involved in the individual case under consideration. The burden is on the employee to demonstrate that the applicable waiver standard has been met.

§ 309.20 Compromise.

Peace Corps may attempt to effect compromise in accordance with the standards set forth in the FCCS (31 CFR part 902).

§ 309.21 Suspension of collection.

Suspension of collection action shall be made in accordance with the standards set forth in the FCCS (31 CFR 903.1–903.2).

§ 309.22 Termination of collection.

Termination of collection action shall be made in accordance with the standards set forth in the FCCS (31 CFR 903.1 and 903.3–903.4).

§ 309.23 Discharge.

Once a debt has been closed out for accounting purposes and collection has been terminated, the debt is discharged. Peace Corps will report discharged debt as income to the debtor to the Internal Revenue Service per 26 U.S.C. 6050P and 26 CFR 1.6050P–1.

§ 309.24 Bankruptcy.

Peace Corps generally terminates collection activity on debts that have been discharged in bankruptcy unless otherwise provided for by bankruptcy law. The CFO will seek legal advice by the General Counsel's office if there is the belief that any claims or offset may have survived the discharge of a debtor.

Dated: February 15, 2008.

Tyler S. Posey,

General Counsel.

[FR Doc. E8–3268 Filed 2–21–08; 8:45 am]

BILLING CODE 6015–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 440

[CMS–2232–P]

RIN 0938–A048

Medicaid Program; State Flexibility for Medicaid Benefit Packages

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement provisions of section 6044 of the Deficit Reduction Act of 2005, Pub. L. 109–171, which amends the Social Security Act by adding a new section 1937 related to the coverage of medical assistance under approved State plans. Under this new section, States have increased flexibility under an approved State plan to define the scope of covered medical assistance by offering coverage of benchmark or benchmark-equivalent benefit packages to certain Medicaid recipients.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. March 24, 2008.

ADDRESSES: In commenting, please refer to file code CMS–2232–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2232–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2232–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Donna Schmidt, (410) 786–5532.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2232–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Under title XIX of the Social Security Act (the Act), the Secretary is

authorized to provide funds to assist States in furnishing medical assistance to needy individuals whose income and resources are insufficient to meet the costs of necessary medical services, including families with dependent children and individuals who are aged, blind, or disabled. To be eligible for funds under this program, States must submit a State plan, which must be approved by the Secretary. Programs under title XIX are jointly financed by Federal and State governments. Within broad Federal guidelines, each State determines the design of its program, eligible groups, benefit packages, payment levels for coverage and administrative and operating procedures.

Before the passage of the Deficit Reduction Act (DRA), States were required to offer at minimum a standard benefit package to eligible populations identified in section 1902(a)(10)(A) of the Act (with some specific exceptions, for example, for certain pregnant women, who could be limited to pregnancy-related services). Under section 1902(a)(10)(A) of the Act, this standard benefit package had to include certain specific benefits identified in the definition of ''medical assistance'' at section 1905(a) of the Act. These identified benefits include inpatient and outpatient hospital services, physician services, medical and surgical services furnished by a dentist, rural health clinic services, federally qualified health center services, laboratory and X-ray services, nursing facility services, early and periodic screening, diagnostic and treatment services for individuals under age 21, family planning services to individuals of child-bearing age, nurse-midwife services, certified pediatric nurse practitioner, and certified family nurse practitioner services. Under section 1902(a)(10)(D) of the Act, the standard benefit package is also required to include home health services.

Section 6044 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted on February 8, 2006), amended the Act by adding a new section 1937 that allows States to amend their Medicaid State plans to provide for the use of benefit packages other than the standard benefit package, namely benchmark benefit packages or benchmark-equivalent packages, for certain populations. The statute delineates what benefit packages qualify as benchmark packages and what would constitute a benchmark-equivalent package. The statute also specifies those exempt populations that may not be included or mandated in the benchmark coverages. To be eligible for funds under this new provision, States must submit a State plan amendment, which must be approved by the Secretary.

This proposed rule would incorporate and integrate into Centers for Medicare & Medicaid Services (CMS) regulations the statutory framework for alternative benchmark packages.

II. Provisions of the Proposed Rule

[If you choose to comment on issues in this section, please include the caption ''PROVISIONS OF THE PROPOSED RULE'' at the beginning of your comments.]

By creating section 1937 of the Act, we believe the Congress intended to provide States unprecedented flexibility within Medicaid State Plans to provide health benefits coverage. This authority, created by section 6044 of the DRA, allows States broad flexibility to develop innovative health coverage plans for Medicaid recipients. States may create more mainstream packages like those found in the private insurance market by implementing health benefit packages mirroring employer sponsored group health plans.

These flexibilities give States new opportunities to provide benefit plans to meet the health care needs of Medicaid populations while maintaining the sustainability of the program. For the first time in the State plan, States may create innovative Medicaid programs that further strengthen and support the overall health care system. States now have the tools they need to provide person-centered care to maximize health outcomes for individuals. These tools may be used in conjunction with other title XIX and XXI authorities and other programs, to strategically align the Medicaid Program with today's healthcare environment to expand access to affordable mainstream coverage; to promote personal responsibility for health and accessing health care; and to improve quality and coordination of care.

The enactment of this provision of the DRA gave States new options to create programs that are more aligned with the needs of today's Medicaid populations and the health care environment. States may use this flexibility to capitalize on the strengths of their existing health care systems by incorporating and building upon the private insurance market. Additionally, we encourage States to use these flexibilities to shape innovations in the health care marketplace. The authority under this provision creates great opportunities for States to focus the health care system on delivering person-centered health care for all individuals. States will be able to reconnect families receiving health care through Medicaid to the larger insurance system that serves most Americans and promote continuity of coverage. This in turn will strengthen the private market and assist in creating better access to health care in the State.

Section 1937 of the Act gives States greater control over the administration of their Medicaid programs by moving innovative programs into State plans. This in turn, provides States with ease in leveraging the private market forces to provide care to Medicaid recipients in much the same way this care is provided to those with benefits through private insurance.

We began issuing guidance about the new flexibilities available to States within months of the enactment of the DRA. For example, on March 31, 2006, we issued a State Medicaid Director letter providing guidance on the implementation of section 6044 of the DRA. This proposed rule is consistent with that guidance.

Under section 1937 of the Act, a State may require that medical assistance to individuals, within one or more groups of individuals specified by the State, be provided through enrollment in a benchmark or benchmark-equivalent benefit coverage package. A State has the option to amend its State plan to provide benchmark or benchmark-equivalent coverage without regard to comparability, statewideness, freedom of choice, the assurance of transportation to medically necessary services and other requirements in order to tailor and provide the coverage to the individuals. The purpose of this section, as indicated in the title of section 6044 of the DRA, was to provide States with increased flexibility. In order to maximize that flexibility, we are proposing to interpret the statutory clause ''notwithstanding any other provision of this title'' to relieve States of the responsibility to assure transportation to and from providers, which is the regulatory requirement at 42 CFR 431.53 that is based on sections 1902(a)(4) and 1902)(a)(19) of the Act. The statute provides benchmark options available to States that are equivalent to those found in the private health insurance market. Generally, private health insurance plans do not offer non-emergency medical transportation as a benefit to enrollees. It would be a strong disincentive for States to offer benchmark coverage through private health insurance plans if States had to supplement benchmark benefit plans with additional transportation benefits. We are therefore proposing to exempt States that elect benchmark coverage from the transportation assurance requirement. This provides maximum

flexibility to states and is consistent with the stated purpose of section 6044.

Populations Affected. Benchmark or benchmark-equivalent coverage packages may only be offered to individuals whose eligibility is based on an eligibility category of the Act that would have been covered under the State's plan on or before the enactment of the DRA on February 8, 2006. We are interpreting the statutory term ''eligibility category'' in this rule to mean an eligibility category listed under section 1905(a) of the Act, in order to maximize State flexibility. All recipients within a covered category would be eligible to participate in a benchmark plan at the State's option, unless specifically exempted by statute as discussed below, even when the State makes modifications to the income and resource eligibility levels for a group or groups under such an eligibility category after February 8, 2006.

A State may require recipients to obtain benefits by enrolling in benchmark or benchmark-equivalent coverage only if they are ''full benefit eligibles.'' A full benefit eligible is an individual who would otherwise be eligible to receive the standard full Medicaid benefit package under the approved Medicaid State plan, but does not include individuals determined eligible by the State for medical assistance under section 1902(a)(10)(C) of the Act, or by reason of section 1902(f) of the Act, or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care (medically needy and spend-down populations).

The statute also specifies other individuals who are also exempt from being required to enroll in benchmark or benchmark-equivalent benefit coverage. These individuals include:

- A pregnant woman who is required to be covered under the State plan under section 1902(a)(10)(A)(i) of the Act;
- A recipient qualifying 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 (SSI) 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;
- A recipient entitled to benefits under any part of Medicare;
- A terminally ill recipient receiving benefits for hospice care under title XIX;
- A recipient who 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 such 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;
- A recipient who is medically frail or otherwise an individual with special medical needs (as described by the Secretary);
- A recipient qualifying based on medical condition for medical assistance for long-term care services described in section 1917 (c)(1)(C) of the Act;
- A recipient with respect to whom aid or assistance is made available under part B of title IV to children in foster care or with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age;
- A recipient qualifying 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);
- Recipients eligible based on the diagnosis of breast or cervical cancer by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act; and
- Recipients who receive limited services because they are eligible only under section 1902(a)(10)(A)(ii)(XII) of the Act because they are TB-infected, or because they are not qualified aliens (as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (Pub. L. 104–193, enacted on August 22, 1996) and receive only the care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

For purposes of the exempted populations under section 1937 of the Act, the Secretary is proposing in § 440.315(f) to define individuals with special medical needs to include those groups defined by Federal regulations at 42 CFR 438.50(d)(1) and §438.50(d)(3) of the managed care regulations. These groups are: dual eligibles and certain children under age 19 who are eligible for Supplemental Security Income (SSI); children eligible under section 1902(e)(3) of the Act/Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) children; individuals in foster care or other out of home placement; individuals receiving foster care or adoption assistance; or individuals receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, as defined by the State in terms of either program participation or special health care needs.

There may be instances when an exempted individual may benefit from enrolling in a benchmark or benchmark-equivalent benefit package. States are permitted to offer these individuals a benchmark or benchmark-equivalent package, but may not require them to enroll in one. In any case in which a State offers an individual the option to enroll in a benchmark or benchmark-equivalent benefit package, the State must inform the individual that the enrollment is voluntary and that he or she may opt out at any time. In addition, the State must inform the individual of the benefits available under the benchmark or benchmark-equivalent benefit package, provide a comparison of how they differ from the benefits available under the regular Medicaid program, and must document that the individual was informed.

Generally, we would expect that the benchmark or benchmark equivalent plan would have sufficient enrollment capacity for eligible individuals. However, there may be circumstances when it is beneficial for the State to limit enrollment or when the benchmark or benchmark-equivalent plan would not have the capacity to enroll all interested and eligible individuals. In these instances, the State would maintain selection criteria for such plans based on factors such as geography or date of application that are not related to health status. The State would provide otherwise available benefits to individuals under the State plan, which may include the option of enrolling in another benchmark or benchmark-equivalent plan. And, if applicable, the State would have a system under which recipients already enrolled in the benchmark or benchmark equivalent plan are given priority to continue enrollment if the plan does not have the capacity to accept all those seeking enrollment under the program.

Benefit Packages. Under section 1937 of the Act, benchmark coverage is either Federal Employees Health Benefit Plan Equivalent Health Insurance Coverage; State Employee Coverage; a Health Maintenance Organization (HMO) plan that has the largest insured commercial, non-Medicaid enrollment in the State; or Secretary approved coverage. Secretary approved coverage is any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate

coverage for the population proposed to be provided this coverage.

In determining the coverage available under a benchmark coverage package, we do not consider cost sharing to be a limitation on the coverage (even when the benchmark plan itself does so). Thus, for example, if the selected benchmark plan document indicates that it provides coverage for only half of the cost of mental health services, we view that as a coinsurance requirement rather than as a limitation on coverage. Cost sharing and premiums for recipients may not exceed cost sharing limits under the State's plan with respect to sections 1916 and 1916A of the Act. The State would assure that all out of pocket costs for the recipients do not exceed the applicable limits. However, benchmark and benchmark-equivalent benefit packages may include annual coverage limitations on the numbers and types of particular services.

In determining whether a proposed health benefits coverage package should be Secretary approved because it provides appropriate health benefits coverage for the proposed population, we would require that States submit full descriptions of the proposed coverage, including comparisons to one of the benchmark plans or to the State's standard full Medicaid coverage package under section 1905(a) of the Act. In addition, the State would submit any other information that would be relevant to a determination that the proposed health benefits coverage would be appropriate for the proposed population. The scope of a Secretary-approved health benefits package will be limited to benefits within the scope of the categories available under a benchmark coverage package or the standard full Medicaid coverage under section 1905(a) of the Act.

In determining Secretary approved coverage, a State may consider a benefit package for a specific population that excludes a certain category of service. For example, a State may utilize a Secretary approved package that is benchmarked to the State employees benefit package which does not include pregnancy-related services. This would be appropriate where the targeted population is a population group that does not require such category of service—for instance non-pregnant adults. If an individual within the targeted population group enrolled in the Secretary approved benefit was initially eligible through a category targeted for the Secretary approved coverage, but later qualified for Medicaid through a group excluded from mandatory enrollment (e.g., non-pregnant female enrolled in the Secretary approved benefit becomes pregnant and qualifies under the State plan under section 1902(a)(10)(A)(i)), such individual must have the opportunity to receive state plan services not available through the benchmark and must be given the choice to remain in the Secretary approved benchmark or revert to traditional Medicaid. In either event, the individual must be provided the State plan services not available through the benchmark through either wrap around coverage to the Secretary approved benefit or by virtue of reverting back to traditional Medicaid.

A State may elect to offer one or more benchmark coverage options. The State may also specify in the State plan criteria establishing the benchmark options, if any, available for any specific group of recipients. For example, the State plan may identify groups of recipients who receive benefits through a Federal Employees Health Benefit Plan (FEHBP) benchmark coverage plan and may identify other groups who receive benefits through a State Employee Coverage benchmark coverage plan.

A State may also elect to offer benchmark-equivalent benefit coverage. Coverage would be considered benchmark-equivalent coverage if it has an aggregate actuarial value equivalent to a benchmark plan described above, and it includes the following basic categories of service: inpatient and outpatient hospital services; physicians' surgical and medical services; laboratory and x-ray services; well-baby and well-child care, including age-appropriate immunizations; and other appropriate preventive services.

In addition to the categories of services set forth above, benchmark-equivalent coverage may include coverage of additional health benefits in categories of services included in the benchmark package or described in section 1905(a) of the Act. If the benchmark coverage package used by the State as a basis for comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes the following four categories of services: prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State. If the benchmark coverage package does not cover one of the additional four categories of services, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

As a condition of approval of benchmark-equivalent coverage, the State must provide an actuarial report with an actuarial opinion that the benchmark-equivalent coverage meets the actuarial requirements.

Benchmark or benchmark-equivalent benefit coverage may be offered through employer sponsored health plans for individuals with access to private health insurance. For example, if an individual has access to employer sponsored coverage and that coverage is determined by the State to offer a benchmark or benchmark-equivalent benefit package (either alone or with the addition of wrap-around services covered separately under Medicaid), a State may elect to provide premium payments on behalf of the recipient to purchase the employer coverage. The State may also provide premium payments on behalf of the recipient to purchase private health insurance coverage. The premium payments would be considered medical assistance, the State could require the recipient to enroll in the group health plan, and the resulting coverage would comprise the Medicaid benefit. In addition, cost sharing for recipients should not exceed cost sharing limits under the State's plan with respect to sections 1916 and 1916A of the Act.

The State must make available to recipients under age 19 who are covered under the State plan under section 1902(a)(10)(A) of the Act benefits consisting of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services which are medically necessary for that individual as defined in section 1905(r) of the Act. For those individuals who are enrolled in benchmark coverage, the individual must seek coverage through the benchmark plan before seeking wrap-around benefits from the State. As always, medical necessity as determined by the State guides the delivery of EPSDT services. A State must also assure that individuals in a benchmark or benchmark-equivalent plan have access, through that coverage or otherwise, to rural health clinic services and federally qualified health center (FQHC) services.

Under section 1937(a)(1)(C) of the Act, States have the option to provide additional or wrap-around services to the benchmark or benchmark-equivalent plans. The wrap-around services do not need to include all State plan services. However, the State plan must describe the populations covered and the

procedures for assuring those services. We interpret the term ''additional or wrap-around services'' to mean health benefits that are of the same type as those covered under the benchmark or considered to be health benefits under the Medicaid statute. We propose in § 440.360 that additional or wrap-around services must be within the scope of categories of services covered under the benchmark plan, or described in section 1905(a) of the Act.

Generally, we would expect that the benchmark or benchmark equivalent plan would have sufficient enrollment capacity for eligible individuals. However, because benchmark and benchmark equivalent plans are not bound by comparability, statewideness, freedom of choice, the assurance of transportation to medically necessary services and other requirements of title XIX of the Act, there may be a circumstance, particularly in rural areas, when a plan is not capable of enrolling all interested and eligible individuals. In this instance, the State must have a process for enrolling the individual in an alternate option. If applicable, the State must have a system under which recipients already enrolled in the benchmark or benchmark equivalent plan are given priority to continue enrollment if the plan does not have the capacity to accept all those seeking enrollment under the program.

Program Integrity. We propose to establish in § 440.370 of this regulation that States are required to implement benchmark coverage in a cost effective and efficient manner. While section 1937 of the Act is premised with a provision that states notwithstanding any other provision of this title, we do not believe that the Congress intended to permit States to bypass efficiency and effectiveness rules that were tightened up in other sections of title XIX. Therefore, we are clarifying that States must deliver benchmark benefits in a manner that is cost effective and efficient. States may not use this provision to recycle funds or deliver services to the detriment of the Federal/State partnership. Benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained. In other words, if benchmark coverage is provided on a fee-for-service basis, the same upper payment limits would apply to each service as to these services under standard full Medicaid coverage. Similarly, the same procurement requirements, or other economy or efficiency principles would apply to this coverage as would apply to the purchase of managed care coverage as under the managed care rules at part 438 of our regulations.

To achieve economy and efficiency, States may use a variety of delivery systems for benchmark and benchmark-equivalent coverage. States may furnish benefits using one or more of the following: a fee-for-service delivery system, a fee-for-service delivery system operated with a primary care case management system, a managed care delivery system, or through premium assistance.

The State may use a selective procurement process to restrict the managed care entity or other provider from (or through) whom a recipient can obtain services, except in emergency situations. The selected provider must meet the reimbursement, quality and utilization standards under the State Plan. If a State chooses to selectively contract for the provider of the benchmark or benchmark equivalent plan services, it can do so without any waiver authority, but only to the extent that: (1) The selected provider complies with the reimbursement, quality, and utilization standards under the State plan; (2) the selection process does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing the benchmark benefit package; and (3) all providers are paid on a timely basis in the same manner as health care practitioners must be paid under § 447.45. To the extent that these conditions are met, the State does not need to obtain a waiver under the authority of section 1915(b)(4) of the Act in order to selectively contract.

Requirements Not Applicable. In authorizing implementation of section 1937 of the Act ''notwithstanding any other provision of this title,'' we believe that the Congress intended to permit States to bypass the comparability, statewideness, freedom of choice, the assurance of transportation to medically necessary services and other requirements of title XIX of the Act in order for States to tailor benefit packages appropriate to specified groups of Medicaid recipients.

We believe that the Congress intended for States to have a great amount of flexibility in crafting programs for those populations which may be mandated into a benchmark or benchmark-equivalent plan. We also believe that the Congress intended for those individuals to have health coverage which mirrored that of the coverage millions of Americans receive through employer sponsored plans in the private health insurance market.

Therefore, we propose in § 440.375, § 440.380, § 440.385, and § 440.390 to provide States this flexibility by allowing them to amend their State plans to provide benchmark or benchmark-equivalent coverage without regard to comparability, statewideness, freedom of choice, the assurance of transportation to medically necessary services, and/or other requirements in order to tailor and provide benefits.

Changes to Regulations Text. We propose to add a new subpart C beginning with § 440.300.

Subpart C—Benchmark Packages: General Provisions

Sections 440.300, 440.305, and 440.310 Basis, Scope, and Applicability

At proposed § 440.300 (Basis), § 440.305 (Scope), and § 440.310 (Applicability), the regulations would reflect the new statutory authority for States to provide medical assistance to recipients, within one or more groups of Medicaid eligible recipients specified by the State, through enrollment in benchmark coverage or benchmark-equivalent coverage. A State may only require that individuals obtain benefits by enrolling in that coverage if they are a ''full benefit eligible'' 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, and are not within exempted categories under the statute. The proposed regulatory definition of full benefit eligible individuals would include individuals who would otherwise be eligible to receive the standard full Medicaid benefit package under the approved Medicaid State plan, but would not include individuals within the statutory exceptions for individuals, who are determined eligible by the State for medical assistance under section 1902(a)(10)(C) of the Act, or by reason of section 1902(f) of the Act, or otherwise eligible based on a reduction of income based on costs incurred for medical or other remedial care (other medically needy and spend-down populations).

Section 440.315 Exempt Individuals

Proposed § 440.315 would reflect statutory limitations on mandatory enrollment of specified categories of individuals. A State may not require enrollment in a benchmark or benchmark-equivalent benefit plan by the following individuals:

- The recipient who is a pregnant woman who is required to be covered

under the State plan under section 1902(a)(10)(A)(i) of the Act.

• The recipient who 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 SSI 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.

• The recipient who is entitled to benefits under any part of Medicare.

• The recipient who is terminally ill and is receiving benefits for hospice care under title XIX.

• The recipient who 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 such 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.

• The recipient who is medically frail or otherwise an individual with special medical needs (as described by the Secretary in section 440.315(f)). For purposes of this section, we would propose that individuals with special needs includes those groups defined by Federal regulations at § 438.50(d)(1) and § 438.50(d)(3) of the managed care regulations (that is, dual eligibles and certain children under age 19 who are eligible for SSI; eligible under section 1902(e)(3) of the Act, TEFRA children; in foster care or other out of home placement; or receiving foster care or adoption assistance). We are not proposing a definition for medically frail populations but we invite public comments to assist us in defining this term in the final regulation.

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

• The recipient who receives aid or assistance under part B of title IV for children in foster care or an individual with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

• The recipient who 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 those individuals who qualify for Medicaid solely on the basis of qualification under the Temporary Assistance for Needy Families (TANF) rules (that is, the State links Medicaid eligibility to TANF eligibility).

• 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. This provision relates to those individuals who are eligible for Medicaid based on the breast or cervical cancer eligibility provisions.

• The recipient qualifies for medical assistance as a TB-infected individual on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

• 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 only care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

Section 440.320 State Plan Requirements: Optional Enrollment for Exempt Individuals

At proposed § 440.320, we would allow States to offer exempt individuals specified in § 440.315 the option to enroll into a benchmark or benchmark-equivalent benefit plan. The State plan must identify in its State plan the exempt groups for which this coverage is available. There may be instances in which an exempted individual may benefit from enrolling in a benchmark or benchmark-equivalent benefit package. States are permitted to elect in the State plan to offer exempted individuals a benchmark or benchmark-equivalent package, but States may not require them to enroll in one. For example, in some States the State employee benchmark coverage may be more generous than the State Medicaid plan. Secretary-approved coverage may offer the opportunity for disabled individuals to obtain integrated coverage for acute care and community-based long-term care services. Additionally, States may be able to better integrate disease management programs to provide better coordinated care which targets the specific needs of individuals with special health needs.

Section 440.325 State Plan Requirements: Coverage and Benefits

At proposed § 440.325, we set forth the conditions under which a State may offer enrollment to exempt recipients specified in § 440.315. When a State offers exempt recipients the option to enroll in a benchmark or benchmark-equivalent benefit package, the State must inform the recipients that enrollment is voluntary and that the individual may opt out of the benchmark or benchmark-equivalent benefit package at any time and regain immediate eligibility for the standard full Medicaid program under the State plan. The State must inform the 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. The State must document in the individual's eligibility file that the individual was informed in accordance with this paragraph and voluntarily chose to enroll in the benchmark or benchmark-equivalent benefit package.

At proposed § 440.325, a State would have the option to choose to specify the benchmark or benchmark-equivalent coverage packages offered under the State's Medicaid plan. A State may select one or all of the benchmark plans described in § 440.330 or establish benchmark-equivalent plans described in § 440.335, respectively.

Section 440.330 Benchmark Health Benefits Coverage

At proposed § 440.330, benchmark coverage is described as any one of the following:

• 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).

• State employee coverage. A health benefits plan that is offered and generally available to State employees in the State involved.

• Health Maintenance Organization (HMO) plan. A health insurance plan that is offered through an HMO (as defined in section 2791(b)(3) of the Public Health Service Act) that has the largest insured commercial, non-Medicaid enrollment in the State.

• Secretary approved coverage. Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided that coverage. States wishing to opt for Secretarial approved coverage should submit a full description of the proposed coverage and include a benefit-by-benefit comparison of the proposed plan to one or more of the three benchmark plans specified above or to the State's standard full Medicaid coverage package under section 1905(a) of the Act, as well as a full description of the

population that would be receiving the coverage. In addition, the State should submit any other information that would be relevant to a determination that the proposed health benefits coverage would be appropriate for the proposed population. The scope of a Secretary-approved health benefits package will be limited to benefits within the scope of the categories available under a benchmark coverage package or the standard full Medicaid coverage package under section 1905(a) of the Act.

A State may select one or more benchmark coverage plan options. The State may also specify the benchmark plan for any specific recipient. For example, one recipient may be enrolled in the FEHBP and another may be enrolled into State Employee Coverage at the option of the State.

Section 440.335 Benchmark-Equivalent Health Benefits Coverage

At proposed § 440.335, we would provide that if a State designs or selects a benchmark plan other than those specified in § 440.330, the State must provide coverage that is equivalent to benchmark coverage. Coverage that meets the following requirements will be considered to be benchmark-equivalent coverage:

- Required Coverage. Benchmark-equivalent coverage includes benefits for items and services within each of the following categories of basic services and must include coverage for the following categories of basic services:
  + Inpatient and outpatient hospital services.
  + Physicians' surgical and medical services.
  + Laboratory and x-ray services.
  + ''Well-baby'' and ''well-child'' care, including age-appropriate immunizations.
  + Other appropriate preventive services, as designated by the Secretary.
- Aggregate actuarial value equivalent to benchmark coverage. Benchmark-equivalent coverage must have an aggregate actuarial value, determined in accordance with proposed § 440.340 that is at least equivalent to coverage under one of the benchmark packages outlined in § 440.330.
- Additional coverage. In addition to the categories of services set forth above, benchmark-equivalent coverage may include coverage for any additional services included in the benchmark plan or described in section 1905(a) of the Act.
- Application of actuarial value for benchmark-equivalent coverage that includes prescription drugs, mental health, vision, and hearing services. Where the benchmark coverage package used by the State as a basis for comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes any or all of the following four categories of services: prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State.

If the benchmark coverage package does not cover one of the four categories of services mentioned above, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

Section 440.340 Actuarial Report for Benchmark-Equivalent Health Benefit Coverage

In accordance with 1937(a)(3) of the Act, at proposed § 440.340, we would require a State as a condition of approval of benchmark-equivalent coverage, to provide an actuarial report, with an actuarial opinion that the benchmark-equivalent coverage meets the actuarial requirements of § 440.335.

At proposed § 440.340, we would require the actuarial report to obtain approval for benchmark-equivalent health benefit coverage and to meet all the provisions of the statute. The actuarial report must state:

- The actuary issuing the opinion is a member of the American Academy of Actuaries (AAA) (and meets Academy standards for issuing an opinion).
- The actuary used generally accepted actuarial principles and methodologies of the AAA, standard utilization and price factors and a standardized population representative of the population involved.
- The same principles and factors were used in analyzing the value of different coverage (or categories of services) without taking into account differences in coverage based on the method of delivery or means of cost control or utilization used.
- The report should also state if the analysis took into account the State's ability to reduce benefits because of the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.
- The actuary preparing the opinion must select and specify the standardized set of utilization and pricing factors as well as the standardized population.
- The actuary preparing the opinion must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State's result.

Section 440.345 EPSDT Services Requirement

At proposed § 440.345, we would require States to make available EPSDT services as defined in section 1905(r) of the Act that are medically necessary for those individuals under age 19 who are covered under the State plan. We expect that most benchmark or benchmark equivalent plans will offer the majority of EPSDT services. To the extent that any medically necessary EPSDT services are not covered through the benchmark or benchmark-equivalent plan, States are required to supplement the benchmark or benchmark-equivalent plan in order to ensure access to these services. Individuals mandated into a benchmark or benchmark-equivalent plan and entitled to have access to EPSDT services cannot opt out of the benchmark or benchmark equivalent plan just to receive these services. While individuals are required to have access to such medically necessary services first under the benchmark or benchmark-equivalent plan, the State may provide wrap-around or additional coverage for medically necessary services not covered under such plan. Any wrap-around benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits package, an individual would have coverage for his or her medically necessary services consistent with the requirements under 1905(r) of the Act. The State plan must include a description of how wrap-around benefits or additional services will be provided to ensure that these recipients have access to full EPSDT services under 1905(r) of the Act.

In addition, individuals must first seek coverage of EPSDT services through the benchmark or benchmark equivalent plan before seeking coverage of such through wrap-around benefits.

Section 440.350 Employer Sponsored Insurance Health Plans

At proposed § 440.350, the use of benchmark or benchmark-equivalent benefit coverage would be at the discretion of the State and may be used in conjunction with employer sponsored health plans as a coverage option for individuals with access to private health insurance. Additionally, the use of benchmark or benchmark-equivalent coverage may be used for individuals with access to private health

insurance coverage. For example, if an individual has access to employer sponsored coverage and that coverage is determined by the State to be benchmark or benchmark-equivalent, a State may, at its option, provide premium payments on behalf of the recipient to purchase the employer coverage. Additionally, a State could create a benchmark or benchmark-equivalent plan combining employer sponsored insurance and wrap-around benefits to that employer sponsored insurance benefit package. The premium payments would be considered medical assistance and the State could require the recipient to enroll in the group health plan.

Section 440.355 Payment of Premiums

At proposed § 440.355, payment of premiums by the State, net of beneficiary contributions, to obtain benchmark or benchmark-equivalent benefit coverage on behalf of beneficiaries under this section will be treated as medical assistance under 1905(a) of the Act.

Section 440.360 State Plan Requirement for Providing Additional Wrap-Around Services

At proposed § 440.360, a State may at its option provide additional wrap-around services to the benchmark or benchmark-equivalent plans. The wrap-around services do not need to include all State plan services. However, the State plan must describe the populations covered and the payment methodology for assuring those services. Such additional or wrap-around services must be within the scope of categories of services covered under the benchmark plan, or described in section 1905(a) of the Act.

Section 440.365 Coverage of Rural Health Clinic and Federally Qualified Health Center (FQHC) Services

At proposed § 440.365, a State that provides benchmark or benchmark-equivalent coverage to individuals must assure that the individual has access, through that coverage or otherwise, to rural health clinic services and FQHC services as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Act. Payment for these services must be made in accordance with the payment provisions of section 1902(bb) of the Act.

Section 440.370 Cost Effectiveness

At proposed § 440.370, benchmark or benchmark-equivalent coverage and any additional benefits must be provided in accordance with Federal upper payment limits, procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Section 440.375 Comparability

At proposed § 440.375, a State may at its option amend its State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to comparability.

Section 440.380 Statewideness

At proposed § 440.380, a State may at its option amend its State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to statewideness.

Section 440.385 Freedom of Choice

At proposed § 440.385, a State may at its option amend its State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to freedom of choice. States may restrict recipients to obtaining services from (or through) selectively procured provider plans or practitioners that meet, accept, and comply with reimbursement, quality and utilization standards under the State Plan, to the extent that the restrictions imposed meet the following requirements:

(+) Do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing the benchmark benefit package.

(+) Do not apply in emergency circumstances.

(+) Require that all provider plans are paid on a timely basis in the same manner as health care practitioners must be paid under § 447.45 of the chapter.

Section 440.390 Assurance of Transportation

At proposed § 440.390, a State may at its option amend its State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to the assurance of transportation to medically necessary services requirement specified in section 42 CFR 431.53.

III. Collection of Information Requirements

While the following requirements are subject to the PRA, they are currently approved under OMB# 0938–0993 with an expiration date of October 31, 2009.

Section 440.320 State Plan Requirements: Optional Enrollment for Exempt Individuals

Section 440.320(a)requires a State to: (1) Inform the individuals 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) 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; and, (3) Document in the exempt recipient's eligibility file that the recipient was informed in accordance with this section and voluntarily chose to enroll in the benchmark or benchmark-equivalent benefit package.

Section 440.330 Benchmark Health Benefits Coverage

Section 440.330(d) requires States wishing to opt for Secretarial-approved coverage to submit a full description of the proposed coverage and include a benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified.

Section 440.340 Actuarial Report for Benchmark-Equivalent Coverage

Section 440.340 requires a State trying to obtain approval for benchmark-equivalent health benefits coverage described in 440.335 to submit, as part of its State Plan Amendment, an actuarial report. The report must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State's result.

Section 440.345 Requirement to Provide EPSDT Services

Section 440.345(a)(2) requires a State to include a description in their State Plan of how the wrap-around benefits or additional services will be provided to ensure that recipients receive full EPSDT services. The description must describe the populations covered and the procedures for assuring those services.

Section 440.350 Employer-Sponsored Insurance Health Plans

Section 440.350(b) requires a State to set forth in the State plan the criteria it will use to identify individuals who would be required to enroll in an available group health plan to receive

benchmark or benchmark-equivalent coverage.

Section 440.360 State Plan Requirement for Providing Additional Wrap-Around Services

This section requires States opting to provide additional services to the benchmark-equivalent plans, to describe the populations covered and the payment methodology for these services in their State plan.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132. Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We issued a State Medicaid Director's letter on March 31, 2006 providing guidance on the new flexibilities available to States as a result of the enactment of the Deficit Reduction Act of 2005. This proposed rule simply codifies that guidance. States have already begun implementing this provision well in advance of this proposed rule. As a result, while we anticipate that implementation of this flexibility would be economically significant, the significance is based on the changes authorized by statute and not based on discretionary policies contained in the rule itself. The impact of the rule would be limited to ensuring uniform policies for States that implement the flexibility afforded under section 1937 of the Social Security Act, as added by the Deficit Reduction Act of 2005. The aggregate amount of Federal savings is estimated to be $2.3 billion from FY 2006 through FY 2010.

We have estimated the impact of this rule by analyzing the potential Federal savings related to lower per capita spending that may be achieved if States choose to enroll beneficiaries in eligible populations in plans that are less costly than projected Medicaid costs. To do this, we developed estimates based on the following assumptions:

- The number of eligible beneficiaries and the Federal Medicaid costs of these beneficiaries are based on 2003 Medicaid Statistical Information System (MSIS) data;
- Projections of the number of eligible beneficiaries and their associated Federal Medicaid costs were made using assumptions from the President's Budget 2007, including enrollment growth rates and per capita spending growth rates;
- The relative costs of the new plans allowed under this rule to current Medicaid spending were estimated based on reviews of Medicaid spending data and the plans described in this rule. Additionally, we have assumed that not all States would immediately use the options made available through this rule; therefore, we assume that State use of these plans would continue to increase through 2011. We assume that use in 2006 will be about 10% of 2011-level of use; 40% in 2007; 60% in 2008; 80% in 2009; and 90% in 2010.''

These estimates assume that there will be a negligible impact on State administration costs. As States already have experience in dealing with alternative plan designs, including through waivers or managed care plans, we have assumed States are equipped to implement these plans and will be part of their normal administrative spending.

These estimates are subject to a substantial amount of uncertainty and actual experience may be significantly different. The range of possible experience is greater than under most other rules for the following two reasons. First, this rule provides the option for States to use alternative plans; to the extent that States participate more or less than assumed here (both the number of States that participate and the extensiveness of States' use of these plans), Federal savings may be greater than or less than estimated. Second, this rule also provides a wide range of options for States in designing these plans; to the extent that States use plans that are relatively more or less costly than assumed here, Federal savings may be less than or greater than estimated.

ESTIMATED ANNUAL FEDERAL SAVINGS DISCOUNTED AT 0%, 3% AND 7%—FROM FY 2006 TO FY 2010

[In millions]

Discount rate	2006	2007	2008	2009	2010	Total 2006–2010
0%	$70	$280	$460	$660	$810	$2,280
3%	68	264	421	586	699	2,038
7%	65	245	375	504	578	1,767

We anticipate that States would phase in alternative benefit programs, and changes would not be fully realized until 2010. The majority of savings would be achieved through cost avoidance of future anticipated costs by providing appropriate benefits based on a population's health care needs, appropriate utilization of services, and through gains in efficiencies through contracting. States would be able to take greater advantage of marketplace dynamics within their State. We also anticipate that a number of States will use this flexibility to create programs that are more similar to their SCHIP programs. Because States are no longer tied to statewideness and comparability rules for non-disabled, non-aged, and non-blind populations, they would be able to offer individuals and families different types of plans consistent with their needs and available delivery systems.

ESTIMATED ANNUAL STATE SAVINGS DISCOUNTED AT 0%, 3% AND 7%—FROM FY 2006 TO FY 2010

[In millions]

Discount rate	2006	2007	2008	2009	2010	Total 2006–2010
0%	$50	$210	$350	$500	$610	$1,720
3%	49	198	320	444	526	1,537
7%	47	183	286	381	435	1,332

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6.5 million to $30.5 million in any 1 year. Individuals and States are not included in the definition of a small entity. We have determined, and the Secretary certifies, that this provision applies to States only and would not affect small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Core-Based Statistical Area and has fewer than 100 beds. We have determined, and the Secretary certifies, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million, updated annually for inflation. That threshold level is currently approximately $127 million. Because this rule does not mandate State participation in using these benchmark plans, there is no obligation for the State to make any change to their Medicaid program. Therefore, there is no mandate for the State.

We believe this proposed rule would not mandate expenditures in that amount.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This proposed rule would not impose direct cost on States or local government or preempt State law. The rule would provide States the option to implement alternative Medicaid benefits through a Medicaid State plan amendment.

B. Anticipated Effects

Before section 6044 of the DRA became effective on March 31, 2006, State Medicaid programs generally were required to offer at minimum the same standard benefit package to each recipient, regardless of income, eligibility category, or geographic location. Some States offered alternative benefit packages to certain recipients under section 1115 demonstration waivers approved by the Centers for Medicare & Medicaid Services. This provision allows for similar program alternatives under the State plan without the constraints of a waiver. Moreover, Medicaid families would gain continuity in coverage as family members move together from Medicaid and the State Children's Health Insurance Program (SCHIP) to, eventually, private coverage. Today, because of the lack of flexibility in Medicaid, one child may be receiving Medicaid, another in SCHIP, and the parent has access to private coverage. With benefit flexibility in State Medicaid programs, families could enroll under the same plan, with the same providers and one set of administrative rules. Administrative simplification can help families maintain health insurance coverage and give them experience with private insurance coverage that would become important when their income rises above Medicaid and SCHIP eligibility levels and to mitigate the need for dependence. States with strong employer-based coverage may emphasize family coverage premium assistance. States may form larger pools by combining Medicaid recipients with their public employees.

C. Alternatives Considered

This rule proposes requirements for States to elect alternative Medicaid benefit programs through the adoption of a Medicaid State plan amendment. The proposed requirements in this rule were designed to maximize State flexibility while assuring that beneficiaries will get quality care that meets their needs. Under this rule, we would permit States to define the alternative benefit packages only by reference to the benchmark or benchmark-equivalent standard (with the exception of the EPSDT wrap-around benefits). We would also permit States to combine an alternative benefit package with alternative benefit delivery methods, such as through managed care, employer-based coverage, or selective contracting. An alternative might have been to require the State to document any deviation from otherwise applicable State plan requirements, much as is required under section 1115 demonstration waivers, 1915(b) waivers, 1915(c) waivers, or any combination thereof. We have not elected this alternative because it would be cumbersome for States, it would not be consistent with the statutory use of benchmark and benchmark-equivalent coverage as reference points for permissible benefit packages, and it would not improve the clarity of the State plan. Another alternative might have been to limit State flexibility under this provision to variation in the amount, duration and scope of benefits without providing authority for an integrated approach combining alternative benefits with alternative benefit delivery methods. We have not elected this alternative because an integrated approach allows greater State flexibility to tailor both benefits and delivery methods to the eligible groups of individuals being served.

D. Accounting Statement

As required by OMB Circular A–4 (available at), *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf),* in Table 15 below, we have prepared an accounting statement showing the classification of the expenditures associated with the provisions of this proposed rule. This table provides our best estimate of the decrease in Medicaid payments as a result of the changes presented in this

proposed rule. All savings are classified as transfers to the Federal Government, as well as to States.

TABLE.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED SAVINGS, FROM FY 2006 TO FY 2010

[In $ millions]

Category	**Transfers**				
	Year Dollar	Units Discount Rate			Period Covered
Annualized Monetized Transfers	.....	7%	3%	0%	.....
	2006	−$430.8	−$445.0	−$456.0	2006–2010
From Whom To Whom?	Federal Government to Beneficiaries, Providers				
Category	**Transfers**				
Year	2006	2007	2008	2009	2010
Annualized Monetized Transfers	−$70	−$280	−$460	−$660	−$810
From Whom To Whom?	Federal Government to Beneficiaries, Providers				
Category	**Transfers**				
	Year Dollar	Units Discount Rate			Period Covered
Annualized Monetized Transfers	.....	7%	3%	0%	.....
	2006	−$324.9	−$335.7	−$344.0	2006–2010
From Whom to Whom?	State Governments to Beneficiaries, Providers				
Category	**Transfers**				
Year	2006	2007	2008	2009	2010
Annualized Monetized Transfers	−$50	−$210	−$350	−$500	−$610
From Whom to Whom?	State Governments to Beneficiaries, Providers				

Column 1: Category—Contains the description of the different impacts of the rule; it could include monetized, quantitative but not monetized, or qualitative but not quantitative or monetized impacts; it also may contain unit of measurement (such as, dollars). In this case, the only impact is the Federal annualized monetized impact of the rule.

Column 2: Primary Estimate—Contains the quantitative or qualitative impact of the rule for the respective category of impact. Monetized amounts are generally shown in real dollar terms. In this case, the federalized annualized monetized primary estimate represents the equivalent amount that, if paid (saved) each year over the period covered, would result in the same net present value of the stream of costs (savings) estimated over the period covered.

Column 3: Year Dollar—Contains the year to which dollars are normalized; that is, the first year that dollars are discounted in the estimate.

Column 4: Unit Discount Rate—Contains the discount rate or rates used to estimate the annualized monetized impacts. In this case, three rates are used: 7 percent; 3 percent; 0 percent.

Column 5: Period Covered—Contains the years for which the estimate was made.

Rows: The rows contain the estimates associated with each specific impact and each discount rate used.

''From Whom to Whom?''—In the case of a transfer (as opposed to a change in aggregate social welfare as described in the OMB Circular), this section describes the parties involved in the transfer of costs. In this case, the costs represent a reduction in Federal Government spending on behalf of beneficiaries. The table may also contain minimum and maximum estimates and sources cited. In this case, there is only a primary estimate and there are no additional sources for the estimate.

Estimated Savings—The following table shows the discounted costs (savings) for each discount rate and for each year over the period covered. ''Total'' represents the net present value of the impact in the year the rule takes effect. These numbers represent the anticipated annual reduction in Federal Medicaid spending under this rule.

E. Conclusion

We project that the use of benchmark plans under this rule will save $2.3 billion from 2006–2010. These savings would arise as States use the plans described by this rule to manage the costs of their Medicaid program by modifying plan benefits for targeted beneficiaries. The actual savings will heavily depend on the number of States that ultimately implement these plans, the number of beneficiaries States cover with these plans, and the specific design and selection of benchmark plans.

For reasons stated above, we are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined that this rule would not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 440

Grant programs—health, Medicaid.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services proposes to amend 42 CFR chapter IV as set forth below:

PART 440—SERVICES: GENERAL PROVISIONS

1. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

2. A new subpart C, consisting of § 440.300 through § 440.390, is added to part 440 to read as follows:

Subpart C—Benchmark Benefit and Benchmark-Equivalent Coverage

Sec.

440.300 Basis.
440.305 Scope.
440.310 Applicability.
440.315 Exempt individuals.
440.320 State plan requirements: Optional enrollment for exempt individuals.
440.325 State plan requirements: Coverage and benefits.
440.330 Benchmark health benefits coverage.
440.335 Benchmark-equivalent health benefits coverage.
440.340 Actuarial report for benchmark-equivalent coverage.
440.345 EPSDT services requirement.
440.350 Employer-sponsored insurance health plans.
440.355 Payment of premiums.
440.360 State plan requirement for providing additional wrap-around services.
440.365 Coverage of rural health clinic and federally qualified health center (FQHC) services.
440.370 Cost-effectiveness.
440.375 Comparability.
440.380 Statewideness.
440.385 Freedom of choice.
440.390 Assurance of Transportation.

Subpart C—Benchmark Benefit and Benchmark-Equivalent Coverage

§ 440.300 Basis.

This subpart implements section 1937 of the Act, which authorizes States to provide for medical assistance to one or more groups of Medicaid-eligible recipients specified by the State under an approved State plan amendment through enrollment in coverage that provides benchmark or benchmark-equivalent health care benefit coverage.

§ 440.305 Scope.

(a) *General.* This subpart sets out requirements for States that elect to provide medical assistance to certain Medicaid eligible recipients within one or more groups of individuals specified by the State, through enrollment of the recipients in coverage, identified as ''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.

§ 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 full benefit eligible if determined by the State to be eligible to receive the standard full Medicaid benefit package under the approved Medicaid State plan if not for the application of the option available under this subpart, but does not include individuals determined eligible as medically needy individuals, or eligible because of a reduction of 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.

§ 440.315 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, individuals with special needs are those individuals described in § 438.50(d)(1) and § 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 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.

§ 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 inform the individuals 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) 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 and voluntarily chose to enroll in the benchmark or benchmark-equivalent benefit package.

(b) [Reserved]

§ 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 that is offered through an HMO, (as defined in section 2791(b)(3) of the Public Health Service Act) that has the largest insured commercial, non-Medicaid enrollment in the State.

(d) *Secretary approved coverage.* Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage. States wishing to opt for Secretarial approved coverage should submit a full description of the proposed coverage, (including a benefit-by-benefit comparison of the proposed plan to one or more of the three other benchmark plans specified above or to the State's standard full Medicaid coverage package under section 1905(a) of the Act), and of the population to which the coverage would be offered. In addition, the State should submit any other information that would be relevant to a determination that the proposed health benefits coverage would be appropriate for the proposed population. The scope of a Secretary-approved health benefits package will be limited to benefits within the scope of the categories available under a benchmark coverage package or the standard full Medicaid coverage package under section 1905(a) of the Act.

§ 440.335 Benchmark-equivalent health benefits coverage.

(a) *Aggregate actuarial value.* Benchmark-equivalent coverage is health benefits coverage that has an aggregate actuarial value, as determined in § 440.340 that is at least actuarially equivalent to the coverage under one of the benchmark benefit packages described in § 440.330 for the identified Medicaid population to which it will be offered.

(b) *Required coverage.* Benchmark-equivalent health benefits coverage must include coverage for the following categories of services:

(1) Inpatient and outpatient hospital services.

(2) Physicians' surgical and medical services.

(3) Laboratory and x-ray services.

(4) Well-baby and well-child care, including age-appropriate immunizations.

(5) Other appropriate preventive services, such as emergency services as designated by the Secretary.

(c) *Additional coverage.* (1) In addition to the categories of services of this section, benchmark-equivalent coverage may include coverage for any additional services in a category included in the benchmark plan or described in section 1905(a) of the Act.

(2) If the benchmark coverage package used by the State for purposes of comparison in establishing the aggregate actuarial value of the benchmark-equivalent package includes any of the following four categories of services: Prescription drugs; mental health services; vision services; and hearing services; then the actuarial value of the coverage for each of these categories of service in the benchmark-equivalent coverage package must be at least 75 percent of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State.

(3) If the benchmark coverage package does not cover one of the four categories of services in paragraph (c)(2) of this section, then the benchmark-equivalent coverage package may, but is not required to, include coverage for that category of service.

§ 440.340 Actuarial report for benchmark-equivalent coverage.

(a) A State plan amendment that would provide for benchmark-equivalent health benefits coverage described in § 440.335, must include an actuarial report. The actuarial report must contain an actuarial opinion that the benchmark equivalent health benefits coverage meets the actuarial requirements set forth in § 440.335. The report must also specify the benchmark coverage used for comparison.

(b) The actuarial report must state that it was prepared according to the following requirements:

(1) By an individual who is a member of the American Academy of Actuaries (AAA).

(2) Using generally accepted actuarial principles and methodologies of the AAA.

(3) Using a standardized set of utilization and price factors.

(4) Using a standardized population that is representative of the population involved.

(5) Applying the same principles and factors in comparing the value of different coverage (or categories of services).

(6) Without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used.

(7) Taking into account the ability of the State to reduce benefits by taking into account the increase in actuarial value of health benefits coverage offered under the State plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(c) The actuary preparing the opinion must select and specify the standardized set of factors and the standardized population to be used in paragraphs (b)(3) and (b)(4) of this section.

(d) The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to replicate the State's result.

§ 440.345 EPSDT services requirement.

(a) The State must assure access to early and periodic screening, diagnostic and treatment (EPSDT) services through benchmark or benchmark-equivalent plan benefits or as wrap-around benefits to those plans for any child under 19 years of age eligible in a category under the State plan.

(1) Sufficiency: Any wrap-around EPSDT benefits must be sufficient so that, in combination with the benchmark or benchmark-equivalent benefits plan, these individuals have access to the full EPSDT benefit.

(2) State Plan requirement: The State must include a description of how the wrap-around benefits will be provided to ensure that these recipients have access to the full EPSDT benefit.

(b) Individuals must first seek coverage of EPSDT services through the benchmark or benchmark equivalent plan before seeking coverage of such through wrap-around benefits.

§ 440.350 Employer-sponsored insurance health plans.

(a) A State may provide benchmark or benchmark-equivalent coverage by obtaining employer sponsored health plans (either alone or with the addition of wrap-around services covered separately under Medicaid) for individuals with access to private health insurance.

(b) The State must assure that employer sponsored plans meet the requirements of benchmark or benchmark-equivalent coverage, including the cost-effectiveness requirements at § 440.370.

(c) A State may provide benchmark or benchmark-equivalent coverage through a combination of employer sponsored health plans and additional benefit coverage provided by the State that wraps around the employer sponsored health plan which, in the aggregate, results in benchmark or benchmark-equivalent level of coverage for those recipients.

§ 440.355 Payment of premiums.

Payment of premiums by the State, net of beneficiary contributions, to obtain benchmark or benchmark-equivalent benefit coverage on behalf of beneficiaries under this section will be treated as medical assistance under section 1905(a) of the Act.

§ 440.360 State plan requirement for providing additional wrap-around services.

If the State opts to provide additional or wrap-around coverage to individuals enrolled in benchmark or benchmark-equivalent plans, the State plan must describe the populations covered and the payment methodology for these services. Additional or wrap-around services must be in categories that are within the scope of the benchmark coverage, or are described in section 1905(a) of the Act.

§ 440.365 Coverage of rural health clinic and federally qualified health center (FQHC) services.

If a State provides benchmark or benchmark-equivalent coverage to individuals, it must assure that the individual has access, through that coverage or otherwise, to rural health clinic services and FQHC services as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Act. Payment for these services must be made in accordance with the payment provisions of section 1902(bb) of the Act.

§ 440.370 Cost-effectiveness.

Benchmark and benchmark-equivalent coverage and any additional benefits must be provided in accordance with Federal upper payment limits, procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

§ 440.375 Comparability.

States have the option to amend their State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to comparability.

§ 440.380 Statewideness.

States have the option to amend their State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to statewideness.

§ 440.385 Freedom of choice.

(a) States have the option to amend their State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to the requirements for free choice of provider in § 431.51 of this chapter.

(b) States may restrict recipients to obtaining services from (or through) selectively procured provider plans or practitioners that meet, accept, and comply with reimbursement, quality and utilization standards under the State Plan, to the extent that the restrictions imposed meet the following requirements:

(1) Do not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing the benchmark benefit package.

(2) Do not apply in emergency circumstances.

(3) Require that all provider plans are paid on a timely basis in the same manner as health care practitioners must be paid under § 447.45 of the chapter.

§ 440.390 Assurance of Transportation.

A State may at its option amend its State plan to provide benchmark or benchmark-equivalent coverage to recipients without regard to the assurance of transportation to medically necessary services requirement specified in § 431.53 of this chapter.

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: October 11, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 1, 2007.

Michael O. Leavitt,

Secretary.

Editorial Note: This document was received at the Office of the Federal Register on February 15, 2008.

[FR Doc. E8–3206 Filed 2–21–08; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 447 and 457

[CMS–2244–P]

RIN 0938–A047

Medicaid Program; Premiums and Cost Sharing

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement and interpret the provisions of sections 6041, 6042, and 6043 of the Deficit Reduction Act of 2005 (DRA), and section 405(a)(1) of the Tax Relief and Health Care Act of 2006 (TRHCA). These sections amend the Social Security Act (the Act) by adding a new section 1916A to provide State Medicaid agencies with increased flexibility to impose premium and cost sharing requirements on certain Medicaid recipients. This authority is in addition to the existing authority States have to impose premiums and cost sharing under section 1916 of the Act. The DRA provisions also specifically address cost sharing for non-preferred