

§ 423.906

42 CFR Ch. IV (10–1–12 Edition)

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.

(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