIP enrollment or renewal processes or to continue any benefits they have accrued through its use. In addition, some stakeholders said that states may want to use ELE as they transition children from CHIP to Medicaid in implementing a PPACA requirement that raises the required income threshold for Medicaid eligibility for certain children.³⁰ Stakeholders also identified a number of reasons why states may not have chosen to implement ELE to date. One reason highlighted by many stakeholders was the significant budget pressures that states are facing, which might make them reluctant to undertake options that would increase Medicaid or CHIP enrollment and costs, including costs for the services additional enrollees would receive. Several stakeholders also noted

²⁸Stan Dorn, Ian Hill, and Fiona Adams, *Louisiana Breaks New Ground*.

²⁹Sean Orzol, Adam Swinburn, and Margaret Colby, *Expanding Coverage Using Express Lane Eligibility: Analysis of Administrative Data from Five States* (abstract for a conference of the Association for Public Policy Analysis and Management, November, 2012).

³⁰Prior to PPACA, states were required to provide Medicaid coverage for children age 6 to 19 with income below 100 percent of the federal poverty level and had the option of extending coverage above that income level under their Medicaid or CHIP programs. Beginning January 1, 2014, PPACA increases the mandatory income level for these children from 100 to 133 percent of the federal poverty level. As a result, those states that have enrolled children age 6 to 19 with income between 100 and 133 percent of the federal poverty level in separate CHIP programs must transfer this population into their Medicaid programs no later than January 1, 2014.

that states have significant responsibilities in preparing to implement PPACA requirements and, as a result, do not have the time to explore and implement new options like ELE. Several stakeholders also noted that states may be thinking that there is no point in implementing ELE if the authority is going to expire in September 2013.

Although current ELE authority under CHIPRA applies only to children, states' interest in the continued availability of ELE may depend to some degree on their ability to use ELE to enroll adults in Medicaid. The stakeholders we interviewed noted benefits to being able to use ELE for adults, such as substantial administrative savings from renewing children and their parents at the same time. Some stakeholders said that not being able to use ELE for parents has made ELE less attractive to states. Furthermore, several stakeholders said that if ELE were made available for adults, states that move forward with Medicaid expansion under PPACA could use ELE to enroll newly eligible adults.³¹ Currently, states with interest in expanding ELE to include adults may request authority to do so through what is known as a section 1115 Medicaid demonstration. The Secretary of Health and Human Services has authority under section 1115 of the Social Security Act to grant states waivers of certain federal Medicaid requirements and to provide federal funds for expenditures that are not otherwise allowable for the purpose of demonstrating alternative approaches to service delivery. Several stakeholders noted, however, that this option is less than optimal for states because section 1115 demonstrations are time-limited and take more administrative time and cost to obtain approval than a state plan amendment. So far, 2 of the 13 states that have implemented ELE (Alabama and Massachusetts) have been approved by CMS to use ELE to enroll certain Medicaid-eligible adults as part of their section 1115 demonstrations.³²

Stakeholders also noted other reasons that states might find it beneficial to be able to use ELE after September 2013:

- PPACA requires that, effective January 1, 2014, states determine Medicaid or CHIP income eligibility for certain categories of individuals using a uniform method—modified adjusted gross income (MAGI)—that is derived from a federal tax-based definition of income.³³ Therefore, if reauthorized, ELE could be useful when federal income tax information cannot be used to determine eligibility, for example, if the household does not file federal income taxes.

³¹PPACA provides for the expansion of Medicaid eligibility to nonpregnant, nonelderly individuals with income at or below 133 percent of the federal poverty level beginning no later than January 1, 2014.

³²HHS has stated that states may also pursue authority to use ELE with children beyond September 30, 2013, through a section 1115 demonstration.

³³Unless there is an exception, states are required to use MAGI in determining eligibility for new Medicaid and CHIP beneficiaries beginning on January 1, 2014. For beneficiaries determined eligible on or before December 31, 2013, states need not apply MAGI until March 31, 2014, or the next regularly scheduled renewal of eligibility. ELE is one of the exceptions to the MAGI requirement; however, because ELE is currently scheduled to expire as of September 30, 2013, this exception is time-limited. For example, a child who was enrolled in a state Medicaid program through ELE prior to September 30, 2013, will not need to have his or her eligibility reevaluated using MAGI until March 31, 2014, or the next regularly scheduled redetermination—up to a year after the ELE-based determination, whichever is later.

- PPACA also requires states to employ efficient, data-driven procedures for determining eligibility that maximize data sharing across agencies and minimize burdens on individuals and families.³⁴ In response, states may be modernizing their existing eligibility and enrollment systems to accommodate the new requirements.³⁵ Until they have modernized such systems, some states may find it helpful to use ELE, although other states may find it cumbersome to maintain ELE-based systems while upgrading their data systems.

Uncertainty Regarding the Potential for Erroneous Excess Payments

Whether states' use of ELE has resulted in erroneous excess payments for children enrolled through ELE is another key consideration related to the availability of ELE beyond September 2013. However, the extent to which erroneous payments may have been made is not known. CHIPRA provides a mechanism to evaluate the potential for erroneous excess payments for children enrolled through ELE and to ensure corrective actions, including corrective adjustment to the federal share of these payments. Specifically, consistent with the definition of traditional Medicaid erroneous excess payment calculations, CHIPRA requires states to compute error rates associated with ELE by conducting full Medicaid eligibility reviews on a statistically valid sample of children enrolled using findings from an Express Lane Agency and to report the rate of erroneous excess payments to CMS annually.³⁶ However, given the complexities of ELE, questions have been raised regarding how an ELE error should be defined. For example, one of the ELE stakeholders we interviewed noted that ELE essentially changed Medicaid and CHIP eligibility rules, and questioned whether a child enrolled through ELE who turned out not to meet standard Medicaid eligibility criteria, but was enrolled appropriately on the basis of the findings of another agency as allowed by ELE, should be considered an error. In addition, technical questions have arisen, such as whether states should include children who were initially enrolled through ELE but subsequently renewed using the state's traditional procedures when calculating errors.

As of November 2012, CMS had begun discussions about error rates internally and with states, but had not yet obtained error rate information from them, according to CMS officials. In February 2010, CMS stated that it would issue guidance to states

³⁴For example, PPACA requires that states participate in a coordinated eligibility and enrollment process for Medicaid and other health insurance programs, including CHIP, and that state eligibility determination systems interface with a Federal Data Services Hub (referred to as the federal hub). The federal hub is an electronic service under development by HHS that states will use to verify certain information with other federal agencies, such as an applicant's citizenship through the Social Security Administration, immigration status through the Department of Homeland Security, and income data through the Internal Revenue Service.

³⁵States may receive federal funds equal to 90 percent of costs incurred between April 19, 2011 and December 31, 2015 for the design, development, installation, or enhancement of Medicaid eligibility determination systems. *Medicaid Program: Federal Funding for Medicaid Eligibility Determination and Enrollment Activities*, 75 Fed. Reg. 21950, 21974 (Apr. 19, 2011).

³⁶If the error rate exceeds 3 percent for either of the first 2 fiscal years in which the state implements ELE, the state must identify the corrective actions taken. If the error rate exceeds 3 percent for any fiscal year in which the state implements ELE, the state must reduce its claim for federal funds in the amount of the erroneous payments made for children included in the sample in excess of the 3 percent error rate. 42 U.S.C. § 1396a(e)(13)(E).

about how to calculate error rates.³⁷ But as of November 2012, the agency had not yet done so. CMS officials said they have instead directed their attention to issues associated with implementation of PPACA, which was enacted approximately 1 year after the ELE option was made available. CMS officials said that they were considering, and have had discussions with states about, various options for how error rates should be calculated, recognizing the complexities of doing so. CMS officials said they do not anticipate issuing proposed rules or guidance about ELE error rates in the immediate future.³⁸

Concluding Observations

The option of implementing ELE is still a relatively new one for states. Although available information on the administrative savings and enrollment effects associated with ELE is limited, early information suggests ELE could create administrative savings for states and could have beneficial effects on enrollment. And while ELE's authority is scheduled to expire, stakeholders suggested that states already using ELE would be interested in continuing its use, including to assist with PPACA implementation. Because of the limited number of states currently using ELE and the uncertainty about the potential costs associated with any erroneous excess payments resulting from states' use of ELE, the savings from and outcomes of ELE implementations cannot be fully understood. We recognize that CMS has directed its attention to issues associated with PPACA implementation, and that determining how error rates associated with ELE should be calculated could take some time. Because CHIPRA's authorization for ELE is scheduled to expire in less than 1 year, we are not making a recommendation at this time. However, if ELE is extended beyond its scheduled September 30, 2013, expiration date, it will be particularly important that CMS place higher priority on clarifying how states should determine ELE error rates and collect information on these erroneous excess payments.

Agency Comments

We provided a draft of this report to HHS for review. HHS did not comment on our findings but provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Acting Administrator of CMS, appropriate congressional committees, and other interested parties. The report also will be available at no charge on the GAO website at <http://www.gao.gov>.

³⁷In a letter to state health officials in February 2010, CMS stated that it would specify a process for the error rate measurement in regulation and also noted that additional guidance would be forthcoming regarding the selection of samples, the calculation of the improper payment rate, and the format and means of reporting the results of the payment reviews. CMS, Letter to State Health Officials, SHO #10-003 (Feb. 4, 2010).

³⁸We did not interview state officials to determine whether they were calculating error rates.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in enclosure I.

Sincerely yours,

A handwritten signature in black ink that reads "Katherine Iritani". The signature is written in a cursive style with a large, prominent initial "K".

Katherine Iritani
Director, Health Care

Enclosure

Enclosure I

GAO Contact and Staff Acknowledgments

Contact

Katherine Iritani, (202) 512-7114 or iritanik@gao.gov

Staff Acknowledgments

In addition to the contact named above, key contributors to this report were Catina Bradley, Assistant Director; Kristen Joan Anderson; Linda McIver; Roseanne Price; Christina Ritchie; and Hemi Tewarson.

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