§ 423.904 Eligibility determinations for low-income subsidies.

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

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

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

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

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

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

(i) Low-income subsidy application forms;

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

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

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

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

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

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

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

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

§ 423.906 General payment provisions.

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

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

(1) Part D drugs; or

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

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

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

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