Inpatient stay means the services received during a continuous period of inpatient days in either a single medical institution or multiple medical institutions, and also includes a return to an inpatient medical institution after a brief period when the return is for treatment of a condition that was present in the initial period. Inpatient has the same meaning as in §440.2 of this chapter.

Non-emergency services means any care or services that are not considered emergency services as defined in this section. This does not include any services furnished in a hospital emergency department that are required to be provided as an appropriate medical screening examination or stabilizing examination and treatment under section 1867 of the Act.

Outpatient services for purposes of imposing cost sharing means any service or supply not meeting the definition of an inpatient stay.

Preferred drugs means drugs that the state has identified on a publicly available schedule as being determined by a pharmacy and therapeutics committee for clinical efficacy as the most cost effective drugs within each therapeutically equivalent or therapeutically similar class of drugs, or all drugs within such a class if the agency does not differentiate between preferred and non-preferred drugs.

Premium means any enrollment fee, premium, or other similar charge.

§ 447.52 Cost sharing.

(a) Applicability. Except as provided in §447.56(a) (exemptions), the agency may impose cost sharing for any service under the state plan.

(b) Maximum Allowable Cost Sharing.

(1) At State option, cost sharing imposed for any service (other than for drugs and non-emergency services furnished in an emergency department, as described in §§447.53 and 447.54 respectively) may be established at or below the amounts shown in the following table (except that the maximum allowable cost sharing for individuals with family income at or below 100 percent of the FPL 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):

<table>
<thead>
<tr>
<th>Services</th>
<th>Maximum allowable cost sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individuals with family income</td>
</tr>
<tr>
<td></td>
<td>≤100% of the FPL</td>
</tr>
<tr>
<td>Outpatient Services (physician visit, physical therapy, etc.)</td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient Stay</td>
<td>75</td>
</tr>
</tbody>
</table>

(2) States with cost sharing for an inpatient stay that exceeds $75, as of July 15, 2013, must submit a plan to CMS that provides for reducing inpatient cost sharing to $75 on or before July 1, 2017.

(3) In states that do not have fee-for-service payment rates, any cost sharing imposed on individuals at any income level may not exceed the maximum amount established, for individuals with income at or below 100 percent of the FPL, described in paragraph (b)(1) of this section.

(c) Maximum cost sharing. In no case shall the maximum cost sharing established by the agency be equal to or exceed the amount the agency pays for the service.

(d) Targeted cost sharing. (1) Except as provided in paragraph (d)(2) of this section, the agency may target cost sharing to specified groups of individuals with family income above 100 percent of the FPL.

(2) For cost sharing imposed for non-preferred drugs under §447.53 and for non-emergency services provided in a hospital emergency department under §447.54, the agency may target cost sharing to specified groups of individuals regardless of income.
(e) Denial of service for nonpayment.

(1) The agency may permit a provider, including a pharmacy or hospital, to require an individual to pay cost sharing as a condition for receiving the item or service if—

(i) The individual has family income above 100 percent of the FPL,

(ii) The individual is not part of an exempted group under §447.56(a), and

(iii) For cost sharing imposed for non-emergency services furnished in an emergency department, the conditions under §447.54(d) of this part have been satisfied.

(2) Except as provided under paragraph (e)(1) of this section, the state plan must specify that no provider may deny services to an eligible individual on account of the individual’s inability to pay the cost sharing.

(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.

§ 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>Maximum allowable cost sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individuals with family income ≤150% of the FPL</td>
</tr>
<tr>
<td>Preferred Drugs</td>
<td>$4</td>
</tr>
<tr>
<td>Non-Preferred Drugs</td>
<td>$8</td>
</tr>
</tbody>
</table>

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