



December 4, 2012

The Honorable Barack Obama  
President of the United States  
The White House  
1600 Pennsylvania Avenue, NW  
Washington, DC 20500

Dear President Obama:

Since the Patient Protection and Affordable Care Act (PPACA) was signed into law, our states have expressed repeated concerns regarding the legal, economic, and policy ramifications of expanding federal entitlements. These issues grow more urgent as the deadlines for implementation draw closer. Hundreds of billions of dollars will be spent to replace current health insurance coverage, creating inequities among individuals and families. Furthermore, we have serious reservations about a blanket expansion of the existing Medicaid program without fundamental reforms to improve health outcomes, clinical quality, and lower costs. Three years ago, you said yourself that, “we can't simply put more people into a broken system that doesn't work.” We write today to open a dialogue about the practical problems states have observed through their considerable experience administering the myriad of existing public assistance programs. Our vision to make Medicaid work for American families is to keep them together under one health coverage plan, smooth the transition between coverage as incomes change, and provide benefits consistent with private health plans. We believe in a safety-net that cares for our most vulnerable population – but also helps people get healthy and back to work.

States have a front-line perspective regarding the design of health coverage programs for our residents and are eager for opportunities to modernize and reform the Medicaid program. From its inception, Medicaid has been a partnership between the federal and state governments where states have financed a significant portion of the cost, with several states fully bearing half the cost. In addition, states have demonstrated their desire to adapt the Medicaid program to best fit the needs of their residents, choosing how to provide benefits and eligibility levels even above and beyond federal requirements. When provided with flexibility, states have proven their ability to implement effective and efficient health care programs.

Since the Supreme Court's ruling, each governor and legislature is now faced with a decision regarding the expansion of their state's Medicaid program. However, faced with a decision to expand within the limits of the current Medicaid model, it is not surprising that many states remain reluctant—even with enhanced federal funding. Whatever the ultimate outcome, we hope that you share our goal to avoid having families broken up into disparate and inequitable health coverage programs.

We have a vibrant vision for health care in America, and with a willingness to meaningfully engage with states interested in pursuing market-driven health care reform, we believe you have the ability to help achieve it. With the necessary flexibility and reforms, we can create a reality where families share an affordable health coverage product with cost-sharing and benefit design that promotes value and achieves optimal health outcomes. We want states to become more efficient purchasers of care, giving individuals greater choice for themselves and their families.

We ask that you engage in immediate, earnest, and open conversations with governors about the enclosed tenets of Medicaid reform in line with the ideas governors have repeatedly suggested. We request your personal commitment and follow-through from the United States Department of Health and Human Services (HHS) to create flexibility and reforms in the program. While each state will have its own set of considerations regarding the future of its Medicaid program, our hope is that this letter can represent the first step in opening those discussions. The ideas governors have put forward on Medicaid reform represent some of the most important issues states have expressed, regardless of their decision to expand. To make any health care reform truly successful, HHS should let states do what they do best – innovate and tailor solutions to the needs of their citizens. The healthcare working group of the Republican Governors Public Policy Committee (RGPPC) respectfully requests a meeting with you as soon as possible to discuss these critical and timely issues.

Sincerely,



Governor Bobby Jindal  
Louisiana



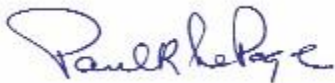
Governor Janice K. Brewer  
Arizona



Governor Rick Scott  
Florida



Governor Terry E. Branstad  
Iowa



Governor Paul R. LePage  
Maine



Governor Phil Bryant  
Mississippi



Governor John R. Kasich  
Ohio



Governor Dennis Daugaard  
South Dakota



Governor Gary R. Herbert  
Utah



Governor Robert F. McDonnell  
Virginia



Governor Matthew H. Mead  
Wyoming

Enclosure

## Tenets of Medicaid Reform

- 1. The eligibility determination process should be simple, accurate and fair.**
  - a. The process for identifying newly eligibles versus traditional eligibles must be administratively simple on the front end and not impose an overly difficult audit procedure at the end of the year. Basing billions of dollars in payments to states on untested methodologies poses significant risk to state budgets.
  - b. Furthermore, HHS should immediately release all planning documents and the business plan for building the federal data hub—particularly how it will interact with a State’s Medicaid program and the status of implementation. With additional information, states can be reassured regarding the implementation timeline and the states’ role in interacting with the hub. This information is essential for states’ ability to make timely and accurate decisions. Conversely, if the deadlines for the hub will not be met, the federal government should not waste any further taxpayer dollars. All components of the hub must be operational soon or states must have sufficient time to develop contingency plans.
  - c. The adoption and use of Modified Adjusted Gross Income (MAGI) will have a disruptive effect on the Medicaid eligibility system and create new inequities among households. States should not have to bear the additional costs of running multiple eligibility systems.
  - d. The Exchanges should be held to the same program integrity rules and regulations as state Medicaid programs. States must maintain the authority for setting eligibility rules to protect the program’s integrity.
  
- 2. States should be allowed to design their program to promote value and individual ownership in health care decisions, including promotion of consumer-directed products, flexibility in benefit design and the imposition of reasonable and enforceable cost-sharing requirements.**
  
- 3. HHS should provide flexibility for states to optimize the private health insurance market through their Medicaid eligibility levels, program design and their ability to offer premium assistance to individuals.**
  - a. States should have the ability to set eligibility requirements for both their current enrollees and expansion population. For example, states should be allowed the flexibility to set their Medicaid eligibility limits at less than 138% Federal Poverty Level and still receive the enhanced FMAP.
  - b. With reasonable plans from a State to provide for continued coverage for currently enrolled children, HHS should waive CHIP maintenance of effort (MOE) requirements not set to expire until 2019. This would allow children to be enrolled in private health insurance plans with their parents or caretakers, rather than shifting healthy risk from the private health insurance market and separating families into different public and private health coverage programs. There is value in keeping families together and having them engage with only one health plan, which will ease their use and promote utilization of routine preventive services.
  - c. HHS should allow a state to grant “premium assistance” for individuals to buy-into the exchange market place at any income level.
  - d. HHS should return full authority to states for setting reimbursement and payment policies, including flexibility to promote value-based insurance design.
  - e. States should have full authority for contracting and oversight of managed care, including the ability to place any Medicaid recipient into a managed care setting.
  
- 4. Under its current waiver authority, HHS should streamline funding and the waiver process to give states more flexibility, coupled with greater accountability tied to improvements in health outcomes.**
  - a. By simplifying funding streams, HHS should allow states to continue to innovate while being held accountable for financial management and outcomes, not processes.
  - b. HHS should allow states to design programs that suit the patient rather than one-size-fits all programs that require the same package of services for every eligible individual.

- c. HHS should confirm that states have the authority to make changes to a State's eligibility limits at any time after 2014 without limitations.
- d. HHS should streamline the waiver process, including shortened timelines and increased accountability for CMS to review and approve Medicaid waiver applications. In particular, CMS should fast-track approval of waivers already approved in other states.

**5. HHS should allow States the flexibility to prevent the undermining of the private insurance market as was done with the popular SCHIP program.**

- a. States should be allowed the flexibility to leverage their private commercial health insurance markets to reduce dependency on public entitlement programs.
- b. States should be permitted to apply the same CHIP flexibilities to the non-disabled, non-elderly Medicaid population.