THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

January 14, 2013

The Honorable Jack Markell
Governor of Delaware and
Chair, National Governors Association

The Honorable Mary Fallin
Governor of Oklahoma and
Vice Chair, National Governors Association
Hall of the States
444 North Capitol Street, Suite 267
Washington, DC 20001-1512

Dear Governor Markell and Governor Fallin:

A year from now, important Medicaid improvements will be in place. As states continue their work to implement the Affordable Care Act, I have heard from governors about the importance of supporting state flexibility to design Medicaid programs that work for their state. I appreciate the constructive suggestions you have made and assure you that the Department of Health and Human Services (HHS) is committed to ensuring states have flexibility to design quality, cost-effective coverage for their residents.

I want to take this opportunity to highlight existing as well as newly proposed flexibilities in the Medicaid program, some of which we have identified in response to specific state requests. I invite you to work with us to identify areas for further strengthening the program.

Notably, states have important new options with respect to benefit design. I think this is critically important. Governors have expressed a desire to design a benefit package that promotes value, achieves optimal health outcomes, and gives individuals greater choice for themselves and their families, and we strongly support those goals. Under the Affordable Care Act, states may design coverage for newly eligible adults that is consistent with private coverage; no waiver is needed. States can select a package that is benchmarked to private plans in their state, or they may design their own benefit package, subject to HHS approval, as long as essential health benefits are covered. States may also select different plans for different groups of individuals, or they can simplify administration and rely on one benefit plan for all adults.

I appreciate and share states' interests in keeping families together under one health coverage plan and to smooth the transition between coverage options as incomes change.

Last month, we provided guidance about state options to use Medicaid and Children's Health Insurance Program (CHIP) funds to purchase private coverage on the Exchange for Medicaid and CHIP beneficiaries so that parents and children can be covered together. This option could also be used by states to allow families to keep their plan as changes in circumstances cause them to shift between Medicaid and the Exchange. Again, no waiver is required to exercise these options.

Many Governors have articulated an interest in adopting cost-sharing requirements for Medicaid beneficiaries, consistent with models used in the private sector. The charges that can be imposed in Medicaid vary based on family income, and there is significant state flexibility to impose cost-sharing for individuals above the poverty level. For example, states can charge adults with incomes above the poverty level cost sharing equal to 10- 20 percent of the cost of the service. We have also committed to provide additional authority and flexibility to states in this area. As a start, in the proposed rule published today, we ask for comments on a proposal to make additional changes in cost sharing with a particular focus on policies for all income groups that encourage cost-effective use of prescription drugs and emergency room services.

One of the most important avenues for ensuring quality and cost-effective care is with respect to the design of the delivery system. Together we are advancing this work in communities across the country. States have broad flexibility related to design of payment strategies and choice of delivery system, and HHS and states have a strong shared interest in reforms that incentivize quality of care over the quantity of services. Based on models proposed by several states, last fall we provided guidance to states about new optional delivery system models that promote coordinated care and support value-based payment to providers. We invite additional state proposals in this area. States also have significant flexibility related to reimbursement levels and payment methods, as long as rates are fair and efficient and beneficiaries have access to care. We welcome discussions with governors that advance an approach on rates and payment methods that provide states more flexibility coupled with accountability tied to access to care and health outcomes. As you know, we are also working on a new initiative through the Centers for Medicare and Medicaid Innovation to support states ready to design or test new delivery system and payment methods; this initiative will also inform our collective work going forward.

While states do not require waivers to implement the options discussed here, waivers remain an important route to innovation, and many Governors have expressed a desire for HHS to streamline the Medicaid waiver process. Over the past year, we have taken

important steps to improve the waiver submission and review processes. We have developed a waiver template to ease states' administrative burden and to streamline the approval processes, and all waiver proposals are now reviewed for completeness within 15 days and posted on our website. The volume and complexity of demonstrations, however, has sometimes meant that the process is not as quick as we would like, and we are working on further improvements. This includes a new system—to be launched early this year—that will eventually eliminate all paper-based transactions between states and Centers for Medicare & Medicaid Services (CMS) and allow for a much simpler, streamlined approval process for demonstrations and state plan amendments.

I also firmly agree with governors who believe that the eligibility determination process should be simple, accurate, and fair. As you know, states and HHS will be working this year to convert to the new modified adjusted gross income (MAGI) standard, so that income eligibility is calculated consistently for Medicaid, CHIP, and the premium tax credits and cost sharing reductions available for plans in the Exchange. Having one method for determining eligibility across these insurance affordability programs will greatly simplify the eligibility process. As states convert their current standards to the new system, we know that some states are interested in flexibility, while others prefer an approach that minimizes state administrative burden. With this in mind, we released guidance last month that offers states the option to use a standardized methodology and federal funding to convert their state-specific income eligibility levels, or to propose an alternative methodology. We are also exploring how states might use the MAGI-based income rules for other populations covered in their programs, to further simplify administration.

We have also worked to provide support to states as they implement these changes. We are providing 90 percent federal matching funds for the new or improved eligibility systems that states are developing to accommodate the new modified adjusted gross income rules and to coordinate coverage with the Exchange. To further reduce system costs, we have promoted ways for states to share elements of their system builds with each other. And, we will continue exploring opportunities to provide states additional support for the administrative costs of eligibility changes.

These are just a few of the areas where we have work underway together to improve care and lower costs in the Medicaid program. We would like to engage with you in further discussions on these and other matters related to our common goals.

Thank you for your commitment to strengthening the Medicaid program. I look forward to our continued work together to on these important issues.

Sincerely,

Kathleen Sebelius

Cc:
Gov. Peter Shumlin
Gov. Bobby Jindal