10. Executive Order 12988

As required by section 3 of Executive Order 12988 (61 FR 4729, February 7, 1996), in issuing this rule, EPA has taken the necessary steps to eliminate drafting errors and ambiguity, minimize potential litigation, and provide a clear legal standard for affected conduct.

11. Executive Order 12630: Evaluation of Risk and Avoidance of Unanticipated Takings

EPA has complied with Executive Order 12630 (53 FR 8859, March 15, 1988) by examining the takings implications of the rule in accordance with the Attorney General's Supplemental Guidelines for the Evaluation of Risk and Avoidance of Unanticipated Takings issued under the Executive Order.

12. Congressional Review Act

EPA will submit a report containing this rule and other information required by the Congressional Review Act (5 U.S.C. 801 *et seq.*) to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

List of Subjects in 40 CFR Part 271

Environmental protection, Administrative practice and procedure, Confidential business information, Hazardous waste, Hazardous waste transportation, Indian lands, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements.

Authority: This action is issued under the authority of sections 2002(a), 3006 and 7004(b) of the Solid Waste Disposal Act as amended 42 U.S.C. 6912(a), 6926, 6974(b).

Dated: April 17, 2006.

James B. Gulliford,

Regional Administrator, Region 7.

[FR Doc. 06–4025 Filed 4–27–06; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 433

[CMS–2231–IFC]

RIN 0938–AO31

Medicaid Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 2006

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

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule with comment period sets forth the methodology and process used to compute and issue each State's allotment for fiscal year (FY) 2006 and FY 2007 that is available to pay Medicare Part B premiums for qualifying individuals. It also provides the preliminary FY 2006 allotments determined under this methodology.

DATES: *Effective date:* These regulations are effective October 1, 2005 for allotments for payment of Medicare Part B premiums from the allocations for FY 2006 and FY 2007.

Comment date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on June 27, 2006.

ADDRESSES: In commenting, please refer to file code CMS–2231–IFC. 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/regulations/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–2231–IFC, P.O. Box 8011, Baltimore, MD 21244–8011.

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–2231–IFC, 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.

FOR FURTHER INFORMATION CONTACT: Richard Strauss, (410) 786–2019.

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–2231–IFC 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/regulations/eRulemaking*. Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will 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.

SUPPLEMENTARY INFORMATION:

I. Background

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

A. Allotments Prior to FY 2005

Section 1902 of the Social Security Act (the Act) sets forth the requirements for State plans for medical assistance. Before August 5, 1997, section 1902(a)(10)(E) of the Act specified that the State Medicaid plan must provide for some or all types of Medicare cost sharing for three eligibility groups of low-income Medicare beneficiaries. These three groups included qualified Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and qualified disabled and working individuals (QDWIs).

A QMB is an individual entitled to Medicare Part A with income at or below the Federal poverty line (FPL) and resources below $4,000 for an individual and $6,000 for a couple. A SLMB is an individual who meets the QMB criteria, except that his or her income is above 100 percent of the FPL and does not exceed 120 percent of the FPL. A QDWI is a disabled individual who is entitled to enroll in Medicare Part A under section 1818A of the Act, whose income does not exceed 200 percent of the FPL for a family of the size involved, whose resources do not exceed twice the amount allowed under the Supplementary Security Income (SSI) program, and who is not otherwise eligible for Medicaid. The definition of Medicare cost-sharing at section 1905(p)(3) of the Act includes payment for premiums for Medicare Part B.

Section 4732 of the Balanced Budget Act of 1997 (BBA), enacted on August 5, 1997, amended section 1902(a)(10)(E) of the Act to require States to provide for Medicaid payment of the Medicare Part B premiums for two additional eligibility groups of low-income Medicare beneficiaries, referred to as qualifying individuals (QIs).

Specifically, a new section 1902(a)(10)(E)(iv)(I) of the Act was added, under which States must pay the full amount of the Medicare Part B premium for qualifying individuals who would be QMBs but for the fact that their income level is at least 120 percent of the FPL but less than 135 percent of the FPL for a family of the size involved. These individuals cannot otherwise be eligible for medical assistance under the approved State Medicaid plan. The second group of QIs added under section 1902(a)(10)(E)(iv)(II) of the Act includes Medicare beneficiaries who would be QMBs except that their income is at least 135 percent but less than 175 percent of the FPL for a family of the size involved, who are not otherwise eligible for Medicaid under the approved State plan. These QIs were eligible for only a portion of Medicare cost sharing consisting only of a percentage of the increase in the Medicare Part B premium attributable to the shift of Medicare home health coverage from Part A to Part B (as provided in section 4611 of the BBA).

Coverage of the second group of QIs ended on December 31, 2002 and the 2003 Welfare Reform Bill (Pub. L. 108–89) eliminated reference to the QI–2 benefit. In each of the years 2002 and 2003, Continuing Resolutions extended the coverage of the first group of QIs (whose income is at least 120 percent but less than 135 percent of the Federal poverty line) through the next fiscal year, but maintained the annual funding at the FY 2002 level.

In 2004, ''A Bill to Amend Title XIX of the Social Security Act to Extend Medicare Cost-Sharing for the Medicare Part B Premium for Qualifying Individuals'' (Pub. L. 108–448) continued coverage of this group through September 30, 2005, again with no change in funding.

The BBA also added a new section 1933 to the Act to provide for Medicaid payment of Medicare Part B premiums for QIs. (The previous section 1933 was re-designated as section 1934.)

Section 1933(a) of the Act specifies that a State plan must provide, through a State plan amendment, for medical assistance to pay for the cost of Medicare cost-sharing on behalf of QIs who are selected to receive assistance. Section 1933(b) of the Act sets forth the rules that States must follow in selecting QIs and providing payment for Medicare Part B premiums. Specifically, the State must permit all qualifying individuals to apply for assistance and must select individuals on a first-come, first-served basis (that is, the State must select QIs in the order in which they apply). Under section 1933(b)(2)(B) of the Act, in selecting persons who will receive assistance in years after 1998, States must give preference to those individuals who received assistance as QIs, QMBs, SLMBs, or QDWIs in the last month of the previous year and who continue to be (or become) QIs.

Under section 1933(b)(4) of the Act, persons selected to receive assistance in a calendar year are entitled to receive assistance for the remainder of the year, but not beyond, as long as they continue to qualify. The fact that an individual is selected to receive assistance at any time during the year does not entitle the individual to continued assistance for any succeeding year. Because the State's allotment is limited by law, section 1933(b)(3) of the Act provides that the State must limit the number of QIs so that the amount of assistance provided during the year is approximately equal to the allotment for that year.

Section 1933(c) of the Act limits the total amount of Federal funds available for payment of Part B premiums for QIs each fiscal year and specifies the formula that is to be used to determine an allotment for each State from this total amount. For States that executed a State plan amendment in accordance with section 1933(a) of the Act, a total of $1.5 billion was allocated over 5 years as follows: $200 million in FY 1998; $250 million in FY 1999; $300 million in FY 2000; $350 million in FY 2001; and $400 million in FY 2002. In 1999, the Department published a notice (64 FR 14931, March 29, 1999) to advise States of the methodology used to calculate allotments and each State's specific allotment for that year. Following that notice, there was no change in methodology and States have been notified annually of their allotments. We did not include the methodology for computing the allocation in our regulations. Although the BBA originally provided coverage of QIs only through FY 2002, through several continuing resolutions, coverage has been continued through the current fiscal year, but without any increase in total allocation over the FY 2002 level.

The Federal medical assistance percentage for Medicaid payment of Medicare Part B premiums for qualifying individuals is 100 percent for expenditures up to the amount of the State's allotment. No Federal funds are available for expenditures in excess of the State allotment amount. The Federal matching rate for administrative expenses associated with the payment of Medicare Part B premiums for QIs remains at the 50 percent matching level. Federal financial participation in the administrative expenses is not counted against the State's allotment.

The amount available for each fiscal year is to be allocated among States according to the formula set forth in section 1933(c)(2) of the Act. The formula provides for an amount to each

State that is to be based on each State's share of the Secretary's estimate of the ratio of: (a) An amount equal to the total number of individuals in the State who meet all but the income requirements for QMBs, whose incomes are at least 120 percent but less than 135 percent of the Federal poverty line, and who are not otherwise eligible for Medicaid, to (b) the sum of all those individuals for all eligible States.

B. Allotments for FY 2005

In FY 2005, some States exhausted their FY 2005 allotments before the end of the fiscal year, which caused them to deny benefits to eligible persons under section 1933(b)(3) of the Act, while other States projected a surplus in their allotments. We asked those States that exhausted or expected to exhaust their FY 2005 allotments before the end of the fiscal year to project the amount of funds that would be required to grant eligibility to all eligible persons in their State, that is, their need. We also asked those States that did not expect to use their full allotments in FY 2005 to project the difference between the amount they expected to spend and their allotment, that is, their surplus. After all States reported these figures, it was evident that the total surplus exceeded the total need. In spite of there being adequate overall funding for the QI benefit, some eligible individuals would have been denied benefits due to the allocation methodology initially used to determine the FY 2005 allotments.

We believed that it was the clear intent of the statute to provide benefits to eligible persons up to the full amount of funds made available for the program. We attributed the difference between the surplus in available QI allotments for some States and the need in other States in FY 2005 as due to the imprecision in the data that we used to provide States with their initial allocations under section 1933 of the Act. Therefore, on August 26, 2005 we published an interim final rule in the **Federal Register** (70 FR 50214) under which we compensated for this imprecision in order to enable States to enroll those QIs whom they would have been able to enroll had the data been more precise.

The interim final rule amended 42 CFR 433.10(c) to specify the formula and the data to be used to determine States' allotments and to revise, under certain circumstances, individual State allotments for a Federal fiscal year for the Medicaid payment of Medicare Part B premiums for qualifying individuals identified under section 1902(a)(10)(E)(iv) of the Act.

The FY 2005 allotments were determined by applying the U.S. Census Bureau data to the formula set forth in section 1933(c)(2)of the Act. However, the statute requires that the allocation of the fiscal year allotment be based upon a ratio of the amount of ''total number of individuals described in section 1902(a)(10)(E)(iv) in the State'' to the sum of these amounts for all States. Because this formula requires an estimate of an unknown number, that is, the number of individuals who could be QIs (rather than the number of individuals who were QIs in a previous period), our use of the Census Bureau data in the formula represented a rough proxy to attain the statutory number. Actual expenditure data, however, revealed that the Census Bureau data yielded an inappropriate distribution of the total appropriated fund as evidenced by the fact that several States projected significant shortfalls in their allotments, while many other States projected a significant surplus by the end of the fiscal year 2005. Census Bureau data were not accurate for the purpose of projecting States' needs because the data could not take into consideration all variables that contribute to QI eligibility and enrollment, such as resource levels and the application process itself.

While section 1933 of the Act requires the Secretary to estimate the allocation of the allotments among the States, it did not preclude a subsequent readjustment of that allocation, when it became clear that the data used for that estimate did not effectuate the statutory objective. The interim final rule published in the **Federal Register** on August 26, 2005 permitted in this specific circumstance a redistribution of surplus funds, as it was demonstrated that the States' projections and estimates resulted in an inequitable initial allocation for FY 2005, such that some States were granted an allocation in excess of their total projected need, while the allocation granted to other States proved insufficient to meet their projected QI expenditures.

In the August 26, 2005 interim final rule, we codified the methodology we have been using to approximate the statutory formula for determining State allotments. However, since certain States projected a deficit in their allotment before the end of fiscal year 2005, the rule permitted fiscal year 2005 funds to be reallocated from the surplus States to the need States. The regulation specified the methodology for computing the annual allotments, and for reallocating funds in this circumstance. The formula used to reallocate funds was intended to minimize the impact on surplus States, to equitably distribute the total needed amount among those surplus States, and to meet the immediate needs for those States projecting deficits. At the time of the publication of the interim final rule on August 26, 2005, the authorization for the QI benefit expired at the end of calendar year 2005, and no additional funds were appropriated for the QI benefit beyond September 30, 2005; therefore, the regulation specified a sunset at the end of calendar year 2005.

Finally, we received only one comment with respect to the August 26, 2005 interim final rule. The comment indicated that the Census Bureau data were inadequate for the purpose of appropriately allocating the funds available for the QI program; in that regard, they commended CMS for modifying the formula to more precisely address States' needs under this program. The comment also asked for clarification on the source of the data used for modifying the allocation formula. Our response to that comment is that the data used are obtained directly from the States and, specifically, are the States' estimates of the expenditures that would be incurred under this program. The August 26, 2005 interim final rule indicated that. As indicated below, the methodology/process for allocation of the QI allotments for FY 2006 and 2007 takes the same approach and uses the same data that were used to reallocate fiscal year 2005 funds.

C. Allotments for FY 2006 and FY 2007

On October 20, 2005 the ''QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005'' was enacted by Congress (Pub. L. 109–91). In particular, section 101 of Pub. L. 109–91 extended the QI program through September 30, 2007 with no change in funding; that is, under this legislation $400 million per fiscal year is appropriated for each of FY 2006 and FY 2007. Under section 101(c), the provisions of section 101 of Pub. L. 109–91 are effective as of September 30, 2005.

We continue to believe that the clear intent of the statute is to provide benefits to eligible persons up to the full amount of funds made available for the program in each fiscal year. We recognize that because of the imprecision in data for computing the States' QI allotments for a fiscal year, there is the potential for a surplus to occur with respect to available QI allotments for some States and a need to occur in other States for FY 2006 and FY 2007. We are publishing this interim final rule for the determination of States' FY 2006 and FY 2007 QI

allotments under which we attempt to compensate for the imprecision in data in order to enable States to enroll those QIs whom they would have been able to enroll if the data were more precise.

II. Provisions of the Interim Final Rule

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

This interim final rule amends 42 CFR 433.10(c) to specify the formula, data, and process to be used for determining and issuing States' QI allotments. This methodology and process provides for an adjustment in the amounts of the QI allotments preliminarily determined for the Medicaid payment of Medicare Part B premiums for qualifying individuals identified under section 1902(a)(10)(E)(iv) of the Act.

Under the methodology and process described in this interim final rule, ''initial'' FY 2006 and FY 2007 allotments will be derived by applying U.S. Census Bureau data to the formula set forth in section 1933(c)(2) of the Act. The statute requires that the allocation of the fiscal year allotment be based upon a ratio of the amount of ''total number of individuals described in section 1902(a)(10)(E)(iv) in the State'' to the sum of these amounts for all States. Because this formula requires an estimate of an unknown number, that is, the number of individuals who could be QIs (rather than the number of individuals who were QIs in a previous period), our use of the Census Bureau data in the formula represents a proxy to attain the statutory number. Use of the Census Bureau data may yield an inappropriate distribution of the total appropriated funds resulting in significant shortfalls in the projected allotments for some States and significant surpluses by the end of the fiscal year for other States. Census Bureau data may not be sufficiently accurate for the purpose of projecting States' needs because the data cannot take into consideration all variables that contribute to QI eligibility and enrollment, such as resource levels and the application process itself. While section 1933 of the Act requires the Secretary to estimate the allocation of the allotments among the States, it does not preclude a subsequent readjustment of that allocation, when it becomes clear that the data used for that estimate did not effectuate the statutory objective.

This interim final rule sets out a methodology and process for determining States' QI allotments for FY 2006 and FY 2007 that permits a redistribution of surplus funds to States whose allotments, determined based only on the formula in section 1933 of the Act, would be insufficient to meet their projected QI expenditures for the fiscal year. In this interim final rule, we are codifying the methodology and process we will use to approximate the statutory formula for determining State allotments and making adjustments in such allotment, as appropriate.

In this interim final rule, we set forth a two step/two phase methodology/process for determining States' QI allotments for FY 2006 and FY 2007. Under the first step of phase one, an ''initial'' allocation would be determined for each State under the formula specified in section 1933 of the Act and based only on the data obtained from the Census Bureau (the 3-year average of the number of Medicare beneficiaries in the State who are not enrolled in the Medicaid program but whose incomes are at least 120 percent of the Federal poverty level and less than 135 percent of the Federal poverty level). However, we would also obtain States' projected QI expenditures for the fiscal year. We would then compare the initial allocations for the fiscal year to the States' projected QI expenditures for the fiscal year to determine those States with a projected need (initial allocation is less than the projected expenditures) or a surplus (initial allocation is greater than the projected expenditures) for the fiscal year. Under the second step, we would adjust the States' initial allocations by considering the States' projected QI expenditures for the fiscal year. This would be done by reducing the States' surpluses by the amount of the total States' need.

In this interim final rule, we will apply this methodology/process in two phases in each fiscal year. That is, at the beginning of each fiscal year, we would determine the initial allocations based on the Census Bureau data, obtain States' projected QI expenditures for the fiscal year, and make any adjustments based on the projected surpluses/needs for the fiscal year. The amount of the States' QI allotments determined under phase one at the beginning of the fiscal year would be considered the ''preliminary'' QI allotments for the fiscal year. Then, under phase two of the process sometime during the fourth quarter of the fiscal year we would obtain States' updated projected QI expenditures for the fiscal year. We would then establish the ''final'' QI allotments for the fiscal year based on these updated projections.

The final QI allotments would be determined by comparing the initial QI allotments for the fiscal year (again which are calculated based on the Census Bureau data) to the States' updated projections of QI expenditures for the fiscal year; this would established the States with a ''final'' projected need (initial allocation is less than the updated projected expenditures) or a surplus (initial allocation is greater than the updated projected expenditures) for the fiscal year. Using the updated projected QI expenditures, we would adjust the States' initial allocations by reducing the surplus States' initial allotments proportionately to meet the need States' deficits. This is the same methodology used for determining the FY 2005 allotments as published in the interim final rule published on August 26, 2005 in the **Federal Register**; the only change is that in computing the FY 2006 and FY 2007 allotments, we will determine the preliminary allotments at the beginning of the fiscal year using States' preliminary projected QI expenditures, and then we will determine the final QI allotments later in the fiscal year using States' updated projected QI expenditures.

The formula used to reallocate the available funds to need States is intended to minimize the impact on surplus States, to equitably distribute the total needed amount among those surplus States, and to meet the needs for those States projecting deficits. Since under Pub. L. 109–91 the authorization for the QI benefit expires at the end of calendar year 2007, and currently no funds have been appropriated for the QI benefit beyond September 30, 2007, this regulation will sunset at the end of calendar year 2007. Should the Congress authorize an extension of the QI benefit and appropriate additional funds for allocation among the States, we will amend the sunset date in this regulation to take into account any extension.

The resulting initial allotments for FY 2006 are shown by State in the table below. In this table each column contains data defined as follows:

Chart—Preliminary FY 2006 Qualified Individuals Allotments

Column A—State. Column A shows the name of each State.

Columns B through D show the determination of the States' Initial FY 2006 QI Allotments, based only on Census Bureau data.

Column B—Number of Individuals. Column B contains the estimated average number of Medicare beneficiaries for the years 2003 through 2005 who are not covered by Medicaid whose family income is between 120 and 135 percent of the poverty level for each State, in thousands, as obtained from the Census Bureau's Annual Social and Economic Supplement to the

Current Population Survey through March of 2005.

Column C—Percentage of Total. Column C provides the percentage of total number of individuals for each State, determined as the Number of Individuals for the State in Column B divided by the sum of the Number of Individuals for all States in Column B.

Column D—Initial QI Allotment. Column D contains each State's Initial FY 2006 QI allotment, calculated as the State's Percentage of Total in Column C multiplied by $400,000,000, the total amount available for FY 2006 for all States.

Columns E through J show the determination of the States' Preliminary FY 2006 QI Allotments.

Column E—FY 2006 Estimated QI Expenditures. Column E contains the States' most recent estimates of their total QI expenditures for FY 2006.

Column F—Need (Difference). Column F contains the additional amount of QI allotment needed for those States whose estimated expenditures in Column E exceed their Initial FY 2006 QI allotments in Column D; for such States, Column E shows the amount in Column E minus the amount in Column D. For other States, Column F shows ''NA.''

Column G—Reduction Pool for Non-Need States. Column G contains the amount of the pool of surplus FY 2006 QI allotments for those States that project they will not need all of their FY 2006 QI allotments (referred to as non-need States). For States whose estimates of QI expenditures for FY 2006 in Column E are equal to or less than their Initial FY 2006 QI allotments in Column D, Column G shows the amount in Column D minus the amount in Column E. For the States with a need, Column G shows ''Need.'' The pool of excess QI allotments is equal to the sum of the amounts in Column G.

Column H—Percent of Total Non-Need States. Column H shows the percentage of the total excess FY 2006 allotments for each Non-Need State, determined as the amount for each Non-Need State in Column G divided by the sum of the amounts for all States in Column G.

Column I—Reduction for Non-Need States. Column I shows the amount of reduction to Non-Need States' Initial FY 2006 QI allotments in Column D in order to provide for the total need shown in Column F. The amount in Column I is determined as the percentage in Column H for Non-Need States multiplied by the sum of the need for all States from Column F.

Column J—Preliminary FY 2006 QI Allotment. Column J contains the Preliminary FY 2006 QI allotment for each State. For States that need additional amounts based on their FY 2006 Estimated QI Expenditures in Column E, Column J is equal to the Initial FY 2006 QI Allotment in Column D plus the amount of Need Column F. For Non-Need States, Column J is equal to the Initial FY 2006 QI Allotment in Column D minus the amount in Column I.

BILLING CODE 4120–01–P

PRELIMINARY FY 2006 QUALIFIED INDIVIDUALS ALLOTMENTS

STATE	Initial QI Allotments for FY 2006			FY 2006 Estimated QI Expenditures /1	Need (Difference)	Reduction Pool for Non-Need States	Percent of Total Non-Need States	Reduction for Non-Need States (Col H x Tot. Col F)	Preliminary FY 2006 QI Allotment /2
	Number of Individuals /3 (000s)	Percentage of Total Col B/Tot. Col B	Initital QI Allotment Col C x $400,000,000		If E>D, E-D	If D > E, D - E	G/(Total of G)	$32,244,853	
A	B	C	D	E	F	G	H	I	J
Alabama	30.3	2.00%	$7,991,218	$16,191,289	$8,200,071	Need	Need	Need	$16,191,289
Alaska	1.3	0.09%	$351,262	$175,000	NA	$176,262	0.1325%	$42,727	$308,536
Arizona	42	2.74%	$10,976,948	$13,646,100	$2,669,152	Need	Need	Need	$13,646,100
Arkansas	21	1.41%	$5,620,198	$4,208,845	NA	$1,411,353	1.0610%	$342,118	$5,278,079
California	134	8.80%	$35,214,050	$12,370,153	NA	$22,843,897	17.1732%	$5,537,466	$29,676,584
Colorado	12	0.79%	$3,161,361	$2,026,296	NA	$1,135,065	0.8533%	$275,145	$2,886,216
Connecticut	13	0.88%	$3,512,623	$7,123,610	$3,610,987	Need	Need	Need	$7,123,610
Delaware	4	0.24%	$965,971	$279,000	NA	$686,971	0.5164%	$166,525	$799,446
District of Columbia	2	0.15%	$614,709	$750,000	$135,291	Need	Need	Need	$750,000
Florida	109	7.18%	$28,715,697	$23,468,000	NA	$5,247,697	3.9450%	$1,272,066	$27,443,631
Georgia	47	3.07%	$12,294,182	$12,515,102	$220,920	Need	Need	Need	$12,515,102
Hawaii	5	0.33%	$1,317,234	$291,000	NA	$1,026,234	0.7715%	$248,764	$1,068,470
Idaho	5	0.31%	$1,229,418	$1,200,000	NA	$29,418	0.0221%	$7,131	$1,222,287
Illinois	79	5.23%	$20,900,110	$11,400,000	NA	$9,500,110	7.1418%	$2,302,870	$18,597,239
Indiana	51	3.36%	$13,435,785	$4,200,000	NA	$9,235,785	6.9431%	$2,238,797	$11,196,988
Iowa	16	1.05%	$4,215,148	$1,898,536	NA	$2,316,612	1.7415%	$561,557	$3,653,591
Kansas	13	0.83%	$3,336,992	$878,090	NA	$2,458,902	1.8485%	$596,049	$2,740,943
Kentucky	31	2.04%	$8,166,850	$4,930,866	NA	$3,235,984	2.4327%	$784,417	$7,382,432
Louisiana	38	2.48%	$9,923,161	$12,829,811	$2,906,650	Need	Need	Need	$12,829,811
Maine	9	0.57%	$2,283,205	$3,208,692	$925,487	Need	Need	Need	$3,208,692
Maryland	19	1.25%	$5,005,488	$3,021,123	NA	$1,984,365	1.4918%	$481,019	$4,524,469
Massachusetts	41	2.68%	$10,713,502	$4,203,561	NA	$6,509,941	4.8939%	$1,578,040	$9,135,462
Michigan	48	3.14%	$12,557,629	$6,280,000	NA	$6,277,629	4.7193%	$1,521,726	$11,035,903
Minnesota	17	1.14%	$4,566,411	$3,075,871	NA	$1,490,540	1.1205%	$361,314	$4,205,097
Mississippi	18	1.19%	$4,742,042	$3,400,000	NA	$1,342,042	1.0089%	$325,317	$4,416,725
Missouri	37	2.41%	$9,659,715	$1,872,000	NA	$7,787,715	5.8545%	$1,887,778	$7,771,937
Montana	8	0.53%	$2,107,574	$481,086	NA	$1,626,488	1.2227%	$394,268	$1,713,306
Nebraska	10	0.68%	$2,722,283	$1,301,324	NA	$1,420,959	1.0682%	$344,447	$2,377,836
Nevada	7	0.44%	$1,756,312	$1,183,734	NA	$572,578	0.4304%	$138,795	$1,617,516
New Hampshire	8	0.50%	$2,019,759	$592,848	NA	$1,426,911	1.0727%	$345,890	$1,673,869
New Jersey	49	3.21%	$12,821,076	$9,169,648	NA	$3,651,428	2.7450%	$885,123	$11,935,953
New Mexico	12	0.79%	$3,161,361	$1,417,627	NA	$1,743,734	1.3109%	$422,689	$2,738,672
New York	92	6.04%	$24,149,286	$36,198,273	$12,048,987	Need	Need	Need	$36,198,273
North Carolina	72	4.76%	$19,055,982	$13,500,000	NA	$5,555,982	4.1768%	$1,346,796	$17,709,187
North Dakota	4	0.24%	$965,971	$310,971	NA	$655,000	0.4924%	$158,775	$807,196
Ohio	61	4.04%	$16,158,068	$13,127,517	NA	$3,030,551	2.2783%	$734,620	$15,423,449
Oklahoma	19	1.27%	$5,093,304	$5,364,336	$271,032	Need	Need	Need	$5,364,336
Oregon	16	1.05%	$4,215,148	$5,339,318	$1,124,170	Need	Need	Need	$5,339,318
Pennsylvania	60	3.93%	$15,718,990	$15,315,000	NA	$403,990	0.3037%	$97,929	$15,621,061
Rhode Island	7	0.44%	$1,756,312	$1,888,421	$132,109	Need	Need	Need	$1,888,421
South Carolina	27	1.80%	$7,200,878	$5,700,000	NA	$1,500,878	1.1283%	$363,820	$6,837,058
South Dakota	5	0.35%	$1,405,049	$806,175	NA	$598,874	0.4502%	$145,170	$1,259,879
Tennessee	32	2.09%	$8,342,481	$290,811	NA	$8,051,670	6.0529%	$1,951,762	$6,390,719
Texas	89	5.88%	$23,534,577	$18,968,954	NA	$4,565,623	3.4323%	$1,106,728	$22,427,849
Utah	6	0.42%	$1,668,496	$323,118	NA	$1,345,378	1.0114%	$326,126	$1,342,370
Vermont	4	0.26%	$1,053,787	$0	NA	$1,053,787	0.7922%	$255,443	$798,344
Virginia	31	2.02%	$8,079,034	$5,370,060	NA	$2,708,974	2.0365%	$656,668	$7,422,366
Washington	19	1.23%	$4,917,673	$3,283,094	NA	$1,634,579	1.2288%	$396,229	$4,521,443
West Virginia	19	1.27%	$5,093,304	$2,900,000	NA	$2,193,304	1.6488%	$531,667	$4,561,637
Wisconsin	19	1.27%	$5,093,304	$583,603	NA	$4,509,701	3.3902%	$1,093,172	$4,000,132
Wyoming	2	0.11%	$439,078	$365,200	NA	$73,878	0.0555%	$17,908	$421,170
Total	1518	100.00%	$400,000,000	$299,224,063	$32,244,853	$133,020,790	100.0000%	$32,244,853	$400,000,000

Footnotes:

/1 FY 2006 Estimates from November 2005 CMS Survey of States

/2 For Need States Preliminary FY 2006 QI Allotment is equal to Initial QI Allotment in Column D increased by amount in Column F
For Non-Need States Preliminary FY 2006 QI Allotment is equal to Initial QI Allotment in Column D reduced by amount in Column I

/3 Three-year average (2003-2005) of number (000) of Medicare beneficiaries in State who are not enrolled in Medicaid but whose incomes are at least 120% but less than 135% of FPL.
Source: Census Bureau Annual Social and Economic Supplement (ASEC) to the Current Population Survey (CPS) for past 3 years through March of 2005

III. Collection of Information Requirements

This document does not impose information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

IV. Waiver of Notice With Comment and 30-Day Delay in Effective Date

[If you choose to comment on issues in this section, please include the caption ''WAIVER OF ADVANCE PUBLIC COMMENT'' at the beginning of your comments.]

We ordinarily publish an advance notice in the **Federal Register** for substantive rules to provide a period for public comment. However, we may waive that procedure if we find good cause that notice and comment are impractical, unnecessary, or contrary to the public interest. In addition, we also normally provide a delay of 30 days in the effective date. However, if adherence to this procedure would be impractical, unnecessary, or contrary to public interest, we may waive the delay in the effective date.

We are publishing this rule as an interim final rule because of the need to notify individual States of the limitations on Federal funds for their Medicaid expenditures for payment of Medicare Part B premiums for qualifying individuals. Some States have experienced deficits in their current allotments that have caused them to deny benefits to eligible applicants, while other States project a surplus in their allotments. This rule permits redistribution of funds and will allow all eligible applicants to receive QI benefits during this calendar year. Because access to Medicare Part B coverage for QIs, who without this coverage would have difficulty paying for needed health care, is critically important, we believe that it is in the public interest to waive the usual notice and comment procedure which we undertake before making a rule final.

Also, for the reasons discussed above, we find that good cause exists to dispense with the normal requirement that a regulation cannot become effective any earlier than 30 days after its publication. States that will have access to additional funds to enroll QIs need to know that these funds are available as soon as possible, so they can begin enrolling QIs. While we believe those States that will have diminished amounts available for this fiscal year will have sufficient funds for enrolling all potential QIs in their States, they also need to know as soon as possible that a certain amount of their unused allocation will no longer be available to them for this fiscal year.

We are publishing this interim final rule with a 60-day period for public comment. However, if we decide that changes are necessary as a result of our consideration of timely comments, we will issue a final rule and respond to the comments in that rule.

V. Regulatory Impact Statement

We have examined the impact 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 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 does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief for 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 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity.

This interim final rule with comment period codifies our procedures for implementing provisions of the Balanced Budget Act of 1997 to allocate, among the States, Federal funds to provide Medicaid payment for Medicare Part B premiums for low-income Medicare beneficiaries. The total amount of Federal funds available during a Federal fiscal year and the formula for determining individual State allotments are specified in the law. We have applied the statutory formula for the State allotments. Because the data specified in the law were not initially available, we used comparable data from the U.S. Census Bureau on the number of possible qualifying individuals in the States. This rule also permits, in a specific circumstance, reallocation of funds to enable enrollment of all eligible individuals to the extent of the available funding.

We believe that the statutory provisions implemented in this interim final rule with comment period will have a positive effect on States and individuals. Federal funding at the 100 percent matching rate is available for Medicare cost-sharing for Medicare Part B premium payments for qualifying individuals and, with the reallocation of the State allotments, a greater number of low-income Medicare beneficiaries will be eligible to have their Medicare Part B premiums paid under Medicaid. In no States will the changes in allotments result in fewer individuals receiving the QI benefit. The FY 2006 and FY 2007 costs for this provision have been included in the FY 2007 President's Budget.

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any rule that may have a significant impact on the operations of a substantial number of small rural hospitals. The analysis must conform to the provisions of section 604 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 a Core-Based Statistical Area and has fewer than 100 beds.

We are not preparing analyses for either the RFA or section 1102(b) of the Act because we have determined and certify that this interim final rule with comment period will not have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. This rule will have no consequential effect on the governments mentioned or on the private sector.

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. Since this regulation does not impose any costs on State or local governments,

the requirements of E.O. 13132 are not applicable.

In accordance with the provisions of Executive Order 12866, this interim final rule with comment period was reviewed by the Office of Management and Budget.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Child support, Claims, Grant programs health, Medicaid, Reporting and recordkeeping requirements.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR Chapter IV as set forth below:

PART 433—STATE FISCAL ADMINISTRATION

■ 1. The authority citation for part 433 continues to read as follows:

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

■ 2. Section 433.10 is amended by revising paragraph (c)(5) to read as follows:

§ 433.10 Rates of FFP for program services.

* * * * *

(c) * * *

(5)(i) Under section 1933(d) of the Act, the Federal share of State expenditures for Medicare Part B premiums described in section 1905(p)(3)(A)(ii) of the Act on behalf of Qualifying Individuals described in section 1902(a)(10)(E)(iv) of the Act, is 100 percent, to the extent that the assistance does not exceed the State's allocation under paragraph (c)(5)(ii) of this section. To the extent that the assistance exceeds that allocation, the Federal share is 0 percent.

(ii) Under section 1933(c)(2) of the Act and subject to paragraph (c)(5)(iii) of this section, the allocation to each State is equal to the total allocation specified in section 1933(c)(1) of the Act multiplied by the Secretary's estimate of the ratio of the total number of individuals described in section 1902(a)(10)(E)(iv) of the Act in the State to the total number of individuals described in section 1902(a)(10)(E)(iv) of the Act for all eligible States. In estimating that ratio, the Secretary will use data from the U.S. Census Bureau.

(iii) If, based on projected expenditures for a fiscal year, the Secretary determines that the expenditures described in paragraph (c)(5)(i) of this section for one or more States are projected to exceed the allocation made to the State, the Secretary may adjust each State's fiscal year 2005, 2006, or 2007 allocation, as follows:

(A) The Secretary will compare each State's projected total expenditures for the expenses described in paragraph (c)(5)(i) of this section to the State's initial allocation determined under paragraph (c)(5)(ii) of this section, to determine the extent of each State's projected surplus or deficit.

(B) The surplus of each State with a projected surplus, as determined in accordance with paragraph (c)(5)(iii)(A) of this section will be added together to arrive at the Total Projected Surplus.

(C) The deficit of each State with a projected deficit, as determined in accordance with paragraph (c)(5)(iii)(A) of this section will be added together to arrive at the Total Projected Deficit.

(D) Each State with a projected deficit will receive an additional allocation equal to the amount of its projected deficit. The amount to be reallocated from each State with a projected surplus will be equal to A x B, where A equals the Total Projected Deficit and B equals the amount of the State's projected surplus as a percentage of the Total Projected Surplus.

(iv) CMS will notify States of any changes in allotments resulting from any reallocations.

(v) The provisions of this paragraph (c)(5) will be in effect through the end of calendar year 2007.

Authority: Sections 1902(a)(10), 1933 of the Social Security Act (42 U.S.C. 1396a), and Pub. L. 105–33.)

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

Dated: January 20, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: February 14, 2006.

Michael O. Leavitt,

Secretary.

[FR Doc. 06–3981 Filed 4–27–06; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

45 CFR Part 146

[CMS–4094–F4]

RIN 0938–AN80

Amendment to the Interim Final Regulation for Mental Health Parity

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

ACTION: Amendment to interim final regulation.

SUMMARY: This document amends the interim final regulation that implements the Mental Health Parity Act of 1996 (MHPA) to conform the sunset date of the regulation to the sunset date of the statute under legislation passed on December 30, 2005.

DATES: *Effective date:* The amendment to the regulation is effective May 30, 2006.

Applicability dates: Under the amendment, the requirements of the MHPA interim final regulation apply to group health plans and health insurance coverage offered in connection with a group health plan during the period commencing May 30, 2006 through December 31, 2006.

FOR FURTHER INFORMATION CONTACT: Dave Mlawsky, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, at 1–877–267–2323, ext. 61565.

SUPPLEMENTARY INFORMATION:

I. Background

The Mental Health Parity Act of 1996 (MHPA) was enacted on September 26, 1996 (Pub. L. 104–204). MHPA amended the Public Health Service Act (PHS Act) and the Employee Retirement Income Security Act of 1974 (ERISA) to provide for parity in the application of annual and lifetime dollar limits on mental health benefits and the application of dollar limits on medical/surgical benefits. Provisions implementing MHPA were later added to the Internal Revenue Code of 1986 (Code) under the Taxpayer Relief Act of 1997 (Pub. L. 105–34).

The provisions of MHPA are set forth in Title XXVII of the PHS Act, Part 7 of Subtitle B of Title I of ERISA, and Chapter 100 of Subtitle K of the Code. The Secretaries of Health and Human Services, Labor, and the Treasury share jurisdiction over the MHPA provisions. These provisions are substantially similar, except for jurisdictional differences. See for example, the amendment to the interim final rule published July 22, 2005 (70 FR 42276).

II. Overview of MHPA

The MHPA provisions are set forth in section 2705 of the PHS Act, section 712 of ERISA, and section 9812 of the Code. MHPA applies to a large group health plan (or health insurance coverage offered in connection with a large group health plan) that provides both medical/surgical benefits and mental health benefits. MHPA's original text included a sunset provision specifying that MHPA's provisions would not apply to