(3) Nothing in this section shall be construed as prohibiting a provider from choosing to reduce or waive such cost sharing on a case-by-case basis.

(f) Prohibition against multiple charges. For any service, the agency may not impose more than one type of cost sharing.

(g) Income-related charges. Subject to the maximum allowable charges specified in §§ 447.52(b), 447.53(b) and 447.54(b), the plan may establish different cost sharing charges for individuals at different income levels. If the agency imposes such income-related charges, it must ensure that lower income individuals are charged less than individuals with higher income.

(h) Services furnished by a managed care organization (MCO). Contracts with MCOs must provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the cost sharing specified in the state plan and the requirements set forth in §§ 447.50 through 447.57.

(i) State Plan Specifications. For each cost sharing charge imposed under this part, the state plan must specify—

(1) The service for which the charge is made;

(2) The group or groups of individuals that may be subject to the charge;

(3) The amount of the charge;

(4) The process used by the state to—

(i) Ensure individuals exempt from cost sharing are not charged,

(ii) Identify for providers whether cost sharing for a specific item or service may be imposed on an individual and whether the provider may require the individual, as a condition for receiving the item or service, to pay the cost sharing charge; and

(5) If the agency imposes cost sharing under § 447.54, the process by which hospital emergency room services are identified as non-emergency service.

DEDUCTIBLE, COINSURANCE, CO-PAYMENT OR SIMILAR COST-SHARING CHARGE

§ 447.53 Applicability; specification; multiple charges.

(a) Basic requirements. Except as specified in paragraph (b) of this section, the plan may impose a nominal deductible, coinsurance, copayment, or similar charge upon categorically and medically needy individuals for any service under the plan.

(b) Exclusions from cost sharing. The plan may not provide for impositions of a deductible, coinsurance, copayment, or similar charge upon categorically or medically needy individuals for the following:

(1) Children. Services furnished to individuals under 18 years of age (and, at the option of the State, individuals under 21, 20, or 19 years of age, or any reasonable category of individuals 18 years of age or over but under 21) are excluded from cost sharing.

(2) Pregnant women. Services furnished to pregnant women if such services related to the pregnancy, or to any other medical condition which may complicate the pregnancy are excluded from cost sharing obligations. These services include routine prenatal care, labor and delivery, routine postpartum care, family planning services, complications of pregnancy or delivery likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy. The postpartum period is the immediate postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends. States may further exclude from cost sharing all services furnished to pregnant women if they desire.

(3) Institutionalized individuals. Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution if the individual is required (pursuant to § 435.725, § 435.733, § 435.832, or § 436.832), as a condition of receiving services in the institution, to spend all but a minimal amount of his income required for personal needs, for medical care costs are excluded from cost sharing.

(4) Emergency services. Services as defined at section 1932(b)(2) of the Act and § 438.114(a).

(5) Family planning. Family planning services and supplies furnished to individuals of child-bearing age are excluded from cost sharing.

(6) Indians. Items and services furnished to an Indian directly by an Indian health care provider or through referral under contract health services.

(c) Prohibition against multiple charges. For any service, the plan may not impose more than one type of charge referred to in paragraph (a) of this section.
Centers for Medicare & Medicaid Services, HHS § 447.54

(d) State plan specifications. For each charge imposed under this section, the plan must specify—

(1) The service for which the charge is made;
(2) The amount of the charge;
(3) The basis for determining the charge;
(4) The basis for determining whether an individual is unable to pay the charge and the means by which such an individual will be identified to providers; and
(5) The procedures for implementing and enforcing the exclusions from cost sharing found in paragraph (b) of this section.

(e) No provider may deny services, to an individual who is eligible for the services, on account of the individual’s inability to pay the cost sharing.


EFFECTIVE DATE NOTE: At 78 FR 42307, July 15, 2013, § 447.53 was revised, effective Jan. 1, 2014. For the convenience of the user, the revised text is set forth as follows:

§ 447.53 Cost sharing for drugs.

(a) The agency may establish differential cost sharing for preferred and non-preferred drugs. The provisions in § 447.56(a) shall apply except as the agency exercises the option under paragraph (d) of this section. All drugs will be considered preferred drugs if so identified or if the agency does not differentiate between preferred and non-preferred drugs.

(b) At state option, cost sharing for drugs may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing shall be increased each year, beginning October 1, 2015, by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher 5-cent increment. Such increase shall not be applied to any cost sharing that is based on the amount the agency pays for the service):

<table>
<thead>
<tr>
<th>Services</th>
<th>Individuals with family income ≤150% of the FPL</th>
<th>Individuals with family income &gt;150% of the FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred Drugs</td>
<td>$4</td>
<td>$4</td>
</tr>
<tr>
<td>Non-Preferred Drugs</td>
<td>8% of the cost the agency pays.</td>
<td></td>
</tr>
</tbody>
</table>

(c) In states that do not have fee-for-service payment rates, cost sharing for prescription drugs imposed on individuals at any income level may not exceed the maximum amount established for individuals with income at or below 150 percent of the FPL in paragraph (b) of this section.

(d) For individuals otherwise exempt from cost sharing under § 447.56(a), the agency may impose cost sharing for non-preferred drugs, not to exceed the maximum amount established in paragraph (b) of this section.

(e) In the case of a drug that is identified by the agency as a non-preferred drug within a therapeutically equivalent or therapeutically similar class of drugs, the agency must have a timely process in place so that cost sharing is limited to the amount imposed for a preferred drug if the individual’s prescribing provider determines that a preferred drug for treatment of the same condition either will be less effective for the individual, will have adverse effects for the individual, or both. In such cases the agency must ensure that reimbursement to the pharmacy is based on the appropriate cost sharing amount.

§ 447.54 Maximum allowable and nominal charges.

Except as provided at §§ 447.62 through 447.82 of this part, the following requirements must be met:

(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 FY 2009, any deductible it imposes does not exceed $2.30 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 6-month period, the maximum deductible which may be imposed on a family for that period of eligibility is $13.80. In succeeding years, any deductible may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component.

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