

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE USE OF EXPRESS LANE
ELIGIBILITY FOR MEDICAID
AND CHIP ENROLLMENT**



**Suzanne Murrin
Deputy Inspector General**

**October 2016
OEI-06-15-00410**

EXECUTIVE SUMMARY: STATE USE OF EXPRESS LANE ELIGIBILITY FOR MEDICAID AND CHIP ENROLLMENT

OEI-06-15-00410

WHY WE DID THIS STUDY

Medicaid and the Children's Health Insurance Program (CHIP) provide health insurance coverage for certain low-income children, yet millions of eligible children are still uninsured. To increase enrollment of eligible children, Congress authorized States to adopt the Express Lane Eligibility (ELE) option, which allows States to expedite and simplify enrollment in Medicaid and CHIP by relying on findings from other agencies' eligibility determinations. Congress will determine whether to reauthorize the ELE option in 2017. We conducted this study in response to a Congressional request that the U.S. Department of Health and Human Services, Office of Inspector General (OIG) examine the benefits and barriers to State use and expansion of ELE. This report is being issued concurrently with two OIG audits that fulfill a Congressional mandate to assess whether State agencies met Federal requirements in making eligibility determinations using ELE and developing eligibility error rates.

HOW WE DID THIS STUDY

We administered questionnaires and conducted telephone interviews with Medicaid and CHIP officials from the 14 States that adopted ELE. Where available, we supplemented this information with enrollment and cost savings data collected from the States.

WHAT WE FOUND

States that used ELE adopted variations of three models, with more than half adopting an automated model that requires minimal action from staff and beneficiaries. All 14 States that used ELE reported benefits, including reduced administrative burden and cost savings, and some States reported that they rely heavily on ELE. Eleven States reported that they encountered barriers when they implemented ELE, such as problems sharing information across agencies, but reported that they overcame these barriers through strong partnerships and integrated eligibility systems. Despite largely positive experiences using ELE, 5 of the 14 States that adopted ELE discontinued its use, mainly because of competing priorities, system changes, and short-term agreements with partner agencies. None of the 9 States still using ELE plan to expand its use.

WHAT WE CONCLUDE

Although State use of ELE is not widespread, ELE appears to meet the intended objective of easing the eligibility and enrollment process. Implementation of ELE is consistent with the goals of the Patient Protection and Affordable Care Act provisions to streamline enrollment processes for Medicaid and CHIP. Based on this review of State experiences with ELE, OIG did not identify any significant impediments to continuing to allow voluntary use of ELE, once States and CMS have corrected process problems and gaps in oversight identified by OIG audits of ELE enrollments. Reauthorization of the ELE option would allow States that rely on ELE to continue its use and give other States the opportunity to adopt ELE and likely experience similar benefits.

TABLE OF CONTENTS

Objectives	1
Background	1
Methodology	5
Findings.....	7
States that used ELE adopted variations of three models, with more than half adopting an automated model that requires minimal action from staff and beneficiaries	7
All 14 States that used ELE reported benefits, including reduced administrative burden and cost savings, and some States rely heavily on ELE	8
Most States that used ELE encountered barriers but reported that they overcame these barriers through strong partnerships and integrated eligibility systems	9
Despite largely positive experiences using ELE, 5 of the 14 States discontinued use, and none of the 9 States still using ELE plan to expand its use.....	11
Conclusion	13
Appendix.....	14
Express Lane Eligibility Models by State.....	14
Acknowledgments.....	15

OBJECTIVES

1. To describe State use of Express Lane Eligibility (ELE) models to enroll beneficiaries in Medicaid and Children’s Health Insurance Program (CHIP);
2. To identify benefits experienced by States and low-income families when using ELE for enrollment; and
3. To identify barriers to using ELE and lessons learned by States in overcoming those barriers.

BACKGROUND

The Medicaid and CHIP programs provide health insurance coverage for certain low-income children, yet millions of eligible children are still uninsured.¹ The ELE option allows States to expedite and simplify enrollment in these programs by using eligibility findings of another agency or program, such as the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps), to qualify children for health coverage. ELE was designed to ease the administrative burden on States and beneficiaries, thereby increasing child enrollment and retention in Medicaid and CHIP, and reduce State costs.

With the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress extended the ELE option for States through September 30, 2017.² Congress must determine whether to reauthorize ELE when this extension expires. MACRA also mandated that the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) report on the number of beneficiaries enrolled through ELE, the extent to which enrollees met eligibility requirements, and the Federal and State expenditures associated with the enrollments, including expenditures for those who did not meet eligibility criteria. Two OIG audits conducted concurrently with this study address the MACRA requirements, using Medicaid and CHIP case reviews to assess whether State agencies met Federal requirements in making eligibility

¹ The Henry J Kaiser Family Foundation, Children’s Health Coverage: Medicaid, CHIP and the ACA, March 26, 2014. Access at <http://kff.org/health-reform/issue-brief/childrens-health-coverage-medicaid-chip-and-the-aca/> on July 13, 2016.

² MACRA, P.L. 114-10, §§ 302 and 305 (Apr. 16, 2015). The MACRA requires the Inspector General of HHS to submit a report to Congress not later than 18 months after its enactment.

determinations using ELE and developing eligibility error rates.³ This study responds to a Congressional request that OIG concurrently examine the benefits and barriers to State use and expansion of ELE.

Medicaid and CHIP

Medicaid provides health care coverage to low-income and medically needy populations, including children up to age 21, pregnant women, senior citizens, and people with disabilities. CHIP covers uninsured children up to age 19 with household incomes above the Medicaid income eligibility threshold but whose families cannot afford private coverage.⁴ States operate and jointly fund Medicaid and CHIP in partnership with the HHS Centers for Medicare & Medicaid Services (CMS).⁵

In 2015, children accounted for almost half of the average monthly Medicaid enrollments (29.6 million of 68.9 million enrollees).⁶ An additional monthly average of 5.8 million children were enrolled in CHIP.⁷ Although enrollments have increased in recent years, in 2015 an estimated 2.8 million children were eligible for Medicaid or CHIP coverage but not enrolled.⁸

Many children enrolled in these programs drop from the rolls and later re-apply and re-enroll, which can be costly for States and may prevent children from receiving appropriate care. According to CMS, administrative barriers, such as complicated renewal requirements, and beneficiaries' and their families' lack of familiarity with the qualifying

³ HHS OIG, *Medicaid Enrollment Using the Express Lane Eligibility Option* (A-04-15-08043) and *CHIP Enrollment Using the Express Lane Eligibility Option* (A-04-15-08045), projected September 2016.

⁴ Titles XIX and XXI of the Social Security Act (SSA).

⁵ CMS, *Brief Summaries of Medicare and Medicaid*, November 1, 2014. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/SummaryMedicareMedicaid.html> on July 13, 2016.

⁶ CMS, *2014 Actuarial Report on the Financial Outlook for Medicaid*, p. 17. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2014.pdf> on July 13, 2016.

⁷ CMS, *2015 CMS Statistics*, p. 15. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2015CMSStatistics.pdf> on September 13, 2016.

⁸ Kenney, Genevieve M., Jennifer Haley, Clare Pan, Victoria Lynch, and Matthew Buettgens, *Children's Coverage Climb Continues: Uninsurance and Medicaid/CHIP Eligibility and Participation Under the ACA*, May 2016, p. 3. Accessed at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000787-Childrens-Coverage-Climb-Continues-Uninsurance-and-Medicaid-CHIP-Eligibility-and-Participation-Under-the-ACA.pdf> on September 12, 2016.

criteria and application process contribute to children not being enrolled or re-enrolled in the programs.⁹

Efforts to Increase Child Retention and Enrollment in Medicaid and CHIP

To increase the number of eligible children who are enrolled in Medicaid and CHIP, the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) provided States with effective new tools and incentives.¹⁰ One of the key tools available to States is ELE, which allows States to use eligibility findings from other agencies for purposes of determining an individual’s eligibility for Medicaid and CHIP.¹¹ CHIPRA also provided incentives for States to implement ELE by making it one of the policies that States could adopt to qualify for performance bonus payments.¹²

The Patient Protection and Affordable Care Act (ACA) and implementing regulations reinforced the ELE principles by requiring States to employ data-driven systems that determine eligibility across State coverage programs, and streamlining enrollment processes for Medicaid and CHIP.¹³

Implementation and Use of ELE

States that wish to adopt ELE must submit and receive CMS approval on a State Plan Amendment to their Medicaid and CHIP programs. States can choose to apply ELE to Medicaid, CHIP, or both, and to use it for enrollments, renewals, or both. State Medicaid and CHIP agencies can use eligibility findings from partner agencies, as defined in the statute and as identified in the State plan. ELE allows States to disregard technical and methodological differences between agencies in determining eligibility when using findings from another agency; however, the State Medicaid or CHIP agency remains responsible for making the final determination of Medicaid and CHIP eligibility.¹⁴ Although ELE is specifically targeted to children, States may request a waiver to enroll

⁹ CMS, Medicaid, *CHIPRA*. Accessed at <https://www.medicaid.gov/chip/chipra/chipra.html> on July 13, 2016.

¹⁰ CHIPRA, P.L. 111-3, § 203 (Feb. 4, 2009); Social Security Act (SSA) § 1902(e)(13).

¹¹ CMS, *SHO # 10-003: Express Lane Eligibility Option*, February 4, 2010. Accessed at <http://ccf.georgetown.edu/wp-content/uploads/2012/03/Official-Letter-February-4-2010-2.pdf> on July 13, 2016.

¹² SSA § 2105(a)(4).

¹³ ACA, P.L. 111-148, § 1413 (Mar. 23, 2010), as amended by the Health Care Reconciliation Act of 2010, P.L. 111-152 (Mar. 20, 2010), collectively known as ACA.

¹⁴ SSA § 1902(e)(13); CMS, *SHO#10-003, loc.cit.*

adults (e.g., parents of eligible children, pregnant women) in Medicaid using streamlined eligibility and enrollment processes similar to ELE.¹⁵

Prior Research about ELE

Several other organizations, including the Kaiser Family Foundation, the Government Accountability Office (GAO), and Mathematica Policy Research, have examined the implementation and use of ELE, with most finding that ELE generally was an effective means of increasing and retaining child enrollment in Medicaid and CHIP. In 2009, shortly after CHIPRA went into effect, the Kaiser Family Foundation outlined a number of possible benefits of ELE, including increased coverage rates, improved access to care, reduced burdens for low-income families and States, program savings for Medicaid and CHIP, and greater coordination across programs.¹⁶ In 2012, GAO identified similar benefits, but noted that budgetary restrictions and competing priorities may have limited the number of States that ultimately chose to adopt ELE.¹⁷ In 2013, Mathematica Policy Research, together with the Urban Institute and Health Management Associates, conducted a comprehensive evaluation of ELE. They found that States adopted different ELE models and that the automatic processing model offered a promising approach for increasing enrollment and reducing States' administrative costs.¹⁸

OIG Audits of ELE Enrollments

This report is being issued concurrently with two OIG audit reports on ELE enrollment, as MACRA requires: *Medicaid Enrollment Using the Express Lane Eligibility Option Did Not Always Meet Federal Requirements* (A-04-15-08043), and *CHIP Enrollment Using the Express Lane Eligibility Option Did Not Always Meet Federal Requirements* (A-04-15-08045). The OIG audits found that States using ELE generally made eligibility determinations in accordance with Federal requirements at the time of enrollment and re-enrollment in Medicaid and CHIP, but that States did not always adhere to income and citizenship verification requirements or follow the approved State plan. OIG also found that States did not develop statistically valid eligibility error rates specific to ELE enrollees in accordance with Federal requirements. This occurred because CMS had not finalized the methodology for States to use in

¹⁵ SSA § 1115(a)(2)

¹⁶ The Henry J Kaiser Foundation, *Why Express Lane Eligibility Makes Sense For States and Low-Income Families*, October 2, 2009. Accessed at <http://kff.org/medicaid/issue-brief/why-express-lane-eligibility-makes-sense-for/> on July 13, 2016.

¹⁷ GAO, *Medicaid and CHIP: Considerations for Express Lane Eligibility* (GAO-13-178R), December 5, 2012, p.1.

¹⁸ Mathematica Policy Research, *op. cit.*, pp. xiii, 120-121. The evaluation was mandated in CHIPRA § 203(b)(1).

identifying error rates, and because States had difficulty identifying the ELE population. OIG recommended that CMS: 1) monitor States use of ELE for compliance with Federal requirements, 2) provide technical assistance to States to accurately identify beneficiaries enrolled through ELE, 3) issue guidance to States for calculating eligibility error rates for beneficiaries enrolled through ELE, and 4) ensure that if necessary, States redetermine the current eligibility status of sample applicants who were enrolled on the basis of eligibility determinations that were not in compliance with Federal requirements. CMS concurred with all recommendations in both reports.

METHODOLOGY

Scope

This review focused on all States that had used ELE at any time, as of the end of our data collection in March 2016. The 14 States that had used ELE were Alabama, Colorado, Georgia, Iowa, Louisiana, Maryland, Massachusetts, New Jersey, New York, Oregon, Pennsylvania, South Carolina, South Dakota, and Utah.¹⁹ In fiscal year (FY) 2015, the latest year for which data is available, these States collectively covered more than a quarter (12.8 of the 45.2 million) of all children participating in Medicaid and CHIP.²⁰

Data Collection and Analysis

We based our report findings on qualitative data collected through questionnaires and telephone interviews with Medicaid and CHIP officials from the 14 ELE States conducted between January and March 2016. We asked about State ELE models, partner agencies, expansion plans, lessons learned, and time and cost savings associated with ELE enrollments and renewals. We reviewed States' supporting documentation, such as enrollment and cost savings data, where available. We also interviewed staff from CMS, Mathematica Policy Research, and the National Academy for State Health Policy for additional insights regarding State Medicaid agency use of ELE.

¹⁹ One U.S. territory has also adopted ELE. CMS, *Express Lane Eligibility for Medicaid and CHIP Coverage*, July 9, 2015. Accessed at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/express-lane-eligibility.html> on July 13, 2016.

²⁰ CMS, *FFY 2015 Number of Children Ever-Enrolled in Medicaid and CHIP*. Accessed at <https://www.medicaid.gov/chip/downloads/fy-2015-childrens-enrollment-report.pdf> on September 13, 2016.

Limitations

Although we reviewed supporting documentation where available, the benefits and challenges described in this report are State-reported and may not reflect all of the benefits and challenges associated with ELE use. Moreover, while we collected the perspectives of officials in State Medicaid and CHIP agencies, we did not interview frontline staff (e.g., eligibility caseworkers) or beneficiaries to gain their perspectives.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

States that used ELE adopted variations of three models, with more than half adopting an automated model that requires minimal action from staff and beneficiaries

CMS gives States discretion in establishing ELE processes for Medicaid and CHIP, including the type of model used to implement ELE. The 14 States that used ELE adopted variations of three models, which the Mathematica Policy Research study categorized as: automated processing, simplified procedure, and simplified application. Most States adopted one model, and three States reported using two different ELE models at one time. Of the 14 States that adopted ELE, 7 used ELE for initial enrollments, 2 used it for renewals, and 5 used it for both initial enrollments and renewals. (See Appendix for a list of ELE models by State.)

Automatic processing. Eight States adopted an automatic processing model, through which States automatically enroll or renew coverage with the family's consent, without an application, by transferring data electronically from eligibility findings for children enrolled in ELE partner agencies' programs. Typically, when State agencies use an automatic processing model to enroll or renew beneficiaries, the eligibility system itself, rather than staff, reviews and determines eligibility. The Mathematica Policy Research study of ELE identified the automatic processing model as the most promising for increased enrollment and retention and decreased administrative costs.²¹

Simplified procedure. Five States adopted a simplified procedure model, through which States process traditional applications using prior eligibility findings of ELE partner agencies to determine eligibility. For example, one State employed this method of shared eligibility findings to simplify eligibility determinations within the Medicaid and CHIP programs. Prior to ELE, applicants had to submit a separate application to CHIP if found ineligible for Medicaid. With an ELE simplified procedure, CHIP staff use the eligibility finding already completed by Medicaid.

Simplified application. Four States reported adopting a simplified application model, through which State Medicaid agencies use eligibility findings of ELE partner agencies to identify children who are likely eligible for Medicaid or CHIP, but not enrolled. In these States, Medicaid agencies send families shortened applications which are prepopulated with

²¹ Mathematica Policy Research, *loc. cit.*

information obtained from the ELE partner agency, serving both to simplify the process and provide program outreach.

All 14 States that used ELE reported benefits, including reduced administrative burden and cost savings, and some States rely heavily on ELE

Regardless of which model States used to implement ELE, all State Medicaid agencies rated their experiences with ELE as positive and reported that ELE met its objective of easing the eligibility and enrollment processes. Officials also reported that using ELE helped prepare the State for implementing ACA requirements to adopt data-driven eligibility systems and procedures across State coverage programs. The OIG audits of State enrollment through ELE, released concurrent with this report, also found largely positive results, reporting that State ELE processes were generally effective in enrolling and retaining eligible beneficiaries into Medicaid and CHIP.

The most commonly reported benefit from ELE was a reduced administrative burden for State agencies and families. Agency officials from 13 of 14 the States reported, and previous research indicated, that ELE reduced State agency administrative tasks to determine eligibility and enroll beneficiaries.²² In one State, one-fifth of its one million Medicaid and CHIP beneficiaries automatically renew through ELE every year because they also receive benefits from SNAP, its ELE partner agency. According to State officials, this saves the State an average of 20 staff minutes per renewal case by reducing the need to mail renewal packets, collect verification information, and process case closings, reopenings, and appeals. Officials in another State reported that adoption of an ELE automated model dropped the State's Medicaid and CHIP application processing time from 15-20 days to 10-11 days. Agency officials also reported that the reduced administrative burden assisted beneficiaries and their families, providing a simpler and faster application and renewal process.

About half of the States reported that using ELE produced cost savings. Medicaid officials in 6 of the 14 States reported cost savings from using ELE, mostly due to reduced staff time to complete enrollments and renewals. Agency officials in one State reported that using an automatic ELE model reduced State costs for initial enrollments and renewals by \$7.3 million between 2011 and 2014. In another State, agency officials indicated that the agency saved \$25.77 per initial enrollment and \$5.15 per

²² Mathematica Policy Research, *loc. cit.*; The Henry J Kaiser Foundation, *loc. cit.*

renewal form, a cost savings they characterized as significant, given the large number of beneficiaries processed through ELE.

For some States, ELE's simpler enrollment and renewal processes also increased enrollment and retention. States reported that use of ELE contributed to increased enrollment (3 of 14 States) and retention (6 of 14 States) of beneficiaries. These States were not able to report data to support this view because of difficulties associated with separating the effect of ELE from other enrollment and population factors. State officials in several of these States also reported that ELE is useful for outreach to low-income families, and that the simplified application process increased the likelihood that families would take action to complete applications and renewals.

Some State Medicaid agencies reported that they rely heavily on ELE and consider ELE critical to enrollment efforts. While all States experienced benefits, five States reported particularly strong support for ELE and believed its use was important to agency operations. Two of these States have expanded the ELE-like process to adult populations in addition to children. One State agency official described ELE as among the most beneficial processes that the State had implemented, and stated that benefits from ELE extended beyond simplified eligibility and enrollment tasks. The official explained that the State had implemented ELE during a recession and indicated that ELE enabled the State to offset staff cutbacks without disrupting services.

Officials in seven States expressed concern about losing ELE if Congress does not extend the current ELE authorization by the end of FY 2017. Officials reported that losing ELE would result in having wasted the administrative costs of implementation, and increase the cost of eligibility and enrollment processes going forward. One State that was particularly reliant on ELE indicated that without ELE, staffing shortages would make it difficult to manage high beneficiary caseloads. This State reported that in 2015, it automatically renewed coverage for 45 percent of its Medicaid beneficiaries using ELE.

Most States that used ELE encountered barriers but reported that they overcame these barriers through strong partnerships and integrated eligibility systems

Medicaid agency officials in 11 of the 14 States encountered barriers to implementing ELE, mostly related to difficulties collaborating with partner agencies and sharing information across systems and processes. The OIG audits also found that some States using ELE struggled to coordinate partners and systems effectively within the provisions of their

CMS-approved State plans for ELE use. Still, State officials reported that they largely overcame barriers in most cases, and officials identified factors that were important to success in implementing ELE.

States cited the importance of strong relationships with partner agencies, and reported partnering most often with SNAP. States with the most positive experiences using ELE emphasized that collaboration with partner agencies was critical to their success. States that reported effective collaboration attributed the success to three factors: (1) long-standing relationships with the partner agencies or programs in their States, (2) data systems that were either fully integrated or could easily share information, and (3) similar agency missions that serve the same low-income beneficiaries as Medicaid and CHIP. States most frequently partnered with SNAP (9 of 14 States), sometimes in combination with the Temporary Assistance for Needy Families (TANF) program (3 of 14 States), to employ ELE. Both SNAP and TANF serve the same or similar populations as Medicaid and CHIP, and use similar eligibility criteria. Agency officials from half of the States (7 of 14) reported partnering with more than one agency for ELE. In addition to SNAP and TANF, agencies partnered with tax agencies (3 of 14 States) and school lunch programs (3 of 14 States). (See Appendix for a list of ELE partner agencies by State.)

State agency officials also emphasized the benefits of using integrated eligibility systems. Most States (10 of 14) encountered some barrier related to the lack of system integration or other data sharing issues when implementing ELE. State agencies without an integrated system had to develop methods for sharing information across program-specific systems, and reported that this often caused confusion among staff. In one State, agency officials described their struggle to re-format data from an ELE partner agency to match the eligibility system that Medicaid and CHIP use.

Agency officials emphasized the importance of having eligibility systems that are integrated with those of ELE partner agencies. Seven of the 14 States reported using integrated systems, some of which the States developed only recently. One State agency official noted that an advantage of integrating an eligibility system with that of an ELE partner agency (e.g., Medicaid, SNAP) is that it allows the agency to use the same benefits specialists to process all applications that come through the integrated system.

States that had difficulty collaborating with ELE partner agencies faced administrative barriers to establishing processes and sharing information. Some State Medicaid agencies had problems collaborating with ELE

partner agencies because establishing the shared enrollment processes required complex administrative agreements. This was particularly challenging when the agreements required action by entities outside the agencies. For example, some agreements required State legislative or process changes to allow information sharing between agencies. For the three States that partnered with tax agencies, sharing tax information not only required the States to pass legislation, but called for substantial revisions of documents and forms. States that partnered with school lunch programs (3 of 14 States) also faced challenges collecting and using data, because each school district administered the programs differently and the data often were not standardized. In one State, local school districts resisted sharing student and family information, considering the information legally protected.

To overcome barriers to collaboration, agency officials stressed the importance of thoroughly discussing with partners the implications of each step involved in operationalizing ELE. The officials suggested that the agencies involved should examine each other's programs; set out the goals, limitations, processes and systems needed to be successful; and request input from each other before entering into a partnership.

Despite largely positive experiences using ELE, 5 of the 14 States discontinued use, and none of the 9 States still using ELE plan to expand its use

Although all States found ELE beneficial, about one third of the small number of States that adopted ELE no longer use it for a variety of reasons. As of April 2016, five States had discontinued use of ELE for Medicaid and CHIP enrollments and renewals. A sixth State reported that it planned to discontinue use within the next 2 years once its eligibility system has the capability to serve all beneficiaries. (One of the States that discontinued use reported that it is considering reactivating ELE in the future.)

Officials in States that stopped using ELE indicated that although they experienced the same benefits as States that retained ELE, competing priorities (3 of 5 States), system changes (2 of 5 States), and short-term agreements with ELE partner agencies (2 of 5 States) caused them to discontinue use. Agency officials in one State explained that a shift in priorities to focus on ACA-related tasks not only was resource intensive, but resulted in system upgrades that integrated program eligibility and enrollment processes, reducing the need for ELE. Officials in another State reported that the State never intended to use ELE long-term. Rather, the State considered ELE a temporary outreach tool to bolster enrollment

and renewals. The State discontinued ELE when the temporary State authorization for sharing information with its ELE partner agency ended.

Further, none of the nine States still using ELE plan to expand its use to other types of applications. Agency officials in these States indicated that while they recognized the benefits of using ELE, they did not consider expansion of ELE critical to their eligibility and enrollment efforts.

CONCLUSION

All State Medicaid agencies that used ELE reported associated benefits, and some States rely heavily on ELE for Medicaid and CHIP enrollment. To the extent that State officials encountered barriers to using ELE, these officials reported that they largely overcame those barriers by forming strong partnerships and integrating data systems with other agencies.

Although State use of ELE is not widespread, ELE appears to meet its intended objective of easing the eligibility and enrollment processes. Implementation of ELE is consistent with the goals of the ACA provisions to streamline enrollment processes for Medicaid and CHIP. Moreover, based on this review of State experiences with ELE, OIG did not identify any significant impediments to continuing to allow the voluntary use of ELE, once States and CMS have corrected process problems and gaps in oversight identified by OIG audits. Reauthorization would allow States that rely on ELE to continue its use and also provide other States with the opportunity to adopt ELE and likely realize similar benefits.

OIG is issuing this report directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-06-15-00410 in all correspondence.

APPENDIX

Table A: Express Lane Eligibility Models by State

State	ELE Model			ELE Partner Agency*						Application			
	Automatic Processing	Simplified Procedure	Simplified Application	SNAP	TANF	WIC	NSLP**	Tax	Medicaid/CHIP	Medicaid	CHIP	Initial	Renewal
Alabama	✓	✓		✓	✓					✓		✓	✓
Colorado	✓	✓		✓	✓		✓			✓	✓	✓	
Georgia	✓					✓				✓	✓	✓	
Iowa		✓	✓	✓					✓	✓	✓	✓	
Louisiana	✓			✓						✓		✓	✓
Massachusetts	✓			✓						✓	✓		✓
Maryland***			✓					✓		✓	✓	✓	
New Jersey			✓	✓			✓	✓		✓	✓	✓	
New York	✓				✓				✓	✓		✓	
Oregon			✓	✓			✓			✓	✓	✓	
Pennsylvania		✓							✓		✓	✓	✓
South Carolina***	✓			✓	✓					✓	✓	✓	✓
South Dakota	✓			✓						✓		✓	✓
Utah		✓						✓			✓		✓

*All but one of the ELE States used the same ELE partner agencies for their Medicaid and CHIP programs. Iowa partnered with SNAP for its Medicaid program, but not for its CHIP program.

**NSLP is the National School Lunch Program.

***Maryland and South Carolina do not have a separate State Plan Amendment to use ELE for CHIP because these States use CHIP funding to cover children in Medicaid.

Note: Georgia, Maryland, New Jersey, Oregon, and Utah are no longer using ELE, and New York has plans to discontinue ELE within the next two years. Alabama, Massachusetts, and New York are the only States with waivers that extend ELE to other types of populations (e.g., parents, caretakers).

Source: OIG analysis of State Plan Amendments, questionnaires, and interview responses collected from States, 2016.

ACKNOWLEDGMENTS

This report was prepared under the direction of Ruth Ann Dorrill, Regional Inspector General for Evaluation and Inspections in the Dallas regional office.

Petra Nealy and Anthony Guerrero-Soto served as the team leaders for this study. Central office staff who provided support include Kevin Farber, Kevin Manley, and Joanne Legomsky.

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of individuals served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

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

Office of Evaluation and Inspections

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

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and individuals. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.