

Centers for Medicare & Medicaid Services, HHS

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(B) Is an Eskimo or Aleut or other Alaska Native;

(C) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(D) Is determined to be an Indian under regulations promulgated by the Secretary;

(iii) Is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) Is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(2) *Indian health care provider* means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

[43 FR 45253, Sept. 29, 1978, as amended at 75 FR 30261, May 28, 2010; 75 FR 38749, July 1, 2010]

ENROLLMENT FEE, PREMIUM OR SIMILAR COST SHARING CHARGE

§ 447.51 Requirements and options.

(a) The plan must provide that the Medicaid agency does not impose any enrollment fee, premium, or similar charge for any services available under the plan upon:

(1) Categorically needy individuals, as defined in § 435.4 and § 436.3 of this subchapter, except for the following populations in accordance with sections 1916(c), (d), (g), and (i) of the Act:

(i) A pregnant woman or an infant under one year of age described in subparagraph (A) or (B) of section 1902(l)(1) of the Act, who is receiving medical assistance on the basis of section 1902(a)(10)(A)(ii)(IX) of the Act and whose family income equals or exceeds 150 percent of the Federal poverty level (FPL) applicable to a family of the size involved;

(ii) A qualified disabled and working individual described in section 1905(s) of the Act whose income exceeds 150 percent of the FPL;

(iii) An individual provided medical assistance only under section 1902(a)(10)(A)(ii)(XV) or section 1902(a)(10)(A)(ii)(XVI) of the Act and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA); and

(iv) A disabled child provided medical assistance under section 1902(a)(10)(A)(ii)(XIX) of the Act in accordance with the Family Opportunity Act; and

(2) An Indian who either is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(b) The plan may impose an enrollment fee, premium, or similar charge on medically needy individuals, as defined in §§ 435.4 and 436.3 of this subchapter, for any services available under the plan.

(c) For each charge imposed under paragraph (a) or (b) of this section, the plan must specify—

(1) The amount of the charge;

(2) The period of liability for the charge; and

(3) The consequences for an individual who does not pay.

(d) The plan must provide that any charge imposed under paragraph (b) of this section is related to total gross family income as set forth under § 447.52.

[43 FR 45253, Sept. 29, 1978, as amended at 75 FR 30261, May 28, 2010]

§ 447.52 Minimum and maximum income-related charges.

For the purpose of relating the amount of an enrollment fee, premium, or similar charge to total gross family income, as required under § 447.51(d), the following rules apply:

(a) *Minimum charge.* A charge of at least \$1.00 per month is imposed on each—

(1) One- or two-person family with monthly gross income of \$150 or less;

(2) Three- or four-person family with monthly gross income of \$300 or less; and

(3) Five- or more-person family with monthly gross income of \$350 or less.

(b) *Maximum charge.* Any charge related to gross family income that is above the minimum listed in paragraph

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(a) of this section may not exceed the standards shown in the following table:

MAXIMUM MONTHLY CHARGE			
Gross family income (per month)	Family size		
	1 or 2	3 or 4	5 or more
\$150 or less	\$1	\$1	\$1
\$151 or \$200	2	1	1
\$201 to \$250	3	1	1
\$251 to \$300	4	1	1
\$301 to \$350	5	2	1
\$351 to \$400	6	3	2
\$401 to \$450	7	4	3
\$451 to \$500	8	5	4
\$501 to \$550	9	6	5
\$551 to \$600	10	7	6
\$601 to \$650	11	8	7
\$651 to \$700	12	9	8
\$701 to \$750	13	10	9
\$751 to \$800	14	11	10
\$801 to \$850	15	12	11
\$851 to \$900	16	13	12
\$901 to \$950	17	14	13
\$951 to \$1,000	18	15	14
More than \$1,000	19	16	15

(c) *Income-related charges.* The agency must impose an appropriately higher charge for each higher level of family income, within the maximum amounts specified in paragraph (b) of this section.

[43 FR 45253, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980]

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 serv-

ices 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.

(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;