DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Centers for Medicaid and State Operations

Dear State Medicaid Director:

Introduction
This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act of 2005 (DRA), Public Law Number 109-171. Section 6082, Health Opportunity Accounts (HOAs), adds a new section 1938 to the Social Security Act (the Act), which allows up to 10 states to operate Medicaid demonstrations to test alternative systems for delivering their Medicaid benefits. Under these demonstrations, States would have the flexibility to deliver their Medicaid benefits to volunteer beneficiaries through a program that is comprised of an HOA and a High Deductible Health Plan (HDHP).

States selected under the demonstration would establish a voluntary program with specific limitations that would be offered to primarily healthy adults and children. (See Eligible Population Groups on page 5). Only 10 HOA demonstrations will be approved during the initial 5 years of the program, which is to begin on January 1, 2007. All States, including those currently operating a section 1115 statewide demonstration are eligible to submit proposals and the proposals are not required to be applied on a statewide basis. At the end of the 5-year period, the programs approved under the initial demonstration may continue unless the Secretary finds that the operating program was unsuccessful based on cost-effectiveness, quality of care, or other criteria established by the Secretary. Moreover, unless the Secretary finds that all of the approved initial demonstrations were unsuccessful, other States may submit proposals and implement State demonstration programs.

Initial Approval Criteria
States interested in submitting proposals to operate an HOA demonstration program must address the following elements:

A. Creating patient awareness of the high cost of medical care;
B. Providing incentives to patients who seek preventive care services;
C. Reducing inappropriate use of health care services;
D. Enabling patients to take responsibility for health outcomes;
E. Providing enrollment counselors and ongoing education activities;
F. Providing transactions involving health opportunity accounts to be conducted electronically and without cash; and
G. Providing access to negotiated provider payment rates.

The Centers for Medicare & Medicaid Services (CMS) will be evaluating each HOA submission to assure that each element is addressed before the proposal would be approved. A State plan preprint is enclosed for your consideration. CMS will approve the first 10 demonstration

requests that fully address the 7 criteria listed above, and include a plan for annual reporting commensurate with the requirements listed in the State plan pre-print and other requirements of the program, which follow in detail.

Alternative Benefits
The demonstration must provide "alternative benefits," which must consist of, at least:

1. coverage for medical expenses in a year for items and services for which benefits are otherwise provided under Medicaid, after an annual deductible has been met, and
2. contribution into an HOA.

The State may, however, provide for coverage of preventive care within the alternative benefits without regard to the annual deductible.

Annual deductible
The amount of the annual deductible shall be at least 100 percent, but no more than 110 percent, of the annualized amount of State contributions to the HOA determined without regard to a contribution limit that may be imposed by the State if the account balance reaches a level specified by the State.

Access to Negotiated Provider Rates
For individuals that participate in these demonstration programs and who obtain services through fee-for-service providers, the State shall provide that the individual may obtain services from:

1. any participating Medicaid provider at the same payment rates that would be applicable if the individual was not subject to the deductible under the demonstration, or
2. any other provider at payment rates that do not exceed 125 percent of the Medicaid rate for the service provided by a Medicaid participating provider if the individual was not subject to the deductible under the demonstration.

For individuals that participate in these demonstration programs and are enrolled in a Medicaid managed care organization (MCO), the State shall enter into an arrangement with the MCO under which the individual may obtain demonstration services from any non-participating Medicaid provider at payment rates that do not exceed 125 percent of the rate that would be paid for that service by a participating Medicaid provider.

The payment rates for demonstration participants, whether under fee-for-service or managed care, must be computed without regard to any cost sharing that would otherwise be applicable under section 1916 or 1916A of the Act.

Definitions
Demonstration program Medicaid services means, with respect to an individual participating in an HOA State demonstration program, services which the individual would be provided under Medicaid, but for the application of the demonstration deductible.

Participating provider means with respect to an individual enrolled in a fee-for-service program, a health care provider that has entered into a participation agreement with the State for the

provision of services to individuals entitled to benefits under the State plan, or with respect to an individual enrolled in an MCO, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under Medicaid.

Effect on Subsequent Benefits
After the deductible is met, alternative benefits for an eligible demonstration individual shall consist of the Medicaid benefits offered under the State plan or statewide demonstration that would otherwise be provided to the individual, including cost sharing relating to those benefits.

Overriding Medicaid Cost Sharing and Comparability Requirements
The provisions of Medicaid, relating to cost sharing for benefits (including sections 1916 or 1916A of the Act) shall not apply with respect to benefits to which the annual deductible applies. The Medicaid provisions of comparability shall not apply with respect to the provision of alternative benefits.

Contributions Treated as Medical Assistance
Payments for alternative benefits, including contributions into an HOA, shall be treated as Medicaid medical assistance. These payments are subject to Federal financial participation (FFP) rules and varying match rates in accordance with Medicaid rules. (See section on HOAs below.)

Use of Tiered Deductible and Cost Sharing
In general, a State may vary the amount of the annual deductible based on the income of the family involved so long as it does not favor families with higher income over those with lower income, and it may vary the amount of the maximum out-of-pocket cost sharing based on the income of the family involved so long as it does not favor families with higher income over those with lower income.

The term *maximum out-of-pocket cost sharing* means, for an individual or family, the amount by which the annual deductible level applied to the individual or family exceeds the balance in the HOA for the individual or family.

Health Opportunity Accounts (HOAs)
An *HOA* means an account that meets the following requirements.

Contributions
No contributions may be made into an HOA except contributions by the State under Medicaid and contributions by other persons and entities, such as charitable organizations, as permitted under section 1903(w) of the Act. The State shall specify the contribution amount that it will deposit into an HOA.

In general, a State may impose limitations on the maximum State contributions that may be deposited into an HOA in a year; it may limit contributions into the HOA once the balance of the account reaches a level specified by the State; and it may not provide contributions to an HOA on behalf of an individual or family to the extent the amount of such contributions (including both Federal and State shares) exceeds, on an annual basis, $2,500 for each individual (or family member) who is an adult and $1,000 for each individual (or family member) who is a child.

The dollar limits specified above shall be annually increased (for each year after 2006) by the Secretary by a percentage that reflects the annual percentage increase in the medical care component of the consumer price index for all urban consumers. A State may provide for dollar limitations in excess of those specified above for specified individuals if the State provides assurances satisfactory to the Secretary that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that would otherwise be permitted in this section.

Contributions are subject to the following limitations on Federal matching. A State may contribute amounts to an HOA in excess of the $2,500 and $1,000 caps specified above, but no FFP shall be provided with respect to contributions in excess of those limitations. No FFP shall be provided with respect to contributions provided by other persons and entities, such as charitable organizations, even if permitted under section 1903(w) of the Act.

The Secretary shall provide a method under which, for expenditures made from an HOA for medical care for which the Federal matching rate exceeds the Federal matching assistance percentage (FMAP), a State may obtain payment under such section at such higher matching rate for such expenditures.

Use of Accounts

Subject to the succeeding provisions, amounts in an HOA may be used for payment of health care expenditures as the State specifies. In no case shall an HOA be used for payment for health care expenditures that are not payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986 – see enclosure for definition).

A State may restrict payment for providers of items and services to providers that are licensed or otherwise authorized under State law to provide the item or service and may deny payment for such a provider on the basis that the provider has been found, whether with respect to Medicaid or any other health benefit program, to have failed to meet quality standards or to have committed any acts of fraud or abuse; and items and services insofar as the State finds they are not medically appropriate or necessary.

The State demonstration program shall provide for a method whereby withdrawals may be made from the account for such purposes using an electronic system and shall not permit withdrawals from the account in cash.

Notwithstanding any other provision of law, if an account holder of an HOA becomes ineligible for benefits under Medicaid because of an increase in income or assets, no additional contribution shall be made into the account by the State; the balance in the account shall be reduced by 25 percent; and subject to the succeeding provisions, the account shall remain

available to the account holder for 3 years after the date on which the individual becomes ineligible for benefits for withdrawals under the same terms and conditions as if the account holder remained eligible for Medicaid, and such withdrawals shall be treated as medical assistance.

Withdrawals from an account by an individual who is no longer eligible for Medicaid may be used to purchase health insurance coverage, and may, if the individual has had an HOA for over 1 year, be used (at the option of the State) for such additional expenditures (such as job training and tuition expenses) specified by the State (and approved by the Secretary) as the State may specify.

The 25 percent reduction shall not apply to the portion of the account that is attributable to contributions by other persons and entities, such as charitable organizations, as permitted under section 1903(w) of the Act. For purposes of accounting for those contributions, withdrawals from an HOA shall first be attributed to State contributions.

An account holder of an HOA, after becoming ineligible for Medicaid, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

A State may coordinate administration of HOAs through the use of a third party administrator and reasonable expenditures for the use of such administrator shall be reimbursable to the State in the same manner as other administrative expenditures under section 1903(a)(7) of the Act.

Amounts in, or contributed to, an HOA shall not be counted as income or assets for purposes of determining eligibility for Medicaid.

A State may establish procedures to penalize or remove an individual from the HOA based on nonqualified withdrawals by the individual from the account and to recoup costs that derive from nonqualified withdrawals.

Eligible Population Groups

As mentioned earlier, individuals who are eligible to participate in the demonstration are primarily healthy adults and healthy children. States have the option to further limit eligibility. For the first 5 years of a demonstration program, individuals are eligible to participate in the demonstration, as long as they are <u>not</u> in one of the following categories:

- Individuals who are 65 years of age or older;
- Individuals who are disabled, regardless of whether or not their eligibility for medical assistance under this title is based on such disability;
- Individuals who are eligible for medical assistance under this title only because they are (or were within the previous 60 days) pregnant; and
- Individuals who have been eligible for medical assistance less than 3 months.

In addition a State demonstration program shall not apply to any individual within a category of assistance described in section 1937(a)(2)(B) of the Act, which includes the following categories:

- The individual is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.
- The individual qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- The individual is entitled to benefits under any part of title XVIII.
- The individual is terminally ill and is receiving benefits for hospice care under title XIX.
- The individual is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.
- The individual is medically frail or otherwise an individual with special medical needs (as described by the Secretary). For purposes of this section, the Secretary has previously described individuals with special needs to include those groups defined in Federal regulations at 42 CFR 438.50(d) of the managed care regulations (e.g., dual eligibles and certain children under 19 who are eligible for SSI; eligible under 1902(e)(3) of the Act; in foster care or other out of home placement; or receiving foster care or adoption assistance).
- The individual qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.
- The individual is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.
- The individual qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after welfare reform effective date defined in section 1931(i) of the Act). This provision relates to those individuals who qualify for Medicaid solely on the basis of qualification under the State's TANF rules (i.e., the State links Medicaid eligibility to TANF eligibility).
- The individual is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act. This provision relates to those individuals who are eligible for Medicaid based on the breast or cervical cancer eligibility provisions.
- The individual qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act or is not a qualified alien (as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act (Tuberculosis infected individuals).

States, at their discretion, may further limit participation in the demonstration program.

Managed Care Organizations and Health Opportunity Accounts
States may allow individuals enrolled in a Medicaid MCO to participate in the HOA demonstration. If a State chooses to provide HOA services through managed care, the State must provide the following assurances:

- The number of individuals enrolled in the MCO who participate in the HOA program will not exceed 5 percent of the total number of individuals enrolled in the MCO;

- The proportion of enrollees in the MCOs who participate in the HOA will not be significantly disproportionate to the proportion of such enrollees in other MCOs who participate in the HOA; and

- The State will provide an appropriate adjustment in the per capita payments to the MCO to account for participation in the HOA. This will take into account the difference in the likely use of health care services between MCO enrollees who participate in the HOA and MCO enrollees who do not participate in the HOA.

Enrollment
An eligible individual shall be enrolled in a State demonstration program only if the individual voluntarily elects to enroll. Except in such hardship cases as the Secretary shall specify, such an enrollment shall be effective for a period of 12 months and may be extended for additional periods of 12 months each with the consent of the individual. At this time the Secretary has not specified any hardship cases.

An eligible individual who, for
any reason is disenrolled from the State demonstration shall not be permitted to re-enroll in the demonstration before the end of the 1 year period that begins on the effective date of the disenrollment.

Submission Procedures
As previously mentioned, this provision is effective January 1, 2007. States wishing to participate in the HOA demonstration should complete and submit the attached State plan amendment preprint and be sure that it is completed fully and addresses all the requirements detailed in this letter. CMS can only approve demonstrations for 10 States in the first 5 years and we will approve the first 10 fully approvable demonstrations received by CMS and, if necessary, clarified through requests for additional information through the Medicaid State plan process. Please submit your State plan amendment (SPA) electronically to your regional office and central office as soon as possible to be considered for this demonstration.

Once a demonstration is approved, the SPA process will be followed for any subsequent changes to the demonstration.

The Government Accountability Office (GAO) is required to evaluate these demonstrations during the 5-year period. As a condition of approval, the State must cooperate with the GAO toward completion of this evaluation.

If you have questions or need additional guidance regarding this provision, please let us know.

The CMS contact for this new legislation is Ms. Jean Sheil, Director, Family and Children's Health Programs Group, who may be reached at 410-786-5647.

Sincerely,

Dennis G. Smith
Director

Enclosures: State Plan Amendment Preprint
Section 213(d) of the Internal Revenue Code of 1986

cc:

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