

# 4

CHAPTER



## ACA Eligibility Changes: Program Integrity Issues

## Key Points

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- ▶ The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) mandates many changes to eligibility processes and policies for Medicaid and the State Children's Health Insurance Program (CHIP). While the ACA changes simplify many aspects of these processes, the overall system remains complex to administer.
- ▶ The ACA requires states to maximize automation of Medicaid and CHIP applications and gives states broader access to third-party sources of data that will be used to verify eligibility. These changes are intended to help states make eligibility determinations more accurately, more quickly, and at less expense. However, states and the Centers for Medicare & Medicaid Services (CMS) must also ensure that they continue to balance the objectives of access and accuracy.
- ▶ CMS has not yet issued updated program integrity rules and procedures that are aligned with the new eligibility rules and that account for the role exchanges will play in determining eligibility. Some policymakers have raised concerns about this lack of guidance, given the potential consequences of eligibility errors.
- ▶ Currently, CMS has two specific strategies to promote the accuracy of eligibility decisions made under new rules and to supplement existing safeguards.
  - All states have developed a verification plan that details how the state will implement and comply with new eligibility regulations. These standardized verification plans will serve as the basis for eligibility quality control audits.
  - All states will participate in a pilot program that will generate timely feedback about the accuracy of determinations based on new eligibility rules. States will also identify process improvements where problems are found.
- ▶ MACPAC will continue to monitor aspects of ACA implementation that may affect program integrity. This will include examining new approaches to improve the efficiency and effectiveness of eligibility quality control programs and to promote overall program integrity.

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The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) mandates many changes to Medicaid and the State Children's Health Insurance Program (CHIP) eligibility processes and policies to reduce complexity and effort on behalf of enrollees and program administrators. These changes affect all states, whether or not they have adopted the Medicaid expansion, and apply to both expansion and existing eligibility groups for children, parents, pregnant women, and non-disabled adults under age 65. At the same time, states must continue to operate legacy systems for determining eligibility for certain other groups, including persons eligible on the basis of age or disability. Thus, while the ACA changes simplify many aspects of the application and renewal process, the overall system remains complex to administer.

These changes are necessary given the increased pressure that Medicaid expansion and enrollment outreach efforts will put on eligibility processes and the desire to align Medicaid with other subsidy programs. In addition, the ACA makes available new resources, such as the federal data services hub, to support eligibility verification. These changes are intended to simplify and streamline enrollment and redetermination processes, increase the share of eligible persons who are able to successfully enroll and retain coverage, and reduce errors associated with administering complex eligibility rules. However, implementing them requires states to invest in additional systems, develop new policies and procedures, and retrain staff. New approaches are being tested to measure the impact these significant policy and procedural changes may have on program integrity.

From the perspective of program integrity, two significant changes include replacing complex income-counting and disregard rules with the streamlined modified adjusted gross income (MAGI) standard, and moving away from in-person and documentation-heavy processes towards online applications and automated third-party data checks. These changes shift much of the burden of demonstrating eligibility from individuals to states and are intended to reduce the number of eligibility errors, including both false

positives (determining a person eligible even though he or she does not meet program standards) and false negatives (denying a person eligibility even though he or she does meet program standards).

The consequences of eligibility errors can be significant: individuals can be enrolled in the wrong program, receive the wrong benefits, be assigned incorrect cost sharing, or be denied enrollment altogether. Errors can also result in states and the federal government making payments for benefits to which people are not entitled or making payments in the wrong amount. Inappropriate denials can result in increases in uncompensated care, avoidance of necessary care, or greater use of state-funded social services. Finally, program assignment errors can have consequences for federal financing, as federal contributions differ for persons who qualify for advanced payment of premium tax credits for qualified health plans, persons who are newly eligible for Medicaid, and persons who qualify for Medicaid under traditional categories.

In rulemaking to implement the ACA Medicaid eligibility provisions, the Centers for Medicare & Medicaid Services (CMS) emphasized the importance of accuracy. CMS stated that program integrity rules and procedures will be aligned with the new eligibility rules and will account for the role exchanges will play in determining eligibility, but deferred additional guidance on these issues (CMS 2012). Some state and federal policymakers have raised concerns about the lack of guidance or clear standards for eligibility program integrity, given the potential consequences of eligibility errors. In addition, a substantial number of eligibility determinations may be made by the federally facilitated exchange, as 11 states have delegated the authority to make Medicaid and CHIP eligibility determinations to the exchange. CMS is now pilot testing processes to measure the errors that occur under new eligibility policies and to identify potential opportunities to reduce errors or improve the measurement process. Results from these pilots will help inform future guidance and rulemaking.

This chapter discusses ACA-related eligibility policy and process changes and considers the impact of these changes on traditional eligibility quality control mechanisms and the potential for eligibility-related errors and fraud. Over the coming year, the Commission will continue its review of Medicaid and CHIP program integrity activities and potential areas for program improvement, focusing on areas where there is overlap and redundancy or where additional guidance would support overall program integrity. As part of this effort, MACPAC will monitor additional eligibility program integrity guidance as it is released by CMS, as well as the initial and ongoing findings from eligibility reviews conducted by all states. This information will be used to further discussion of key policy questions.

## Eligibility Policy and Process Issues Post-MAGI

All persons enrolled in Medicaid and CHIP must be initially determined eligible (that is, the state must determine that applicants meet the relevant income and non-financial criteria, such as age, citizenship, disability, and pregnancy) and then have their eligibility periodically redetermined. To minimize errors, states have historically used a variety of methods to validate eligibility information, including in-person interviews, review of paper documentation supplied by applicants, and third-party database checks.

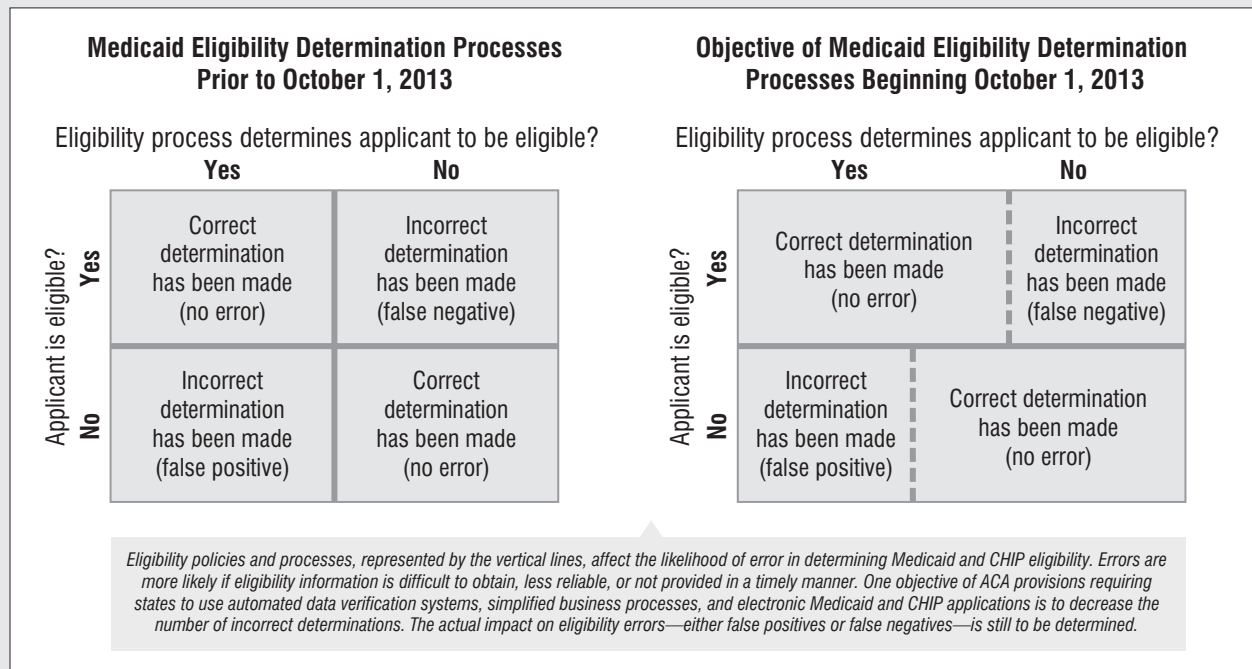
In the late 1990s, out of concern that some eligibility validation processes were creating enrollment delays or resulting in denial of coverage when applicants failed to complete the eligibility process, CMS began encouraging states to accept applicant self-attestation or use third-party sources of information to validate certain documented eligibility criteria, other than citizenship and immigration status (CMS 1998). Many states adopted eligibility simplification strategies for certain types of applicants or specific situations (e.g., paper documentation was required for

the initial application, but the state would use third-party data sources to redetermine eligibility after one year). These changes simplified the eligibility process for applicants and, in some cases, helped decrease administrative burden on states and streamline some state functions. The Congress later codified some of these strategies; for example, in 2009, the Congress passed the Children’s Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) allowing states to adopt the Express Lane Eligibility option, which allowed them to use findings from another public agency to assist in determining that a child was eligible for Medicaid or CHIP.

The ACA, enacted in 2010, mandated many additional changes to Medicaid and CHIP eligibility processes and policies to further simplify enrollment and increase the share of eligible persons able to successfully enroll and obtain coverage, as well as to align with the processes and policies used to determine

exchange coverage. The ACA requires states to maximize automation and real-time adjudication of Medicaid and CHIP applications through the use of electronic verification policies, simplified business processes, and the use of multiple application channels, including online applications. The ACA also gave states broader access to third-party sources of data and required states to use these sources to verify eligibility whenever possible for most non-disabled adults under age 65 and children, instead of requiring applicants to document their eligibility. When these changes are fully in place, determinations of both eligibility and ineligibility should be made more accurately, more quickly, and at less expense. However, the widespread adoption of new processes to support automation and rapid adjudication will require new strategies to ensure that they effectively balance the objectives of access and accuracy (Figure 4-1).

**FIGURE 4-1. Illustrative Impact of Medicaid Eligibility Determination Process Changes on Potential for Eligibility Errors**



Source: MACPAC analysis.



**Self-reported information and the reasonable compatibility standard.** For the first time, Medicaid and CHIP will primarily verify program eligibility through trusted electronic sources instead of paper documentation and accept applicant self-attestation of most elements of eligibility. There has been a longstanding policy allowing states to accept self-reported information in certain circumstances, but, as of January 1, 2014, states are prohibited from requiring applicants to provide documentation unless self-reported information is not reasonably compatible with the information in government databases; exceptions are citizenship and immigration status, which cannot be self-attested (42 CFR 435.945, 435.948, 435.949, 435.952, 457.380, 45 CFR 155.300).<sup>1</sup> States must now compare application information to data available from a number of third-party sources, which they will access via direct linkage to state-based systems or through the federal data services hub. For most eligibility factors, states must establish a reasonable compatibility standard to be used when there is an inconsistency between the information obtained from electronic data sources and the information provided by the applicant. These third-party electronic data sources are expected to provide reliable and timely information on various eligibility factors, but the actual availability of current information to support eligibility determination has not been widely tested. In addition, implementation of these changes requires significant systems changes, development of new interagency agreements, development (or purchase) of new data sources, and retraining for eligibility workers. While these changes are likely to simplify the enrollment process for applicants, the effect on program integrity is yet to be determined.

If an applicant's attestation and data are not within the state-defined threshold for compatibility (e.g., self-reported income is at 125 percent of the federal poverty level (FPL), but the federal data hub indicates that the applicant's income the

prior year was at 140 percent FPL), states can only require the individual to provide additional documentation if the information cannot be obtained electronically or if establishing an additional data match would not be effective. A state can rely on an applicant's explanation for a discrepancy (e.g., recent job loss or reduction in hours) without additional documentation. CMS has instructed states that they must compare the administrative costs associated with data matching to the administrative costs related to relying on paper documentation before requesting additional documentation. States must also consider the impact on program integrity, in terms of the potential for ineligible individuals to be approved, as well as for eligible individuals to be denied coverage (42 CFR 435.952, 42 CFR 457.380).

State Medicaid and CHIP programs have greater flexibility in this area than does the federal exchange to determine eligibility for premium subsidies for persons with incomes too high for Medicaid or CHIP. For the exchanges, the reasonable compatibility threshold has been set at 10 percent, so if an applicant's self-reported income is 10 percent less than data matches indicate, the federal exchange must request a reasonable explanation for the discrepancy from the applicant, try to verify the self-reported information using additional federal sources, or request additional documentation. State-based exchanges can determine a broader standard of reasonable compatibility or choose to limit requests for additional documentation to a statistically valid sample of applications (45 CFR 155.315).

**Post-enrollment verification.** To further support the goal of real-time eligibility determinations, states may use post-enrollment verification processes to validate application information. States have the option to determine a Medicaid or CHIP applicant eligible based on self-reported eligibility information, then verify as needed through matching to electronic data sources after the determination is made (42

CFR 435.952). A state can determine a threshold for reasonable compatibility and consider an applicant's attestation to be verified if the data obtained post enrollment are within the state's established threshold for compatibility. If post-enrollment data checks indicate a significant discrepancy, the state will contact the applicant to obtain additional information and then terminate benefits (with appropriate advance notice) if supporting evidence is not provided within appropriate timeframes. Like other changes to the processes for verifying application information, the impact and potential risks of these new processes require close monitoring.

**Administrative renewal.** New policies for periodic renewals are also intended to minimize the burden on program enrollees but should be carefully monitored to measure the impact on program integrity. The eligibility of Medicaid and CHIP enrollees must be redetermined once every 12 months. State agencies must use available information, such as third-party databases and information otherwise known to the state, to facilitate the annual redetermination process. If the state is unable to complete the renewal process based on available data, it must provide the enrollee with a pre-populated enrollment form and at least 30 days to respond with any necessary information. The state must also provide a 90-day grace period, in which an enrollee who has missed the 12-month renewal date can renew without a new application (42 CFR 435.916, 457.343, 45 CFR 155.335).

Administrative renewal has been used in the past by some states and has been shown to increase retention without raising the eligibility error rate (CMS 2013a). However, similar to the other changes described above, these procedures have not been used on a wide scale and will require the development of new systems and additional training for eligibility workers. The potential effect on program integrity has not been precisely determined.

The impact of new administrative renewal policies is also complicated by ACA-mandated changes to redetermination timeframes. Before the ACA, states were required to redetermine eligibility for Medicaid and CHIP enrollees at least once every 12 months, but many states chose to conduct renewals more frequently (on a quarterly or semiannual basis). States may no longer require midyear status reporting; redeterminations will be conducted at 12-month intervals. While Medicaid enrollees are required to report changes in circumstances that may affect continued eligibility, the elimination of midyear reporting in some states may result in some people maintaining enrollment for longer periods of time after an unreported change, as well as some people whose circumstances do not change and who maintain enrollment longer.

**Coordination with exchanges.** Coordination and sharing of eligibility information among Medicaid, CHIP, and the exchanges is an important component of new eligibility policy, and ensuring the accuracy of this information sharing is likewise an important aspect of eligibility program integrity efforts. The ACA establishes exchanges to purchase insurance coverage for persons without access to affordable employer-sponsored coverage. If individuals with incomes between 100 percent and 400 percent FPL obtain coverage through an exchange, they may qualify for premium tax credits. Some persons who apply for premium subsidies may have income low enough to qualify for Medicaid or CHIP in their state. For this reason, the ACA explicitly requires Medicaid and CHIP to coordinate with the exchange in each state to ensure that eligible applicants are enrolled in the appropriate program and to make coordinated decisions wherever possible.

States must share information about persons determined ineligible for Medicaid and CHIP with the exchange and accept information from the exchange to make a final determination of eligibility for Medicaid and CHIP. States can

also delegate authority for making Medicaid and CHIP eligibility determinations to the exchange; as of October 2013, 11 states (out of 34 using the federally facilitated exchange) have wholly or partially delegated the authority to make Medicaid or CHIP eligibility determinations to the federally facilitated exchange (CMS 2013b); for applicants in other states, the federally facilitated exchange assesses Medicaid or CHIP eligibility but does not make a determination. Federal rules require states to have written agreements with federal or state agencies that will determine Medicaid eligibility on behalf of the Medicaid agency, while allowing states to retain oversight responsibilities for all decisions (42 CFR 431.10, 42 CFR 431.11). CMS is testing procedures to review Medicaid and CHIP eligibility determinations made by state or federal exchanges, as described in more detail below, but the impacts of these changes on program integrity are yet to be determined.

## Strategies to Support Program Integrity

The ACA does not change current law regarding enrollee fraud. Applicants are required to accurately and fully report information needed to establish eligibility and sign applications (in writing or electronically) under penalty of perjury (42 CFR 435.907). States must ensure that only eligible persons receive benefits and implement necessary verification procedures to promote program integrity (42 CFR 435.940). However, the adoption of new processes to support automation and real-time eligibility adjudication, as described above, requires additional strategies to ensure that eligibility determinations are being made correctly. CMS has implemented two strategies to support the development of appropriate methods to ensure the accuracy of eligibility decisions made under new rules. These strategies will supplement existing safeguards.

**Verification plans.** States now have more flexibility in establishing verification procedures for various factors of eligibility (e.g., income, residency, age, household composition). For example, states can choose to accept self-attestation of information without additional verification (if the information is reasonably compatible with other data sources) or they can choose to verify elements of eligibility after enrollment. In addition to establishing a reasonable compatibility standard, states must also determine which third-party data sources will be used at the time of application at renewal, or for post-enrollment verification.

To catalog these state choices, states must develop a verification plan and submit it to CMS, which will then assess the plan for compliance with the new eligibility regulations. In early 2013, states submitted verification plans for individuals whose eligibility is based on MAGI, using a template provided by CMS (CMS 2013c). CMS has published completed verification plans on its website and released summary information on the plans. For example, as of October 2013, 5 states had indicated that they would accept self-attestation of income at application (without further information from the individual), and 10 states indicated they would accept self-attestation of income with post-eligibility verification. Most eligibility rules for non-MAGI groups (e.g., persons who qualify for Medicaid on the basis of disability) have not changed, so CMS plans to issue guidance on verification plans for these groups at a future date. The verification plan will serve as the basis for eligibility quality control audits, as discussed below (42 CFR 435.945, 42 CFR 457.380).

**Retrospective eligibility quality control programs.** Given the widespread changes being implemented in Medicaid and CHIP eligibility policies and processes, CMS has temporarily replaced broad-based retrospective eligibility quality control programs with pilot programs.<sup>2</sup> These pilot programs are intended to provide rapid



feedback to inform improvements for fiscal year (FY) 2014 through FY 2016, but will not support program-wide estimates of eligibility errors.

To help ensure that Medicaid and CHIP eligibles are enrolled in the appropriate program and receive the benefits and cost-sharing support to which they are entitled, and to help reduce the rate of eligibility errors that cause improper payments, states conduct in-depth retrospective reviews of a sample of eligibility decisions, measuring the extent to which errors occur and identifying process mistakes for corrective action. (Note that these reviews are different from the limited post-enrollment verifications described above.) As discussed in MACPAC's June 2013 report to the Congress, states must conduct two different types of retrospective reviews of eligibility determinations: Medicaid Eligibility Quality Control (MEQC) reviews and Payment Error Rate Measurement (PERM) reviews (MACPAC 2013). The rules for these two federally required programs overlap and do not align well with each other, which creates burdens for states and the federal government. The rules have also not been aligned with the significant changes in eligibility policies and processes required by the ACA.

In recognition of the challenges states will face in implementing all of the ACA-mandated eligibility policy and process changes for Medicaid and CHIP and the need to update program integrity guidance, CMS is implementing a new 50-state pilot program strategy that will replace PERM and MEQC for federal FY 2014 through FY 2016 (CMS 2013d).<sup>3</sup> These pilots will be designed to provide states and CMS with timely feedback about the accuracy of determinations based on new eligibility rules and help support the development of improvements or corrections where problems are found. The initial pilot in each state will focus on MAGI-based determinations and will require all states to sample, review, and report on 200 Medicaid and CHIP cases determined eligible or denied

between October 1, 2013, and March 31, 2014, and to report findings by June 2014. All states will participate each year (whether or not other components are being measured for PERM) and will conduct four pilots over the three fiscal years.

The Medicaid and CHIP eligibility review pilots will be designed to provide programmatic assessments of the performance of new processes and systems to adjudicate eligibility decisions, identify strengths and weaknesses in operations and systems that can lead to errors, and test the effectiveness of corrections and improvements. The pilots will also inform CMS' approach to rulemaking that it will undertake prior to the resumption of the PERM eligibility measurement component in 2017 (CMS 2013d). In particular, the rapid nature of the pilots may help CMS determine how to incorporate strong feedback loops that support real-time intervention into the design of the permanent Medicaid eligibility quality control program.

## Policy Considerations

Over the past 20 years, states and the federal government have taken incremental steps to simplify and streamline the Medicaid eligibility determination process.<sup>4</sup> The changes mandated by the ACA complete the de-linking of Medicaid from public assistance programs begun in 1996 and create a new, separate system for enrolling many low-income persons in health care coverage.<sup>5</sup> While traditional eligibility policies and procedures required applicants to demonstrate their eligibility, the ACA-mandated changes shift much of that responsibility to the states and federal government, while providing them with new tools to automate the verification process. Implementation of these changes has required that states and the federal government redesign business operations and systems, and has created new interactions between state and federal agencies. The goals

of these changes are to simplify and streamline the enrollment and renewal processes, increase the share of eligible persons who are able to successfully enroll in and retain coverage, and reduce errors associated with administering complex eligibility rules. As these changes are implemented over the next year, it will be important for policymakers to measure the extent to which these goals are being met.

Policymakers will be interested in monitoring three aspects of the implementation that will affect program integrity. First, as responsibility for the accuracy of eligibility information shifts more to the states and to centralized systems, it will be important to monitor the extent to which these data sources and systems are able to provide sufficient, timely, and reliable information for states to make accurate eligibility determinations. In addition, as the ACA places Medicaid in a continuum of coverage that includes exchange-based coverage and premium tax credits, it will also be important to evaluate the accuracy and efficiency of program assignments and handoffs among programs. Finally, while the ACA simplifies the Medicaid and CHIP eligibility determination process in many ways, it also introduces new complexities that may affect program integrity, such as the addition of an alternative Medicaid benefit package for some enrollees that complicates the assignment process, as well as different federal financial match rates for different eligibility categories. States and the federal government must measure the extent to which these types of errors occur and their causes in order to inform and prioritize improvements. The eligibility review pilots that replace PERM and MEQC for FY 2014 through FY 2016 will provide critical information on both the performance of new processes and systems and the effectiveness of corrections and improvements.

The three-year pilot period will also provide an opportunity to revisit the overall eligibility program

integrity framework and adapt it to better reflect the new system, which includes multiple access points and a continuum of coverage across programs. For example, traditional eligibility quality control programs have focused solely on individual programs at the state level, and states are required to repay the federal government for costs incurred by ineligible persons, even if the person would have qualified for another program. As the ACA supports a continuum of coverage that includes Medicaid, CHIP, and subsidies for coverage purchased through the exchanges, policymakers should reconsider how to evaluate errors in assignment across programs. Similarly, because MEQC and PERM focus on state actions, they exclude from review enrollees whose eligibility is based on an outside determination, such as persons eligible on the basis of disability in states that accept disability determinations from the Social Security Administration (SSA) (42 CFR 431.812, 42 CFR 431.978). Similar to the SSA decisions in some states, exchanges now provide an outside but overlapping eligibility pathway that will need to be assessed. Policymakers should consider these exclusions and processes in counting errors. Processes will also need to be developed to measure and attribute eligibility errors made by the state and federally facilitated exchange or resulting from any incorrect data accessed through the federal data services hub.

The ACA has transformed the rules and business processes associated with eligibility determinations, but it did not make corresponding changes in program integrity standards and processes to reflect the new eligibility paradigm. This creates a need to examine the standards and processes for measuring the accuracy of these determinations and to develop new approaches that reflect the current policy environment. Policymakers can use the next three years to consider novel approaches that improve the efficiency and effectiveness of eligibility quality control programs and promote overall program integrity.

## Endnotes

- <sup>1</sup> Federal regulations provide an explicit threshold for reasonable compatibility for evaluating income information provided on an application for coverage through the exchange. (Annual income within 10 percent of the income reported on prior tax data must be accepted without further verification.)
- <sup>2</sup> Medicaid programs are required to participate in two retrospective eligibility quality control programs, as described in 42 CFR 431 Subparts P and Q.
- <sup>3</sup> PERM managed care and fee-for-service reviews will continue in federal FY 2014, FY 2015, and FY 2016. CMS will continue to report annual Medicaid and CHIP improper payment rates based on payment data and an estimated eligibility component based on historical data.
- <sup>4</sup> The Deficit Reduction Act of 2005 (DRA, P.L. 109-171) required that individuals applying for Medicaid present proof of citizenship and identity. The Congress revised this requirement in 2009, allowing states to verify citizenship directly with the Social Security Administration.
- <sup>5</sup> The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193), which replaced the Aid to Families with Dependent Children program with the Temporary Assistance to Needy Families program, also severed the link between welfare and Medicaid such that receipt of cash assistance no longer automatically qualified a family for Medicaid coverage. The ACA changes some eligibility policies and procedures but does not create a separate system for determining Medicaid eligibility for persons eligible on the basis of age, blindness, or disability.

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