

§ 423.904

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the State for the fiscal year in which the month occurs.

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 20509, Apr. 15, 2008]

§ 423.904 Eligibility determinations for low-income subsidies.

(a) *General rule.* The State agency must make eligibility determinations and redeterminations for low-income premium and cost-sharing subsidies in accordance with subpart P of part 423.

(b) *Notification to CMS.* The State agency must inform CMS of cases where eligibility is established or redetermined, in a manner determined by CMS.

(c) *Screening for eligibility for Medicare cost-sharing and enrollment under the State plan.* States must—

(1) Screen individuals who apply for subsidies under this part for eligibility for Medicaid programs that provide assistance with Medicare cost-sharing specified in section 1905(p)(3) of the Act.

(2) Offer enrollment for the programs under the State plan (or under a waiver of the plan) for those meeting the eligibility requirements.

(d) *Application form and process—(1) Assistance with application.* No later than July 1, 2005, States must make available—

(i) Low-income subsidy application forms;

(ii) Information on the nature of, and eligibility requirements for, the subsidies under this section; and

(iii) Assistance with completion of low-income subsidy application forms.

(2) *Completion of application.* The State must require an individual or personal representative applying for the low-income subsidy to—

(i) Complete all required elements of the application and provide documents, as necessary, consistent with paragraph (d)(3) of this section; and

(ii) Certify, under penalty of perjury or similar sanction for false statements, as to the accuracy of the information provided on the application form.

(3) *The application process and States.*
(i) States may require submission of statements from financial institutions for an application for low-income subsidies to be considered complete; and

(ii) May require that information submitted on the application be subject to verification in a manner the State determines to be most cost-effective and efficient.

(4) *Other information.* States must provide CMS with other information as specified by CMS that may be needed to carry out the requirements of the Part D prescription drug benefit.

§ 423.906 General payment provisions.

(a) *Regular Federal matching.* Regular Federal matching applies to the eligibility determination and notification activities specified in § 423.904(a) and (b).

(b) *Medicare as primary payer.* Medicare is the primary payer for covered drugs for Part D eligible individuals. Medical assistance is not available to full-benefit dual eligible individuals, including those not enrolled in a Part D plan, for—

(1) Part D drugs; or

(2) Any cost-sharing obligations under Part D relating to Part D drugs.

(3) The effective date of paragraphs (b)(1) and (b)(2) of this section is January 1, 2006.

(c) *Noncovered drugs.* States may elect to provide coverage for outpatient drugs other than Part D drugs in the same manner as provided for non-full benefit dual eligible individuals or through an arrangement with a prescription drug plan or a MA-PD plan.

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 20509, Apr. 15, 2008]

§ 423.907 Treatment of territories.

(a) *General rules.* (1) Low-income Part D eligible individuals who reside in the territories are not eligible to receive premium and cost-sharing subsidies under subpart P of this part.

(2) A territory may submit a plan to the Secretary under which medical assistance is to be provided to low-income individuals for the provision of covered Part D drugs.

(3) Territories with plans approved by the Secretary will receive increased grants under section 1935(e)(3) of the Act as described in paragraph (c) of this section.

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(b) *Plan requirements.* Plans submitted to the Secretary must include the following:

(1) A description of the medical assistance to be provided.

(2) The low-income population (income less than 150 percent of the Federal poverty level) to receive medical assistance.

(3) An assurance that no more than 10 percent of the amount of the increased grant will be used for administrative expenses.

(c) *Increased grant amounts.* The amount of the grant provided under section 1108 (f) of the Act as increased by section 1108 (g) of the Act for each territory with an approved plan for a year is the amount in paragraph (d) of this section multiplied by the ratio of—

(1) The number of individuals who are entitled to benefits under Part A or enrolled under Part B and who reside in the territory (as determined by the Secretary based on the most recent available data for the beginning of the year); and

(2) The sum of the number of individuals in all territories in paragraph (c)(1) of this section with approved plans.

(d) *Total grant amount.* The total grant amount is—

(1) For the last three quarters of fiscal year 2006, \$28,125,000;

(2) For fiscal year 2007, \$37,500,000; and

(3) For each subsequent year, the amount for the prior fiscal year increased by the annual percentage increase described in § 423.104(d)(5)(iv).

§ 423.908. Phased-down State contribution to drug benefit costs assumed by Medicare.

This subpart sets forth the requirements for State contributions for Part D drug benefits based on full-benefit dual eligible individual drug expenditures.

§ 423.910 Requirements.

(a) *General rule.* Each of the 50 States and the District of Columbia is required to provide for payment to CMS a phased-down contribution to defray a portion of the Medicare drug expenditures for individuals whose projected Medicaid drug coverage is assumed by Medicare Part D.

(b) *State contribution payment—*

(1) *Calculation of payment.* The State contribution payment is calculated by CMS on a monthly basis, as indicated in the following chart. For States that do not meet the monthly reporting requirement for the monthly enrollment reporting, the State contribution payment is calculated using a methodology determined by CMS.

ILLUSTRATIVE CALCULATION OF STATE PHASED-DOWN MONTHLY CONTRIBUTION FOR 2006

	Item	Illustrative Value	Source
(i)	Gross per capita Medicaid expenditures for prescription drugs for 2003 for full-benefit dual eligibles not receiving drug coverage through a comprehensive Medicaid managed care plan, excluding drugs not covered by Part D.	\$2,000	CY MSIS data
(ii)	Aggregate State rebate receipts in calendar year 2003	\$100,000,000	CMS-64
(iii)	Gross State Medicaid expenditures for prescription drugs in calendar year 2003.	\$500,000,000	CMS-64
(iv) ...	Rebate adjustment factor	0.2000	(2) ÷ (3)
(v)	Adjusted 2003 gross per capita Medicaid expenditures for prescription drugs for full-benefit dual eligibles not in comprehensive managed care plans.	\$1,600	(1) × [1 - (4)]
(vi) ...	Estimated actuarial value of prescription drug benefits under comprehensive capitated managed care plans for full-benefit dual eligibles for 2003.	\$1,500	To be Determined
(vii) ...	Average number of full-benefit dual eligibles in 2003 who did not receive covered outpatient drugs through comprehensive Medicaid managed care plans.	90,000	CY MSIS data
(viii) ..	Average number of full-benefit dual eligibles in 2003 who received covered outpatient drugs through comprehensive Medicaid managed care plans.	10,000	CY MSIS data
(ix) ...	Base year State Medicaid per capita expenditures for covered Part D drugs for full-benefit dual eligible individuals (weighted average of (5) and (6)).	\$1,590	[(7) × (5) + (8) × (6)] ÷ [(7) + (8)]