

§ 423.894

sponsor agreement is assigned is subject to all applicable statutes and regulations and to the terms and conditions of the sponsor agreement.

§ 423.894 Construction.

Nothing in this part must be interpreted as prohibiting or restricting:

(a) A Part D eligible individual who is covered under employment-based retiree health coverage, including a qualified retiree prescription drug plan, from enrolling in a Part D plan;

(b) A sponsor or other person from paying all or any part of the monthly beneficiary premium (as defined in § 423.286) for a Part D plan on behalf of a retiree (or his or her spouse or dependents);

(c) A sponsor from providing coverage to Part D eligible individuals under employment-based retiree health coverage that is—

(1) Supplemental to the benefits provided under a Part D plan; or

(2) Of higher actuarial value than the actuarial value of standard prescription drug coverage (as defined in § 423.104(d)); or

(d) Sponsors from providing for flexibility in the benefit design and pharmacy network for their qualified retiree prescription drug coverage, without regard to the requirements applicable to Part D plans under § 423.104, as long as the requirements under § 423.884 are met.

Subpart S—Special Rules for States—Eligibility Determinations for Subsidies and General Payment Provisions

§ 423.900 Basis and scope.

(a) *Basis.* This subpart is based on sections 1935(a) through (d) of the Act as amended by section 103 of the MMA.

(b) *Scope.* This subpart specifies State agency obligations for the Part D prescription drug benefit.

§ 423.902 Definitions.

The following definitions apply to this subpart:

Actuarial value of capitated prescription drug benefits is the estimated actuarial value of prescription drug benefits provided under a comprehensive

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Medicaid managed care plan per full-benefit dual eligible individual for 2003, as determined using data as the Secretary determines appropriate. This value will be established using data determined by the Secretary to be the best available among the following options:

(1) State rate setting documentation for drug costs to the full dual eligible population;

(2) State encounter and enrollment record databases including cost data; and

(3) State managed care plan-specific financial cost data; and

(4) Other appropriate data.

Applicable growth factor for each of 2004, 2005, and 2006, is the average annual percent change (to that year from the previous year) of the per capita amount of prescription drug expenditures (as determined based on the most recent National Total Drug National Health Expenditure projections for the years involved). The growth factor for 2007 and succeeding years will equal the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals for the 12-month period ending in July of the previous year, as described in § 423.104(d)(5)(iv). CMS provides further detail regarding the sources of data to be used and how the annual percentage increase will be determined via operational guidance to States.

Base year Medicaid per capita expenditures are equal to the weighted average of:

(1) The gross base year (calendar year 2003) per capita Medicaid expenditures for prescription drugs, reduced by the rebate adjustment factor; and

(2) The estimated actuarial value of prescription drug benefits provided under a comprehensive capitated Medicaid managed care plan per full-benefit dual eligible for 2003. The per capita payments for full-benefit dual eligibles with comprehensive managed care and non-managed care are weighted by the respective average monthly full dual eligible enrollment populations reported through the Medicaid Statistical Information System (MSIS).