U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

January 22, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This letter responds to your request that we address questions submitted for the record related to the December 3, 2014 hearing entitled *The Future of the Children's Health Insurance Program*. GAO's responses to these questions are enclosed and are based on previous work related to the areas addressed.

If you have any questions about these responses or need additional information, please contact Carolyn L. Yocom at yocomc@gao.gov or call (202) 512-7114.

Sincerely yours,

Carolyn L. Yocom
Director, Health Care

Enclosure

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Post-Hearing Questions for the Record
Submitted to Carolyn Yocom
From the Honorable Joseph R. Pitts and the Honorable Frank Pallone, Jr.

"The Future of the Children's Health Insurance Program"

December 3, 2014

The Honorable Joseph R. Pitts

1. **Under the Affordable Care Act/Obamacare, states are only permitted to use a waiting period of up to 90 days before a child who is otherwise eligible is permitted to enroll in CHIP. Before Obamacare, states could require waiting periods of up to a year. This was designed to ensure that CHIP coverage does not crowd out private coverage. What, if any, concerns does the removal of state options for implementing longer waiting periods raise and to what extent does this needlessly increase federal spending?**

   Our prior work suggests that it is unclear whether having required waiting periods for CHIP, and the length of those periods, affect crowd-out, i.e., the substitution of public health coverage through CHIP for private health insurance**.** In 2009, we reported that 39 states used waiting periods to minimize crowd-out, with16 of those states requiring periods of 3 months or less, 20 states requiring 4 months or longer (generally 4 to 6 months), and 3 states requiring different periods for different situations, such as different income levels.[1] All 39 states included exemptions designed to account for instances where a child involuntarily lost private health insurance. The studies GAO identified that focused on the effects of waiting periods and cost sharing requirements found that such requirements can have a negative effect on individuals' participation in CHIP. These studies also suggested that policies to minimize crowd-out may deter CHIP enrollment by eligible uninsured children at a faster rate than they deter use by individuals who have private coverage. We found that little is known about the effects of the different lengths of waiting periods on minimizing crowd-out.

2. **Express Lane Eligibility allows states to determine eligibility for children in Medicaid or CHIP by using certain information, such as information from other public-assistance programs that enroll children. While express lane eligibility can result in administrative simplification, what, if any, concerns does this initiative raise for CHIP program integrity?**

   Our prior work suggests that express lane eligibility (ELE) could result in administrative savings and have beneficial effects on enrollment.[2] However, we also reported that

[1]See GAO, *State Children's Health Insurance Program: CMS Should Improve Efforts to Assess Whether SCHIP is Substituting for Private Insurance*, GAO-09-252 (Washington, D.C.: Feb. 20, 2009).

[2]See GAO, *Medicaid and CHIP: Considerations for Express Lane Eligibility*, GAO-13-178R (Washington, D.C.: Dec. 5, 2012).

whether states' use of ELE has resulted in erroneous excess payments would be another key consideration when deciding whether to extend the option. We reported in December 2012 that the extent to which erroneous payments had been made as a result of ELE was not known. Though CHIPRA requires states to compute error rates related to ELE and report those to CMS annually, CMS had begun discussions about payment error rates internally and with states and was not planning to issue rules or guidance to states in the near future. We reported that if ELE was extended beyond its original expiration date of September 30, 2013, it would be particularly important that CMS place a higher priority on clarifying how states should determine ELE error rates and collect information on these erroneous excess payments. Congress most recently extended ELE through September 30, 2015. A recent evaluation of ELE for the Department of Health and Human Services (HHS) that focused on implementation in Louisiana included the state's overall payment error rate for Medicaid but did not include an error rate specific to those enrolled through ELE.

3. **With all of the outreach that has occurred under the current CHIP program and given the amount of federal dollars spent on outreach to encourage consumers to get enrolled in health coverage related to the Affordable Care Act/Obamacare, what, if any, policy rationale is there for continued federal funding of CHIP performance bonuses? Given GAO's historic concerns regarding possible duplication, isn't this a role a state could fund and perform if the state deemed it necessary or useful?**

   We have not done any work assessing the effects of CHIP performance bonuses or the interaction of these financial incentives with other federal funds for outreach related to the new coverage options through health insurance exchanges.

4. **Under HHS rules, states are permitted to continue coverage for CHIP-eligible children for a period of 12 months regardless of changes in family composition or income that may otherwise affect their eligibility status. This means that a child could be eligible in January, become ineligible in February, and still be on the CHIP rolls using services through the end of the year. What concerns does such a policy raise about the appropriate use and safeguards of federal dollars?**

   In states electing the option to grant 12-month continuous eligibility for children in CHIP, a child remains eligible for coverage regardless of a change in family income that may otherwise affect their eligibility. Thus, a child enrolled in January who experiences, for example, an increase in income in February that exceeds the income requirements for the program, would remain eligible for CHIP coverage. As an eligible enrollee, any payments made on behalf of that individual would be consistent with program regulations. Providing 12-month continuous eligibility potentially results in higher costs associated with higher-income enrollees remaining in CHIP. However, it also avoids additional administrative costs related to more frequent eligibility determinations, and minimizes individuals moving in and out of the CHIP program, which has the potential to improve continuity of care. GAO has not done studies aimed at examining these trade-offs.

5. **States have told us that, as a result of the modified-adjusted gross income (MAGI) calculation's treatment of lump sum payments, lottery winners are currently enrolled in Medicaid. In fact, in 2014, one state reported to us that roughly one in four of their lottery winners were enrolled in Medicaid or had a family member in Medicaid. This includes at least one individual who won more than $25 million. Since CHIP uses MAGI calculations as well, is it possible that CHIP is providing coverage for lottery winners? Please explain how lump sum payments such as lottery winnings are treated under the MAGI calculation? Does GAO have an opinion on whether or not it is an appropriate use of federal dollars to provide Medicaid coverage to multi-million dollar lottery winners?**

   Under the MAGI methodology, income received as a lump sum, such as lottery winnings, is counted as income in the month that the payment was received. Assets, including savings, are not considered for individuals whose eligibility for Medicaid or CHIP is determined using the MAGI methodology, although any interest earned on savings or other assets would be considered.[3] Therefore, it is possible that children in families with lottery winnings could be eligible and enrolled in CHIP. Prior to the implementation of MAGI, almost all states did not consider or had reduced consideration of assets when determining eligibility for CHIP.[4] As a result, it is not clear that the MAGI changes have affected the extent to which individuals with large lump payments might qualify for CHIP.

6. **GAO recently issued a report raising concerns about gaps in state and federal efforts to ensure Medicaid managed care program integrity. According to CRS, in fiscal year 2013, approximately 84 percent of separate CHIP program enrollees received coverage under some form of managed care. Do these same gaps in program integrity issues exist in CHIP? What efforts exist to ensure the integrity of the CHIP program?**

   In our recent work on Medicaid program integrity, we found that managed care presents a gap in Medicaid program integrity efforts—as state and federal program integrity officials primarily focus on fee-for-service claims rather than Medicaid managed care payments. [5] We also found that federal entities have taken few steps to address Medicaid managed care program integrity. We recommended that CMS increase its oversight of Medicaid managed care program integrity through a number of mechanisms, including requiring states to audit payments to and by Medicaid managed care plans. We did not assess the extent to which these gaps in program integrity efforts exist in separate CHIP programs. If similar gaps exist in CHIP program integrity efforts,

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[3]The MAGI methodology does not apply to certain eligibility groups, including the aged, blind, or disabled, and individuals seeking coverage for long-term services and supports.

[4]See GAO, *Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance*, GAO-12-648 (Washington, D.C.: June 22, 2012).

[5]See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014).

our recommendations would be relevant for CHIP as well, given the prevalence of managed care coverage in separate CHIP programs.

7. **As Congress moves to probably extend CHIP funding in some form, does GAO have relevant Medicaid or CHIP policies which you would recommend Congress consider that might either be targeted offsets or common-sense program integrity policies to include in legislation extending CHIP funding?**

   GAO has several open agency recommendations related to Medicaid program integrity, but we have not been asked to conduct work assessing CHIP program integrity issues. Our Medicaid program integrity recommendations include suggestions for CMS to strengthen the Medicaid Integrity Program, eliminate duplication, and more efficiently use audit resources;[6] strengthen oversight of program integrity for Medicaid managed care;[7] and increase efforts to ensure that states are correctly reporting overpayments.[8] GAO also has an open matter for Congressional consideration regarding improving the transparency of and accountability for Medicaid non-disproportionate share hospital (DSH) supplemental payments. In November 2012, we reported that Congress should consider requiring the Administrator of CMS to require states to 1) improve state reporting of non-DSH supplemental payments, 2) clarify permissible methods for calculating such payments, and 3) submit an annual independent certified audit verifying state compliance with permissible methods for calculating non-DSH supplemental payments.[9]

<u>The Honorable Frank Pallone, Jr.</u>

1. **Sometimes we hear people criticize Medicaid, and even CHIP, as being a "government-run" program. While the federal government provides financial support and broad parameters, states have a lot of flexibility to design their programs. Do you agree?**

   We have reported in prior work that the federal-state CHIP partnership has provided an important opportunity for innovation on the part of states for the overall benefit of children's health.[10] Providing three design choices—states may create a separate CHIP program, provide coverage to CHIP-eligible children through their Medicaid programs, or

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[6]See GAO, *Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency*, GAO-13-50 (Washington, D.C.: Nov. 13, 2012).

[7]See GAO, *Medicaid Program Integrity: Increased Oversight Needed to Ensure Integrity of Growing Managed Care Expenditures*, GAO-14-341 (Washington, D.C.: May 19, 2014).

[8]See GAO, *Medicaid: CMS Should Ensure that States Clearly Report Overpayments*, GAO-14-25 (Washington, D.C.: Dec. 6, 2013).

[9]See GAO, *Medicaid: More Transparency and Accountability for Supplemental Payments are Needed*, GAO-13-48 (Washington, D.C.: Nov. 6, 2012).

[10]See GAO, *Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences and Considerations for Reauthorization*, GAO-07-558T (Washington, D.C.: Mar. 1, 2007).

use a combination of these two approaches—allows states to focus on their unique needs and specific priorities. For example, provision of coverage through Medicaid (referred to as a CHIP-funded Medicaid expansion) offers Medicaid's comprehensive benefits and administrative structures and ensure children's coverage if states exhaust the CHIP allotments. In contrast, separate CHIP programs offer the state more flexibility in designing the program and may allow the state to better control program spending than when coverage is provided through a CHIP-funded Medicaid expansion.

2. **Isn't it true that most of the coverage provided under both Medicaid and CHIP is provided through private insurance companies, either HMOs or some other arrangement?**

   We have not been asked to conduct any work looking at the use of managed care in CHIP. However, data indicate that the use of managed care in Medicaid and CHIP is substantial. According to statistics developed by MACPAC, about 80 percent of enrollees in states with separate CHIP programs were enrolled in managed care in fiscal year 2013.[11] Though we did not identify comparable data for children in CHIP-funded Medicaid expansion programs, the most recent data for Medicaid managed care enrollment show that about 63 percent of Medicaid children were enrolled in comprehensive managed care in fiscal year 2011.

3. **What Medicaid and CHIP do guarantee, however, is coverage that is child-appropriate. In Medicaid, and in CHIP programs provided through Medicaid, children are guaranteed the Early Periodic Screening Detection and Treatment (EPSDT) benefit. Could you discuss what EPSDT provides that is critical for children?**

   The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit entitles children in Medicaid to receive age-appropriate periodic screening services that include a comprehensive health and developmental history, a comprehensive physical exam, appropriate immunizations, laboratory tests, and health education. EPSDT also covers dental, vision, and hearing services and other necessary health care services, such as diagnostic follow up tests when concerns are identified, as well as the services necessary to control, correct, or reduce health conditions discovered through screenings and diagnostic tests, regardless of whether these services are typically covered by the state's Medicaid plan for other beneficiaries. Separate CHIP programs are not required to provide full EPSDT services but some separate CHIP programs do so.

4. **In the responses from Governors that the Committee received to its July 2014 letter on the CHIP program, most governors expressed interest that Congress should act quickly to extend CHIP funding. I strongly agree that we need to act quickly. Please share some of the administrative and operational challenges that states would face if Congress were to delay acting on this issue?**

   We have not done work to assess how the timing of an extension of CHIP funding could affect states. However, states are likely to face challenges if Congress ultimately decides

[11] As of fiscal year 2013, 5.3 million children across 39 states were enrolled in separate CHIP programs, and 2.5 million children across 32 states were enrolled in CHIP-funded Medicaid expansions.

not to extend funding. For example, states may not be prepared to seamlessly transition children to coverage in qualified health plans (QFP) offered through health insurance exchanges. As we noted in my testimony before the Committee, if CHIP funding is not extended, PPACA requires that beginning in October 2015 states must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility. If ineligible for Medicaid, children are to be enrolled in a QHP.[12] For states with CHIP-funded Medicaid expansions, children would remain in Medicaid in the absence of CHIP funds, but the state would receive a lower federal matching rate, increasing state costs.

5. **In terms of physician access, I understand you and other researchers have reported that CHIP and Medicaid enrollees experience similar challenges as individuals covered by private insurance. Would you agree that issues with access experienced by families with children in CHIP reflect broader system-wide challenges, rather than problems with CHIP itself?**

   In 2013, we reported that our review of survey data indicated that most CHIP enrollees reported positive responses regarding their ability to obtain care, and the proportion of positive respondents was generally comparable to those with Medicaid or with private insurance.[13] While over 88 percent of CHIP enrollees reported that they had a usual source of care and always or almost always got the care they needed, it is likely that some proportion of children with each type of coverage experience challenges in accessing care. Our prior work suggests that any access issues may be more pronounced for children in CHIP or Medicaid. For example, physicians we surveyed in 2010 experienced much greater difficulty referring children in Medicaid and CHIP to specialty care compared to privately insured children.[14] These studies relied on survey information collected prior to many of the changes required under PPACA, which could have affected children's access to care in all markets.

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[12]The QHPs for children transitioning out of CHIP must be certified by the Secretary of HHS as offering benefits and imposing cost-sharing for children in a manner that is at least comparable to the covered services and cost-sharing protections under the state's CHIP plan.

[13]See *GAO, Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, GAO-14-40 (Washington, D.C.: Nov. 21, 2013).

[14]See GAO, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624 (Washington, D.C.: June 30, 2011).