

§ 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.

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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

drugs and non-emergency care furnished in a hospital emergency department.

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

ADDRESSES: In commenting, please refer to file code CMS-2244-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-2244-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-2244-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-2244-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

A. General

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109-171, enacted on February 8, 2006), States now have new options to create programs that are aligned with today's Medicaid populations and the health care environment. Alternative cost sharing,

benefit flexibility through benchmark plans, and the health opportunity accounts (HOA) demonstration provide the greatest opportunities to modernize Medicaid, to make the cost of the program and health care more affordable, and to expand coverage for the uninsured. States will be able to reconnect families to the larger insurance system that serves most Americans and promote continuity of coverage. The sweeping DRA provisions on Medicaid include six chapters and 39 sections. Through a combination of new options for States and new requirements related to program integrity, the DRA will help ensure the sustainability of the Medicaid program over time.

B. Statutory Authority

Sections 6041, 6042, and 6043 of the DRA established a new section 1916A of the Social Security Act (the Act). Section 405(a)(1) of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109-432, enacted on December 20, 2006) modified section 1916A of the Act. Section 1916A sets forth options for alternative premiums and cost sharing, including options for higher cost sharing for non-preferred prescription drugs and for non-emergency use of a hospital emergency room.

Section 6041 of the DRA established new subsections 1916A(a) and (b), of the Act, which allow States to amend their State plans to impose alternative premiums and cost sharing on certain groups of individuals, for items and services other than drugs (which are subject to a separate provision discussed below), and to enforce payment of the premiums and cost sharing. Subsections 1916A(a) and (b) set forth limitations on alternative premiums and cost-sharing that vary based on family income, and exclude some specific services from alternative cost sharing. Section 6041 also created a new section 1916(h) of the Act, which requires the Secretary to increase the "nominal" cost sharing amounts under section 1916 for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (CPI-U) as rounded up in an appropriate manner. Section 405(a)(1) of the TRHCA modified subsections 1916A(a) and (b) of the Act.

Section 6042 of the DRA created section 1916A(c) of the Act, which provides States with additional options for establishing cost sharing requirements for drugs to encourage the use of preferred drugs. Section 405(a)(1) of the TRHCA also modified section 1916A(c) of the Act. Under section

1916A(c), States may amend their State plans to require increased cost sharing for certain groups of individuals for non-preferred drugs and to waive or reduce the otherwise applicable cost sharing for preferred drugs. States may also permit pharmacy providers to require the receipt of a cost sharing payment from an individual before filling a prescription. We believe the Congress intended to provide additional flexibilities to States in issuing the DRA. Thus, we have not defined preferred drugs or non-preferred drugs within a class of such drugs in this rule and we believe defining these terms should be at State discretion. We would anticipate that States would publish schedules of preferred drugs as part of, or as a supplement to, the required public schedule of cost sharing under 42 CFR 447.76.

Section 6043 of the DRA created section 1916A(e) of the Act, which permits States to amend their State plans to allow hospitals, after an appropriate medical screening examination under section 1867 (EMTALA) of the Act, to impose higher cost sharing upon certain groups of individuals for non-emergency care or services furnished in a hospital emergency department. Section 405(a)(1) of the TRHCA modified section 1916A(e) of the Act. Under this option, if the hospital determines that an individual does not have an emergency medical condition, before providing the non-emergency services and imposing cost sharing, it must inform the individual that an available and accessible alternate non-emergency services provider can provide the services without the imposition of the same cost sharing and that the hospital can coordinate a referral to that provider. After notice is given, the hospital may require payment of the cost sharing before providing the non-emergency services to the individual.

II. Provisions of the Proposed Regulations

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

A. Overview

The Department began issuing guidance about the new flexibilities available to States within months of the enactment of the DRA. We released two letters to State Medicaid directors and health officials providing guidance on sections 6041, 6042 and 6043 of the DRA, and section 405(a)(1) of the TRHCA as it relates to sections 6041 and

6042 of the DRA respectively. States and Territories have used this guidance to design and implement the new options. These regulations formalize the guidance on alternative premiums and cost sharing.

These proposed regulations would amend existing Medicaid cost sharing regulations at 42 CFR part 447 and State Children's Health Insurance Program (SCHIP) cost sharing regulations at 42 CFR part 457. We propose this approach to assist the reader in easily accessing all Medicaid and SCHIP cost sharing regulations.

B. Medicaid Regulations

1. Maximum Allowable Charges (§ 447.54)

We are proposing to revise § 447.54 to update the existing "nominal" Medicaid cost sharing amounts, specifically the nominal deductible amount described at § 447.54(a)(1) and the nominal copayment amounts described at § 447.54(a)(3). We are also proposing to add § 447.54(a)(4) to establish a maximum copayment amount for services provided by a managed care organization (MCO).

Section 6041(b)(2) of the DRA requires the Secretary to increase the nominal cost sharing amounts under section 1916 of the Act for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner. In accordance with the statute, we propose to increase the nominal amounts on the beginning of the Federal Fiscal Year (FY) (October 1) in each calendar year by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the period of September to September ending in the preceding calendar year. We use this period to update other amounts, such as the Medicaid spousal impoverishment standards, by inflation. The first adjustment would be for FY 2007, and would be based on the CPI-U increases during the period September 2004 to September 2005. The medical care component of the CPI-U increased by 3.9 percent between September 2004 and September 2005, so we propose to update the nominal amounts by that factor and then round to the next higher 10-cent increment. We propose to round to the next higher 10-cent increment because it will simplify calculation and collection of the amounts involved. Based on this methodology, we propose a maximum deductible for \$2.10 per month per family for each period of

Medicaid eligibility. In addition, we propose the following copayment maximum amounts:

State payment for the service	Maximum copayment
\$10 or less	\$.60
\$10.01 to \$25	1.10
\$25.01 to \$50	2.10
\$50.01 or more	3.20

States should use these updated nominal amounts during FY 2007. Thereafter, these amounts will be updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding year, rounded to the next higher 10-cent increment.

In addition, we have proposed to specify a maximum copayment amount for services provided by an MCO. When we published the final Medicaid managed care rules on June 14, 2002 (67 FR 40989), we also issued at § 447.60, a requirement that contracts with MCOs limit cost sharing charges an MCO may impose on Medicaid enrollees to the amounts that could be imposed if fee-for-service payment rates were applicable. Since some States do not have fee-for-service programs, we have proposed to specify maximum copayment amounts for services provided by an MCO.

2. Premiums and Cost Sharing: Basis, Purpose and Scope (§ 447.62)

Section 1916A of the Act allows States to impose alternative premiums and cost sharing that are not subject to the limitations on premiums and cost sharing under section 1916 of the Act. Section 1916A of the Act does not affect the Secretary's existing waiver authority with regard to premiums and cost sharing. Section 447.62 of the regulations briefly describes this statutory provision which is the basis for § 447.64 through § 447.82. Section 447.62 also sets forth limitations on the scope of these regulations by indicating that they do not limit the Secretary's waiver authority, or affect existing waivers, concerning premiums or cost sharing.

Section 405(a)(1) of the TRHCA amended section 1916A by explicitly providing certain exemptions from the provisions, and other protections, for the population with family incomes at or below 100 percent of the FPL. The statute also includes protections for individuals with family incomes between 100 and 150 percent of the FPL and individuals with family incomes above 150 percent of the FPL.

3. Premiums, Enrollment Fees, or Similar Fees: State Plan Requirements (§ 447.64)

Section 1916A(a)(1) of the Act requires that the State plan specify the group or groups of individuals upon which it will impose alternate premiums. In accordance with the statute, at § 447.64(a), we propose that the State plan describe the group or groups of individuals that may be subject to such premiums, enrollment fees, or similar charges. For example, States may impose premiums upon all non-exempt childless adults (with family incomes over 150 percent of the FPL). We further propose in § 447.64(b) that the State plan must include a schedule of the premiums, enrollment fees, or similar charges and the process for informing recipients, applicants, providers, and the public of the schedule. States may vary the premiums, enrollment fees, or similar charges among the groups of individuals.

Section 1916A(b)(4) of the Act requires that the State plan specify the manner and the period for which the State determines family income. In accordance with the statute, at § 447.64(c), we propose that the State plan describe the methodology used to determine family income, including the period and periodicity of those determinations. We also propose in § 447.64(d) that the State plan describe the methodology the State will use to ensure that the aggregate amount of premiums and cost sharing imposed for all individuals in the family does not exceed 5 percent of family income as applied during the monthly or quarterly period specified by the State.

Section 1916A(d)(1) of the Act requires that the State specify the group or group of individuals for whom payment of premiums is a condition of eligibility. In accordance with the statute, at § 447.64(e), we propose that the State plan, list the group or groups of individuals. We further propose in § 447.64(f) that the State plan describe the premium payment terms for the group or groups.

4. General Premium Protections (§ 447.66)

Under section 1916A(b)(3)(A) of the Act, the State plan may not impose premiums upon the following:

- Individuals under 18 years of age who are required to be provided medical assistance under section 1902(a)(10)(A)(i) of the Act, and including individuals with respect to whom child welfare services are made available under Part B of title IV on the

basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of that title, without regard to age;

- Pregnant women;
- Any terminally ill individual receiving hospice care, as defined in section 1905(o) of the Act;
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if the individual 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;
- Women who are receiving Medicaid on the basis of the breast or cervical cancer eligibility group under sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act; and
- Disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

In accordance with the statute, at § 447.66(a), we propose that the State exclude these classes of individuals from the imposition of premiums.

Section 1916A(b)(3)(C) of the Act clarifies that a State may exempt additional classes of individuals from premiums. At proposed § 447.66(b), we would implement this section.

5. Copayments, Coinsurance, Deductibles, or Similar Cost Sharing Charges: State Plan Requirements (§ 447.68)

Section 1916A(a)(1) of the Act requires that the State plan specify the group or groups of individuals upon which it opts to impose cost sharing. In accordance with the statute, at § 447.68(a), we propose that the State plan describe the group or groups of individuals that may be subject to cost sharing. For example, States may impose cost sharing for non-exempt items and services to individuals in the section 1931 eligibility group with family incomes between 100 and 200 percent of the FPL. We further propose that the State plan must include a schedule of the copayments, coinsurance, deductibles, or similar cost sharing charges, the items or services for which the charges apply, and the process for informing recipients, applicants, providers, and the public of the schedule. States may vary cost sharing among the types of items and services.

Section 1916A(b)(4) of the Act requires that the State plan specify the

manner and the period for which the State determines family income. In accordance with the statute, at § 447.68(b), we propose that the State plan describe the methodology used to determine family income, including the period and periodicity of such determinations.

We also propose that the State plan describe the methodology the State will use to ensure that the aggregate amount of premiums and cost sharing imposed for all individuals in the family does not exceed 5 percent of family income as applied during the monthly or quarterly period specified by the State. We further propose that the State plan describe the State's methods for tracking cost sharing charges, informing recipients and providers of their liability, and notifying recipients and providers when individual recipients have reached their aggregate limit on premiums and cost sharing. States can use the same methods that SCHIP programs use to track cost sharing. For example, States can program their automated systems to track and compute recipients' cost sharing.

Finally, we propose that the State plan specify whether the State permits a provider participating under the State plan to require payment of authorized cost sharing as a condition for the provision of covered care, items, or services.

6. General Cost Sharing Protections (§ 447.70)

Under section 1916A(b)(3)(B) of the Act, the State plan may not impose alternative cost sharing under 1916A(a) for the following:

- Services furnished to individuals under 18 years of age who are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom child welfare services are made available under Part B of title IV on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of that title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income;
- Services furnished to pregnant women, if those services relate to pregnancy or to any other medical condition that may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice

care (as defined in section 1905(o) of the Act);

- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if the individual 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;

- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;

- Family planning services and supplies described in section 1905(a)(4)(C) of the Act;

- Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act (breast or cervical cancer provisions); and

- Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

In addition, section 1916A(c)(1)(B) of the Act prohibits the State plan from imposing otherwise applicable cost sharing for preferred drugs for individuals "for whom cost sharing may not otherwise be imposed under subsection (a) due to the application of 1916A(b)(3)(B) of the Act." Therefore, in accordance with the statute, at § 447.70(a)(1)(x), we propose that the State plan exclude these classes of individuals from the imposition of cost sharing for preferred drugs within a class.

Section 1916A(b)(3)(C) of the Act clarifies that a State may exempt additional individuals or services from cost sharing. At proposed § 447.70(c), we would implement this section.

Finally, section 1916A(c)(3) of the Act requires a State to charge cost sharing applicable to a preferred drug in the case of a non-preferred drug if the prescribing physician determines that the preferred drug would not be as effective for the individual or would have adverse effects for the individual or both. We would implement this section at proposed § 447.70(b). We further propose at § 447.70(b) that such overrides meet State criteria for prior authorization and be approved through the State prior authorization process.

7. Premium and Cost Sharing Exemptions and Protections for Individuals With Family Income at or Below 100 Percent of the FPL (§ 447.71)

Under section 1916A(a)(2)(A) of the Act, the State plan may not impose premiums on individuals whose family income is at or below 100 percent of the FPL. In accordance with the statute, at § 447.71(a) we propose that the State plan exclude these individuals from the imposition of premiums.

Under section 1916A(a)(2)(A) of the Act, the State plan may not impose cost sharing on individuals whose family income is at or below 100 percent of the FPL with the exception of cost sharing for non-preferred drugs and for non-emergency services furnished in a hospital emergency department.

However, section 1916A(c)(2)(A)(i) of the Act prohibits a State from imposing, with respect to a non-preferred drug, cost sharing that exceeds the nominal amount as otherwise determined under section 1916 of the Act and described at § 447.54(a)(3) or (4) for those individuals. In addition, section 1916A(e)(2)(B) of the Act prohibits a State from imposing, with respect to non-emergency services furnished in a hospital emergency department, cost sharing that exceeds the nominal amount as otherwise determined under section 1916 of the Act and described at § 447.54(a)(3) or (4). Furthermore, a State may only impose nominal cost sharing with respect to non-emergency services so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative health care provider in the geographic area of the hospital emergency department involved.

In accordance with the statute, we propose at § 447.71(b)(1) that cost sharing for non-preferred drugs for those individuals not exceed the nominal cost sharing amount. In addition, we propose at § 447.71(b)(2) that cost sharing for non-emergency services furnished in a hospital emergency department for those individuals not exceed the nominal cost sharing amount and be imposed only so long as no cost sharing is imposed on those individuals to receive such care through an outpatient department or other alternative non-emergency services provider in the geographic area of the hospital emergency department involved.

Section 1916A(a)(2)(B) of the Act provides that the total aggregate amount of cost sharing imposed under sections 1916A(c), 1916A(e), and/or 1916 of the Act upon individuals whose family income is at or below 100 percent of the FPL may not exceed 5 percent of the

family income of the family involved, as applied on a quarterly or monthly basis as specified by the State. In accordance with the statute, we propose at § 447.71(c) that aggregate cost sharing for individuals whose family income is at or below 100 percent of the FPL applicable to a family of the size involved not exceed the maximum permitted under § 447.78(b). At § 447.78(b), we propose that the total aggregate amount of cost sharing may not exceed 5 percent of such family's income for the monthly or quarterly period, as specified in the State plan.

8. Premium and Cost Sharing Exemptions and Protections for Individuals Whose Family Income is Above 100 Percent but Does Not Exceed 150 Percent of the FPL (§ 447.72)

Under section 1916A(b)(1)(A) of the Act, the State plan may not impose premiums on individuals whose family incomes exceeds 100 percent, but does not exceed 150 percent of the FPL applicable to a family of the size involved. In accordance with the statute, at § 447.72(a), we propose that the State plan exclude these individuals from the imposition of premiums.

Section 1916A(b)(1)(B)(i) of the Act provides that, in the case of individuals whose family income exceeds 100 percent, but does not exceed 150 percent of the FPL applicable to a family of the size involved, cost sharing imposed under the State plan may not exceed 10 percent of the cost of such item or service. However, section 1916A(c)(2)(A)(i) of the Act prohibits a State from imposing, with respect to a non-preferred drug, cost sharing that exceeds the nominal amount as otherwise determined under section 1916 of the Act and described at § 447.54(a)(3) for those individuals. In addition, section 1916A(e)(2)(A) of the Act prohibits a State from imposing, with respect to non-emergency services furnished in a hospital emergency department, cost sharing that exceeds twice the nominal amount as otherwise determined under section 1916 of the Act and described at § 447.54(a)(3) for those individuals.

Therefore, in accordance with the statute, we propose at § 447.72(b) that cost sharing for those individuals under the State plan not exceed 10 percent of the payment the agency makes for that item or service, with the exception that it not exceed the nominal cost sharing amount for non-preferred drugs or twice the nominal cost sharing amount for non-emergency services furnished in a hospital emergency department. In the case of States that do not have fee-for-service payment rates, we propose that

any copayment that the State imposes for services provided by an MCO may not exceed \$5.20 for FY 2007. This proposal would provide greater flexibility to State Medicaid programs consistent with that provided to State SCHIP programs. Thereafter, any copayment that the State imposes for services provided by an MCO may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 10-cent increment.

Section 1916A(b)(1)(B)(ii) of the Act provides that the total aggregate amount of cost sharing imposed under section 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis as specified by the State. In accordance with the statute, we propose at § 447.72(c) that aggregate cost sharing for individuals whose family income exceeds 100 percent, but does not exceed 150 percent of the FPL applicable to a family of the size involved, not exceed the maximum permitted under § 447.78(a). At § 447.78(a), we propose that the total aggregate amount of cost sharing may not exceed 5 percent of such family's income for the monthly or quarterly period, as specified in the State plan.

9. Premium and Cost Sharing Protections for Individuals With Family Income Above 150 Percent of the FPL (§ 447.74)

Under section 1916A(b)(2) of the Act, the State plan may impose premiums upon individuals whose family income exceeds 150 percent of the FPL applicable to a family of the size involved provided that, as described at section 1916A(b)(2)(A) of the Act, the total aggregate amount of premiums and cost sharing imposed under section 1916 and 1916A of the Act not exceed 5 percent of the family income. In accordance with the statute, at § 447.74(a), we state that the State plan can impose premiums upon individuals with family income above 150 percent of the FPL subject to the aggregate limit on premiums and cost sharing.

Section 1916A(b)(2)(B) of the Act provides that, in the case of individuals whose family income exceeds 150 percent of the FPL applicable to a family of the size involved, cost sharing imposed under the State plan may not exceed 20 percent of the cost of that item (including a non-preferred drug) or service. Therefore, in accordance with the statute, we propose at § 447.74(b) that cost sharing for those individuals

under the State plan not exceed 20 percent of the payment the agency makes for that item or service. In the case of States that do not have fee-for-service payment rates, we propose that any copayment that the State imposes for services provided by an MCO may not exceed \$5.20 for FY 2007. This proposal would provide greater flexibility to State Medicaid programs consistent with that provided to State SCHIP programs. Thereafter, any copayment that the State imposes for services provided by an MCO may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 10-cent increment.

Section 1916A(b)(2)(A) of the Act provides that the total aggregate amount of cost sharing imposed under section 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a quarterly or monthly basis as specified by the State. In accordance with the statute, we propose at § 447.74(c) that aggregate cost sharing for individuals whose family income exceeds 150 percent of the FPL applicable to a family of the size involved, not exceed the maximum permitted under § 447.78(a). At § 447.78(a), we propose that the total aggregate amount of premiums and cost sharing may not exceed 5 percent of such family's income for the monthly or quarterly period, as specified in the State plan.

10. Public Schedule (§ 447.76)

As described in this preamble, section 1916 and 1916A of the Act provides authority for States to impose premiums and cost sharing for items and services, including prescription drugs and non-emergency use of a hospital emergency department, and to require a group or groups of individuals to make payment as a condition of eligibility or of receiving that item or service. In § 447.76(a), we propose that State plans provide for schedules of premiums and cost sharing. In § 447.76(a), we propose that the public schedule contain the following information: (1) Current premiums, enrollment fees, or similar fees; (2) current cost sharing charges; (3) the aggregate limits on premiums and cost sharing or only cost sharing; (4) mechanisms for making payments for required premiums and charges; (5) the consequences for an applicant or recipient who does not pay a premium or charge; and (6) a list of hospitals charging alternative cost sharing for non-emergency use of the emergency

department. In addition, at § 447.76(b) we propose that the State make the public schedule available to recipients, at the time of enrollment and reenrollment and when charges are revised, applicants, all participating providers, and the general public.

11. Aggregate Limits on Premiums and Cost Sharing (§ 447.78)

As described above, section 1916A(b)(1)(B)(ii) of the Act provides that the total aggregate amount of cost sharing imposed under section 1916 and 1916A of the Act upon individuals with family income above 100 percent but at or below 150 percent of the FPL may not exceed 5 percent of the family income, as applied on a quarterly or monthly basis as specified by the State. Section 1916A(c)(2)(C) of the Act reiterates that this aggregate limit includes cost sharing for prescription drugs and section 1916A(e)(2)(C) of the Act reiterates that this aggregate limit includes cost sharing for non-emergency use of a hospital emergency department. Section 1916A(b)(2)(A) of the Act provides that the total aggregate amount of premiums and cost sharing imposed under section 1916 and 1916A of the Act upon individuals with family income above 150 percent of the FPL may not exceed 5 percent of the family income, as applied on a quarterly or monthly basis as specified by the State. Again, section 1916A(c)(2)(C) of the Act reiterates that this aggregate limit includes cost sharing for prescription drugs, and section 1916A(e)(2)(C) of the Act reiterates that this aggregate limit includes cost sharing for non-emergency use of a hospital emergency department. Finally, section 1916A(a)(2)(B) of the Act provides that to the extent that cost sharing under section 1916A(c) of the Act for prescription drugs, cost sharing under section 1916A(e) of the Act for non-emergency use of a hospital emergency department, and/or cost sharing under section 1916 of the Act is imposed upon individuals whose family income is at or below 100 percent of the FPL, the total aggregate amount of premiums and cost sharing imposed may not exceed 5 percent of the family income.

In accordance with these provisions, at § 447.78(a), we propose that for individuals with family income above 100 percent of the FPL the aggregate amount of premiums (when applicable) and cost sharing under section 1916 and 1916A of the Act not exceed 5 percent of a family's income for the monthly or quarterly period, as specified by the State in the State plan. At § 447.78(b), we propose that for individuals whose family income is at or below 100

percent of the FPL the aggregate amount of cost sharing under sections 1916, 1916A(c), and/or 1916A(e) of the Act not exceed 5 percent of a family's income for the monthly or quarterly period, as specified by the State in the State plan. We also propose at § 447.78(c) that family income shall be determined in a manner and for that period as specified by the State in the State plan. We clarify that States may use gross income to compute family income and that they may use a different methodology for computing family income for purposes of determining the aggregate limits than for determining income eligibility.

12. Enforceability of Premiums and Cost Sharing (§ 447.80)

Section 1916A(d)(1) of the Act permits a State to condition Medicaid eligibility upon the prepayment of premiums imposed under section 1916A of the Act or to terminate Medicaid eligibility for the failure to pay such a premium for 60 days or more. The statute provides States flexibility to implement these requirements for some or all groups of individuals as specified in the State plan. The statute also provides flexibility to waive payment of any premium in any case where the State determines that requiring that payment would create undue hardship.

In accordance with the statute, we propose at § 447.80(a) to permit a State to condition eligibility for a group or group of individuals upon prepayment of premiums, to terminate the eligibility of an individual from a group or groups of individuals for failure to pay for 60 days or more, and to waive payment in any case where requiring the payment would create undue hardship.

Section 1916A(d)(2) of the Act permits a State to allow a provider to require that an individual, as a condition of receiving an item or service, pay the cost sharing charge imposed under section 1916A of the Act. The provider is not prohibited by this authority from choosing to reduce or waive cost sharing on a case-by-case basis. However, section 1916A(a)(2)(A) specifies that section 1916A(d)(2) shall not apply in the case of an individual whose family income does not exceed 100 percent of the FPL applicable to a family of the size involved.

In accordance with the statute, at § 447.80(b) we propose that a State permit a provider, including a pharmacy, to require an individual to pay cost sharing imposed under section 1916A of the Act as a condition of receiving an item or service. However, at § 447.80(b)(1) we specify that a

provider, including a pharmacy or hospital, may not require an individual whose family income is at or below 100 percent of the FPL to pay the cost sharing charge as a condition of receiving the item or service. In addition, at § 447.80(b)(2) we propose that a hospital that has determined after an appropriate medical screening under section 1867 of the Act that an individual does not have an emergency medical condition must first provide the name and location of an available and accessible alternate non-emergency services provider, the fact that the alternate provider can provide the services without the imposition of that cost sharing, and a referral to coordinate scheduling of treatment before it can require payment of the cost sharing. Finally, at § 447.80(b)(3) we propose that a provider may reduce or waive cost sharing imposed under section 1916A of the Act on a case-by-case basis.

13. Restrictions on Payments to Providers (§ 447.82)

Proposed § 447.82 requires States to reduce the amount of State payments to providers by the amount of recipients' cost sharing obligations under section 1916A of the Act. However, States have the ability to increase total State plan rates to providers to maintain the same level of State payment when cost sharing is introduced.

C. SCHIP Regulations

1. Maximum Allowable Cost Sharing Charges on Targeted Low-Income Children in Families With Incomes From 101 to 150 Percent of the FPL (§ 457.555)

We are revising § 457.555 to update the existing "nominal" SCHIP cost sharing amounts, specifically the copayment amounts described at § 457.555(a)(1) and (2), (c), and (d) and the deductible amount described at § 447.555(a)(4). Section 6041(b)(2) of the DRA requires the Secretary to increase the nominal Medicaid cost sharing amounts under section 1916 of the Act for each year (beginning with 2006) by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) as rounded up in an appropriate manner. While section 6041(b)(2) of the DRA does not require the Secretary to increase the SCHIP nominal cost sharing amounts, we believe that our proposal is consistent with sections 2103(e)(3)(A)(ii) and 2103(e)(1)(B) of the SCHIP statute. Section 2103(e)(3)(A)(ii) of the Act specifies that a State SCHIP

plan may not impose a deductible, cost sharing, or similar charge that exceeds an amount that is nominal as determined consistent with Medicaid regulations at § 447.54, with an appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable. Section 2103(e)(1)(B) of the Act prohibits a State SCHIP plan from imposing cost sharing that favors children from families with higher income over children from families with lower income. By updating the existing SCHIP nominal cost sharing amounts by the annual percentage increase in the medical care component of the CPI-U by the period of September to September ending in the preceding calendar year, we would retain nominal cost sharing amounts that reflect a SCHIP recipient's ability to pay higher cost sharing. The medical care component of the CPI-U increased by 3.9 percent between September 2004 and September 2005, so we propose to update the nominal amounts by that factor and then round to the next higher 10-cent increment. We propose to round to the next higher 10-cent increment because it will simplify calculation and collection of the amounts involved. Based on this methodology, we propose the following copayment maximum amounts:

Total cost of services	Maximum amount
\$15.00 or less	\$1.10
\$15.01 to \$40	2.10
\$40.01 to \$80	3.20
\$80.01 or more	5.20

We also propose that the copayments for services provided by an MCO and for emergency services provided by an institution not exceed \$5.20 per visit and that the copayment for non-emergency services furnished in a hospital emergency room to targeted low-income children with family income from 101 to 150 percent of the FPL not exceed \$10.40. Finally, we propose that a deductible not exceed \$3.20 per family per month.

States should use these updated nominal amounts during FY 2007. Thereafter, we will update these amounts each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounding to the next higher 10-cent increment.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 60-

day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements:

Section 447.64 Premiums, Enrollment Fees, or Similar Fees: State Plan Requirements

Section 447.64 requires a State imposing premiums, enrollment fees, or similar fees on individuals to describe in the State plan:

(a) The group or groups of individuals that may be subject to the premiums, enrollment fees, or similar charges.

(b) The schedule of the premiums, enrollment fees, or similar fees imposed.

(c) The methodology used to determine family income for purposes of the limitations related to family income level that are described below, including the period and periodicity of those determinations.

(d) The methodology used to ensure compliance with the requirements of § 447.78 that the aggregate amount of premiums and cost sharing imposed for all individuals in the family does not exceed 5 percent of the family income of the family involved.

(e) The process for informing the recipients, applicants, providers, and the public of the schedule of premiums, enrollment fees, or similar fees for a group or groups of individuals in accordance with § 447.76.

(f) The notice of, timeframe for, and manner of required premium payments for a group or groups of individuals and the consequences for an individual who does not pay.

The burden associated with this requirement is the time and effort it would take for a State to include this detailed description in the State plan. We estimate it would take one State approximately 20 minutes to

incorporate this information in their plan. We believe 56 States will be affected by this requirement for a total annual burden of 18.67 hours.

Section 447.68 Copayments, Coinsurance, Deductibles, or Similar Cost Sharing Charges: State Plan Requirements

Section 447.68 requires a State imposing copayments, coinsurance, deductibles, or similar cost sharing charges on individuals to describe in the State plan:

(a) The group or groups of individuals that may be subject to the cost sharing charge.

(b) The methodology used to determine family income, for purposes of the limitations on cost sharing related to family income that are described below, including the period and periodicity of those determinations.

(c) The item or service for which the charge is imposed.

(d) The methods, such as the use of integrated automated systems, for tracking cost sharing charges, informing recipients and providers of their liability, and notifying recipients and providers when individual recipients have paid the maximum cost sharing charges permitted for the period of time.

(e) The process for informing recipients, applicants, providers, and the public of the schedule of cost sharing charges for specific items and services for a group or groups of individuals in accordance with § 447.76.

(f) The methodology used to ensure that:

(1) The aggregate amount of premiums and cost sharing imposed for all individuals with family income above 100 percent of the FPL does not exceed 5 percent of the family income of the family involved.

(2) The aggregate amount of cost sharing under sections 1916, 1916A(c), and/or 1916A(e) of the Act for individuals with family income at or below 100 percent of the FPL does not exceed 5 percent of the family income of the family involved.

(g) The notice of, timeframe for, and manner of required cost sharing and the consequences for failure to pay.

The burden associated with this requirement is the time and effort it would take for a State to include this detailed description in the State plan. We estimate it would take one State approximately 20 minutes to incorporate this information in their plan. We believe 56 States will be affected by this requirement for a total annual burden of 18.67 hours.

Section 447.76 Public Schedule

Section 447.76(a) requires States to make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current premiums, enrollment fees, or similar fees.

(2) Current cost sharing charges.

(3) The aggregate limit on premiums and cost sharing.

(4) Mechanisms for making payments for required premiums and charges.

(5) The consequences for an applicant or recipient who does not pay a premium or charge.

(6) A list of hospitals charging alternative cost sharing for non-emergency use of the emergency department.

The burden associated with this requirement is the time and effort it would take the State to prepare and make available to appropriate parties a public schedule. We estimate that it would take 20 minutes per State. We believe 56 States will be affected by this requirement for an annual burden of 18.67 hours.

Section 447.80 Enforceability of Premiums and Cost Sharing

Section 447.80(b)(1) states that a hospital that has determined after an appropriate medical screening pursuant to section 489.24, that an individual does not have an emergency medical condition before imposing cost sharing on an individual must provide the name and location of an available and accessible alternate non-emergency services provider as defined in section 1916A(e)(4)(B) of the Act, the fact that the alternate provider can provide the services with the imposition of a lesser cost sharing amount or no cost sharing, and a referral to coordinate scheduling of treatment by this provider before requiring payment of cost sharing.

The burden associated with this requirement is the time and effort it would take for a hospital to provide the name and location of an alternate provider who can provide services of a lesser cost sharing amount or no cost sharing and a referral. We estimate the burden on a hospital to be 30 minutes. We believe the number of hospital visits will be 4 million; therefore, the total annual burden is 2 million hours.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

If you comment on these information collection and recordkeeping

requirements, please mail copies directly to the following:
 Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attn: Melissa Musotto, [CMS-2244-P], Room C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850; and
 Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503,
 Attn: Katherine Astrich, CMS Desk Officer, CMS-2244-P, *katherine_astrich@omb.eop.gov*. Fax (202) 395-6974.

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). This rule reaches the economic threshold and thus is considered a major rule.

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 \$31.5 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 rule would not have a significant economic impact on a substantial number of 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 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. We have determined that this rule would require new spending in excess of the threshold. Table 2 outlines the total increase to Medicaid enrollees cost sharing as a result of all the provisions of the DRA. This includes an estimated cost increase to Medicaid recipients of \$105 million in 2007, \$155 million in 2008, \$255 million in 2009, \$375 million in 2010, and \$455 million in 2011.

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. We have determined that this rule would not impose substantial direct requirement costs on State and local governments.

B. Anticipated Effects

The following chart summarizes our estimate of the anticipated effects of this rule.

TABLE 1.—ESTIMATED SAVINGS OF THE COST SHARING PROVISIONS OF THE DEFICIT REDUCTION ACT (DRA) OF 2005
 [Savings in millions of dollars]

	2007	2008	2009	2010	2011
Federal Share					
Sec. 6041 Optional alternative premiums/cost sharing	65	85	135	190	220
Sec. 6042 Cost sharing for prescription drugs	40	65	120	185	240
Sec. 6043(a) Copays for non-emergency care in ER	5	10	15	20	25
State Share					
Sec. 6041 Optional alternative premiums/cost sharing	50	65	105	145	165
Sec. 6042 Cost sharing for prescription drugs	30	50	90	140	180
Sec. 6043(a) Copays for non-emergency care in ER	5	5	10	15	20

TABLE 2.—MEDICAID ENROLLEES COST SHARING IMPACT AS A RESULT OF THE PROVISIONS OF THE DEFICIT REDUCTION ACT (DRA) OF 2005
 [Costs in millions of dollars]

	2007	2008	2009	2010	2011
Medicaid Enrollee Share					
Total increase in Medicaid enrollee/cost sharing for all provisions	105	155	255	375	455

These estimates are based on data regarding copayments in the Medicaid program derived from a 2004 Kaiser Family Foundation survey, and data on premiums from a 2004 report by the U.S. Government Accountability Office. In addition, we have used enrollment data from the Medicaid Statistical Information System and utilization data from the 2002 Medicaid Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality.

We assume that only States that currently charge copayments and/or premiums for some groups will take advantage of the option to expand the use of premiums and copayments under the DRA provisions. States now charging copayments are assumed to increase them on average to 75 percent of maximum possible levels by 2011, and states currently charging premiums are assumed to add premiums requirements for some groups not currently allowed, also reaching 75 percent of the maximum possible by 2011.

In addition to direct savings from increased cost sharing, we assume there

would be declines in utilization as some enrollees subject to new cost sharing requirements choose to decrease their use of services. The decline is assumed to create additional savings of 75 percent of direct savings for physician and outpatient hospital services, 100 percent for drugs, and 125 percent for dental services. These additional savings are assumed to be reduced somewhat as a result of some providers failing to collect copayments. Savings are split between Federal and State governments using an average matching rate of 57 percent.

Table 2 illustrates that the estimated impact for Medicaid enrollees as a result of all of the cost-sharing provisions of the DRA are \$105 million for 2007, \$155 million for 2008, \$255 million for 2009, \$375 million for 2010, and \$455 million for 2011. Although, these estimates reflect an increase of costs to beneficiaries, we do not believe this will pose a barrier to accessing health care. The law provides that States can impose alternative cost sharing. We believe through the use of alternative cost

sharing, States will help recipients become more educated and efficient health care consumers. We do, however, solicit comments on these assumptions.

C. Alternatives Considered

This rule is necessary to implement section 1916A of the Social Security Act, which was established by the Deficit Reduction Act of 2005 (DRA) and amended by the Tax Relief and Health Care Act of 2006 (TRHCA).

D. Accounting Statement and Table

As required by OMB Circular A-4 (available at <http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf>), in the table 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 payment as a result of the changes presented in this proposed rule. All savings are classified as transfers to the Federal Government.

TABLE.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES, FROM FY 2007 TO FY 2011
[In millions]

Category	Transfers				
Annualized Monetized Transfers	3% Units Discount Rate \$278.2		7% Units Discount Rate \$270.7		
From Whom To Whom?	Beneficiaries to Federal Government				
Category	Transfers				
Year	2007	2008	2009	2010	2011
Annualized Monetized Transfers	\$110	\$160	\$270	\$395	\$485
From Whom To Whom?	Beneficiaries to Federal Government				
Category	Transfers				
Annualized Monetized Transfers	3% Units Discount Rate \$210.6		7% Units Discount Rate \$205.0		
From Whom To Whom?	Beneficiaries to Federal Government				
Category	Transfers				
Year	2007	2008	2009	2010	2011
Annualized Monetized Transfers	\$85	\$120	\$205	\$300	\$365
From Whom To Whom?	Beneficiaries to Federal Government				

E. Conclusion

We expect that this rule would promote the modernization of the Medicaid program. The proposed rule would provide a new option to States to create programs that are aligned with today's Medicaid populations and the health care environment. Through alternative cost sharing, States would

help recipients become more educated and efficient health care consumers. Thus, this rule would help ensure the sustainability of the Medicaid program over time.

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

List of Subjects

42 CFR Part 447

Accounting, Administrative practice and procedure, Drugs, Grant programs—Health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Part 457

Administrative practice and procedure, Grant programs—Health, Health insurance, Reporting and recordkeeping requirements.

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

PART 447—PAYMENTS FOR SERVICES

1. The authority citation for part 447 continues to read as follows:

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

- 2. Section 447.54 is amended by—
 - a. Republishing the introductory text to paragraph (a).
 - b. Revising paragraphs (a)(1) and (a)(3).
 - c. Adding new paragraph (a)(4).
 The republication, revisions, and additions read as follows:

§ 447.54 Maximum allowable and nominal charges.

(a) *Non-institutional services.* Except as specified in paragraph (b) of this section, for non-institutional services, the plan must provide that the following requirements are met:

(1) For Federal Fiscal Year 2007, any deductible it imposes does not exceed \$2.10 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for the period of eligibility is \$6.30. Thereafter, any deductible should not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher 10-cent increment.

* * * * *

(3)(i) For Federal Fiscal Year 2007, any copayments it imposes under a fee-for-service delivery system do not exceed the amounts shown in the following table:

State payment	Maximum copayment
\$10 or less	\$.60
\$10.01 to \$25	1.10
\$25.01 to \$50	2.10
\$50.01 or more	3.20

(ii) Thereafter, any copayments should not exceed these amounts as updated each October 1 by the percentage increase in the medical care

component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 10-cent increment.

(4) For Federal Fiscal Year 2007, any copayment it imposes for services provided by an MCO may not exceed \$5.20 per visit. Thereafter, any copayment should not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 10-cent increment.

* * * * *

3. Section 447.55 is amended by revising paragraph (b) to read as follows:

§ 447.55 Standard copayment.

* * * * *

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in § 447.54(a) and (b) to the agency's average or typical payment for that service. For example, if the agency's typical payment for prescribed drugs is \$4 to \$5 per prescription, the agency might set a standard copayment of \$.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under § 447.54(a)(3).

4. New §§ 447.62, 447.64, 447.66, 447.68, 447.70, 447.71, 447.72, 447.74, 447.76, 447.78, 447.80, and § 447.82, and a new undesignated center heading are added to read as follows:

ALTERNATIVE PREMIUMS AND COST SHARING UNDER SECTION 1916A

§ 447.62 Alternative premiums and cost sharing: Basis, purpose and scope.

(a) Section 1916A of the Act sets forth options for alternative premiums and cost sharing, which are premiums and cost sharing that are not subject to the limitations under section 1916 of the Act as described in § 447.51 through § 447.56. For States that impose alternative premiums, § 447.64 through § 447.66, § 447.72, § 447.74, § 447.78, and § 447.80 prescribe State plan requirements and options for alternative premiums and the standards and conditions under which States may impose them. For States that impose alternative cost sharing, § 447.68 through § 447.72, § 447.74, § 447.78, and § 447.80 prescribe State plan requirements and options for alternative cost sharing and the standards and conditions under which States may

impose alternative cost sharing. For other individuals, premiums and cost sharing must comply with the requirements described in § 447.50 through § 447.60.

(b) Neither section 1916A of the Act nor the regulations referenced in paragraph (a) of this section affect the following:

- (1) The Secretary's authority to waive limitations on premiums and cost sharing under this subpart.
- (2) Existing waivers with regard to the imposition of premiums and cost sharing.

§ 447.64 Alternative premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes alternative premiums, enrollment fees, or similar fees on individuals, the State plan must describe the following:

- (a) The group or groups of individuals that may be subject to the premiums, enrollment fees, or similar charges.
- (b) The schedule of the premiums, enrollment fees, or similar fees imposed.
- (c) The methodology used to determine family income for purposes of the limitations related to family income level that are described below, including the period and periodicity of those determinations.

(d) The methodology used to ensure compliance with the requirements of § 447.78 that the aggregate amount of premiums and cost sharing imposed for all individuals in the family do not exceed 5 percent of the family income of the family involved.

(e) The process for informing the recipients, applicants, providers, and the public of the schedule of premiums, enrollment fees, or similar fees for a group or groups of individuals in accordance with § 447.76.

(f) The notice of, time frame for, and manner of required premium payments for a group or groups of individuals and the consequences for an individual who does not pay.

§ 447.66 General alternative premium protections.

(a) States may not impose alternative premiums upon the following individuals:

(1) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i) of the Act, and including individuals with respect to whom child welfare services are made available under Part B of title IV on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(2) Pregnant women.

(3) Any terminally ill individual receiving hospice care, as defined in section 1905(o) of the Act.

(4) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if the individual 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.

(5) Women who are receiving Medicaid on the basis of the breast or cervical cancer eligibility group under sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(6) Disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(b) States may exempt additional classes of individuals from premiums.

§ 447.68 Alternative copayments, coinsurance, deductibles, or similar cost sharing charges: State plan requirements.

When a State imposes alternative copayments, coinsurance, deductibles, or similar cost sharing charges on individuals, the State plan must describe the following:

(a) The group or groups of individuals that may be subject to the cost sharing charge.

(b) The methodology used to determine family income, for purposes of the limitations on cost sharing related to family income that are described below, including the period and periodicity of those determinations.

(c) The item or service for which the charge is imposed.

(d) The methods, such as the use of integrated automated systems, for tracking cost sharing charges, informing recipients and providers of their liability, and notifying recipients and providers when individual recipients have paid the maximum cost sharing charges permitted for the period of time.

(e) The process for informing recipients, applicants, providers, and the public of the schedule of cost sharing charges for specific items and services for a group or groups of individuals in accordance with § 447.76.

(f) The methodology used to ensure that:

(1) The aggregate amount of premiums and cost sharing imposed for all individuals with family income above 100 percent of the FPL does not exceed 5 percent of the family income of the family involved.

(2) The aggregate amount of cost sharing under sections 1916, 1916A(c),

and/or 1916A(e) of the Act for individuals with family income at or below 100 percent of the FPL does not exceed 5 percent of the family income of the family involved.

(g) The notice of, time frame for, and manner of required cost sharing and the consequences for failure to pay.

§ 447.70 General alternative cost sharing protections.

(a)(1) States may not impose alternative cost sharing for the following items/services. Except as indicated, these limits do not apply to alternative cost sharing for non-preferred prescription drugs within a class of such drugs or non-emergency use of the emergency room.

(i) Services furnished to individuals under 18 years of age who are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom child welfare services are made available under Part B of title IV on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(ii) Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income.

(iii) Services furnished to pregnant women, if those services relate to pregnancy or to any other medical condition which may complicate the pregnancy.

(iv) Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act).

(v) Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if the individual 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.

(vi) Emergency services as defined at § 447.53(b)(4), except charges for services furnished after the hospital has determined, based on the screening and any other services required under § 489.24 of this chapter, that the individual does not have an emergency medical condition consistent with the requirements of paragraph (a)(2) of this section and § 447.80(b)(1).

(vii) Family planning services and supplies described in section 1905(a)(4)(C) of the Act.

(viii) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act (breast or cervical cancer provisions).

(ix) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(x) Preferred drugs within a class for individuals for whom cost sharing may not otherwise be imposed as described in paragraphs (a)(1)(i) through (a)(1)(ix) of this section.

(2) A State may impose nominal cost sharing as defined in § 447.54 for services furnished in a hospital emergency department, other than those required under § 489.24 of this chapter, if the hospital has determined based on the screening required under § 489.24 that the individual does not have an emergency medical condition, the requirements of § 447.80(b)(1) are met, and no cost sharing is imposed to receive the care through an outpatient department or another alternative health care provider in the geographic area of the hospital emergency department involved.

(b) In the case of a drug that is a preferred drug within a class, cost sharing may not exceed the levels permitted under section 1916 of the Act. Cost sharing can be imposed that exceeds section 1916 levels only for drugs that are not preferred drugs within a class in accordance with section 1916A(c).

(c) In the case of a drug that is not a preferred drug, the cost sharing is limited to the amount imposed for a preferred drug if the following conditions are met:

(1) The prescribing physician determines that the preferred drug would be less effective or would have adverse effects for the individual or both.

(2) State criteria for prior authorization, if any, are met.

(d) States may exempt additional individuals, items, or services from cost sharing.

§ 447.71 Alternative premium and cost sharing exemptions and protections for individuals with family incomes at or below 100 percent of the FPL.

(a) The State may not impose premiums under the State plan on individuals whose family income is at or below 100 percent of the FPL.

(b) The State may not impose cost sharing under the State plan on

individuals whose family income is at or below 100 percent of the FPL, with the following exceptions:

(1) The State may impose cost sharing for non-preferred drugs that does not exceed the nominal amount as defined in § 447.54.

(2) The State may impose cost sharing for non-emergency services furnished in a hospital emergency department that does not exceed the nominal amount as defined in § 447.54 so long as no cost sharing is imposed to receive such care through an outpatient department or other alternative non-emergency services provider in the geographic area of the hospital emergency department involved.

(c) Aggregate cost sharing of the family under sections 1916, 1916A(c), and/or 1916A(e) may not exceed the maximum permitted under § 447.78(b).

§ 447.72 Alternative premium and cost sharing exemptions and protections for individuals with family incomes above 100 percent but at or below 150 percent of the FPL.

(a) The State may not impose premiums under the State plan on individuals whose family income exceeds 100 percent, but does not exceed 150 percent, of the FPL.

(b) Cost sharing may not exceed 10 percent of the payment the agency makes for the item or service, with the following exceptions:

(1) Cost sharing for non-preferred drugs cannot exceed the nominal amount as defined in § 447.54.

(2) Cost sharing for non-emergency services furnished in the hospital emergency department cannot exceed twice the nominal amount as defined in § 447.54. A hospital must meet the requirements described at § 447.80 before the cost sharing can be imposed.

(3) In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO may not exceed \$5.20 for Federal Fiscal Year 2007. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 10-cent increment.

(c) Aggregate cost sharing of the family may not exceed the maximum permitted under § 447.78(a).

§ 447.74 Alternative premium and cost sharing protections for individuals with family incomes above 150 percent of the FPL.

(a) States may impose premiums consistent with the aggregate limits set forth in § 447.78(a).

(b) Cost sharing may not exceed 20 percent of the payment the agency makes for the item (including a non-preferred drug) or service, with the following exception: In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO may not exceed \$5.20 for Federal Fiscal Year 2007. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 10-cent increment.

(c) Aggregate premiums and cost sharing of the family may not exceed the maximum permitted under § 447.78(a).

§ 447.76 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current premiums, enrollment fees, or similar fees.

(2) Current cost sharing charges.

(3) The aggregate limit on premiums and cost sharing or just cost sharing.

(4) Mechanisms for making payments for required premiums and charges.

(5) The consequences for an applicant or recipient who does not pay a premium or charge.

(6) A list of hospitals charging alternative cost sharing for non-emergency use of the emergency department.

(b) The State must make the public schedule available to the following:

(1) Recipients, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, and the aggregate limits are revised.

(2) Applicants, at the time of application.

(3) All participating providers.

(4) The general public.

§ 447.78 Aggregate limits on alternative premiums and cost sharing.

(a) If a State imposes alternative premiums or cost sharing, the total aggregate amount of premiums and cost sharing under section 1916, 1916A(c) or 1916A(e) for individuals with family income above 100 percent of the FPL may not exceed 5 percent of the family's

income for the monthly or quarterly period, as specified by the State in the State plan

(b) The total aggregate amount of cost sharing under sections 1916, 1916A(c), and/or 1916A(e) of the Act for individuals with family income at or below 100 percent of the FPL may not exceed 5 percent of the family's income for the monthly or quarterly period, as specified in the State plan.

(c) Family income shall be determined in a manner and for that period as specified by the State in the State plan.

(1) States may use gross income or any other methodology.

(2) States may use a different methodology for determining the aggregate limits than they do for determining income eligibility.

§ 447.80 Enforceability of alternative premiums and cost sharing.

(a) With respect to alternative premiums, a State may do the following:

(1) Require a group or groups of individuals to prepay.

(2) Terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(3) Waive payment of a premium in any case where it determines that requiring the payment would create an undue hardship.

(b) With respect to alternative cost sharing, a State may permit a provider, including a pharmacy, to require an individual, as a condition for receiving the item or service, to pay the cost sharing charge, except as specified below.

(1) A provider, including a pharmacy and a hospital, may not require an individual whose family income is at or below 100 percent of the FPL to pay the cost sharing charge as a condition of receiving the service.

(2) A hospital that has determined after an appropriate medical screening pursuant to § 489.24, that an individual does not have an emergency medical condition, before imposing cost sharing on an individual, must provide the name and location of an available and accessible alternate non-emergency services provider as defined in section 1916A(e)(4)(B), the fact that the alternate provider can provide the services with the imposition of a lesser cost sharing amount or no cost sharing, and a referral to coordinate scheduling of treatment by this provider before requiring payment of cost sharing.

(3) The provider is not prohibited by this authority from choosing to reduce or waive cost sharing on a case-by-case basis.

§ 447.82 Restrictions on payments to providers.

The plan must provide that the agency reduces the payment it makes to any provider by the amount of a recipient's cost sharing obligation, regardless of whether the provider successfully collects the cost sharing.

PART 457—ALLOTMENTS AND GRANTS TO STATES

5. The authority citation for part 457 continues to read as follows:

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

6. Section 457.555 is amended by—
a. Republishing paragraph (a) introductory text.

b. Revising paragraphs (a)(1), (a)(2), and (a)(4).

c. Revising paragraph (c).

d. Revising paragraph (d).

The republication and revisions read as follows:

§ 457.555 Maximum allowable cost sharing charges on targeted low-income children in families with income from 101 to 150 percent of the FPL.

(a) *Non-institutional services.* For targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State plan must provide that for non-institutional services, including emergency services, the following requirements must be met:

(1)(i) For Federal Fiscal Year 2007, any copayment or similar charge the State imposes under a fee-for-service delivery system may not exceed the following amounts:

Total cost	Maximum amount
\$15.00 or less	\$1.10
\$15.01 to \$40	2.10
\$40.01 to \$80	3.20
\$80.01 or more	5.20

(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 10-cent increment.

(2) For Federal Fiscal Year 2007, any copayment that the State imposes for services provided by a managed care organization may not exceed \$5.20 per visit. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding

calendar year and then rounded to the next higher 10-cent increment.

* * * * *

(4) For Federal Fiscal Year 2007, any deductible the State imposes may not exceed \$3.20 per month, per family for each period of eligibility. Thereafter, any deductible may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 10-cent increment.

* * * * *

(c) *Institutional emergency services.* For Federal Fiscal Year 2007, any copayment that the State imposes on emergency services provided by an institution may not exceed \$5.20. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 10-cent increment.

(d) *Non-emergency use of the emergency room.* For Federal Fiscal Year 2007, for targeted low-income children whose family income is from 101 to 150 percent of the FPL, the State may charge up to twice the charge for non-institutional services, up to a maximum amount of \$10.40, for services furnished in a hospital emergency room if those services are not emergency services as defined in § 457.10. Thereafter, any charge may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 10-cent increment.

* * * * *

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

Dated: October 5, 2007.

Kerry Weems,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: November 1, 2007.

Michael O. Leavitt,

Secretary.

[FR Doc. E8-3211 Filed 2-21-08; 8:45 am]

BILLING CODE 4120-01-P

DEPARTMENT OF HOMELAND SECURITY

Federal Emergency Management Agency

44 CFR Part 67

[Docket No. FEMA-B-7763]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, DHS.

ACTION: Proposed rule.

SUMMARY: Comments are requested on the proposed Base (1 percent annual-chance) Flood Elevations (BFEs) and proposed BFE modifications for the communities listed in the table below. The purpose of this notice is to seek general information and comment regarding the proposed regulatory flood elevations for the reach described by the downstream and upstream locations in the table below. The BFEs and modified BFEs are a part of the floodplain management measures that the community is required either to adopt or show evidence of having in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP). In addition, these elevations, once finalized, will be used by insurance agents, and others to calculate appropriate flood insurance premium rates for new buildings and the contents in those buildings.

DATES: Comments are to be submitted on or before May 22, 2008.

ADDRESSES: The corresponding preliminary Flood Insurance Rate Map (FIRM) for the proposed BFEs for each community are available for inspection at the community's map repository. The respective addresses are listed in the table below.

You may submit comments, identified by Docket No. FEMA-B-7763, to William R. Blanton, Jr., Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646-3151, or (e-mail) bill.blanton@dhs.gov.

FOR FURTHER INFORMATION CONTACT:

William R. Blanton, Jr., Chief, Engineering Management Branch, Mitigation Directorate, Federal Emergency Management Agency, 500 C Street, SW., Washington, DC 20472, (202) 646-3151 or (e-mail) bill.blanton@dhs.gov.

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency (FEMA) proposes to make