to family income level that are described in §447.78(c) of this chapter, including the period and periodicity of those determinations.

(c) The schedule of the copayments, coinsurance, deductibles, or similar cost sharing charges imposed for each item or service for which a charge is imposed.

(d) The methodology used by the State to identify beneficiaries who are subject to premiums or cost sharing for specific items or services and, if families are at risk of reaching the total aggregate limit for premiums and cost sharing under Medicaid defined at §447.78, track beneficiaries’ incurred premiums and cost sharing through a mechanism developed by the State that does not rely on beneficiaries, in order to inform beneficiaries and providers of beneficiaries’ liability and notify beneficiaries and providers when individual beneficiaries have incurred family out-of-pocket expenses up to that limit and are no longer subject to further cost sharing for the remainder of the family’s current monthly or quarterly cap period.

(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 under section 1916 and section 1916A of the Act for all individuals in the family enrolled in Medicaid with family income above 100 percent of the Federal poverty level (FPL) does not exceed 5 percent of the family’s income of the family involved.

(2) The aggregate amount of cost sharing imposed under section 1916 and section 1916A of the Act for all individuals in the family enrolled in Medicaid with family income at or below 100 percent of the FPL does not exceed 5 percent of the family’s income of the family involved.

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

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

(5) 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.

(6) Emergency services as defined at section 1932(b)(2) of the Act and §438.11(a), 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

\[73 \text{ FR 71851, Nov. 25, 2008, as amended at 75 FR 30262, May 28, 2010}\]
§ 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 under authority provided under section 1916 of the Act and consistent with the levels described in such section and § 447.54.

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

(3) 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 as long as the services are available in a timely manner without cost sharing through an outpatient department or another alternative non-emergency health care provider in the geographic area of the hospital emergency department involved.

(c) In the case of a drug that a State’s Medicaid program either has identified as a preferred drug within a class or has not otherwise identified as a non-preferred drug within a class, cost sharing may not exceed the nominal levels permitted under section 1916 of the Act as specified in § 447.54 of this chapter. Cost sharing can be imposed that exceeds the nominal levels permitted under section 1916 of the Act for drugs that are identified by a State’s Medicaid program as non-preferred drugs within a class in accordance with section 1916A(c) of the Act.

(d) In the case of a drug that is identified by a State’s Medicaid program as a non-preferred drug within a class, the cost sharing is limited to the amount imposed for a preferred drug if the individual’s prescribing physician determines that the preferred drug for treatment of the same condition either would be less effective for the individual or would have adverse effects for the individual or both.

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