

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID ENROLLMENT USING
THE EXPRESS LANE ELIGIBILITY
OPTION DID NOT ALWAYS MEET
FEDERAL REQUIREMENTS**

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EXECUTIVE SUMMARY

States generally determined Medicaid eligibility using the express lane eligibility option in accordance with Federal requirements. However, we found that States' eligibility determinations for calendar year 2014 were not always complete and accurate, resulting in an estimated 86,672 potentially ineligible beneficiaries with payments totaling an estimated \$284.1 million. In addition, States did not develop eligibility error rates in accordance with Federal requirements.

WHY WE DID THIS REVIEW

The Children's Health Insurance Program [CHIP] Reauthorization Act of 2009 (CHIPRA) provided States with a new tool, known as Express Lane Eligibility (ELE), to simplify States' identification, enrollment, and retention of individuals eligible for CHIP or Medicaid. Using the ELE option, a State's CHIP or Medicaid program can use findings from a different agency within the State to determine eligibility, despite what may be different methods of assessing income or other eligibility factors.

On April 16, 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which requires the U.S. Department of Health and Human Services, Office of Inspector General, to submit a report to Congress on (1) the number of beneficiaries enrolled in CHIP and Medicaid under the ELE option, (2) whether those beneficiaries met all eligibility requirements, and (3) the estimated dollar value of both proper and improper payments made on behalf of those beneficiaries.

This report addresses the use of the ELE option in Medicaid, and we will issue a separate report addressing the use of the ELE option in CHIP (A-04-15-08045). Together, these reports respond to the MACRA reporting requirement. In addition, we will report separately on the results of an evaluation of the benefits of and challenges to State use and expansion of the ELE option (OEI-06-15-00410).

Our objectives were to verify whether State agencies met Federal requirements when (1) making Medicaid eligibility determinations using the ELE option and (2) developing eligibility error rates.

HOW WE DID THIS REVIEW

We reviewed Medicaid eligibility determinations made by States that used the ELE option for enrollment or reenrollment at any time in calendar year 2014. With respect to the second element under the reporting requirement in MACRA, section 305, we performed two tests of each eligibility determination supported by the ELE data. First, we reviewed whether the eligibility determination met applicable ELE requirements in the Social Security Act. Second, we reviewed the same eligibility determinations to assess whether the determination met the appropriate State Medicaid requirements for verifying eligibility. These reviews identified eligibility determinations that did not meet Federal requirements under both the ELE and Medicaid requirements. Beneficiaries enrolled on the basis of determinations that did not meet

Federal requirements may not have been eligible for Medicaid coverage. We refer to these beneficiaries as “potentially ineligible” rather than “improperly enrolled” because some of these individuals may have been eligible if the State agency had determined eligibility in accordance with all Federal requirements.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, Federal law requires States to cover certain population groups with an option to expand coverage to additional groups. Individuals are eligible when they satisfy certain Federal and State requirements, such as income, residency, verified U.S. citizenship, status as a U.S. national, or eligible immigration status. Most eligibility groups are subject to income requirements.

Medicaid is funded jointly by the Federal Government and States based on an approved State plan specific to each State. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. CMS and States monitor the accuracy of eligibility determinations in Medicaid using the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs. However, for Federal fiscal years 2014 through 2016, the eligibility component of PERM and MEQC has been replaced with the Medicaid and CHIP Eligibility Review Pilots. CMS has issued a notice of proposed rulemaking that modifies its PERM requirements to incorporate changes mandated by the Affordable Care Act.

Express Lane Eligibility

Under the ELE option, a State Medicaid agency can use findings (e.g., income) from eligibility determinations made by a different agency, e.g., the State agency that determines eligibility for the Temporary Assistance for Needy Families program, within the State to facilitate enrollment into Medicaid. These agencies are known as Express Lane agencies. State Medicaid agencies must identify the Express Lane agencies in the Medicaid State Plan as being capable of making determinations regarding one or more program eligibility requirements using information the Express Lane agencies already collect. However, the State Medicaid agency remains responsible for making the ultimate determination of Medicaid eligibility. Most Medicaid eligibility determinations supported by ELE data are for income-based, mandatory enrollment categories for beneficiaries. However, if a beneficiary is not found to be eligible using the ELE option, the State must then conduct a full, traditional eligibility determination.

States may, but are not required to, rely on a finding from an Express Lane agency, such as a determination of household income, without repeating the data collection, calculation, or verification that an Express Lane agency had already conducted. However, before completing a determination of Medicaid eligibility for an individual in this situation, the State Medicaid agency must satisfy all other eligibility verification requirements using the processes described in its Medicaid verification plans. In particular, States must verify the individual’s status as a U.S. national or eligible immigrant.

To take advantage of the ELE option for Medicaid, a State must submit a State plan amendment to CMS and obtain CMS's approval of it. During the period of our review, 12 States had obtained CMS's approval to use the ELE option. State Medicaid agencies with an approved CMS waiver may apply the ELE option to beneficiaries up to the age of 21 or older. The CHIPRA allows States to select a variety of other State agencies to serve as an Express Lane agency. In addition, States can use the ELE option for initial identification of potentially eligible enrollees or for retention of existing Medicaid enrollees. This flexibility allows States to adapt the ELE option to their specific needs.

The ELE option was originally set to expire in 2013 but has been extended through September 30, 2017.

WHAT WE FOUND

States generally determined Medicaid eligibility using the ELE option in accordance with Federal requirements. From our sample of 157 beneficiaries, States correctly determined eligibility for 133 beneficiaries. We found no eligibility errors in 6 of the 10 States reviewed; however, 4 States did not determine eligibility for 17 beneficiaries in accordance with Federal requirements. Seven additional beneficiaries in five States were mistakenly identified as having been determined to be eligible using the ELE option, but these beneficiaries were enrolled through traditional eligibility processes. On the basis of our sample, we estimated that 731,365 beneficiaries were eligible, but 86,672 were potentially ineligible. We also estimated that Federal and State Medicaid payments on behalf of eligible beneficiaries totaled \$1,461,503,169, and Federal and State Medicaid payments made on behalf of potentially ineligible beneficiaries totaled \$284,104,281. We attribute the enrollment of potentially ineligible beneficiaries to State-specific eligibility determination errors.

In addition, States did not develop the mandated error rates specific to the ELE population because CMS did not provide States with an error rate methodology. Without a methodology for determining an ELE eligibility error rate, contrary to Federal requirements, some States relied on the PERM program to identify eligibility errors before 2014. In addition, even if CMS had provided a methodology, six States had difficulty identifying their ELE population, which would have limited their ability to produce statistically valid error rates.

WHAT WE RECOMMEND

We recommend that CMS:

- monitor States that use the ELE option for Medicaid eligibility determinations for compliance with Federal requirements;
- provide technical assistance to States to accurately identify beneficiaries who enroll through the ELE option;
- issue guidance to States to calculate statutorily required eligibility error rates for those enrolled through the ELE option; and

- ensure States appropriately redetermine, if necessary, the current eligibility status of the sample applicants who were enrolled on the basis of eligibility determinations that were not made in compliance with Federal requirements.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described steps it was taking to address the findings in this report. CMS requested that we make available the sample case information so that it can ensure that redetermination efforts are taking place on the eligibility status of the sample applicants that it enrolled on the basis of eligibility determinations found not to be in compliance with Federal requirements. We plan to share the sample case information with CMS.

In addition, CMS provided technical comments on our draft report that we incorporated where appropriate.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Children's Health Insurance Program [CHIP] Reauthorization Act of 2009 (CHIPRA, P. L. No. 111-3, § 203(a)) provides States with a new tool, known as Express Lane Eligibility (ELE), to simplify States' identification, enrollment, and retention of individuals eligible for CHIP or Medicaid. Using the ELE option, a State's CHIP or Medicaid program can use findings from a different agency within the State despite different methods of assessing income or other eligibility factors.

On April 16, 2015, Congress enacted the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. No. 114-10 § 305), which requires the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), to submit a report to Congress on (1) the number of beneficiaries enrolled in CHIP and Medicaid under the ELE option, (2) whether those beneficiaries met all eligibility requirements, and (3) the estimated dollar value of both proper and improper payments made on behalf of those beneficiaries.

This report addresses the use of the ELE option in Medicaid, and we will issue a separate report addressing the use of the ELE option in CHIP.¹ Together, these reports respond to the MACRA reporting requirement. In addition, we will report separately on the results of an evaluation of the benefits of and challenges to State use and expansion of the ELE option.²

OBJECTIVES

Our objectives were to verify whether State agencies met Federal requirements when (1) making Medicaid eligibility determinations using the ELE option and (2) developing eligibility error rates.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. To participate in Medicaid, Federal law requires States to cover certain population groups, which include mandatory poverty level groups. Individuals are eligible when they satisfy certain Federal and State requirements such as income, residency, verified U.S. citizenship, status as a U.S. national, or eligible immigration status. Most eligibility groups are subject to income requirements.

¹ See report A-04-15-08045.

² See report OEI-06-15-00410.

Beginning in 2014, the Patient Protection and Affordable Care Act³ (ACA) established new income eligibility requirements and many new eligibility and enrollment simplifications for both Medicaid and CHIP. Income eligibility for most Medicaid beneficiaries, including children, parents, pregnant women, and the adult expansion group, is now based on modified adjusted gross income, which uses Federal income tax rules to establish household size and calculate income. The enrollment simplifications include the use of a single streamlined application (for Medicaid, CHIP, and coverage in a qualified health plan offered through ACA marketplaces), which can be submitted through multiple channels; primary reliance on electronic verification data; and a data-driven renewal process. States must first attempt to retain enrollees using eligibility information and data available to the agency, including through ELE, and, if a beneficiary's eligibility cannot be determined with available information, the State must send the beneficiary a renewal form.

Medicaid is funded jointly by the Federal Government and States based on an approved State plan specific to each State. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. CMS and States monitor the accuracy of eligibility determinations in Medicaid using the Payment Error Rate Measurement (PERM) and Medicaid Eligibility Quality Control (MEQC) programs. However, for Federal fiscal years 2014 through 2016, the eligibility component of PERM and MEQC has been replaced with the Medicaid and CHIP Eligibility Review Pilots. In June 2016, CMS issued a notice of proposed rulemaking that modifies its PERM requirements to incorporate changes mandated by the ACA.⁴

Express Lane Eligibility

Under the ELE option, a State Medicaid agency can use findings (e.g., income) from eligibility determinations made by a different agency within the State to facilitate enrollment into Medicaid. These agencies are public agencies known as Express Lane agencies, including agencies that determine eligibility for assistance for any of the following programs or under any of the following authorities: the Temporary Assistance for Needy Families program funded under part A of title IV of the Social Security Act; a State program funded under title IV-D of the Social Security Act (Child Support Enforcement); the State Medicaid or CHIP program; the Supplemental Nutrition Assistance Program (SNAP) (formerly the Food Stamp Program); the Richard B. Russell National School Lunch Act (school lunch programs); the Child Nutrition Act of 1966 (the Special Supplemental Nutrition Program for Women, Infants, and Children, or "WIC"); and others. State Medicaid agencies must identify the Express Lane agencies in the Medicaid State Plan as being capable of making determinations regarding one or more Medicaid eligibility requirements using information the Express Lane agencies already collect. However, the State Medicaid agency remains responsible for making the ultimate determination of Medicaid eligibility. Most Medicaid eligibility determinations supported by ELE data are for

³ P.L. 111-148 § 2002 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010).

⁴ 81 Fed. Reg. 40596 (June 22, 2016).

income-based mandatory enrollment categories for beneficiaries.⁵ However, if a beneficiary is not found to be eligible using the ELE option, the State must then conduct a full, traditional eligibility determination.

States may rely on a finding from an Express Lane agency, such as a determination of household income, without repeating the data collection, calculation, or verification that an Express Lane agency already had conducted. However, before completing a determination of Medicaid eligibility for such an individual, the State Medicaid agency must satisfy all other eligibility verification requirements using the processes described in its Medicaid verification plans.

To take advantage of the ELE option for Medicaid, a State must submit a State Plan amendment (SPA) to CMS and obtain CMS's approval of it. State Medicaid agencies may apply the ELE option to beneficiaries up to the age of 21 or older⁶ with an approved CMS waiver. The CHIPRA allows States to select from a variety of other State agencies to serve as the Express Lane agency. In addition, States can use the ELE option for initial identification of potentially eligible enrollees or for retention of existing Medicaid enrollees. This flexibility allows States to adapt the ELE option to their specific needs.

The ELE option was originally set to expire in 2013. However, it has been extended through September 30, 2017, through MACRA's amendment to section 1902(e)(13)(I) of the Social Security Act (MACRA § 302).

Eligibility Determinations

When making a Medicaid eligibility determination using the ELE option, States continue to follow the processes outlined in their verification plans. Except for the findings obtained from the Express Lane agency, which do not need to be reverified, the State would verify the individual's Social Security number, U.S. citizenship, status as a U.S. national or eligible immigration status, date of birth and age, State residency, household composition, and household income using the data sources and processes described in its verification plan.

Under the ELE option, a State Medicaid agency may rely on findings from an Express Lane agency to make an eligibility determination even if the Express Lane agency uses different information than the State Medicaid agency.⁷ This could result in the State Medicaid agency making an eligibility determination using the ELE option that does not meet traditional Medicaid eligibility requirements because of the differences in methodology used by the Express Lane agency and the State Medicaid agency. For example, a State may determine eligibility by using an income finding from an Express Lane agency that uses either gross or adjusted gross income

⁵ Medicaid has numerous other mandatory and optional enrollment categories under which a beneficiary may be eligible if the beneficiary is assessed using traditional eligibility determinations.

⁶ States must have a State Plan amendment to use the ELE option, which is generally used for children. With an additional waiver approved by CMS, States may enroll individuals over age 21.

⁷ A State Medicaid agency can "rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B) and 1137(d) or any differences in budget unit, disregard, deeming or other methodology" (Social Security Act § 1902(e)(13)(A)(i)).

obtained from State income tax records or returns, but the Medicaid agency may use modified adjusted gross income to determine eligibility.

For citizenship, State Medicaid agencies that use the Express Lane option must continue to meet traditional Medicaid documentation requirements to verify citizenship status for individuals who declare that they are citizens or nationals of the United States (Social Security Act § 1902(e)(13)(A)(i)(IV)). To appropriately verify citizenship status, State Medicaid agencies generally have multiple options. The CHIPRA, section 211, established a new option for States to verify citizenship through a data match with the Social Security Administration. States can also verify citizenship status by obtaining satisfactory documentation from applicants (e.g., birth certificates) (Social Security Act § 1903(x)). States may also verify immigration status through a data match with the Department of Homeland Security (42 CFR § 435.949).

Enrollment Data

We obtained aggregate enrollment data from States that used the ELE option for enrollment for calendar years (CYs) 2010 through 2013. We present this unaudited enrollment data in Table 1.

Table 1: Aggregate State Medicaid ELE Enrollment by Calendar Year

Calendar Year	Aggregate Enrollment⁸
2010	72,435
2011	208,874
2012	448,133
2013	607,481

In addition, we obtained aggregate eligibility determination data for CY 2014, which we audited in detail for beneficiaries enrolled in Medicaid using the ELE option for any time in CY 2014.

HOW WE CONDUCTED THIS REVIEW

We contacted the 12 States and the Virgin Islands that CMS identified on its Web site as of May 6, 2015⁹, as having an approved SPA that allows using the ELE option for Medicaid enrollment. We requested the following information regarding the 12 States' and the Virgin Islands' use of the ELE option: Medicaid SPAs, number of beneficiaries enrolled using the ELE option, and any information about reviews or evaluations of the ELE option conducted by the respective States. We also met with CMS to gain an understanding of its management and oversight of States' use of the ELE option.

⁸ Georgia could not provide historical enrollment numbers (before CY 2014). South Dakota did not use ELE for Medicaid enrollment before CY 2014. The U.S. Virgin Islands (Virgin Islands) did not respond to our repeated inquiries.

⁹ As of October 11, 2016, CMS no longer lists Georgia as one of the States with an approved SPA to use ELE for Medicaid enrollment.

We reviewed the Medicaid eligibility determinations made by Alabama, Colorado, Georgia, Iowa, Louisiana, Massachusetts, New Jersey, New York, South Carolina, and South Dakota.¹⁰ We reviewed 157 out of 972,680 Medicaid beneficiaries¹¹ that had coverage at any time during CY 2014 and whose eligibility determinations involved factors verified through the ELE option. These eligibility determinations were made in either CYs 2013 or 2014 for Medicaid coverage effective in CY 2014. We reviewed the supporting documentation to evaluate whether the State determined the applicants' or beneficiaries' eligibility in accordance with Federal requirements. We tested eligibility for Medicaid using each State's Medicaid eligibility standards in place at the time of enrollment or reenrollment.

To meet the second element under the mandate in MACRA, section 305, we performed two tests of each eligibility determination.¹² First, we reviewed whether the eligibility determination met applicable ELE requirements in the Social Security Act, section 1902(e)(13). This allowed us to review whether the State Medicaid agency met specific ELE requirements for determining eligibility, such as using an Express Lane agency that was included in its ELE SPA. Second, we reviewed documentation from both the Medicaid and ELE agency supporting the eligibility determination to assess whether the beneficiary would have been eligible under the standards for mandatory poverty level Medicaid eligibility categories and State section 1115 demonstration waivers, as applicable in certain States.¹³ This allowed us to review whether the eligibility determination supported by the ELE data would have met States' Medicaid eligibility requirements under the applicable categories by, for instance, recalculating a beneficiary's income to assess whether the beneficiary met applicable income thresholds.

These reviews identified eligibility determinations that did not meet Federal requirements. Beneficiaries enrolled on the basis of these determinations may not be eligible for Medicaid coverage. We refer to these beneficiaries as "potentially ineligible" rather than "improperly enrolled" because some of these individuals may have been eligible if the State agency had determined eligibility in accordance with all Federal requirements. We did not assess beneficiaries for other CHIP or Medicaid eligibility categories other than the category they were enrolled in based on the eligibility determination that used the ELE option.¹⁴ For instance, we did not obtain all data sources for income verification that a State uses to make an eligibility

¹⁰ Individuals from Maryland were not included in our sample because Maryland could not identify those individuals enrolled in Medicaid through the use of ELE. Individuals from Oregon were not included in our sample because Oregon did not use ELE to enroll individuals into Medicaid after early 2013. Individuals from the Virgin Islands were not included in our sample because of logistical issues.

¹¹ We pulled a statistical sample of 150 records which corresponded to 157 beneficiaries. See Appendix B for details on our sampling methodology.

¹² MACRA, section 305, paragraph 2, required OIG to determine whether beneficiaries met all eligibility requirements.

¹³ Alabama and Massachusetts both used Social Security Act section 1115 waiver demonstration programs to use ELE for eligibility determinations for certain waiver populations.

¹⁴ We did not contact beneficiaries directly to request additional documentation, which is another step States are required to perform before determining a beneficiary is ineligible for CHIP or Medicaid.

determination based on modified adjusted gross income. As a result of these limitations, we did not determine whether beneficiaries were eligible or ineligible for Medicaid or CHIP.

With respect to individual State eligibility determinations, we limited our review of internal controls to those related to (1) verifying applicant or beneficiary identity, (2) determining applicant or beneficiary eligibility for Medicaid enrollment or reenrollment, and (3) coordinating between the respective State Medicaid agencies and their Express Lane agencies.

We performed fieldwork from September 2015 through June 2016 in participating States and at CMS’s offices in Baltimore, Maryland.

We conducted this performance audit 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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our sample design and methodology, and Appendix C contains the details of our sample results and estimates.

FINDINGS

States generally determined Medicaid eligibility using the ELE option in accordance with Federal requirements. From our sample of 157 beneficiaries, States correctly determined eligibility for 133 beneficiaries. We found no eligibility errors in 6 of the 10 States reviewed; however, 4 States did not determine eligibility for 17 beneficiaries in accordance with Federal requirements. Seven additional beneficiaries in five States were mistakenly identified as having been determined to be eligible using the ELE option, but these beneficiaries were enrolled through traditional eligibility processes.¹⁵ Table 2 summarizes the results.

Table 2: Summary of Sample Results (157 beneficiaries in total)

Correctly Enrolled Using ELE	Did Not Meet ELE Requirements	Did Not Meet Medicaid Requirements	Not Enrolled Using ELE
133	2	15	7

On the basis of our sample, we estimated that 731,365 beneficiaries were eligible, but 86,672 were potentially ineligible. We also estimated that Federal and State Medicaid payments on behalf of eligible beneficiaries totaled \$1,461,503,169, but Federal and State Medicaid payments made on behalf of potentially ineligible beneficiaries totaled \$284,104,281. We attribute the enrollment of potentially ineligible beneficiaries to State-specific eligibility determination errors.

¹⁵ Because of this misclassification by the States, we did not include the eligibility determinations for these beneficiaries as errors for the purpose of projecting potentially ineligible beneficiaries and the associated payments made on behalf of those potentially ineligible beneficiaries.

In addition, States did not develop statistically valid eligibility error rates specific to the ELE enrollees in accordance with Federal requirements. This occurred because, first, CMS had not finalized the methodology that States were to use in identifying the error rates. Without a methodology for determining an ELE eligibility error rate, contrary to Federal requirements, some States relied on the PERM program to identify eligibility errors before 2014. Second, even if CMS had provided a methodology, six States had difficulty identifying their ELE population, which would have limited their ability to produce statistically valid error rates.

STATES DID NOT ALWAYS MAKE ELIGIBILITY DETERMINATIONS IN ACCORDANCE WITH FEDERAL REQUIREMENTS

State eligibility determinations did not always follow Federal requirements for Medicaid or the ELE option. Specifically, States (1) either enrolled beneficiaries with incomes that did not meet Medicaid eligibility thresholds or did not verify incomes; (2) did not verify citizenship, status as a U.S. national, or eligible immigration status; or (3) did not follow their approved SPAs. From our sample of 157 beneficiaries, 4 States made eligibility determinations that did not meet Federal requirements for 17 beneficiaries. On the basis of our sample, we estimated that States enrolled 86,672 potentially ineligible beneficiaries. We also estimated that Federal and State Medicaid payments on behalf of those potentially ineligible beneficiaries totaled \$284,104,281.

Income: States Enrolled Potentially Ineligible Beneficiaries

To determine income eligibility for beneficiaries using ELE, a State may rely on a finding from an Express Lane agency made “without regard to differences in budget unit, disregard, deeming or other methodology” between the Express Lane agency and Medicaid (Social Security Act § 1902(e)(13)(A)(i)). States must maintain records that include in each applicant’s record facts to support the State’s determination of initial and continuing eligibility for Medicaid (42 CFR § 431.17).

Massachusetts enrolled seven beneficiaries and Alabama enrolled one beneficiary on the basis of information provided by the State ELE agencies. The ELE option specifically allows the State Medicaid agencies to rely on findings from their respective ELE agencies for eligibility determinations. However, the eligibility determination for these eight beneficiaries did not meet traditional Medicaid income eligibility requirements.

In Massachusetts, the ELE agency was not able to provide supporting documentation for the income calculation used as a basis for the eligibility determination. The State ELE agency indicated that because of a system redesign, these documents were difficult to obtain and not all documents were scanned and maintained in the system. Therefore, we were unable to verify that the eligibility determinations for these seven beneficiaries met the income standards for Medicaid. In Alabama, supporting income documentation showed that the ELE agency had miscalculated the income for the beneficiary, resulting in an understatement of income and an inaccurate eligibility determination.¹⁶

¹⁶ In Alabama, this beneficiary was enrolled in the Alabama Section 1115 waiver *Alabama Plan First*, in CY 2013, which had a financial eligibility threshold of 133 percent of the Federal poverty level. After correcting the ELE

Nonfinancial Eligibility: States Enrolled Potentially Ineligible Beneficiaries

To properly verify citizenship, status as a U.S. national, or eligible immigration status of beneficiaries enrolled under the ELE option, States must ensure that those individuals declaring to be citizens or nationals of the United States, or who have eligible immigration status, have established that status in accordance with the applicable verification requirements (Social Security Act § 1902(e)(13)(A)(i)(IV)). To satisfy the verification requirements, States must verify citizenship by obtaining satisfactory documentary evidence or electronically verify citizenship or immigration status with the Social Security Administration or the Department of Homeland Security (42 CFR §§ 435.406, 435.407, and 435.949).

For six beneficiaries in Massachusetts¹⁷ and one beneficiary in South Dakota, the State Medicaid agency determined these beneficiaries eligible for Medicaid without verifying citizenship in accordance with Federal requirements. For these beneficiaries, the States relied on information received from the Express Lane agencies to verify citizenship status. However, the Express Lane agencies relied on the beneficiaries' attestation of citizenship instead of requiring documentation or electronic verification.

For one beneficiary in Massachusetts, the State Medicaid agency relied on information from another State agency¹⁸ to verify citizenship. However, the State agency could not provide documentation that citizenship was verified in accordance with Federal requirements.

State Plan Amendment: A State Enrolled Potentially Ineligible Beneficiaries

State Medicaid agencies must determine that the public agency serving as the Express Lane agency is capable of making the determinations for one or more Medicaid eligibility requirements and identify the agency in the Medicaid SPA implementing the ELE option (Social Security Act § 1902I(13)(F)(i)(I) and (II)).

Colorado determined two beneficiaries to be eligible for Medicaid without following an approved State Plan. Specifically, Colorado had an approved SPA that allowed it to rely on data from the agency for the State's school lunch program. However, instead of relying on school lunch program data, the State Medicaid agency relied on data from the State agency for the SNAP, which was not an approved ELE agency.

agency's miscalculation, the beneficiary had an income above the Federal poverty level threshold for Medicaid. The beneficiary may have been eligible for Medicaid under other eligibility categories.

¹⁷ One of these individuals was also included in our list of income errors. However, the payments associated with this individual were only used once in our estimate of potential overpayments.

¹⁸ Massachusetts relied on the Department for Public Health to verify citizenship for this beneficiary. The Department for Public Health was not an Express Lane agency for the purposes of Massachusetts' ELE verification, but it was authorized to verify citizenship for certain Medicaid eligibility determinations in Massachusetts.

STATES DID NOT DEVELOP ELIGIBILITY ERROR RATES IN ACCORDANCE WITH FEDERAL REQUIREMENTS

States are required to annually submit to the Secretary of HHS a statistically valid sample (that is approved by the Secretary) of the children who have been enrolled in Medicaid or CHIP through a finding made by an Express Lane agency; States create that statistically valid sample by conducting a full eligibility review for the purposes of determining an eligibility error rate (Social Security Act §§ 1902(e)(13)(E)(i)(II) and (III)). CMS guidance states that “[c]onsistent with the requirements of CHIPRA, States will be required to ensure the accuracy of Express Lane eligibility determinations through eligibility reviews based on a statistically valid sample of the children enrolled through Express Lane. CMS will specify the process for this error rate measurement in regulation” (SHO #10-003, CHIPRA #14, February 4, 2010, page 6). Additionally, States are required to exclude beneficiaries determined eligible using ELE from any data or samples used to show compliance with a PERM requirement (Social Security Act § 1902(e)(13)(E)(i)(II)).

In addition, to implement the ELE option, States agree to “assign such codes as the Secretary shall require to the children who are enrolled in the State Medicaid plan or the State CHIP plan through reliance on a finding made by an Express Lane agency for the duration of the State’s election under this paragraph” (Social Security Act § 1902(e)(13)(E)).¹⁹ These codes were intended to allow States to accurately identify Medicaid beneficiaries who were determined eligible through the ELE option.

States did not develop the mandated error rates specific to the ELE population because CMS did not provide States with an error rate methodology. Without a methodology for determining an ELE eligibility error rate, contrary to Federal requirements, some States relied on the PERM program to identify eligibility errors before 2014. In addition, even if CMS had provided a methodology, six States had difficulty identifying their ELE population, which would have limited their ability to produce statistically valid error rates.

In correspondence with OIG, CMS officials stated that CMS did not specify the methodology for States to use in developing samples or calculating eligibility error rates for the ELE population because “when the Express Lane Eligibility (ELE) option was first established, it was initially set to expire in September 2013. As CMS was considering putting out guidance on error rate methodology, the ELE option was about to sunset. However, given the subsequent congressional action to extend the ELE option, currently through Fiscal Year 2017, CMS is now working to provide additional guidance....”

Some States did not remove the ELE population from their PERM populations before 2014 either because they could not separately identify the ELE population or they failed to follow CMS guidance to remove ELE beneficiaries from their populations used for PERM calculations.

¹⁹ The Secretary must assign codes to Medicaid and CHIP beneficiaries enrolled through Express Lane Eligibility (Social Security Act § 1903(e)(13)). CMS did not assign specific codes but instead addressed this requirement by notifying States that it expected them to have the ability to accurately identify the population of beneficiaries enrolled through ELE (SHO #10-003, CHIPRA #14, February 4, 2010).

Maryland could not separately identify Medicaid beneficiaries who had their eligibility determined through the ELE option and could not produce eligibility data specific to these beneficiaries. In addition, seven beneficiaries included in the State counts from five States did not have their eligibility determined using the ELE option. Specifically:

- For three beneficiaries, State agency officials in Alabama said that their ELE identifier code was manually entered by caseworkers. Although these three beneficiaries had previously been determined to be eligible for SNAP, they were not current SNAP beneficiaries eligible for Medicaid enrollment using the ELE option.
- For one beneficiary in Louisiana and one beneficiary in South Carolina, State agency officials in both States said that their data included both the ELE population and other populations targeted as future ELE renewals that could be suspended or reversed by the ELE agency. Thus, the data provided by these States were not limited to only those beneficiaries who were actually enrolled or renewed using the ELE option.
- For one beneficiary in New Jersey, State agency officials explained that the beneficiary was originally identified as part of the ELE population because New Jersey attempted to conduct an income match with the State tax agency (New Jersey's ELE agency). When the match failed, New Jersey enrolled the individual in Medicaid using the traditional eligibility determination process.
- For one beneficiary in Colorado, State agency officials said that, although the beneficiary was eligible for enrollment using ELE, the individual chose not to be determined eligible using the ELE option.

Without the ability to accurately identify beneficiaries who were determined eligible through the ELE option or a CMS methodology for developing ELE error rates, States could not produce statistically valid error rates for these beneficiaries as required by law.

RECOMMENDATIONS

We recommend that CMS:

- monitor States that use the ELE option for Medicaid eligibility determinations for compliance with Federal requirements;
- provide technical assistance to States to accurately identify beneficiaries who enroll through the ELE option;
- issue guidance to States to calculate statutorily required eligibility error rates for those enrolled through the ELE option; and
- ensure States appropriately redetermine, if necessary, the current eligibility status of the sample applicants who were enrolled on the basis of eligibility determinations that were not made in compliance with Federal requirements.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described steps it was taking to address the findings in this report. CMS requested that we make available the sample case information so that it can ensure that redetermination efforts are taking place on the eligibility status of the sample applicants that it enrolled on the basis of eligibility determinations found not to be in compliance with Federal requirements. CMS's comments are included in their entirety as Appendix D. We plan to share the sample case information with CMS.

In addition CMS provided technical comments on our draft report that we incorporated where appropriate.

OTHER MATTERS

CMS DID NOT OBTAIN A STATISTICALLY VALID SAMPLE OF BENEFICIARIES ENROLLED THROUGH EXPRESS LANE ELIGIBILITY IN THE MANDATORY EVALUATION OF MEDICAID

The CHIPRA, section 203(b)(1), states in part that the Secretary must conduct a comprehensive, independent evaluation of the ELE option provided under the amendments made by subsection 203(a). That evaluation must include a statistically valid sample of the children who were enrolled and a determination of the percentage of children who were erroneously enrolled (§ 203(b)(1)(A)).

CMS issued reports in response to this mandate. However, those reports did not address the statistical evaluation of the ELE enrollment because “CMS had not finalized the methodology that States would use to report error rates.”²⁰

CMS IMPROPERLY ALLOWED THE U.S. VIRGIN ISLANDS TO USE THE EXPRESS LANE ELIGIBILITY OPTION

Although many provisions of the Social Security Act treat the Virgin Islands as a State, the Act defines a State for purposes of the ELE option as “1 of the 50 States or the District of Columbia” (Social Security Act § 1902(e)(13)(F)(v)).

The Virgin Islands submitted, and CMS approved, an SPA under the Social Security Act, section 1902(e)(13), which permits the State to rely on a finding made by an Express Lane agency in determining eligibility for Medicaid. Generally, the term “State” for the purposes of Medicaid is

²⁰ Mathematica, *CHIPRA Mandated Evaluation of Express Lane Eligibility: First Year Findings: Final Report*, 2012; Mathematica, *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Findings*, December 2013.

defined in Social Security Act § 1101.²¹ However, the definition specifically allows for “State” to have a different meaning where otherwise provided in law. The definition of “State” for the purposes of the ELE option is otherwise defined more narrowly than the definition of “State” under the Social Security Act, section 1101.

As a result of CMS’s approval of the Virgin Islands’ SPA, the Virgin Islands relied on this approved SPA to make eligibility determinations using the ELE option. We note that, for logistical reasons, we did not include the Virgin Islands among the States that we sampled to perform detailed eligibility reviews, and this report makes no comment regarding the potential error rates attributable to the Virgin Islands’ participation in the ELE option. In addition, because the Virgin Islands relied on CMS’s approval in good faith, we are not recommending recovery of any Federal money spent by the Virgin Islands on behalf of ELE enrollees.

²¹ “The term “State,” *except where otherwise provided*, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, XIX, and XXI includes the Virgin Islands and Guam” (emphasis added) (Social Security Act § 1101).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the following States that used the ELE option for enrollment at any time in CY 2014: Alabama, Colorado, Georgia, Iowa, Louisiana, Massachusetts, New Jersey, New York, South Carolina, and South Dakota.

We limited our review of internal controls to those related to determining an applicant's eligibility for enrollment in Medicaid and the States' development of the ELE error rate. Our testing of controls included a review of supporting documentation at both the State Medicaid and ELE agencies to evaluate whether the State determined the applicant's eligibility in accordance with Federal requirements. We did not assess ELE beneficiaries' eligibility for alternative Medicaid eligibility categories or contact beneficiaries to obtain additional supporting documentation.

We performed fieldwork from September 2015 through June 2016 at participating States throughout the country and at CMS offices in Baltimore, Maryland.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements, CMS guidance, and SPAs regarding the implementation and use of the ELE option;
- reviewed the CMS contractor's final report entitled *CHIPRA Mandated Evaluation of Express Lane Eligibility: First Year Findings*, dated December 2012;
- reviewed the CMS contractor's final report entitled *CHIPRA Mandated Evaluation of Express Lane Eligibility: Final Finding*, dated December 2013;
- conducted phone conferences with congressional staff to reach agreement on how to proceed with this review;
- conducted an entrance conference with CMS officials to understand the guidance and oversight they provided to the States regarding the implementation and use of the ELE option;
- met with and held telephone conferences with various State Medicaid agency officials to:
 - obtain their policies and procedures for implementing the ELE option, identifying beneficiaries enrolled through the ELE option, determining the error rate of the ELE enrollees, and reducing the error rate of ineligible ELE enrollees;

- obtain a data file containing all beneficiaries enrolled in Medicaid at any time during CY 2014 who were determined to be eligible through the ELE option;
- obtain an annual count of beneficiaries determined to be eligible for Medicaid through the ELE option since its implementation;
- obtain interagency agreements between the Express Lane agencies and the various State Medicaid agencies;
- obtain all correspondence between the State agencies and CMS concerning approval and implementation of the ELE option; and
- understand the State agency’s methodology for determining Medicaid eligibility;
- selected a stratified random sample that included 157 beneficiaries from a total of 972,680 beneficiaries²² that States determined to be eligible for Medicaid through the ELE option and:
 - contacted the various State Medicaid agencies to obtain documentation to verify the Medicaid eligibility of each sampled individual,
 - obtained the final paid claim amounts for each service received in CY 2014 for each sampled individual,²³ and
 - contacted the various Express Lane agencies to obtain documentation to verify the Medicaid eligibility of each sampled individual;
- analyzed the State agency’s documentation supporting beneficiaries’ Medicaid eligibility; and
- discussed the results of our review with CMS officials.

We conducted this performance audit 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.

²² We pulled a statistical sample of 150 records, which corresponded to 157 beneficiaries. See Appendix B for details on our sampling methodology.

²³ We did not review individual claims payments for accuracy as part of this review. Instead, we categorized all claims payments on behalf of individuals who were determined ineligible as improper payments and all payments made on behalf of individuals who were determined to be eligible as proper payments.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

TARGET POPULATION

The target population consisted of individuals who were determined to be eligible using the ELE option and enrolled in Medicaid at any time during CY 2014.

SAMPLING FRAME

The sampling frame consisted of an Excel spreadsheet containing Medicaid records from 10 States (Alabama, Colorado, Georgia, Iowa, Louisiana, Massachusetts, New Jersey, New York, South Carolina, and South Dakota). The records for all States except Louisiana consisted of beneficiaries whom the States enrolled in Medicaid at some time during CY 2014 and whom the States determined to be eligible using the ELE option. The records for Louisiana consisted of households that had at least one member who was enrolled in Medicaid at any time during CY 2014 and whom the State determined to be eligible using the ELE option.

From the target population of individuals from the 12 States and the Virgin Islands, we removed the records for the Virgin Islands, Maryland, and Oregon, which left records from 10 States in the sampling frame. The records from the Virgin Islands were not included in the sampling frame because of logistical issues. We did not include the records from Maryland in the sampling frame because Maryland could not identify those beneficiaries enrolled in Medicaid through the use of the ELE option. We did not include the records from Oregon in the sampling frame because Oregon did not use the ELE option to enroll individuals into Medicaid after early 2013. The sampling frame consisted of 872,595 Medicaid records associated with 972,680 beneficiaries.

SAMPLE UNIT

The sample unit was a Medicaid record.

SAMPLE DESIGN

We used a stratified random sample. We separated the records from Alabama, Louisiana, and South Carolina and obtained Medicaid payment information. These records represented approximately 68 percent of the total sampling frame of records determined to be eligible during the audit period through the ELE option. We then sorted the records from Alabama, Louisiana, and South Carolina by dollar amount of payment. Records from all the other States (Colorado, Georgia, Iowa, Massachusetts, New Jersey, New York, and South Dakota) were assigned to stratum 5. This assignment resulted in five total strata as shown in Table 3.

Table 3: Individuals by Stratum

Stratum	Range	Description	Number of Records
1	\$1,083.99 and below	Records in AL, LA, and SC	425,928
2	\$1,084.00 - \$3,265.99	Records in AL, LA, and SC	124,724
3	\$3,266.00 - \$13,560.99	Records in AL, LA, and SC	32,690
4	\$13,561.00 and above	Records in AL, LA, and SC	3,235
5		Records in CO, GA, IA, MA, NJ, NY, SD	286,018

SAMPLE SIZE

We selected 150 records²⁴ for detailed review of eligibility as follows in Table 4.

Table 4: Sample by Stratum

Stratum	Number of Records	Number of Sample Items
1	425,928	20
2	124,724	20
3	32,690	20
4	3,235	20
5	286,018	70

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OIG/OAS), RAT-STATS statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the records in each stratum of our Excel spreadsheet. After generating the random numbers for each stratum, we selected the corresponding records in the sample frame for our sample.

ESTIMATION METHODOLOGY

We calculated point estimates and 90-percent confidence intervals for the total amount of eligible and ineligible Medicaid payments for any records for which the State agency claimed reimbursement and for the total number and percent of potentially ineligible beneficiaries. These calculations were performed using the OIG/OAS variable appraisal programs in RAT-STATS. The one exception is the percent of potentially ineligible beneficiaries. This percent was

²⁴ These 150 records belonged to 157 total beneficiaries because the 28 records selected for Louisiana covered 35 ELE beneficiaries.

calculated using the R statistical computing language because it was based on the combined ratio estimator rather than the difference estimator.

Our sample design did not allow us to report separate error rates for each State.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Table 5: Sample Results

Stratum	Frame Size (Records)	Sample Size	Value of Sample	Total Sampled Beneficiaries	Potentially Ineligible Beneficiaries	Value of Potentially Improper Payments
1	425,928	20	\$14,729	20	1	\$930
2	124,724	20	30,777	20	0	0
3	32,690	20	95,789	22	0	0
4	3,235	20	212,968	25	0	0
5	286,018	70	256,728	70	16	64,684
Totals	872,595	150	\$610,991	157	17	\$65,614

ESTIMATES

Table 6: Estimated Values for the Audit Period
Limits Calculated at the 90-Percent Confidence Level

	Point Estimate	Lower Limit	Upper Limit
Number of Potentially Ineligible Beneficiaries	86,672	44,334	129,009
Percentage of ELE Enrollees Who Were Potentially Ineligible	10.60%	5.42%	15.77%
Proper Payments	\$1,461,503,169	\$1,266,057,227	\$1,656,949,110
Potentially Improper Payments	\$284,104,281	\$151,273,391	\$416,935,171

APPENDIX D: CMS COMMENTS



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: SEP 16 2016

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt 
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicaid Enrollment Using the Express Lane Eligibility Option Did Not Always Meet Requirements (A-04-15-08043)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on Express Lane Eligibility (ELE) in Medicaid. CMS takes seriously its commitment to supporting states in complying with Express Lane Eligibility requirements.

The ELE option, as authorized in the Children's Health Insurance Program Reauthorization Act of 2009, has helped states successfully enroll individuals into Medicaid and/or CHIP coverage. The ELE option allows state Medicaid agencies to rely on findings made by public agencies as specified in the statute in determining eligibility for coverage, therefore providing another way for state agencies to identify and enroll children who may be eligible for Medicaid but who remain without health coverage. ELE has helped address shortfalls in enrollment in these programs and provide coverage stability for these beneficiaries.

Other ELE benefits include significant flexibility provided to states to develop ELE policies for enrollment and retention that meet their unique state needs using the ELE option, streamlining enrollment and renewal through reduced staff time on processing beneficiary cases and improved coordination across ELE partner agencies that administer need-based programs by sharing findings on eligibility determinations.

Given the success of the ELE program, CMS takes seriously OIG's findings and is committed to providing technical assistance to the select states OIG identified in this study.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

OIG recommends that CMS monitor States that use the ELE option for Medicaid eligibility determinations for compliance with Federal requirements.

CMS Response

CMS concurs with OIG's recommendation. CMS is working to provide guidance to states clarifying Federal requirements around the ELE option, including recently proposed changes to the Payment Error Rate Measurement (PERM) methodology issued on June 20, 2016 that would not exclude monitoring of ELE cases. In addition, when state site visits are conducted in the future, CMS will consider including a review of the state's ELE process as a component of the visit.

OIG Recommendation

OIG recommends that CMS provide technical assistance to States for accurately identifying beneficiaries who enroll through the ELE option.

CMS Response

CMS concurs with OIG's recommendation. CMS is committed to providing individual technical assistance to the State agencies identified in the OIG's report to further clarify how to accurately identify beneficiaries in the states' eligibility systems who enroll or renew through the ELE option. This can be achieved through the regular technical assistance CMS provides to states via monthly conference calls with the Eligibility Technical Advisory Group (ETAG). In addition, CMS will work with the Systems Technical Advisory Group (S-TAG) and directly with state systems staff to provide information around the system changes necessary to accurately identify beneficiaries who enroll/renew through the ELE option.

OIG Recommendation

OIG recommends that CMS issue guidance to States for calculating statutorily required eligibility error rates for those enrolled through the ELE option.

CMS Response

CMS concurs with OIG's recommendation. At the time CMS was considering issuing guidance on error rate methodology, the ELE option was initially set to sunset in September 2013. However, given subsequent congressional action to extend the ELE option, through Fiscal Year 2017, CMS will work to develop guidance clarifying a process/methodology for calculating an ELE error rate. In addition, the PERM changes that CMS issued on June 20, 2016, as part of a notice of proposed rulemaking, would no longer exclude ELE cases.

OIG Recommendation

OIG recommends that CMS ensure States appropriately redetermine, if necessary, the current eligibility status of the sample applicants who were enrolled on the basis of eligibility determinations that were not made in compliance with Federal requirements.

CMS Response

CMS concurs with OIG's recommendation. Should OIG make available the specific case information, CMS will work with the States from OIG's study, if still necessary, to ensure that redetermination efforts are taking place on the eligibility status of the sample applicants that were enrolled on the basis of eligibility determinations found to be not in compliance with Federal requirements. While the sample was taken from 2014, CMS will work to confirm whether these errors in eligibility determinations were corrected.

CMS appreciates OIG's input and feedback on enrollment in Medicaid through the ELE option and looks forward to working with OIG on this and other issues in the future.