STATEMENT OF

GARY COHEN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

AND

CYNTHIA MANN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR
CENTER FOR MEDICAID & CHIP SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

ON

"IMPLEMENTATION OF THE AFFORDABLE CARE ACT'S EXCHANGES AND MEDICAID EXPANSION"
BEFORE THE

U. S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY & COMMERCE,
SUBCOMMITTEE ON HEALTH

DECEMBER 13, 2012

U.S. House of Representatives Committee on Energy & Commerce

Subcommittee on Health

"Implementation of the Affordable Care Act's Exchanges and Medicaid Expansion"

December 13, 2012

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for your interest in the recent efforts of the Centers for Medicare & Medicaid Services (CMS) to implement the Affordable Care Act. The Affordable Care Act ensures that American families will get the health care they need and protects Americans from the worst insurance company abuses. CMS is focused on strengthening the private health insurance market in order to make coverage more available, affordable, and accountable to Americans. Our work continues towards 2014 with the implementation of the Affordable Insurance Exchanges along with Medicaid's streamlined modernization and eligibility expansion. CMS has been steadily working with States, issuing guidance and providing technical assistance, as well as building Exchange infrastructure and initiating the many information technology (IT) and business activities needed to assure readiness for Exchange open enrollment beginning October 1, 2013.

Improving Private Health Insurance

Since enactment, CMS has worked to put into place the strong consumer protections that provide new coverage options and give consumers the tools needed to make informed choices about their health care included in the Affordable Care Act. These provisions allow for a stronger health insurance marketplace, and begin the transition to additional market reforms and the Affordable Insurance Exchanges to begin in 2014.

Increasing Private Health Insurance Options

The Affordable Care Act is strengthening the private health insurance market by making affordable, high-quality coverage accessible to millions of Americans. Because of important reforms in the Affordable Care Act, many young adults under 26 can now be covered under their parents' plans, people with costly pre-existing conditions are able to find health coverage, and health insurance companies are prohibited from denying children coverage on the basis of their

pre-existing conditions. The Affordable Care Act has helped 6.6 million young adults stay on their parents' plans until the age of 26, including 3.1 million young adults who are newly insured. The Pre-Existing Conditions Insurance Plan (PCIP) is helping over 90,000 Americans with pre-existing medical conditions access critical health care services. The Early Retiree Reinsurance Program (ERRP) has provided reinsurance payment support to more than 2,800 employers and other sponsors of retiree plans to help over 19 million individuals in plans that have received support.

Strengthening Private Health Insurance Protections

In addition to helping more people access private health insurance coverage, CMS is working to ensure private health insurance is working better for consumers. During the past two years, CMS has implemented important private health insurance reforms included in the health care law that are providing new rights and benefits to put consumers in charge of their health care. Specifically:

- Insurance companies cannot drop or rescind people's coverage because they made an unintentional mistake on their application, place lifetime limits on the dollar value of essential health benefits, or impose an annual dollar limit on essential health benefits of less than $2 million; and within 2014 they will no longer be able to place any annual dollar limits on essential health benefits.
- An estimated 54 million insured Americans are receiving expanded and lower-cost coverage of recommended preventive services, and have a new rights to appeal decisions made by their insurance company not to pay for medical care to an independent third party and to use the nearest emergency room without higher cost-sharing, regardless of whether it is in their plan's network.
- Health insurers and group health plans are required to provide a clear summary of benefits and coverage in a uniform format that can easily be compared by the millions of Americans shopping for private health coverage. If people are looking to buy private health insurance now, they also can compare plans at www.HealthCare.gov, which provides information about what health insurance coverage is available to consumers based on where they live.

Making Private Health Insurance Coverage More Affordable

The Affordable Care Act helps make coverage more affordable by providing States with resources to improve their review of proposed health insurance rate increases and by holding insurance companies accountable for increases in premium rates. The law strengthens States' rate review activities by providing $250 million in resources to build and upgrade States' premium rate review infrastructures, hire new staff, and improve the availability of rate review information to consumers. CMS has awarded $160 million to date and plans to continue to award grants to States to strengthen their rate review programs. Insurers in all States are now required to provide a justification for any rate increase of 10 percent or more, and all of those increases are reviewed by independent experts, who determine whether they are unreasonable. Additionally, the medical loss ratio (MLR) provision generally requires that insurance companies use at least 80 or 85 percent of premium revenue, depending on the market, to either provide or improve the quality of health care for their customers. Insurance companies that did not meet the MLR rule provided approximately 13 million Americans with more than $1.1 billion in rebates this year. By holding insurance companies accountable, together, rate review and the Affordable Care Act's MLR policy (or 80/20 rule) have yielded an estimated $2.1 billion in savings to consumers in one year.

Moving Private Health Insurance Forward

We are continuing our progress towards 2014 by releasing new rules, guidance, and grants to help shape a consumer-friendly insurance marketplace and prepare the insurance market for the implementation of the Exchanges. For example, on November 30, 2012, the Department released the proposed 2014 Notice of Payment Parameters which, when finalized, implements many of the key features of the premium stabilization programs along with additional guidance on the advance payments of the premium tax credit and cost-sharing reductions. Also in November of 2012, CMS issued proposed rules to implement Affordable Care Act provisions that would make it illegal for insurance companies to discriminate against people with pre-existing conditions, would make it easier for consumers to compare health plans based on the essential health benefits provided, and would promote and encourage employee wellness. Over the last two years, CMS has worked hard to prepare for the implementation of the Exchanges,

including publishing regulations that define the eligibility and enrollment processes for the Exchanges and Medicaid program, and providing financial and technical support for States establishing their Exchanges and Medicaid enrollment IT systems.

Guaranteeing Availability of Coverage and Fair Premiums

The newly proposed rules include health insurance market reforms (CMS-9972-P)[1] that would prohibit health insurance companies from discriminating against individuals because of a pre-existing or chronic condition, beginning in 2014. Under this rule, insurance companies would be allowed to vary premiums based only on age, tobacco use, family size, and geography, and only within a certain range for each factor. In addition, health insurance companies would be prohibited from denying coverage to any American because of a pre-existing condition or from charging higher premiums to certain enrollees because of their current or past health problems, gender, occupation, and small employer size or industry. These provisions guarantee the availability and renewability of coverage, as well as ensuring Americans receive fair health insurance premiums.

Additionally, the rule proposes that health insurance issuers maintain a single statewide risk pool for each of their individual and small employer markets, unless a State chooses to merge the individual and small group pools into one pool. This provision directs that the cost of health insurance is spread across all of an issuer's enrollees in the market, without regard to their health status. The proposed rule would also ensure that young adults and people for whom coverage could otherwise be unaffordable have access to a catastrophic plan in the individual market.

Stabilizing Premiums

The proposed Notice of Benefit and Payment Parameters for 2014[2] expands upon the standards set forth in the Premium Stabilization and Exchange final rules, and provides further information on risk adjustment, reinsurance and risk corridors programs, advance payments of the premium tax credit, and cost-sharing reductions. These programs are designed to reduce issuer incentives

[1] Health Insurance Market Rules: file:///C:/Users/M62Q/Downloads/CMS-2012-0141-0001.htm
[2] 2014 Payment Notice: http://www.ofr.gov/OFRUpload/OFRData/2012-29184_PI.pdf

to avoid sicker Americans, lower premiums in the individual and small group markets, protect against uncertain rate setting, and make insurance more affordable.

Providing Essential Health Benefits

The Essential Health Benefits proposed rule[3] (CMS-9980-P) outlines policies and standards for coverage of essential health benefits, while giving States flexibility to implement this provision of the health care law. States would have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." This approach would give States the flexibility to select a plan that would best meet the needs of their citizens. If States choose not to select a benchmark, HHS proposes that the default benchmark will be the small group plan with the largest enrollment in the State. These plans are available for public comment.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets must meet certain actuarial values, or the percentage of total average costs for covered benefits that a plan will cover. The actuarial values to meet are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. To streamline and standardize the calculation of actuarial values for health insurance issuers, the rules proposes a publicly available actuarial value calculator provided by CMS, which issuers can use to determine health plan actuarial values, based on a national, standard population. This approach provides consumers with the ability to more transparently compare plans available in the new marketplace in 2014.

Under the Essential Health Benefits proposed rule, beginning in 2015, CMS will accept state-specific claims data sets for the standard population if States choose to submit alternate data for the calculator. The proposed rule includes standards and considerations for plans with benefit designs that the actuarial value calculator cannot easily accommodate. Recognizing that simply calculating the actuarial value of a high-deductible health plan based on the insurance plan alone could understate the value of the coverage, CMS proposed that employer contributions to health savings accounts and amounts newly made available under health reimbursement accounts

[3] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

should count within the plan design. The proposed actuarial value calculator is posted on the Center for Consumer Information and Insurance Oversight website.[4]

CMS also provided guidance to State Medicaid programs outlining how existing Alternative Benefit Plans in Medicaid can meet the standards of the Essential Health Benefits provision. The guidance clarifies the policy which allows States to use commercial plans as their benchmarks for Medicaid benefits for the population of adults who will be newly eligible in 2014. In addition, the guidance offers flexibility on how States can design, define, and target benefit plans to meet the needs of their Medicaid population.

Encouraging Wellness

The Wellness proposed rule[5] (CMS-9979-P), jointly released by the Departments of Health and Human Services, Labor, and the Treasury, implements and expands policies to promote employment-based wellness programs that improve health and help control health care spending, while also ensuring that individuals are protected from unfair underwriting practices that could otherwise reduce benefits based on health status.

These three newly proposed rules are shaping the marketplace Americans use to obtain insurance in the individual and small group markets, both inside and outside the Exchanges. By establishing these rules for insurers, we are preparing important stakeholders for the law's full implementation in 2014.

Providing More Choices

The Affordable Care Act also creates a new type of nonprofit health insurer, called Consumer Operated and Oriented Plans (CO-OPs). The CO-OP program offers low-interest loans to eligible private, nonprofit groups to help establish and maintain new health plans. CO-OPs are directed by their customers and designed to offer individuals and small businesses additional affordable, consumer-friendly, high-quality health insurance options. Starting January 1, 2014, CO-OPs will offer health plans through Exchanges, and they may also offer health plans outside

[4] Actuarial Value Calculator: http://cciio.cms.gov/resources/regulations/index.html#pm
[5] Wellness: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28361.htm

of an Exchange. To date, a total of 23 non-profits offering coverage in 23 States have been awarded loans for start-up and solvency requirements.

Establishing the Affordable Insurance Exchanges

CMS is continuing to work with States to implement Affordable Insurance Exchanges which, beginning in 2014, will provide improved access to insurance coverage choices for millions of Americans. The Congressional Budget Office has estimated that between 25 and 26 million people will ultimately receive coverage through the new Exchanges. Individuals will be able to access high-quality, affordable health insurance plan options through the Exchange market. This will be particularly helpful for consumers when they do not receive health benefits coverage through their employers. We expect the robust employer-sponsored insurance market to continue, with the additional protections and benefits described earlier that make private insurance fair and affordable for consumers.

Exchanges will make purchasing private health insurance easier by providing eligible individuals and small businesses with one-stop shopping where they can choose qualified health plans that best fit their needs.[6] New premium tax credits and cost-sharing reductions will help ensure that eligible individuals and families can afford to pay for the cost of a private qualified health plan purchased through the Exchanges.

The planning, development, and testing necessary to build the Exchanges is well underway. CMS has been diligently working with States through Exchange Planning and Establishment Grants to support their infrastructure. To date, 34 States and the District of Columbia have received approximately $1.8 billion in Exchange Establishment Level One and Level Two cooperative agreements to fund their progress toward building Exchanges. CMS also issued

[6] Essential health benefits must include items and services within at least 10 categories -- ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

guidance[7] to help States understand the full scope of activities that can be funded under the available grant funding as they work to build Exchanges.

CMS has encouraged States to establish their own Exchanges, and we have worked to provide States with the flexibility, guidance, regulations, and resources they need to do so. States are making progress towards establishing their own Exchanges. To date, HHS has received 35 letters from States in regards to the Declaration of an Exchange. Fifteen Declaration Letters have been received for State-Based Exchanges,[8] four declaring a State partnership Exchange,[9] and seven choosing to participate in a Federally-facilitated Exchange.[10] We have conditionally approved six State-Based Exchanges for 2014, and have received Blueprints from several more States.

The Exchange Final Rule, released on March 12, 2012 (CMS-9989-F),[11] offers a framework to assist States in setting up their Exchanges. It allows States to decide whether their Exchanges should be operated by a non-profit organization or a public agency, how to select and certify plans to participate, and whether to work with HHS on some key functions. The rule offers significant additional flexibility regarding eligibility determinations for Exchanges and insurance affordability programs. It also lays out standards for small businesses to get qualified health plan coverage through the Small Business Health Options Program (SHOP). Through the SHOP, employers can offer employees a variety of qualified health plans, and their employees can choose the plans that fit their needs and their budget.

HHS will operate a Federally-Facilitated Exchange in each of those States that do not establish a State-Based Exchange to ensure that residents of every State have access to the affordable health insurance offered through Exchanges in 2014. All Exchanges will open for enrollment in October 2013. The Federally-Facilitated Exchanges will operate in any State that chooses to

[7] Exchange Establishment Cooperative Agreement Funding FAQs: http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html
[8] State-Based Exchanges: California, District of Columbia, Hawaii, Vermont, Mississippi, Colorado, Connecticut, Kentucky, Maryland, Minnesota, New York, Oregon, Rhode Island, and Washington
[9] State partnership Exchange: Delaware, Illinois, Iowa, and North Carolina
[10] Federally-Facilitated Exchange: Alabama, Alaska, Arizona, Nebraska, Oklahoma, Texas, and Wisconsin
[11] Exchange Final Rule: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

utilize this model on a temporary or permanent basis. On May 16, 2012[12] and November 30, 2012,[13] CMS released guidance describing our approach to implementing a Federally-Facilitated Exchange. We will provide consumer support to help purchasers of health insurance determine eligibility and apply for a qualified health plan. For example, we are building a website with interactive capabilities and a call center. Consumers will be able to use this to compare qualified health plans, check their eligibility for affordability programs, and enroll in a qualified health plan.

CMS is building a tool called the data services hub to help with verifying applicant information used to determine eligibility for enrollment in qualified health plans and insurance affordability programs for all types of Exchanges, as well as for Medicaid and CHIP. CMS has completed the technical design and reference architecture for this work, and is establishing a cross-agency security framework and protocols, and has begun testing the hub. CMS is also establishing a system to determine consumer eligibility and a mechanism for eligible consumers to enroll in a qualified health plan. CMS has already released the elements of a streamlined, consumer-focused application that consumers applying for any insurance affordability program in all States that choose to use it will complete starting in the fall of 2013.[14] The application will help individuals and families identify various insurance affordability programs such as advanced payment of premium tax credits for Exchanges or Medicaid that may be available to help them get and pay for health insurance.

CMS has also released an Exchange Blueprint,[15] which sets forth the approval process for State-Based Affordable Insurance Exchanges. If a State chooses to operate its own Exchange, CMS will review and potentially approve or conditionally approve the State-Based Exchange no later than the statutory deadline of January 1, 2013. The Blueprint also sets forth the application process for States seeking to enter into a State Partnership Exchange in which the State will

[12] Federally-Facilitated Exchange Guidance: http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf
[13] Federally-Facilitated Exchange Guidance: http://cciio.cms.gov/resources/files/Files2/FFE%20Progress%20fact%20sheet.pdf)?
[14] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html
[15] Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges: hhttp://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf

operate the plan management or consumer assistance functions of the Exchange, or both. States may apply to operate a State Partnership Exchange by February 15, 2013. If a State decides not to operate an Exchange for its residents, CMS will operate a Federally-Facilitated Exchange in that State. CMS will consult with a variety of stakeholders to implement Federally-Facilitated Exchanges in those States. A State may apply at any time to run an Exchange in future years.

We are committed to providing States with the flexibility, resources, and time they need to deliver the benefits of the Affordable Care Act. On December 10, 2012, CMS issued Frequently Asked Questions[16] to respond to questions that we have received from States to ensure that States have all of the information they need to make their decisions. We will continue to provide additional guidance about the Exchanges as needed, and we will do everything possible to answer specific State questions on an one-on-one basis and provide technical assistance to States and stakeholders.

Moving Medicaid Forward

The Medicaid program provides care for more than 56 million Americans, and plays an important role in providing coverage for low-income children, pregnant women, people with disabilities and seniors needing long term care services and supports. Under the Affordable Care Act, Medicaid eligibility for adult coverage will be simplified and it will cover millions of low-income people who are uninsured today. Because Medicaid is jointly funded by States and the Federal government, and is administered by States, we both have key roles as responsible stewards of the program. Under the Medicaid Federal-State partnership, the Federal government sets forth a policy framework for the program and States have significant flexibility to choose options that enable them to deliver quality, cost-efficient care for their residents. Through our daily work with States, we are fostering health care transformation by finding new ways to pay for and deliver care that improves health and health care while lowering costs.

We are also modernizing the administration of the Medicaid program by moving from a paper-driven, process-intensive approach to more streamlined ways of doing business with States.

[16] http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

Through our Federal-State partnership, CMS is working with States to build systems and standards that ensure Medicaid is working at optimal levels for beneficiaries, States, and health care providers. To help States fund these improvements, CMS has made available 90 percent matching funds for upgrades to State eligibility and enrollment systems through December 31, 2015 for eligibility system design and development, and the enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements. Forty-eight States and the District of Columbia have been approved for over $2.4 billion in Federal matching for important investments to automate and modernize enrollment, eligibility, and other system operations.

To further reduce system costs, we have promoted ways for States to share elements of their system builds with each other, and we will be sharing the business rules for adopting modified adjusted gross income in the new eligibility systems. In addition we are designing, with extensive State and stakeholder consultation, a new combined and streamlined application that States can adopt (or modify subject to Secretarial approval). And, we will continue exploring opportunities to ease processes or provide States additional support for the administrative costs of eligibility changes implementing the new coverage provisions of the Affordable Care Act. These and other initiatives relating to state systems development will lower administrative costs.

This focus on improving Medicaid efficiency and modernizing its systems, at both the State and Federal level, ensures Medicaid coverage will be simplified, less burdensome for States and beneficiaries, enrollment will be coordinated with the Exchanges, and enrollment systems will be ready for the expansion in Medicaid eligibility provided by the Affordable Care Act in 2014. Thanks to new initiatives, new funding, and State efforts, today the Medicaid program is moving forward towards becoming a strong, modern program that provides quality care to the people we serve.

Streamlining Medicaid and Coordinating with the Exchanges

On March 23, 2012, CMS published its Medicaid eligibility and enrollment final rule (CMS-2349-F) which defines the streamlined, income-based rules set forth in the health care law. This

final rule provides States with flexibility and confirms the importance of coordination with the Exchanges to ensure the success of the Affordable Care Act in giving all Americans access to health coverage. Eligibility, enrollment and renewal processes will be modernized, building on the successful State efforts that are already underway.

In particular, the rule implements the simplified financial eligibility set forth under the Affordable Care Act by relying on a single "Modified Adjusted Gross Income" (MAGI) standard for determining eligibility for most Medicaid and CHIP enrollees and by consolidating eligibility categories into four main groups – adults, children, parents and pregnant women. The eligibility verification procedures are similarly modernized by relying primarily on electronic data sources, including through the Federal data services hub that links States with Federal data sources, which is being developed both for Exchange enrollment and Medicaid eligibility processes. These procedures reduce State and beneficiary burden, allowing Medicaid to work as quickly and efficiently as possible to get eligible people enrolled in a timely and efficient way.

The new MAGI rules and enrollment procedures are aligned with those that will apply for determining eligibility for an advance premium tax credit in the Exchange. Coordination with the Exchange is important to ensuring that consumers may apply for coverage and enroll in a plan through a single, streamlined process.

While ensuring coordination, the final rule also offers States flexibility in how they will design the system of coordinated eligibility determinations. The rule provides two options for States for applications submitted to the Exchange: the Exchange can determine Medicaid eligibility based on the State's Medicaid eligibility rules as it considers eligibility for advance payment of premium tax credits; or the Exchange can make a Medicaid eligibility assessment and rely on the State Medicaid and CHIP agencies for a final eligibility determination. Under either option, timely and coordinated eligibility determinations are ensured.

Since the issuance of these regulations, CMS has continued to provide guidance that gives States support to modernize their systems and ensure they operate seamlessly with the Exchanges. On

December 10, 2012, we issued Frequently Asked Questions to respond to questions that we have received from States.[17]

Expanding Eligibility

The Affordable Care Act not only modernized Medicaid eligibility rules and procedures, but it also included an eligibility expansion designed to close the coverage gap that now exists in the program for the lowest income adults. The law would bring eligibility for adults to 133 percent of the Federal poverty level (roughly $15,000 for a single individual and $30,600 for a parent in a family of four in fiscal year 2012). Currently, parents are covered at state-established income eligibility levels equal to about 64 percent of the Federal poverty level in the median State. Prior to the enactment of the Affordable Care Act, States could not cover other nonelderly adults—younger adults just starting out, older adults whose children are grown, and others without children—at any income level unless they were pregnant or disabled, except through a waiver.

The Supreme Court's decision this summer upheld all aspects of the Affordable Care Act, including the Medicaid provisions, except that a State may not, as a consequence of not participating in the low-income adult expansion, lose Federal funding for its existing Medicaid program. In effect, the decision means that the choice to expand is left to States. Other aspects of the law affecting Medicaid remain in place including the very generous Federal support that will be available for the expansion. The Federal government will pay the full cost of coverage for newly eligible adults in 2014, 2015, and 2016. Beginning in 2017, the rate drops gradually, reaching 90 percent in 2020 and staying there indefinitely. This is the most generous matching rate applied to any coverage group in the history of the program. We have recently provided guidance on the benefit flexibility available to States if they cover this new adult population; benefits will be designed by States by reference to commercial benchmark plans.

There is no deadline for a State to tell CMS its plans on the Medicaid eligibility expansion. We have advised States that they may choose to adopt the expansion at any time and if they adopt the expansion they may drop it at a later date if they so choose. We believe the very favorable

[17] http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Governor-FAQs-12-10-12.pdf

financing and the flexibility available to States to design benefits and establish their delivery systems will encourage States to move forward with this opportunity to provide coverage to the poorest working families in their States and, in so doing, to dramatically reduce the burden of uncompensated care on their hospitals and other health care providers.

CMS continues to work closely with States to provide options and tools that make it easier for States to make changes in their Medicaid programs to improve care and lower costs. We have released guidance giving States flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses,[18] designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a State to adopt selective contracting in the program,[19] and developed a detailed tool to help support States interested in extending managed care arrangements to long term services and supports.[20] We have also established learning collaboratives with States to consider together five focus areas, including improvements in data analytics, value-based purchasing and other topics of key concern to States and stakeholders,[21] and the Center for Medicare and Medicaid Innovation has released several new initiatives to test new models of care relating to Medicaid populations.[22] We welcome continued input and ideas from States and others.

States can implement delivery system and payment reforms in their programs whether or not they adopt the low-income adult expansion. With respect to the expansion group in particular, States have considerable flexibility regarding coverage for these individuals. For example, States can choose a benefit package benchmarked to a commercial package or design an equivalent package. States also have significant cost-sharing flexibility for individuals above 100 percent of

[18] Health Homes for Enrollees with Chronic Conditions State Medicaid Director Letter: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf
[19] Revised Review and Approval Process for Section 1115 Demonstrations State Medicaid Director Letter: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SHO-12-001.pdf
[20] On-line resource for Managed Long Term Services and Supports: http://www.medicaid.gov/mltss/#Link706872Context
[21] For more information, please visit: http://www.medicaid.gov/State-Resource-Center/MAC-Learning-Collaboratives/Medicaid-and-CHIP-Learning-Collab.html
[22] For more information, please visit: http://medicaid.gov/State-Innovations.html

the Federal poverty level, and we intend to propose other cost-sharing changes that will modernize and update our rules.

Additionally, we are interested in working with States to promote better health and health care at lower costs and have been supporting, under a grant program established by the Affordable Care Act,[23] State initiatives that are specifically aimed at promoting healthy behaviors. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and State Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite States to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes.

In the Years Ahead

In the coming months, we will implement enhanced payments for primary care physicians and integrated care models that improve care and lower costs. But more work remains as we continue our partnership with state leaders and other stakeholders to establish and implement the Exchanges and increase access to the Medicaid program. These new rules and programs are stepping stones on the path to fully implementing the Affordable Care Act. In the meantime, CMS will continue our hard work to strengthen health insurance options with the help of our partners in Congress, state leaders, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CMS has been doing to implement the Affordable Care Act.

[23] Initial Announcement for the Medicaid Incentives for Prevention of Chronic Diseases: http://innovation.cms.gov/Files/x/mipcd_foa.pdf