

**CHIPRA Express Lane
Eligibility Evaluation**

**Case Study of South Carolina's
Express Lane Eligibility
Processes**

Final Report

November 22, 2013

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HEALTH MANAGEMENT ASSOCIATES

MATHEMATICA

Policy Research

Mathematica Reference Number:
06988.700

Submitted to:
U.S. Department of Health and Human
Services, Office of the Assistant Secretary
for Planning and Evaluation
200 Independence Ave., SW
Washington, DC 20201

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EXECUTIVE SUMMARY

South Carolina implemented Express Lane Eligibility (ELE) to simplify children’s Medicaid renewals in April 2011, followed by ELE for Medicaid enrollment in September 2012. In South Carolina, Medicaid includes the Title XIX program as well as the Title XXI Medicaid expansion and is administered by the Department of Health and Human Services (DHHS). For both ELE enrollment and renewal, the Medicaid program receives information from the Department of Social Services (DSS) about children’s eligibility for Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance to Needy Families (TANF) in lieu of families providing documentation of Medicaid eligibility. DHHS enrolls or renews the child’s coverage based on this information without requiring consent or other action on the part of the family, a policy which likely contributes to high rates of ELE participation. This report, part of a larger evaluation of ELE mandated by Congress, presents findings from a case study of South Carolina’s ELE policies, conducted in June 2013. South Carolina’s ELE initiatives have resulted in large enrollment and retention improvements. As of June 2013, more than 92,000 children have enrolled in Medicaid through ELE, and over 276,000 children’s Medicaid benefits have been renewed through ELE. Table ES.1 summarizes key facts about the state’s ELE processes.

Table ES 1. Key Facts About South Carolina’s Express Lane Eligibility Processes

Policy Simplification Adopted?	ELE
Policy in Medicaid, CHIP, or both?	Both. Title XIX Medicaid and Title XXI Medicaid-expansion CHIP population
Processes affected?	Enrollment and renewal
If ELE, what eligibility factors are addressed by ELE?	Income, State Residence, Identity, Social Security Number
Implementation date?	Renewal: April 2011 Enrollment: September 2012
Partner agencies?	Department of Social Services, which administers TANF and SNAP. The SNAP income limit is 130% of the FPL and TANF income limit is 50% of the FPL
Is process different from view of the enrollee/applicant?	Yes, families do not need to file application or renewal forms
Faster time to coverage for applicants?	Yes, up to 23 days faster for initial applications
Any time savings for the state?	90 minutes per application and 25 minutes per renewal
Estimated cost to implement?	\$538,000 in programming and other technical implementation costs
Estimated ongoing net administrative costs or savings?	\$1.6 million in net savings annually

Source: Facts about time savings, implementation costs, and ongoing net administrative costs and savings are from Mathematica analysis of interview and administrative data.

CHIP=children’s health insurance program; ELE=express lane eligibility; FFS=fee-for-service; FPL=federal poverty level; SNAP=Supplemental Nutrition Assistance Program; TANF=Temporary Assistance for Needy Families.

Prior to implementing ELE, South Carolina ranked 45th in the country in coverage rates for low-income children (up to 200 percent of the federal poverty level) (Kaiser Family Foundation, 2013). In 2010-2011, almost 163,000 children or 19 percent of low-income children in South Carolina were uninsured (Kaiser Family Foundation 2013). The state also experienced significant churn: half of

children enrolled in Medicaid were losing coverage each year, with 65 percent returning within a year and 42 percent returning within a month (Supra 2011). DHHS estimated that tens of thousands of hours were being used to re-enroll children in coverage after they were disenrolled for failure to complete the renewal process (South Carolina Department of Health and Human Services 2012).

During the recent economic recession, some in the Medicaid agency had been reluctant to consider ways to streamline enrollment and renewal because of concerns about the impact of higher enrollment on the Medicaid budget. The legislature, however, supported enrollment and renewal simplification by authorizing electronic data matching in 2008. In January 2011, a new governor and the Medicaid agency provided their support for covering existing Medicaid eligibles by using ELE for renewal purposes initially (and later for enrollment). DHHS began a fast-paced, successful effort to write a state plan amendment (SPA) to use ELE for renewal before the April 2011 deadline for the CHIPRA performance bonuses (if approved, ELE would potentially qualify the state for a bonus).

In addition to improving coverage, ELE held the promise of lower administrative costs for South Carolina. A DHHS labor analysis conducted in the first year of ELE implementation projected it would save 50,000 hours and \$1 million in staff time and expenses (Supra 2011). Subsequent analysis by Mathematica Policy Research as part of this evaluation finds that using ELE for enrollment and renewal is saving the state about \$1.6 million annually. Because of ELE, the state has not needed to replace about 200 eligibility workers who left their jobs through attrition in the last few years. DHHS is now considering retraining many remaining staff to promote health service utilization, rather than to process applications and renewals. The agency intends to retrain some enrollment workers to serve as community health workers who will assist families in getting connected to and using appropriate health care services. According to the Medicaid director, helping children use health services appropriately, particularly well-child visits, supports the agency's mission "to purchase the most health for our citizens in need at the least possible cost to the taxpayer."

With CMS approval, South Carolina implemented ELE for enrollment without an explicit consent mechanism on the SNAP application. Thus, South Carolina's experience can help address an important question about ELE enrollment: Is enrollment without families' explicit acceptance of coverage (i.e., consent) an effective approach to improving use of needed services? That is, do children continue to underuse services (as uninsured children do) because families either do not recognize they have coverage or do not want the coverage? Preliminary analysis of claims by DHHS shows that about one-third of children enrolled through ELE since September 2012 had used services as of May 2013, similar to the experience of non-ELE enrollees. Further data analysis is planned to examine patterns of utilization such as rates of primary care and emergency department visits.

State officials believe that the positive experience with ELE for children supports extending ELE to eligible but unenrolled adults. Although South Carolina does not at this time intend to implement the optional Medicaid expansion that is permitted under the Affordable Care Act, there are an estimated 160,000 to 200,000 eligible but unenrolled adults who may benefit from simplified

enrollment and renewal via ELE. South Carolina has begun discussing an adult ELE policy with CMS.¹

Key lessons learned in South Carolina include the following:

- DHHS was able to build support for ELE by articulating its value in addressing the state's commitment to covering children.
- Interagency data sharing can be simple when agencies work together, and the linkage between SNAP and TANF and Medicaid are particularly well-suited because of the similar rigor of the documentation process and similar income thresholds.
- Children enrolled in Medicaid through the ELE process were assigned to the fee-for-service benefits, rather than managed care, until their first use of services. In addition to giving flexibility to families to choose their own managed care plan, it is a useful strategy to avoid paying managed care premiums for children not yet using services.
- Automated enrollment and renewal processes that do not require parents to take action return forms can lead to very large enrollments, particularly in states that have not conducted extensive outreach in the past.
- After enrollment, families may need additional assistance in connecting to a primary care medical home and using services effectively.
- Parents no longer face the application and renewal paperwork burden, particularly the challenges of asking their employers to provide wage information and experiencing long waits at county DHHS offices.
- Enrollment assistors report that Medicaid enrollment through the SNAP application process avoids potential misunderstandings families may otherwise have about eligibility, assets, and the consequences of working, and reduces the impact of past negative experiences with the enrollment process that may keep families from applying.

¹ Because CHIPRA does not authorize ELE for adults, statutory change would be needed to enable states to use ELE for adults without obtaining a section 1115 waiver from CMS.

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1. INTRODUCTION

The Children’s Health Insurance Program (CHIP), a landmark legislative initiative passed in 1997 to help close the health insurance coverage gap for low-income children, was reauthorized with bipartisan support in 2009. Although CHIP had helped to fuel a substantial increase in health insurance coverage among children, Congress remained concerned about the many children—estimated at 4.4 million in 2010—who are eligible for but not enrolled in coverage (Kenney et al. 2012). In the CHIP Reauthorization Act (CHIPRA) of 2009, Congress gave states new tools to address enrollment and retention shortfalls, along with new incentives to do so.

One of these new options is a policy called Express Lane Eligibility (ELE). With ELE, a state’s Medicaid and/or CHIP program can rely on another agency’s eligibility findings to qualify children for public health insurance coverage, even when programs use different methods to assess income or otherwise determine eligibility. ELE thus gives states another way to try to identify, enroll, and retain children who are eligible for Medicaid or CHIP but who remain uninsured. The concept of using data from existing government databases and other means-tested programs to expedite and simplify enrollment in CHIP and Medicaid has been promoted for more than a decade; before CHIPRA, however, federal law limited state reliance on information from other agencies by requiring such information to be cross-walked into the Medicaid and CHIP eligibility methodologies (Families USA 2010; The Children’s Partnership n.d.). To promote adoption of ELE, Congress made it one of the eight simplifications states could implement to qualify for performance bonus payments. These were new funds available to states that implemented five of the eight named simplifications and which also increased Medicaid enrollment (CHIPRA Section 104).

Federal and state policymakers are keenly interested in understanding the full implications of ELE as a route to enrolling children, or keeping them enrolled, in public coverage. To that end, Congress mandated an evaluation of ELE in the CHIPRA legislation. In addition to reviewing states that implemented ELE, the evaluation provides an opportunity to study other methods of simplified or streamlined enrollment or renewal (termed “non-ELE strategies”) that states have pursued, and to assess the benefits and potential costs of these methods compared with those of ELE. Taken together, findings from the study will help Congress and the nation better understand and assess the value of ELE and related strategies.

This report summarizes findings from a case study of South Carolina’s ELE program. Although the South Carolina legislature had promoted the use of data matching to improve Medicaid enrollment and renewal in 2008, agency budgetary concerns stalled implementation. In 2011, with a new governor and Medicaid director, South Carolina proceeded to quickly design and seek approval for using ELE for renewal from the Centers for Medicare & Medicaid Services (CMS). With the help of staff from three states that preceded South Carolina in implementing ELE renewals, and the collaboration of federal and local CMS staff, South Carolina submitted its state plan amendment (SPA) in time to qualify for the 2011 CHIPRA bonus payments. In 2012, South Carolina sought and received approval to use ELE for enrollment as well.

2. STATE CONTEXT: WHY PURSUE ELE?

The main impetus behind South Carolina’s 2011 pursuit of ELE was the desire by the governor and Medicaid director to improve health insurance coverage for eligible but uninsured children. Prior to ELE, South Carolina ranked 45th in the country in coverage rates for low-income children (up to 200 percent of the federal poverty level) (Kaiser Family Foundation 2013). Almost 163,000 children, or 19 percent of low-income children in South Carolina, were uninsured (Kaiser Family Foundation 2013). Further, half of children enrolled in Medicaid were losing coverage each year, although many of them remained eligible, with 65 percent returning within a year and 42 percent returning within a month (Supra 2011), leading to redundant renewal processing. Additionally, enrollment staff made up two-thirds of the Medicaid agency staff (800 out of 1,200 employees), a heavy administrative burden for the state. An analysis of ELE’s potential impact, along with the past experience of the new South Carolina Medicaid director with ELE in Louisiana, contributed to the agency’s decision to pursue an ELE SPA. Table 1 summarizes key facts about the program.

Table 1. Key Facts About South Carolina’s Medicaid Program

Medicaid program name	Medicaid
Upper income limits for Medicaid (Title XIX)	Up to 150% of the FPL for children birth-19 years of age
Upper income limits for Medicaid-expansion CHIP (Title XXI)	151% to 200% of the FPL for children birth-19 years of age
Delivery system	Primarily risk-based managed care, with FFS for some populations. Children enrolled through ELE are in the FFS delivery system until they pick a managed care plan or are assigned one based on their utilization.
12 months continuous eligibility?	Yes
Presumptive eligibility for children?	No
In-person interview required?	No
Asset test?	Asset limit of \$30,000
Joint Medicaid and CHIP forms for application and renewal?	Yes (Medicaid and CHIP are operated as a single program, so they use a single application)
Premium assistance subsidies?	Yes, Health Insurance Premium Payment Program
Adult coverage?	Unemployed parents with dependent children and income below 50% of the FPL, and working parents with dependent children with incomes up to 89% of the FPL, are eligible for Medicaid
Renewal processes	Since April 2011, renewals for children are first checked against SNAP and TANF files for an active case, which would make the child eligible for renewal through ELE. If not, a renewal form is mailed and families must document income (which was the standard renewal process in place prior to ELE)

Sources: Site Visit Interviews, Kaiser State Health Facts.

CHIP=children’s health insurance program; ELE=express lane eligibility; FFS=fee-for-service; FPL=federal poverty level; SNAP=Supplemental Nutrition Assistance Program; TANF=Temporary Assistance for Needy Families.

South Carolina's Department of Health and Human Services (DHHS), the Medicaid agency, also knew that it had a ready source of eligibility information in the Department of Social Services (DSS), the agency that administers the temporary assistance for needy families (TANF) program and supplemental nutrition assistance program (SNAP). Pre-dating ELE, DHHS and DSS had a data sharing agreement that allowed them to share program eligibility information, and staff at both agencies had experience working together. Already, the legislature had cleared the way in 2008 for DHHS and DSS to do electronic data matching to streamline enrollment and renewal.

Finally, a third facilitating factor for implementing ELE was the hiring in 2011 of Tony Keck to lead the Medicaid agency. Keck had been Chief of Staff and Deputy Secretary at the Louisiana Department of Health and Hospitals, which had implemented ELE in its Medicaid program in 2010. During his confirmation hearings, his message about Medicaid coverage focused on the fact that South Carolina had already made the commitment to cover children up to 200 percent of the poverty level and that failing to align processes to achieve this outcome exposed the state to a potential unfunded liability.

3. PLANNING AND DESIGN: WHAT WAS NEEDED TO DEVELOP THE POLICY?

ELE for Renewal Policy

The CHIPRA performance bonus application deadline of April 1, 2011, pushed the agency to design their ELE renewal process quickly between January and April 2011. ELE would be the fifth of eight required simplifications that, along with growth in Medicaid enrollment, would qualify South Carolina for a CHIPRA bonus. DHHS staff spoke extensively to Medicaid leaders in Alabama, Louisiana, and Oregon to identify lessons they learned in designing their ELE renewal programs and gaining CMS's approval for them. South Carolina DHHS also worked directly with CMS to discuss key issues, using SPAs from other states for guidance. South Carolina chose to start with renewals rather than enrollment because of the large number of children who would benefit quickly.

The decision to use income eligibility information from SNAP and TANF data for the ELE renewal match (and later the enrollment match) was straightforward because the agencies had a preexisting agreement that allowed them to share eligibility information between programs. Despite the data agreement, there were challenges to sharing the needed information: both DHHS and DSS operate older systems that are difficult to update and use. DHHS and DSS staff met to work through a specific ELE data transfer, including deciding which variables would be needed and if the data could be provided at the individual level rather than the household level. DHHS staff sought to minimize the burden at DSS, because DSS officials reported that modifying the file to meet DHHS' needs would have been somewhat onerous. Ultimately, to assure that DSS was not over-burdened, a decision was made to eliminate any modification of the file by DSS and instead to transfer all eligibility data to DHHS. DHHS would run the match of SNAP and TANF data against the Medicaid enrollment data and determine which children were eligible for Medicaid renewal (and later, enrollment).

South Carolina's SPA for renewals was approved effective on April 1, 2011, earning the state a CHIPRA bonus that year of \$2.7 million.

ELE for Enrollment Policy

In the summer of 2012, ELE renewal had been in place for a year, and DHSS was ready to look at using ELE for enrollment. DHSS compared the number of children with an active TANF or SNAP case to those without an open Medicaid case and found about 10,000 children who could be enrolled in Medicaid through ELE. The usual enrollment process required that families visit a DHHS office and provide documentation of eligibility. Agency officials understood that some parents found the time and documentation requirements burdensome. The agency wanted to proactively offer eligible children coverage and minimize the burden on families. South Carolina faced the ELE requirement that families must consent to enrollment, yet agency staff were aware that some families would not actively respond to an offer of coverage. The solution they

developed, which was approved in the second SPA submitted to CMS in December 2011, informs families in their approval letter of the option of opting out of Medicaid enrollment by calling a toll-free number to reach the DHHS Call Center. As an additional measure, the process allows families to consent to Medicaid enrollment through the managed care choice process. Most children in South Carolina are enrolled into a managed care plan within 60 days of Medicaid enrollment; however, it was decided that children eligible through ELE would be enrolled into fee-for-service (FFS) coverage at the outset unless they selected a managed care plan, as is encouraged in the enrollment information sent to families. Children who are enrolled through ELE are not auto-enrolled into a managed care plan. However, once the child uses services, the family is given a second chance to select a managed care plan and is later assigned a plan if one is not selected within 90 days. CMS is allowing South Carolina to use this process until 2014, when South Carolina will have to develop a new way to assure parents' acceptance of coverage.²

Focus Groups Findings: ELE is an Unexpected but Happy Surprise

None of the focus group participants expected a new and simplified renewal process. None remembered reading they had an option to turn down Medicaid benefits, though none would have done so.

"I was shocked. I thought I was going to have to do extra paperwork. This is smart."

"It was so fast. No waiting at the DHHS office. No rushing. No tight schedule."

4. IMPLEMENTATION: WHAT HAPPENED?

ELE for Renewal Policy

All renewals, whether through ELE or otherwise, begin 60 days before the anniversary of coverage. DSS sends DHHS the SNAP and TANF eligibility information, and DHHS conducts the matching to see if the child is currently receiving either SNAP or TANF benefits. If the child has an active SNAP or TANF case, the Medicaid eligibility system automatically renews the child for Medicaid, and the family gets a letter notifying it that the child has coverage for the next 12 months. Eligibility staff are not involved in the cases that are successfully matched. If there is no open SNAP or TANF case, the renewal is handled as it has been before ELE: a letter and a blank renewal form are sent, and families are required to provide documentation of income with their renewal form. The

²The CHIPRA statute does not require consent for ELE when used for renewal, only for new enrollment.

family has 60 days to complete the renewal process, or the case is closed and the child’s Medicaid benefits are terminated.

The first data match for ELE renewals took place in April 2011 (see Table 2 for the implementation timeline). Because of some imprecisions in the algorithm, which were subsequently identified and addressed, DHHS re-ran the match in July 2011 for all children due to renew between April 1 and June 30, 2011. About 30,000 children were renewed automatically in that second match. Families received a letter notifying them of the ELE renewal and indicating that no further action was needed. Since then, South Carolina has averaged about 9,200 ELE renewals per month, which represents about one-third of all monthly Medicaid renewals for children.

Table 2. Timeline of ELE Implementation in South Carolina

Date	Activity
2008	Legislature authorizes DHHS to use electronic data matching to improve enrollment and retention in Medicaid. However, concerns about Medicaid spending prevent DHHS from implementing ELE.
January-April 2011	Governor Haley sworn in; Tony Keck confirmed as new Medicaid Director. DHHS decides to pursue ELE for renewing Medicaid enrollees. South Carolina receives CMS approval of ELE renewal SPA; data transfer process between DSS and DHHS for ELE begins April 2011.
July 2011	DHHS renews coverage for 65,000 children eligible for renewal in April through June who can be matched to TANF or SNAP enrollment data
November 2011	Over 200,000 ELE renewals completed
December 2011	South Carolina receives CMS approval of ELE application SPA.
September 2012	DHHS initiates ELE enrollment of 65,000 children in Medicaid via SNAP and TANF enrollment data

ELE for Enrollment Policy

Once children already receiving SNAP or TANF but identified as uninsured were enrolled in Medicaid, DHHS began using ELE on new SNAP or TANF enrollees. DSS identifies a child newly eligible for SNAP or TANF and sends the child’s information to DHHS, which automatically approves the child’s eligibility for Medicaid as well. The automated process currently takes up to a month because of the way cases are batched, but DHHS hopes that further streamlining can shorten the time. DHHS sends families of children eligible for enrollment through the ELE process a letter saying the eligible child/children has/have been enrolled in Medicaid. If the family does not want to participate, parents can call a toll free number at the DHHS call center to opt out. To date, state officials report that the most common reason to opt-out is that family members have other health insurance.

Focus Group Findings: The Importance of Streamlined Enrollment

Ease of enrollment made a big difference to busy parents. Many parents compared the ELE enrollment process to a prior experience for themselves or for an older child who got Medicaid.

“This was very fast. I think the forms were very long before.”

“My employer took ten to fourteen days to give me the information I needed for the state. I didn’t know if I’d make it.”

Federal rules require that express lane partner agencies notify families that their information will be shared with the Medicaid or CHIP agencies, solely to determine Medicaid or CHIP eligibility, and families must be able to opt out of sharing this information. To use the automatic enrollment option that South Carolina uses, states must obtain the family's consent to enroll the child, and the family must be informed about the available services, how to access them, if there is cost sharing and how to maintain the coverage (Center for Medicaid and State Operations 2010). In the Rights and Responsibilities section of the South Carolina SNAP application, there is a statement that informs applications that their information will be shared with other programs. DHHS tried to have DSS add a statement on the SNAP application that would inform families that their information would be shared with DHHS for determining Medicaid eligibility unless they checked a box opting out. However, that proved to be too difficult for DSS to do, given the time constraints. For now DHHS has an opt-out process whereby families receive a letter saying their child has been approved for Medicaid and they can call the DHHS Call Center to opt out of Medicaid (a toll free number is provided).

Also, upon enrollment, the state's enrollment broker sends families information to help them select the health plan that meets their needs. Although all children are eligible for care through fee-for-service arrangements with providers, about 15 percent of families select a plan when first offered the opportunity. DHHS does not auto-enroll any ELE-enrolled children into a health plan until that child has accessed health care services. If a child uses services, this is considered an acceptance of coverage. DHHS will then offer families a second chance to pick a health plan. If they do not pick one within 90 days, they are automatically assigned one.

Focus Group Findings: Health Plan Enrollment

Parents remembered the enrollment packet and liked the information it contained, as well as the option to get more information if they needed it.

"I liked the choice of health plan. And if you don't know which one you should pick, you can call and get more information."

"I got my managed care choice letter within a week of getting enrolled. I picked one, but I know I can change it later if I don't like it."

"I liked seeing the stars ranking the health plans. It helped me make a good choice."

Some problems with data prevented South Carolina's data matching from being completely automated. Called "exceptions" by staff, there are situations where a match cannot be made under the existing algorithm. The largest group of exceptions is newborns and others without a social security number. They cannot be added to the Medicaid eligibility file because it would likely result in a duplicate record—one with and one without a social security or ID number. DHHS expects to create more complete automation over time. For now, exceptions are manually reviewed.

Focus Group Findings: Access

Parents reported access to coverage is very good with Medicaid, and they don't know how they'd get by without it. All parents reported their children had gotten dental care and could see a doctor at a clinic or for urgent care without scheduling problems.

"Medicaid makes such a difference. I can get all my child's needs met. I don't know how I would pay, or who would see me, without Medicaid."

DHHS was concerned about how providers would react if they experienced a sudden influx of Medicaid children in their offices due to the ELE enrollment process. To prepare providers, DHHS programmed their eligibility system to approve ELE eligibility cases incrementally, and decided to implement ELE over time, one region of the state at a time. The initial runs were about 6,000 children per batch. In advance of the roll out in each region of the state, DHHS sent an outreach staff person to the region to educate providers on what the

ELE process meant for them and to ensure they were ready and willing to see these new enrollees. DHHS determined the order of the roll-out based on physician capacity. DHHS officials reported the providers are all very supportive, and provider capacity has not been a problem.

Families who participated in focus groups generally reported good access to providers in the Medicaid program, including dentists, who are often hard to find in other states. South Carolina's providers participate at high rates in the Medicaid program, likely because of the generous provider payment rates.³ However, DHHS's analysis of utilization data finds that over half of Medicaid enrolled children (59 percent) are using the emergency department, which leads them to conclude that some children need assistance getting connected to a primary care medical home.

Staff involved in the data-matching felt that the concept of ELE is clear, but the details "can trip you up." The state continues to analyze the eligibility determination process to streamline it further. Some staff did not fully understand what ELE permits in terms of using eligibility data from other agencies, and were still approaching eligibility in terms of avoiding errors when ELE for enrollment first began. Agency leaders from DHHS are working on setting parameters in ELE eligibility determinations that match the program requirements without requiring as much staff involvement.

DHHS described two possible changes they are considering that could further extend their use of ELE. For families who cannot be renewed through ELE at first try and who return the renewal form and any required documentation, the Medicaid agency would like the eligibility worker to be able to check the SNAP or TANF file one more time manually before processing the paper renewal. While there would be no time savings for the family, the state would save processing time on the renewal. The same process could be applied to new applications: before reviewing documentation for a new application, the worker could look for SNAP or TANF eligibility manually and then enroll eligible children through ELE. A third ELE simplification under consideration would involve using a single application for SNAP, TANF, and Medicaid, a change that can occur with DSS and DHHS collaboration.

There is some uncertainty about whether or not CMS will require South Carolina in the future to implement a process for parents to affirm their interest in receiving Medicaid benefits (i.e., "opt-in") for their children, rather than allowing continuation of the current process, whereby children are enrolled without any explicit consent and parents can then "opt out" by phone or simply not use services. DHHS has thought about ways of gaining consent without losing eligible children. One idea is to ask families to call to activate their Medicaid cards. Activation would imply consent and acceptance of Medicaid. Parents would likely be familiar with such a process because they use it already for credit and bank cards.

5. OUTCOMES: WHAT ARE THE OBSERVED OUTCOMES?

Key stakeholders believe the implementation of ELE for enrollment and renewals has been successful. Key outcomes include:

³ The Medicaid fee index measures each state's physician fees relative to national average Medicaid fees. South Carolina's fee index for all physician fees is 1.18, ranking it in the upper third of state fee index. (Kaiser State Health Facts, 2013).

- **Increased Medicaid enrollment.** Between September 2012 and June 2013, ELE has helped over 92,000 children gain new coverage.
- **Reduced churn.** State officials believe that ELE renewal has greatly reduced the unnecessary loss of coverage each year by children who previously did not complete the old renewal process but then later returned to Medicaid. Over 276,000 renewals have been conducted automatically between April 2011 and June 2013 through the ELE renewal process.
- **Through automation, ELE has reduced the staff needed to process paperwork, which lowers cost.** South Carolina is saving 90 minutes per application and 25 minutes per renewal processed through ELE; together, these ELE processes are saving the state about \$1.6 million annually. Through attrition, South Carolina lost one-fourth of its eligibility staff in the past three years; however, remaining staff have been able to meet the timeliness goals because about a third of all Medicaid renewals for children are processed through ELE.
- **Even with automated ELE processes, staff need training to implement ELE.** Confusion among some case workers led to their editing ELE cases so that the family structure met the usual Medicaid criteria—a step that was unnecessary. Misunderstanding of the automated process led eligibility workers to manually handle about 4000 cases needlessly. In hindsight, the agency realized that some level of information and training for eligibility workers would have been helpful.

In addition, DHHS continues to improve the ELE process to reduce the number of cases requiring human review (called “exceptions”) and to process more cases through electronic enrollment or renewal.

6. LOOKING FORWARD: FUTURE PROSPECTS FOR USING ELE

Moving from enrollment to engagement. One of the most intriguing changes reported by officials is the planned shift in focus from coverage to improving the health of those enrolled. Within the next 18 months, South Carolina expects to have changed the agency’s focus from benefit administration and eligibility determination towards meeting community health needs and connecting people with appropriate care. While the technology exists to administratively enroll children, connecting children to care lags behind. By reducing worker caseloads and giving caseworkers more time to focus on this new initiative, ELE has made this shift possible.

To help families better understand how to use their health benefits, the state plans to retrain eligibility workers to act as community health workers who can connect families to services that promote prevention and wellness. DHHS has identified a curriculum developed in Minnesota that may be helpful in developing South Carolina’s plans. In addition, the state will increase its outreach staff from one person to eight. These regional outreach staff will enlist community groups in education efforts to help people understand the value of health care and learn how to use health care services. DHHS is monitoring the use of health services by ELE enrolled children compared to non-ELE enrolled children to determine if outreach needs to be different for the two groups.

Expanding use of ELE, if permitted. Key informants in South Carolina were universally in favor of continuing the ELE option and expanding its use to adults.⁴ South Carolina is also involved in a demonstration project to enroll low-income families in all the programs for which they are eligible. Participants see greater use of ELE in the future as an important component of that effort.

Moving towards Affordable Care Act implementation. South Carolina residents will be served by a federally facilitated Marketplace beginning in 2014. The governor has opposed Medicaid expansion but favors efforts to enroll more eligible adults in coverage through ELE, if permitted through federal statutory change. SNAP would be a good source of data matching for adults, according to agency staff, and preliminary analysis is underway to identify the number of eligible but unenrolled adults who could be enrolled through this channel. CMS has recently encouraged states to consider SNAP eligibility as a means of simplifying Medicaid enrollment for adults (Centers for Medicare & Medicaid Services 2013). Another Affordable Care Act provision encourages the use of a simplified, unified application for Medicaid, SNAP, and TANF, which South Carolina is considering.

7. LESSONS LEARNED

South Carolina's experience with Express Lane Eligibility strategies teaches many important lessons.

Implementing ELE for renewal first and then proceeding to ELE for enrollment can help achieve buy-in for ELE. Key informants believe that it is easier to get approval for ELE for renewals than for ELE enrollment because the children are already in the system and their eligibility has been determined at least once in accordance with Medicaid standards. Further, early, short-term administrative savings from renewal helped build momentum for applying ELE to applications, where the financial implications of adding large numbers of new beneficiaries may be greater.

An ELE partnership that uses data from SNAP and TANF can enroll and renew large numbers of children efficiently. Particularly in states where there may be some resistance to ELE, state officials have to consider which partners make the most sense for ELE implementation. SNAP and TANF are good matching programs for ELE because their verification processes are rigorous and their income eligibility levels are lower than Medicaid's, assuaging some stakeholders' concerns about opening Medicaid eligibility too broadly.

South Carolina's ELE processes were built on a foundation of data analysis that was persuasive in gaining approval. Knowing the overlap among SNAP, TANF, and Medicaid eligibility and enrollment helped stakeholders understand the benefits—and potential impact—of implementing ELE. Further, a study of the time enrollment workers spent processing applications for children who churned in and out of coverage provided convincing evidence that significant savings could be achieved.

ELE has freed up staff resources. Implementing ELE has helped DHHS to have the resources to focus on analyzing how ELE enrollees use health care services. State officials reported

⁴ Both actions would require a statutory amendment by Congress.

that they plan to redirect staff resources that had previously been used in application processing to focus on more rapidly connecting children with appropriate services, such as well child visits.

Outreach and education on ELE helped prepare providers for resulting new enrollees. Outreach by DHHS staff helped providers anticipate an influx of new patients and understand the policy changes underlying the higher enrollment. DHHS could then prioritize implementation in counties based on provider readiness for more patients.

In a short period of time, South Carolina has become a leader in using ELE to enroll and retain eligible children in Medicaid. The state's success in enrolling large numbers of children as a result of this simplification may motivate other states with many low-income uninsured children to follow a similar path, one that allows expanding coverage without incurring the heavy burden of outreach or an increase in the number of enrollment personnel. South Carolina's analysis of the use of services by children enrolled through ELE compared to traditional enrollment methods illuminates the next layer of improvements states must undertake, which is to ensure that coverage leads to timely use of needed services that will improve health.

ACKNOWLEDGEMENTS

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