

“benchmark” or “benchmark-equivalent.”

(b) *Limitations.* A State may only apply the option in paragraph (a) of this section for an individual whose eligibility is based on an eligibility category under section 1905(a) of the Act that would have been covered under the State’s plan on or before February 8, 2006.

(c) A State may not require but may offer enrollment in benchmark or benchmark-equivalent coverage to the Medicaid eligible individuals listed in § 440.315. States allowing individuals to opt in must be in compliance with the rules specified at § 440.320.

(d) Any State that opts to offer alternative benchmark or benchmark-equivalent coverage to Medicaid beneficiaries must secure public input prior to the submission of any State plan amendment to CMS.

(e) In implementing benchmark or benchmark-equivalent package, States must comply with the managed care rules at section 1932 of the Act and part 438 of this chapter if benchmark or benchmark-equivalent benefits are provided through managed care plans unless the State demonstrates that such requirements are impractical in the context of, or inconsistent with, methods of offering coverage appropriate to meet the health care needs of the targeted population.

#### § 440.310 Applicability.

(a) *Enrollment.* The State may require “full benefit eligible” recipients not excluded in § 440.315 to enroll in benchmark or benchmark-equivalent coverage.

(b) *Full benefit eligible.* A recipient is a full benefit eligible if determined by the State to be eligible to receive the standard full Medicaid benefit package under the approved State plan if not for the application of the option available under this subpart.

#### § 440.315 Exempt individuals.

For recipients within one (or more) of the following categories, the State plan may offer, but may not require under § 440.310, the opportunity to obtain benefits through enrollment in benchmark or benchmark-equivalent coverage:

(a) The recipient is a pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act.

(b) The recipient qualifies for medical assistance under the State plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

(c) The recipient is entitled to benefits under any part of Medicare.

(d) The recipient is terminally ill and is receiving benefits for hospice care under title XIX.

(e) The recipient is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual’s income required for personal needs.

(f) The recipient is medically frail or otherwise an individual with special medical needs. For these purposes, the State’s definition of individuals with special needs must at least include those individuals described in § 438.50(d)(3) of this chapter.

(g) The recipient qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

(h) The recipient is an individual with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

(i) The recipient qualifies for medical assistance on the basis of eligibility to receive assistance under a State plan funded under part A of title IV (as in effect on or after welfare reform effective date defined in section 1931(i) of the Act). This provision relates to

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those individuals who qualify for Medicaid solely on the basis of qualification under the State's TANF rules.

(j) The recipient is a woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(a) of the Act.

(k) The recipient qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

(l) The recipient is not a qualified alien (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) and receives care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

(m) The recipient is determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

**§ 440.320 State plan requirements: Optional enrollment for exempt individuals.**

(a) *General rule.* A State plan that offers exempt individuals as defined in § 440.315 the option to enroll in benchmark or benchmark-equivalent coverage must identify in its State plan the exempt groups for which this coverage is available, and must comply with the following provisions:

(1) In any case in which the State offers an exempt individual the option to obtain coverage in a benchmark or benchmark-equivalent benefit package, the State must effectively inform the individual prior to enrollment that the enrollment is voluntary and that the individual may opt out of the benchmark or benchmark-equivalent coverage at any time and regain immediate access to standard full Medicaid coverage under the State plan.

(2) Prior to any enrollment in benchmark or benchmark-equivalent coverage, the State must inform the exempt recipient of the benefits available under the benchmark or benchmark-equivalent benefit package and provide a comparison of how they differ from the benefits available under the standard full Medicaid program.

(3) The State must document in the exempt recipient's eligibility file that the recipient was informed in accordance with this section prior to enrollment, was given ample time to arrive at an informed choice, and voluntarily chose to enroll in the benchmark or benchmark-equivalent benefit package.

(4) For individuals who the State determines have become exempt individuals while enrolled in benchmark or benchmark-equivalent coverage, the State must comply with the requirements in paragraphs (a)(1) through (a)(3) of this section within 30 days after such determination.

(b) *Disenrollment or Opt/Out Process.*

(1) The State must act upon requests promptly for exempt individuals who choose to opt out of benchmark or benchmark-equivalent coverage.

(2) The State must have a process in place to ensure that exempt individuals have continuous access to services while opt out requests are being processed.

**§ 440.325 State plan requirements: Coverage and benefits.**

Subject to requirements in § 440.345 and § 440.365, States may elect to provide any of the following of types of health benefits coverage:

(a) Benchmark coverage in accordance with § 440.330.

(b) Benchmark-equivalent coverage in accordance with § 440.335.

**§ 440.330 Benchmark health benefits coverage.**

Benchmark coverage is health benefits coverage that is equal to the coverage under one or more of the following benefit plans:

(a) *Federal Employees Health Benefit Plan Equivalent Coverage (FEHBP—Equivalent Health Insurance Coverage).* A benefit plan equivalent to the standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in and offered to Federal employees under 5 U.S.C. 8903(1).

(b) *State employee coverage.* Health benefits coverage that is offered and generally available to State employees in the State.

(c) *Health maintenance organization (HMO) plan.* A health insurance plan