Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

August 20, 2013

Carol Backstrom, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Ms. Backstrom:

The Centers for Medicare & Medicaid Services (CMS) has recently completed the review and approval of Minnesota's Medicaid state plan amendment (SPA) 12-17 related to premium assistance for enrollment of Medicaid-eligible individuals in cost-effective employer-sponsored group health plans under section 1906 of the Social Security Act (the Act). Through SPA 12-17, Minnesota is removing high deductible health plans associated with health savings accounts (HSAs) from the automatically excluded list of cost-effective health plans. If such a plan does not meet Minnesota's established threshold criteria for cost-effective treatment, then the state will evaluate the plan on a case-by-case basis.

Recognizing that the modification to Minnesota's state plan brought about by SPA 12-17 is not problematic in itself, CMS has approved this SPA. However, we are concerned that Minnesota's procedures for determining the cost-effectiveness of employer-sponsored group health plans may not be consistent with the federal requirements under section 1906(e)(2) of the Act, both with respect to a high deductible health plan and other types of employer-sponsored coverage. Attachment 4.22-C of Minnesota's state plan does not clearly convey all of the factors required under section 1906(e)(2) to demonstrate cost-effectiveness.

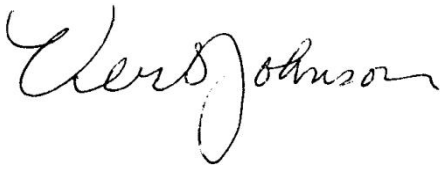
Section 1906(e)(2) applies the same meaning of "cost-effective" as that described in section 2105(c)(3)(A) of the Act. This requires that the cost of purchasing coverage under a group health plan, including administrative expenditures, for a Medicaid-eligible individual is comparable to providing direct coverage under the Medicaid state plan. As outlined in section 3910.11 of the State Medicaid Manual, and further explained in a February 2, 2010 CMS letter to State Health Officials, the factors required to be considered in a state's cost-effectiveness test include the following:

- the costs of paying premiums, deductibles, and coinsurance;
- the costs of paying all excess cost sharing charges required under the group health plan that are not permitted under Medicaid;
- the costs of providing wraparound benefits for items and services covered under the Medicaid state plan that are not included under the group health plan; and
- additional administrative expenditures.

Within 90 days from the date of this letter, we are requesting that Minnesota provide further information to explain how its current cost-effectiveness methodology is consistent with federal requirements, or submit to CMS a SPA to revise its methodology and bring the state plan into compliance. Also, we request that Minnesota specifically describe how the state will determine the cost-effectiveness of high deductible health plans associated with HSAs, in light of the addition of these HSA-associated health plans to the list of plans that may now be considered for cost-effectiveness.

During the 90 days, CMS will be available to provide technical assistance. If you have any questions concerning this companion letter, please have a member of your staff contact Courtenay Savage at (312) 353-3721 or via e-mail at Courtenay.Savage@cms.hhs.gov.

Sincerely,



Verlon Johnson
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cc: Ann Berg, MDHS
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