

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
<i>Wells/Bowling</i>	<i>6-15-01</i>

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000784</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Deps</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4120
Atlanta, Georgia 30303-8909

CENTERS for MEDICARE & MEDICAID SERVICES

CMS

June 12, 2007

Ms. Susan B. Bowling, Acting Director
South Carolina Department of Health & Human Services
P. O. Box 8206
Columbia, South Carolina 29202-8206

Dear Ms. Bowling:

We are pleased to inform you of the approval of South Carolina's Medicaid State Plan Amendment (SPA) 07-002. This Demonstration SPA is the first in the nation to offer Medicaid beneficiaries the option of enrolling in a high deductible Health Opportunity Account (HOA). This innovative program provides medical benefits through a high deductible plan in conjunction with an account from which beneficiaries direct their own care. This approval allows the State to provide another alternative delivery system for Medicaid eligibles. Enrollment is voluntary and generally is limited to Medicaid children and parents. The SPA is effective April 1, 2007.

This program will create patient awareness of the high cost of medical care; and provide incentives to seek preventive care services. It also encourages beneficiaries to assume a more proactive role in their health care, and it provides enrollment counselors and ongoing education activities. The program also incorporates the use of electronic transactions without the use of cash, and provides access to negotiated provider payment rates.

Beneficiaries will receive coverage of preventive care without regard to an annual deductible. They will also receive incentives to obtain appropriate preventive care including periodic health evaluations including annual physicals, routine prenatal and well-child care, and child and adult immunizations. If an individual loses Medicaid eligibility, this provision will allow the individual to use any remaining account balances (less 25%) for three years to purchase health insurance and for tuition expenses and job training. Initial implementation will be limited to 1,000 beneficiaries who are Richland County residents. The State will implement this program by geographic area and will comply with Federal requirements of advance public notice, which can include, but is not limited to State website posting or public service announcements.

We congratulate your State's pioneering efforts to implement the flexibility afforded to states under section 1938 of the Act for your Medicaid beneficiaries.

RECEIVED

JUN 15 2007

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Ms. Susan B. Bowling
June 12, 2007

Page 2

A formal hard copy of the SPA and the 179 will follow in the mail. If you have any questions, please contact Ms. Elaine Elmore at (404) 652-7408.

Sincerely,

A handwritten signature in cursive script, reading "Renard L. Murray".

Renard L. Murray, D.M.
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Cheryl Powell

Department of Health & Human Services
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Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: Cheryl Powell

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SC 07-002	2. STATE South Carolina
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2007

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1938 of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 (1.75 million x .6954 x 50%) \$ 608,475
b. FFY 2008 (1.75 million x .6979) \$1,221,325

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

SECTION 3.1-H; PAGES 1 thru 11
Supplement 1 to Section 3.1-H; pages 1 thru 6

10. SUBJECT OF AMENDMENT:
ALTERNATIVE BENEFITS STATE PLAN AMENDMENT

HEALTH OPPORTUNITY ACCOUNTS DEMONSTRATION PROGRAM

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Mr. Kerr was designated by the Governor
to review and approve all State Plans.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//S//

16. RETURN TO:

13. TYPED NAME:
Robert M. Kerr
14. TITLE:
Director
South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

15. DATE SUBMITTED:
March 14, 2007

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: March 14, 2007
18. DATE APPROVED: June 12, 2007

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2007

20. SIGNATURE OF REGIONAL OFFICIAL:
Robert L. Murray

21. TYPED NAME:
Renard L. Murray, D.M.
22. TITLE: Associate Regional Administrator for
Division of Medicaid & Children's Health Opns

23. REMARKS:

Attached is the original submitted Form HCFA-179 with appropriate signatures. This is a
revision.

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
07-002

2. STATE
South Carolina

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR

4. PROPOSED EFFECTIVE DATE
April 1, 2007

HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1938 of the Social Security Act.

7. FEDERAL BUDGET IMPACT:
a. FFY 2007 \$457,000
b. FFY 2008 \$197,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

SECTION 3.1-H; PAGES 1 thru 11
Supplement 1 to Section 3.1-H; pages 1 thru 5

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14. TITLE:

Director

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March 14, 2007

South Carolina Department of Health and Human Services
Post Office Box 8206
Columbia, SC 29202-8206

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

19. EFFECTIVE DATE OF APPROVED MATERIAL: PLAN APPROVED - ONE COPY ATTACHED

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

ATTACHMENT 3.1-H.

Approval # 0938-1007

ALTERNATIVE BENEFITS

STATE PLAN AMENDMENT

HEALTH OPPORTUNITY ACCOUNTS DEMONSTRATION PROGRAM

I. Approved State Demonstration Programs

The implementation date of this program is April 1, 2007. (must be after January 1, 2007)

Check all items (marked ___/) that specifically apply to this amendment.

II. Program Elements

A. 1938(a)(1)

The State elects to operate a demonstration program to provide alternative benefits, as defined in section V. The alternative benefits consist of at least (1) coverage for medical expenses in a year for items and services which would otherwise be provided under Medicaid, after an annual deductible has been met and (2) contributions into a Health Opportunity Account (HOA) as defined under subsections (c) and (d) under section 1938 of the Social Security Act (the Act).

B. 1938(c)

The State will contribute to an HOA. The amount of the annual deductible must be at least 100 percent and no more than 110 percent of the amount of the HOA contribution. See section VI. B. for the specific amount the State will contribute for each eligibility group.

C. 1938(a)(3)

The State demonstration program addresses/incorporates all of the following criteria as described in section 1938(a)(3) of the Act. Describe how each of these required program elements are implemented, monitored, and measured (below or on a separate page). (See Supplement 1 to Attachment 3.1-H, Pages 1, 2 & 3)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1007. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Supersedes
TN No.: New

Approval Date: 06/12/07

Effective Date: 04/01/07

1. Creating patient awareness of the high cost of medical care;
2. Providing incentives to patients to seek preventive care services;
3. Reducing inappropriate use of health care services;
4. Enabling patients to take responsibility for health outcomes;
5. Providing enrollment counselors and ongoing education activities;
6. Providing transactions involving HOAs to be conducted electronically and without cash; and
7. Providing access to negotiated provider payment rates.

D. 1938(a)(3)

 X / The State provides incentives for individuals enrolled in the HOA demonstration to obtain appropriate preventive care as defined for purposes of section 223(c)(2)(C) of the Internal Revenue Code of 1986, such as additional account contributions for an individual demonstrating healthy prevention practices, regardless of whether they have met the deductible. Preventive care does not generally include any service or benefit intended to treat an existing illness, injury, or condition.

If the State provides incentives for preventive care, describe the incentives and how they will be implemented.

(See Supplement 1 to Attachment 3.1-H, Page 3)

- / Additional account contributions for an individual demonstrating healthy prevention practices.
- X / Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
- X / Routine prenatal and well-child care.
- X / Child and adult immunizations.
- / Tobacco cessation programs.
- / Obesity weight loss programs.
- / Screening services.
- / Other (describe)

III. Statewide

A. 1938(a)(4)

 / The State implements this demonstration on a statewide basis.

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OR

B. 1938(a)(4)

X/The State implements this demonstration on less than a statewide basis, specifically, only in the following areas:
(Specify) **See Supplement 1 to Attachment 3.1-H, Page 3.**

IV. **Eligibility**

A. 1938(b)(2)

The following individuals will not be enrolled in the demonstration during the first 5 years after it is approved:

- 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;
- Individuals who have been eligible for medical assistance for a continuous period of less than 3 months; and

B. 1938(b)(3)

The following individuals within a category of assistance described in section 1937(a)(2)(B) of the Act will not be enrolled in the demonstration:

- 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 section 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) of the Act 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).

C. 1938(b)(4)(A) / The state will further limit eligibility by excluding the following groups:

(List and Define Groups)

D. 1938(b)(1) The demonstration will include the following groups of individuals: (List and Define Groups.)

(See Supplement 1 to Attachment 3.1-H, Page 5).

E. 1938(b)(4)(B) / The State allows individuals enrolled in a Medicaid MCO to participate in the HOA demonstration.

The State assures that the following conditions are met with respect to each managed care organization that is participating.

1. The number of individuals enrolled in the MCO(s) who participate in the HOA program do not exceed 5 percent of the total number of individuals enrolled in the MCO;
2. The proportion of enrollees in the MCOs who participate in the HOA is not significantly disproportionate to the proportion of such enrollees in other MCOs who participate in the HOA; and
3. The State will provide an adjustment in the per capita payments to the MCO to account for participation in the HOA. This shall 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. (Describe how this adjustment will be calculated below.)

F. 1938(b)(5) Voluntary Participation

An eligible individual will be enrolled in the State demonstration program only if the individual voluntarily enrolls. Enrollment will 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.

G. 1938(b)(6) Describe how the State will assure and document an individual's voluntary enrollment. (See Supplement 1 to Attachment 3.1-H, Page 4)
One Year Moratorium for Enrollment

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

V. Alternative Benefits

A. 1938(c)(1) The alternative benefits consist of:

1. Coverage for medical expenses for items and services for which Medicaid benefits are otherwise provided, after the annual deductible described in section V.B. has been met; and
2. A State contribution into an HOA, as described in section VI.B.2.

X / 3. Coverage of preventive care without regard to the annual deductible, as described in section II.D.

B. 1938(c)(2) Annual deductible.

The amount of the annual deductible described in paragraph (A) above shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the HOA under section VI.B. 1.a., determined without regard to any limitation described in section VI.C.2.. For each eligibility group please specify the amount of the deductible (between 100 percent and 110 percent of the annualized State contribution to the HOA – see section VI.B. below):

(See Supplement 1 to Attachment 3.1-H, Pages 4 & 5)
Eligibility Group Annual Deductible

C. 1938(c)(3) Access to Negotiated Provider Payment Rates

1. Fee-for-service enrollees. In the case of an individual who is participating in a State demonstration program and who is not enrolled with a Medicaid MCO, the State assures that the individual may obtain demonstration program Medicaid services from--
 - a. any participating provider under this section at the same payment rates that would be applicable to such services if the deductible described in section V.B. above was not applicable; or
 - b. any other provider at payment rates that do not exceed 125 percent of the payment rate that would be applicable to such services furnished by a participating provider under this section if the deductible described in section V.B. above was not applicable.
3. Treatment under Medicaid managed care plans. In the case of an individual who is participating in a State demonstration program and is enrolled with a Medicaid MCO, the State assures it has entered into an arrangement with the organization under which the individual may obtain demonstration program Medicaid services from any provider described in section V.C.1. at

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payment rates that do not exceed the payment rates that may be imposed under that clause.

3. Computation. The payment rates described in sections 1 and 2 above shall be computed without regard to any cost sharing that would be otherwise applicable under sections 1916 and 1916A of the Act.

4. Definitions. For purposes of this section:

- a. The term 'demonstration program Medicaid services' means, with respect to an individual participating in the State demonstration program, services for which the individual would be provided medical assistance under this title but for the application of the deductible described above in V.B.
- b. The term 'participating provider' means--
 - i. with respect to an individual described in section V.C.1., 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
 - ii. with respect to an individual described in section V.C.2. who is enrolled in a Medicaid MCO, a health care provider that has entered into an arrangement for the provision of services to enrollees of the organization under this title.

D. 1938(c)(4)

No effect on Subsequent Benefits.

After the individual has satisfied the annual deductible described in paragraphs A and B of this section, alternative benefits for an eligible individual shall consist of at least the benefits that would otherwise be provided to the individual, including cost sharing relating to such benefits, if the individual was not enrolled in the demonstration.

E. 1938(c)(5)

Overriding Cost Sharing and Comparability Requirements for Alternative Benefits

The Medicaid provisions relating to cost sharing for benefits (including sections 1916 and 1916A of the Act) will not apply with respect to benefits to which the annual deductible under section V.A. applies. The provisions of section 1902(a)(10)(B) of the Act (relating to comparability) shall not apply with respect to the provision of alternative benefits (as described in this section).

F. 1938(c)(7) Use of Tiered Deductible and Cost Sharing

- / 1. The State will use a tiered deductible. The amount of the annual deductible is based on the income of the family involved. The amount will not favor families with higher income over those with lower income; and
- / 2. The State will have tiered cost sharing. The amount of the maximum out-of-pocket cost sharing is based on the income of the family involved. The amount does not favor families with higher income over those with lower income.

VI. Health Opportunity Account

A. 1938(d)(1) The term 'HOA' means an account that meets the requirements of this section.

B. 1938(d)(2) Contributions

1. No contribution may be made into an HOA except--

- a. contributions by the State under 1938 of the Act; and
- b. contributions by other persons and entities, such as charitable organizations, as permitted under section 1903 (w) of the Act.

2. State Contribution – Specify for each eligibility group the contribution amount that shall be deposited into an HOA. See section V.B. for limits on annual deductibles for the groups based on these contributions.

(See Supplement 1 to Attachment 3.1-H, Page 5)

<u>Eligibility Group</u>	<u>Contribution</u>
All groups	\$2500 per eligible adult \$1000 per eligible child

C. 1938(d)(2) Limitation on Annual State Contribution Provided and Permitting Imposition of Maximum Account Balance

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X / 1. The maximum amount that will be deposited into an HOA by the State in a year is \$2500. The State will allow the participant to carry balances forward from a prior year.

/ 2. If the balance in an HOA reaches _____ no more contributions can be made under VI.B.2

3. Except as described in subsections 4. and 5. below for 2006 the State will not provide contributions described in section VI.B.1. to an HOA on behalf of an individual or family to the extent the amount of such contributions (including both State and Federal 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. For subsequent years these amounts will be the updated amounts specified by the Secretary.

4. Budget neutral adjustment. The State provides assurances that contributions otherwise made to other individuals will be reduced in a manner so as to provide for aggregate contributions that do not exceed the aggregate contributions that would otherwise be permitted under this subparagraph.

/ 5. The State will provide contributions in excess of the above limitations, will not claim and is not entitled to claim Federal financial participation under section 1903(a) of the Act for the excess contributions.

6. The State will not claim and is not entitled to claim Federal financial participation under section 1903(a) of the Act for any contributions made to an HOA pursuant to section VI.B.1.b., above.

D. 1938(d)(2)

Application of Different Matching Rates –

The State will have a method for identifying expenditures from HOAs that are eligible for an enhanced matching rate consistent with guidance from the Secretary.

E. 1938(d)(3)

Use

1. General Uses

- a. Amounts in an HOA may be used for payment of the following health care expenditures, which must be for payment of medical care (as defined by section 213(d) of the Internal Revenue Code of 1986), except at provided in section VI.F.2.

b. State Restrictions -

- i. X / Amounts in an HOA may not be used to pay providers of items and services unless the providers are licensed or otherwise authorized under State law to provide the item or service. The State will deny payment for such a provider if the provider has been found, whether with respect to title XIX of the Act or any other health benefit program, to have failed to meet quality standards or to have committed any acts of fraud or abuse;
- ii. X / Amounts in an HOA may not be used to pay providers of items and services if the State finds that the items and services are not medically appropriate or necessary. The State will deny payment for such a provider if the provider has been found to have submitted claims for such items and services.

- c. Electronic Withdrawals - The State demonstration program will use the following method to ensure that withdrawals will be made from the HOA using an electronic system, and that withdrawals will not be permitted in cash.

Describe the method. (See Supplement 1 to Attachment 3.1-H, Pages 5 & 6)

F. 1938(d)(3)

Maintenance of HOA After Becoming Ineligible for Public Benefit

1. If an account holder of an HOA becomes ineligible for benefits under title XIX of the Act because of an increase in income or assets—
 - a. no additional contribution will be made into the account by the State under section VI.B.1.a.;
 - b. the balance in the account will be reduced by 25 percent, except to the extent it represents private contributions to the account; and
 - c. consistent with the provisions described in this section, the account shall remain available to the account holder for 3 years after the date on which the individual becomes ineligible for such benefits for withdrawals

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under the same terms and conditions as if the account holder remained eligible for such benefits.

2. Special Rules - Withdrawals from an account—

- a. can be used to purchase health insurance coverage; and
- b. X / may, subject to 4. below, be used for the following additional expenditures:

 X / job training
 X / tuition expenses
 / other (please describe)

(See Supplement 1 to Section 3.1-H, Page 6)

3. Condition for Non-Health Withdrawals - No withdrawal will be permitted from an account under 2.b. above unless the account holder has participated in the demonstration program for at least 1 year.
4. No Requirement for Continuation of Coverage - An account holder of an HOA, after becoming ineligible for medical assistance under this title, is not required to purchase high-deductible or other insurance as a condition of maintaining or using the account.

G. 1938(d)(4)

 X /Administration - The State will coordinate administration of HOAs through the use of a third party administrator and reasonable expenditures for the use of such administrator will be reimbursable to the State in the same manner as other administrative expenditures under section 1903(a)(7) of the Act.

H. 1938(d)(5)

Treatment - Amounts in, or contributed to, an HOA shall not be counted as income or assets for purposes of determining eligibility for benefits under this title.

I. 1938(d)(6)

Unauthorized Withdrawals - The State will establish procedures—

1. to penalize or remove an individual from the HOA based on nonqualified withdrawals by the individual from such an account; and
2. to recoup costs that derive from such nonqualified withdrawals.

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II. PROGRAM ELEMENTS

C. 1938(a)(3)

The State demonstration program addresses/incorporates all of the following criteria as described in section 1938(a)(3) of the Act. Describe how each of these required program elements are implemented, monitored, and measured (below or on a separate page).

1. Creating patient awareness of the high cost of medical care;

The State will be providing, through its enrollment broker, information to the potential voluntary enrollees at the time they are made aware of their options. The information will include general information regarding the increase in Medicaid expenses in South Carolina, an outline of this option, how it is different from regular Medicaid and the use of the potential incentive at the conclusion of their Medicaid eligibility. Additionally, monthly the voluntary enrollees will receive detailed feedback on the care they have received, the HOA balance, and suggestions for further reducing their medical expenses. The suggestions might include communications such as “you are irregularly filling your maintenance drug,” or “you visited the ER for an earache during your Physician’s regular office hours.”

2. Providing incentives to patients to seek preventive care services;

Expenses for routine preventive care which is covered by the South Carolina Medicaid program, will be covered outside of the HOA expense. For example, annual physicals and EPSDT checkups are paid by Medicaid regardless of HOA balance and without deducting the payment from the HOA balance. Necessary follow-up services related to preventive check ups are subject to HOA expense.

3. Reducing inappropriate use of health care services;

Enrollees will be required to have a primary care provider to coordinate care. Use of an emergency room for non-emergent care will result in a deduction from the HOA, reducing the balance of any carry forward or post-Medicaid HOA balance. There is no co-pay for appropriate use of the emergency room. The monthly statement of expense will include consumer tips on changes in consumer behavior that would have reduced expense

and improve outcomes. Initially, this may be limited to reminders such as “this prescription has a generic equivalent of NAME, please ask your primary care provider if it is appropriate for you” or “this is an non-emergent visit to an emergency room, your primary care physician provides 24 hour phone coverage at 800-999-9999.”

4. Enabling patients to take responsibility for health outcomes;

The enrollees have exposure to the cost and take direct responsibility through the HOA. To the extent that they obtain preventive care and outcome effective delivery of service, they will have an account balance to carry forward. If they do not seek preventive services and those that have effective outcomes, they will likely experience expensive, episodic delivery of service and routinely exhaust their account.

5. Providing enrollment counselors and ongoing education activities;

The State has already awarded a contract for enrollment counselor and education services. This project will be incorporated into the counselor services. The contract includes contact with Medicaid eligibles to obtain a healthcare assessment, explain all Medicaid delivery models available to the applicant, obtain information to enroll the client into a plan and Medicaid education services. This will include information on the HOA option. Ongoing education is provided by the counselor through customer service calls and the recipient’s statement of expenditures.

6. Providing transactions involving HOAs to be conducted electronically and without cash; and

The recipients that volunteer to participate will receive the standard Medicaid card or one very similar. The card will have additional capabilities since it will be linked to the enrollee’s HOA. As the provider renders service, the card is swiped for billing purposes. Providers that do not have access to swipe card technology are provided alternatives through standard electronic and paper claim processes. Providing that routine program requirements are met, a payment will be issued to the medical provider. An electronic transaction will be communicated to the HOA for routine reporting.

7. Providing access to negotiated provider payment rates.

The State will pay providers using the existing Medicaid state plan methodologies established under the fee-for-service program. The Medicaid rates are public information available on the web, are established in the State Plan and are available to the HOA beneficiary. The Medicaid rate paid is noted on the beneficiary's HOA statement.

D. 1938(a)(3) If the State provides incentives for preventive care, describe the incentives and how they will be implemented.

☐ / Additional account contributions for an individual demonstrating healthy prevention practices.

☒ / Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals. There will be no patient obligation or HOA withdrawal for these services, to encourage regular utilization.

☐ / Periodic physicals and EPSDT evaluations are covered and not subject to a deduct from the HOA.

☒ / Routine prenatal and well-child care. To encourage regular utilization, there will no patient obligation or HOA withdrawal for these services.

☐ / Well child EPSDT exams are covered, pregnant women are excluded from the program

☒ / Child and adult immunizations. To encourage regular utilization, there will no patient obligation or HOA withdrawal for these services.

☐ / Child and adult immunizations covered without HOA deduct
☐ / Tobacco cessation programs.
☐ / Obesity weight loss programs.
☐ / Screening services.
☐ / Other (describe)

III. Statewide

B. 1938(a)(4) ☒ / The State implements this demonstration on less than a statewide basis, specifically, only in the following areas:

Initial implementation will be limited to Richland County and 1000 recipients. As success is demonstrated, the plan will be expanded to other areas.

The State understands that the implementation of the 1000 volunteers cannot discriminate on the basis of sex, race, color, national origin, handicap, disability and age. The State will operationalize the 1000 volunteer limit by:

- Enrolling volunteers on a first come, first serve basis
- Establishing a waiting list should volunteers exceed 1000
- As volunteers withdraw or are otherwise removed from the program, the next beneficiary on the waiting list will be contacted to determine continued interest in the plan
- If the volunteer indicates continued interest, the plan is again reviewed to ensure understanding of the differences from regular Medicaid and the member is enrolled for the next month.

IV Eligibility

F. 1938(b)(5)

Voluntary Participation

Describe how the State will assure and document an individual's voluntary enrollment.

Each voluntary participant will be counseled by an enrollment counselor who explains all options including the HOA program.

The HOA participant will be required to sign a statement indicating that they understand that the participation is voluntary and that they are choosing to disenroll from the standard Medicaid program.

V. Alternative Benefits

B. 1938(c)(2)

Annual deductible.

The amount of the annual deductible described in paragraph (A) above shall be at least 100 percent, but no more than 110 percent, of the annualized amount of contributions to the HOA under section VI.B. 1.a., determined without regard to any limitation described in section VI.C.2.. For each eligibility group please specify the amount of the deductible (between 100 percent and 110 percent of the annualized

State contribution to the HOA – see section VI.B. below):

<u>Eligibility Group:</u>	<u>Annual Deductible:</u>
Transitional Medical Assistance (TMA)-	
Section 1902(a)(10)(A)(i)(I) Section 1925	110%
Infants (OCWI) – Section 1902(a)(10)(A)(i)(IV)	110%
Partners for Healthy Children (PHC) –	
Section 1902(a)(10)(A)(i)(VI)and (VII)	110%
Section 1931 Low Income Families (LIF) – Section 1902(a)(10)(A)(i)(I)	110%
and Section 1931	110%
Ribicoff – Section 1902(a)(10)(A)(i)(I)	110%

VI. Health Opportunity Account

B. 1938(d)(2) Contributions

2. State Contribution – Specify for each eligibility group the contribution amount that shall be deposited into an HOA. See section V.B. for limits on annual deductibles for the groups based on these contributions.

<u>Eligibility Group:</u>	<u>Contribution</u>
Transitional (TMA)	\$2500 per eligible adult \$1000 per eligible child
OCWI Infants	\$2500 per eligible adult \$1000 per eligible child
PHC	\$2500 per eligible adult \$1000 per eligible child
LIF	\$2500 per eligible adult \$1000 per eligible child
Ribicoff.	\$2500 per eligible adult \$1000 per eligible child

E. 1938(d)(3) Use

1. General Uses

- Electronic Withdrawals - The State demonstration program will use the following method to ensure that withdrawals will be made from the HOA using an electronic system, and that withdrawals will not be permitted in cash.

The eligibility card provided will resemble a normal Medicaid card. Transactions will be processed according to covered services of the Medicaid program. No other withdrawals are permitted until the beneficiary is no longer eligible for Medicaid. At that time, 75% of the account is available to the beneficiary. The federal share of the 25% is refunded to the federal government. At that time, the former beneficiary contacts the Medicaid program to process acceptable transactions (health plan coverage, education).

First expense dollars come from the account made by the State contribution. Should the beneficiary expend the State contribution, they have a responsibility of 10% out of pocket deductible. Provider and beneficiary education will be important. As the beneficiary receives medical services, the provider will bill the State however claims will be maintained as encounter data only; reimbursement will not be made. Billing and payment for the non-covered (out of pocket) service(s) will be coordinated between the provider and the beneficiary. The State will monitor this data and will communicate to the beneficiary by monthly statements of the status of their deductible, and inform providers through electronic verification systems messages. After the 10% deductible is satisfied, the State will resume payment at the normal Medicaid rate reimbursement. Regular state plan cost sharing rules will not apply to the beneficiary.

F. 1938(d)(3)

Maintenance of HOA After Becoming Ineligible for Public Benefit

2. Special Rules - Withdrawals from an account—

b. X / may, subject to 4. below, be used for the following additional expenditures:

 X / job training
 X / tuition expenses
 / other (please describe)

Job training and tuition expenses are allowed for the beneficiary at any postsecondary educational institution accredited by accrediting agencies and state approval agencies recognized by the U.S. Secretary of Education. Undergraduate and graduate courses are eligible. Courses taken for academic credit but not necessarily for the completion of a degree are eligible. After the first allowance, members must provide proof of a passing grade before further expenses are allowed.