

## **Demonstration to Maintain Independence and Employment**

### **Clarification Points**

#### **Initial Posting (April 5, 2004)**

**1. What services will be reimbursed at the state's Federal Medical Assistance Percentage (FMAP)?**

Services that are listed in the State's Medicaid Plan for the optional categorically needy group will be reimbursed at the State's FMAP rate.

**2. Can other federal funds be used as the State's share?**

Sec. 204 of the Ticket to Work and Work Incentives Act (TWWIA) never uses the words "match" or "cost share" so no match is required for this grant. The statute (Sec. 204(c)(2)(E)) does say that the State will only be reimbursed for a portion (equal to the Federal medical assistance percentage) of the medical services. The statute is silent on how the remaining portion is to be paid. Federal matching requirements (e.g., OMB Circular A-87 and the GAO Red Book "Appropriations Law – Vol II") do prohibit the use of funds provided under this grant from being used as match for other Federal grants. Therefore, the answer is a qualified "Yes." Other Federal funds may be used to pay for the non-CMS-funded portion of medical assistance so long as the use is a permitted one by the other Federal source and the CMS funds are not used as match for another Federal grant

**3. What is the date for the applicants' teleconference on the "Demonstration to Maintain Independence and Employment" grant?**

Every two weeks, beginning April 7, 2004 at 2:00 Eastern Time. The last call will be May 19, 2004.

**4. This proposal references title XIX of the Ticket to Work and Work Incentives Improvement Act of 1999 in terms of the definition of "state;" however, can you clarify for me if only Medicaid State Agencies (i.e. Pennsylvania Department of Public Welfare) can apply directly with CMS for this demo project while working through qualified contractors such as health maintenance organizations (HMOs) who would conduct the actual project evaluation or can HMOs apply directly to CMS as well?**

Only State Medicaid Agencies can apply directly; however, the State Medicaid Agency may partner with other organizations that can conduct the demonstration and do the evaluation. CMS would not see an HMO as an appropriate organization to perform the independent evaluation.

**5. There is no form for the Letter of Intent to Apply. What information should be included?**

While a letter of intent is not binding, submitting one ensures that you will receive the responses to the questions and answers by e-mail and will allow us to plan the

appropriate number of conference lines for the bi-weekly call. Please send an e-mail to DMIE@cms.hhs.gov, and include the name of the State, the contact name, title, organization, address, telephone and fax numbers, and the e-mail address.

**6. If I have a question, how do I get an answer?**

We request that you put it in an e-mail addressed to DMIE@cms.hhs.gov. We will address it at the bi-weekly teleconference and post it here on the website, [www.cms.hhs.gov/twwiia/independ.asp](http://www.cms.hhs.gov/twwiia/independ.asp).

**7. Is the grant targeted and limited to non-Medicaid eligible individuals or may grant monies be used to provide non-Medicaid reimbursable services to Medicaid eligible persons?**

The grant is not available for Medicaid eligible individuals.

**8. Clearly the intent of the project is to maintain employment for at-risk individuals through the provision of medical assistance and other supports. Could "other supports" include services such as supported housing and other housing assistance?**

Yes; however, CMS will not fund projects that attempt to use this demonstration to supplant the level of state funds expended for workers with potentially severe disabilities under programs in effect for such individuals at the time the demonstration project is approved. Such a proposal should provide strong justification that supported housing, or any other non-medical support, is required to maintain employment.

**9. Are individuals with a primary diagnosis of substance abuse excluded from the demonstration project?**

No; however, the diagnosis must be consistent with the Social Security definition and include other behavioral and physical changes (see 20 CFR Ch. III Pt. 404, Subpt. P, App. 1, Part A., Sec. 12.10).

**April 16, 2004 Posting**

**10. Could a state use this demonstration to provide Medicaid to individuals in a state's high risk pool?**

Yes, so long as the services are targeted to the populations described in the solicitation.

**11. Where can the state match come from?**

It can come from a variety of sources including private sources, local and state government, premiums, and other federal sources (so long as the other federal source approves its use and the CMS funding is not used for match.)

**13. Our state was interested in using this for youth transitioning to adulthood by buying services that would replace home and community based waiver services. Is this a potential population?**

If the youth are eligible for waiver services, they are not eligible for the demonstration because they are currently Medicaid eligible. Further, they must be employed.

**14. What is the definition of employed?**

The applicant must define their employment criteria. Employment can either be defined as not less than 40 hours per month at Federal minimum wage or an acceptable equivalent. Such equivalent definitions might include a clearly defined ramp-up period or grace periods for temporary absence from employment. States may set a higher minimum threshold (in terms of hours worked or income earned), but they may not set a maximum earnings threshold. (See page 11 of the solicitation.)

**15. Does it matter if a state has a Medicaid buy-in program?**

No.

**16. Regarding sustainability, does CMS have the expectation that states offer this after 2009 at state cost?**

There is no requirement that these demonstrations continue beyond the terms of the grant; however, if the projects demonstrate positive results, states and/or the Congress may decide to continue them.

**17. Is CMS amenable to setting up a program with a control group? With multiple intervention groups?**

Yes. Please refer to the evaluation paper on the website. While CMS appreciates the difficulty in designing a project with a strict experimental design, having a randomly assigned control group is still the “gold standard.” The evaluation paper discusses other possible approaches. Multiple intervention groups are possible so long as statistical power is maintained. Further, all treatment groups must be eligible for the full range of medical assistance.

**18. Can states choose to put enrollees in managed care or fee-for-service?**

Yes, either; however, managed care projects should make provision to track actual medical assistance and other support costs for the purposes of receiving reimbursement.

**19. On page 12 under “Intervention” it talks about using funds to wrap around the buy-in. Is this allowable?**

This sentence should have been edited out during the clearance process and was missed. Individuals eligible for the buy-in do not qualify for this demonstration since they have already been determined to be disabled.

**20. Is it true that the medical package provided to individuals must be equal to or greater than that provided to categorically needy Medicaid eligible individuals in a state?**

Yes. Applicants should refer to their state's medical assistance plan since there may be differences from state-to-state.

**21. States will need to get legislation passed to come up with the state match. Will this be offered again in the future?**

CMS may release the solicitation immediately after this round if it determines that there are funds left to commit or that there is an insufficient number of qualifying proposals. CMS will not offer the solicitation after this year because there will be insufficient time for the demonstrations to be conducted before September 30, 2009.

**22. If states want to meet priority 1 (mental health), can the state limit the medical benefits it offers to only mental health services?**

No. The project must offer benefits equivalent to those in the state's medical assistance plan for categorically needy individuals.

**23. How did the current states operating under this program get funding through their legislatures?**

We are researching the answer to this question; however, the initial version of the solicitation required the use of state funds. The assumption at the time was that the process was the same as it would be for any Medicaid expansion.

**24. In states that have counties match federal Medicaid dollars, can counties provide the match for this program?**

Yes, however, the non-supplantation provisions would apply.

**25. Can a state require that participants have employer-based insurance?**

Yes. In fact, that would be a requirement to address priority 4.

**26. Why do states need to offer the full Medicaid benefits package?**

It is a provision of the the law that established this demonstration. Medical assistance must be "equal to that provided under section 1905(a) of the Social Security Act."

**27. Could a state wrap around employer coverage and get FMAP for wrap services?**

Yes; however, the grantee can not use the employer covered costs as non-federal share.

**28. If a state covered a population that has employer coverage equal to the Medicaid benefits package, could the state use the grant funding to provide only other services such as child care and transportation?**

Yes, so long as those services were determined to be essential for the individual to maintain employment. It is not appropriate to use Demonstration funds to build infrastructure such as transportation programs or systems.

**29. Is the project available to individuals who receive medical assistance under a state general assistance program and who lose that assistance through employment?**

Yes, so long as they meet the projects criteria for having a potentially disabling condition and are employed.

**30. How should a project determine appropriate disabling conditions to include?**

Applicants should provide evidence in the application that the particular conditions have a high probability of leading to Social Security level of disability. They must describe how they will determine that each participant has the selected conditions.

**31. If a state has a Medicaid Buy-In for workers with disabilities and a potential participant in the Demonstration meets the Buy-In eligibility requirements, can the individual participate in the Demonstration?**

No. To enroll the individual in the demonstration would result in the supplantation of the state Medicaid program.

**32. Questions from the "Demonstration to Maintain Independence and Employment Evaluation" document:**

\* **Health status and quality of life are major outcome variables. Is there any guidance on how these should be measured? Are you looking for something on the order of the basic health status self-report item used in major national surveys (see below) or do you want more comprehensive measures such as the Medical Outcomes Trust (MOT), Health Assessment Lab (HAL) and QualityMetric's SF-36(r) or an physical evaluation conducted by a nurse or physician?**

\* **For the evaluation methodology would it be acceptable to do a randomized controlled design with a wait-list control group?**

\* **For the difference-in-difference design would it not be stronger to go with a case control or matched samples design where the intervention and control groups are matched on all hypothetical confounds at the pre stage?**

\* **The document aptly notes that statistical power is a function of both variability and sample size. Without a literature base to draw upon, or pilot data how are states to make an educated guess on the variance side, and therefore determine what their needs are in terms of sample size?**

The evaluation document provides general, not specific, guidance. It is our expectation that a successful application will have a well-conceived evaluation plan that addresses the main points of the document. There are many possible evaluation designs. CMS will not attempt to prejudge a project evaluation design by responding to this level of specific question. In other words, CMS views these

all as issues and questions that the demonstration designers must address in the development of their proposal.

**33. Is there guidance CMS can give on HIPAA compliance issues relevant to the Demo evaluation? It is mentioned that CMS may want to access any data collected, so should any application contain the legal documents necessary to begin a data users agreements and secure data transfer protocol?**

Qualified evaluators will need to address HIPAA compliance issues in their proposals. We have no further guidance to provide. Applicants should be prepared to provide person-level data to CMS. Successful applicants will need to be prepared to enter into data use agreements and secure data transfer protocols. These arrangements will be made after the grant is made.

**34. What is an appropriate “N” or participant size for the demonstration?**

It depends upon the nature of the demonstration project. CMS views this as a question that must be addressed by the applicant in the design of the project.

**35. Can CMS give us a rough estimate of how many grants it plans on awarding for this next round of DMIE funding?**

Fewer than 10.

**April 21, 2004 Posting**

**36. We are considering serving transition-age young adults in our demonstration. Could some of the required 40 hours of work be in the form of education or job training? For example, could an enrollee in this population work 30 hours per month and spend ten hours in education or job training? I appreciate any guidance you can offer on this point.**

While there is some latitude in using an equivalent definition of work, it is not clear which “transition-age young adults” are being considered for your demonstration. Are they primarily in the labor force (i.e., workers) or are they primarily students? Since the demonstration is targeted at those individuals who are employed and at high risk of becoming eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), you must make the case that a high proportion of these young adults would, without participating in this project, become eligible for SSI or SSDI. A key question that you must address is whether the study and comparison populations are of sufficient size to be able to measure the effect in terms of employment and SSI and SSDI eligibility.

**37. A general comment regarding population selection:**

Keep in mind that this is a grant program to demonstrate effective strategies to prevent individuals from entering the Social Security disability system; it is not a grant program to simply provide services to underserved groups in a state or community.

**38. A note on the supplantation issue.**

Discussions with current grantees and the above question, raises the issue of supplantation. If your proposal seeks to provide services to a population already served, even if there is a waiting list for state- or locally-funded services, your proposal may not be eligible for consideration. You must demonstrate in your proposal that none of the services provided to the demonstration population will in any way supplant services that these individuals would be eligible for if the demonstration intervention was not in place.

**39. Are any medical, pharmacy, mental health/substance abuse services, etc paid 100% by CMS? Or are all services provided to the participants reimbursed at the state's FMAP rate?**

If the services are covered in the State Medicaid Plan, they are to be reimbursed at the state's federal medical assistance percentage (FMAP); otherwise, they can be reimbursed in full (100%).

**40. Does a notice of intent commit the state to turn in a proposal?**

No.

**41. Does not submitting an intent to apply preclude eligibility to turn in a proposal?**

No.

**42. How would a multi-state grant work?**

There must be a single application with the other states' Medicaid agencies certifying that they agree to all conditions. The single application must include a common demonstration protocol to be conducted across each state. The only difference can be the medical assistance service package based upon each state's Medicaid plan. One of the states must be responsible for the independent evaluation of the total project. Each state must provide operational budgets for direct services, data collection, and other administrative tasks provided within that state according to the solicitation guidelines. Should a grant be awarded, each state will be reimbursed separately.

**April 22, 2004, Posting**

**43. How many states have submitted letters of intent regarding the Demonstration to Maintain Independence and Employment?**

As of April 21, 2004, CMS has received 11. Also see items 40. and 41.

**44. Can CMS provide any guidance regarding the scope of a potential demonstration? How many enrollees is considered excessive? How many is too few? For evaluation purposes, what size n is most appropriate?**

CMS anticipates that the state will have an independent evaluator as a partner. These questions are appropriately addressed to the partner. CMS will evaluate

proposals on how well the overall demonstration, particularly the evaluation design addresses the fundamental question: can a program of medical assistance and other supports forestall or prevent the loss of employment and independence due to a potentially disabling and medically determinable physical or mental impairment. In general, simple, straight-forward designs will probably score better than complex, esoteric ones.

While there are no maximum grant sizes established, proposals must consider that grants will be providing direct services to numbers of participants over four plus years.

**45. We currently fund behavioral health services for non-Medicaid eligible persons determined to have a serious mental illness with 100% state funds. Is it possible to target these individuals in the demonstration and use these existing state monies to fund the portion of the medical assistance cost that is not reimbursed through the FMAP?**

~~No. This approach would constitute supplantation of state funding, which is not allowed under the legislation creating this demonstration grant program.~~

Yes, according to CMS General Counsel, so long as the overall appropriated state monies are not reduced or supplanted, these funds could be applied to the demonstration population.

**46 What might be acceptable consumer "medical" documentation or evaluative information to indicate the presence of a potentially disabling condition and could criteria be developed to rapidly decide that the individual would not likely meet the SSA "blueBook" guidelines at this time?**

The applicants approach to this issue is part of the design of their proposal. We have no comment.

**47. Could individuals with impairments who were previously on Medicaid due to their poverty status (e.g. General Assistance) and now are ineligible because of an income due to work and who also meet the above criteria for potentially disabling conditions, be eligible for Medicaid services from the DMIE grant?**

Yes.

**48. Could an 18 - 22 year old transitioning student with severe emotional disturbance who is not on SSI receive Medicaid as they entered the workforce rather than currently be in the workforce? They would have to meet documentation for a disabling impairment.**

If by Medicaid you mean services under the demonstration, the answer is no. They are not currently employed; they are students.

**49. Does CMS have a sense of how to identify individuals who should be in the demonstration? Does it expect the use of employee assistance plans or other mechanisms?**

Both of these questions must be answered in the proposal. We have no preconceived design.

**50. If two states wanted to have differently targeted interventions but want to pull together a cross state evaluation team, how would that be received?**

Since the interventions are different, two distinct proposals would be required, including evaluation plans, but the two proposals might use the same evaluation team.

**51. In regard to the % of costs not reimbursable by the feds, can we use foundation money to have workers purchase private insurance covering the health care components of the service package?**

Yes. See the more detailed response to item number 62.

**52. What about personal assistance services? Can it be 100% federally funded?**

Only if personal assistance services are not included as a state Medicaid plan service.

**53. Can states use one specific employer or a group of defined employers to find the target group?**

Yes. The concern is the size of the pool in order to demonstrate an effect.

**54. Can a demonstration be set up to target all diagnoses that are potentially disabling, not just one?**

Yes. That would be appropriate to priorities 2 and 4.

**55. Can employment be defined at a particular wage level?**

Yes, so long as it is at least the federal minimum wage level. States can set a higher minimum employment level than 40 hours per month at minimum wage.

**56. What about the preference stated in the solicitation for states that do not have existing work incentive grants-What grants are included?**

We were referencing the Medicaid Infrastructure Grants and existing Demonstration to Maintain Independence and Employment Grants. This is a CMS attempt to encourage the seven states that have not participated in either program. It should not deter others who have participated as it is very likely that most of the awardees will come from this group.

**57. How should states make the determination of likely to be disabled?**

That is a key component of the proposal. CMS will not respond because our suggestion may limit the ideas of applicants which would not be a positive outcome.

**58. The solicitation preferences workers who have been in the workforce a long time. What about new employees, are they an acceptable target population?**

Yes, but the proposal should address the probability that, without the intervention, they have a high expectation of becoming disabled according the Social Security definition.

**59. The supplantation restrictions and requirement to provide the entire Medicaid package of services makes this just an expansion of Medicaid. Correct?**

No. This grant program, although it relies on certain Medicaid definitions, is outside the Medicaid program. Further, it is time limited and does not represent an entitlement except for the defined participant group. It's intent is to prevent participants from becoming Medicaid recipients.

**60. Could a state use as their target population state employees who have a medical condition or conditions (as defined in the grant), or would using state employees be considered a conflict of interest.**

Yes, it could. Again, the issue is whether that will make a valid demonstration.

**61. Could people over 65 years of age with a medical condition or conditions (as defined in the grant) and who are receiving retirement benefits and Medicare, but not SSDI, be a part of the target population.**

No. They have no risk of becoming disabled according to the Social Security disability definition. Because they are over 64, SSDI is not available and SSI would be received based on age rather than disability.

**62. As we understood your response to the caller from California, a private foundation or an employer paying the premiums for private health care coverage could count as the "match", even though no medical services are provided through Medicaid. In other words, the participants would receive their medical coverage through privately funded health insurance paid for by a third party, and all other needed services would be provided through the grant. Did we understand this correctly? If so, we assume that the private health insurance would have to be equal to or better than the Medicaid coverage through the State Plan, or that Medicaid would have to provide any medical services not offered by the private insurance. Is this a correct assumption?**

Our understanding of the question was that the participant group (and perhaps a control or comparison group) would receive a private subsidy to cover premiums and include them in an insured participant group. This would not be part of CMS funding. DMIE does not have a "match" requirement; however, it will only pay for Medicaid equivalent medical services at the federal medical assistance percentage of the particular state.

If the "other needed services" include additional medical assistance services (e.g., physical therapy, personal care, mental health counseling), then the FMAP is applied; if the other services are non-medical in nature (i.e., not included in the state Medicaid plan), then the grant can pay 100%.

May 5, 2004 Posting

**63. Can Medicaid Infrastructure Grant funds be used as the state's portion of the FMAP for medical services?**

No. Medicaid Infrastructure Grant funds are not available to provide direct services, especially medical assistance.

**64. We are formulating a proposal in which our state would like to form a private/public partnership in assessing the cost-effectiveness of early intervention services for at-risk employees. The solicitation states that CMS will reimburse at a State's FMAP for "medical assistance services included in the state's Medicaid plan for the optionally categorical needy population".**

We would like to ask these questions:

**a. Do these medical assistance services have to be provided by the State's Medicaid program?**

If you mean within the state's Medicaid administrative structure, the answer is that the Demo must be handled separately from the Medicaid program. If you mean can it use the State's provider network the answer is, "yes."

**b. Will CMS reimburse at FMAP for purchasing the monthly insurance premium for private health coverage (that is equivalent to the coverage in the Medicaid state plan) instead of enrolling the participant in the State's Medicaid program? If so, can an insurance carrier and/or an employer contribute the non-CMS portion of the monthly premium cost of a participant?**

If you are suggesting that the participant would be otherwise eligible for Medicaid (including under the Buy-In), the answer is, "no." If you mean can these funds be used to contribute to a privately administered insurance plan, along with the employer and the participant, the answer is, "yes."

**c. Would CMS also provide FMAP for the participant's co-payments?**

No.

**d. Is the amount the employer would have paid for health insurance (for example, \$200 monthly) be collected and applied against the total cost of the private insurance being purchased for participants (for example, \$800 monthly), so that CMS reimburses at FMAP the remainder (\$600 monthly)? This would then constitute a three way financial participation in the cost of the monthly premium.**

In other words, the employer pays \$200 per month; the grant pays \$300 per month; and the non-federal source picks up the remaining \$300 (assuming a 50 percent rate for the state). Much of this example depends upon the larger design of the project, but such an arrangement would be possible.

- e. **We also have a question regarding a different design: could participants receive Medicaid coverage from a State's Medicaid program by paying a monthly co-pay (similar to our Medicaid buy-in program) that is partially reimbursed (FMAP) by the grant, with the remaining contributed by private sources? If so, could the monthly co-pay amount be on an income-based sliding scale?**

Keeping in mind that individuals participating in the demonstration cannot be eligible for Medicaid, the answer is, "yes." Co-pay amounts can be on an income-based sliding fee scale.

- 65. We realize that states cannot set a limit on a demonstration enrollee's income. However, can states establish minimum income thresholds for enrollment? The solicitation uses SGA as an example of a minimum threshold, but are states free to establish other minimum thresholds? Can we target enrollees at various income levels?**

Yes, so long as you do not go below the minimum threshold of 40 hours per month at the prevailing minimum wage. Yes, you can target enrollees at various income levels so long as you do not weaken the overall design of the demonstration in the process.

- 66. Will CMS be willing to negotiate with states regarding the final award amounts of the grants? For example, if a state submits a good proposal and CMS has concerns about the amount requested, will CMS negotiate with that state or will it simply deny the proposal?**

Yes, we will negotiate. The key will be the quality of the design and the quality of the program budget. Without a clear and detailed budget document, we will be unable to negotiate.

#### **May 18, 2004 Posting**

- 67. Can funding come from insurance companies?**

Yes; however, it cannot come from Health Management Organizations as they are provider organizations and may not contribute. See section 1903(w) of the Social Security Act.

- 68. You want us to collect service costs but what exactly do you want in managed care vs. fee-for-service? Is it the per-member-per-month rate or service costs for each individual?**

Because this is a demonstration project, it is critical that projects provide data on actual service utilization and costs for each individual.

- 69. In our high risk pool we have a 20% discount for medical providers. Can we use this or similarly, the Medicaid negotiated rate for service providers?**

Yes you may, but nothing in the grant conditions requires you to do so.

**70. If providers will accept the federal share without any non-federal share, can they participate?**

Such an arrangement amounts to a voluntary or involuntary contribution by the provider to the State, which ultimately administers the grant, and is therefore treated as a donation. Such donations are severely limited by 42 CFR 433.54 even though this demonstration is separate from Medicaid.

**71. You say that no funding can come from medical providers. What is the definition of a provider?**

A health care provider is an individual or organization that receives any payment or payments for health care items or services provided. Nor can funding come from an entity related to a health care provider, including an HMO or association, corporation, or partnership formed by or on behalf of a health care provider. (42 CFR 433.52)

**72. In their proposals, must states discuss what will happen to enrollees after the demonstration period ends? If so, in what detail?**

No; however, it might be helpful to reviewers.

**73. Can you clarify what is meant by "medical assistance and other support costs" in Question 18? Can medical assistance costs mean either a capitation rate or line item costs? Can states use encounter data or do actual service costs need to be delineated?**

Medical assistance includes those services defined in the State Medicaid plan. Other support services would be those services and supports provided to participants that are beyond the state plan, for example, career counseling. It will be critical to the evaluation of these demonstration projects that accurate information is provided as to the actual services provided and the costs and reimbursements for these services. We are concerned that use of a capitation rate may mask the true costs of the demonstration, particularly if non-demonstration covered individuals are used to determine the rate.

**May 20, 2004 Posting**

**74. Will states be expected to gather data on expenditures that are related to a demonstration enrollee's employer-based insurance coverage?**

It would seem that this information would be valuable to the overall understanding of the health costs for the individual. This information would also be important to determine the respective shares of the individual's health care to be covered by the private insurance and the grant.

**75. Can you more clearly define the data elements "job type" and "employer type" mentioned under Section #9: Data Collection?**

For job type use the Department of Labor Standard Occupational Classification System (SOC) and for employer type use the Standard Industrial Classification System (SIC).

**76. Revision to the answer to question 45. regarding the supplantation of state funds.**

Please see the revision to CMS response to question 45.

**77. Can we use the Medicaid population as the control group?**

No. Both the control and study group would have to be employed, not be eligible for Medicaid or Supplemental Security Income.

**78. The announcement directs states to project Medicaid costs of the program participants in developing the budget. Does this mean that the FMAP monies come out of the project budget? If so, is the money in that line "locked into" FMAP if those costs prove to be less than projected, or can they be used toward services that are 100% federally funded?**

The budget preparation guidance is provided on page 24 of the solicitation. Section B of Form 424A can be used to break out the state Medicaid plan services, other medical services, other services and supports, administration, evaluation, and other costs (if necessary). Yes, you must budget for the expenses to which the FMAP is applied. Medical and non-medical services will be reimbursed quarterly based on actual expenditures. Unlike many grants, this demonstration is cost reimbursable and is not budget driven. CMS will look very carefully at the project budget to ensure that the estimates of service costs are realistic and well-documented.

**June 18, 2004 Posting**

**79. Can CMS assure the state that people in the intervention group who are in a high deductible plan, with demonstration services as a wraparound, will still be able to participate in HSAs (Health Savings Accounts)?**

No, CMS cannot provide such an assurance. The solicitation and the enabling legislation are silent on HSAs. CMS has no control over the Health Savings Account Title of the Medicaid Modernization Act. Title XII amends the Internal Revenue Code.

**80. If CMS does re-release the Demo solicitation this year, will states that have already been awarded a grant be able to reapply for purposes of expanding the demonstration to additional populations?**

No. CMS is not favorably disposed to having two demonstration grants operating in one state at the same time. CMS would prefer that the additional population be included in a single grant.