Subpart B—Payment Methods: General Provisions

447.200 Basis and purpose.
447.201 State plan requirements.
447.202 Audits.
447.203 Documentation of payment rates.
447.204 Encouragement of provider participation.
447.205 Public notice of changes in statewide methods and standards for setting payment rates.

Subpart C—Payment For Inpatient Hospital and Long-Term Care Facility Services

447.250 Basis and purpose.

PAYMENT RATES

447.251 Definitions.
447.252 State plan requirements.
447.253 Other requirements.
447.255 Related information.
447.256 Procedures for CMS action on assurances and State plan amendments.

FEDERAL FINANCIAL PARTICIPATION

447.257 FFP: Conditions relating to institutional reimbursement.

UPPER LIMITS

447.271 Upper limits based on customary charges.
447.272 Inpatient services: Application of upper payment limits.

SWING-BED HOSPITALS

447.280 Hospital providers of NF services (swing-bed hospitals).

Subpart D [Reserved]

Subpart E—Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients

447.296 Limitations on aggregate payments for disproportionate share hospitals for the period January 1, 1992 through September 30, 1992.
447.297 Limitations on aggregate payments for disproportionate share hospitals beginning October 1, 1992.
447.298 State disproportionate share hospital allotments.
447.299 Reporting requirements.

Subpart F—Payment Methods for Other Institutional and Noninstitutional Services

447.300 Basis and purpose.
447.301 State plan requirements.
447.304 Adherence to upper limits; FFP.

OUTPATIENT HOSPITAL AND CLINIC SERVICES

447.321 Outpatient hospital and clinic services: Application of upper payment limits.

OTHER INPATIENT AND OUTPATIENT FACILITIES

447.325 Other inpatient and outpatient facility services: Upper limits of payment.
447.342 [Reserved]

PREPAID CAPITATION PLANS

447.362 Upper limits of payment: Nonrisk contract.

RURAL HEALTH CLINIC SERVICES

447.371 Services furnished by rural health clinics.

Subparts G–H [Reserved]

Subpart I—Payment for Drugs

447.500 Basis and purpose.
447.502 Definitions.
447.504 [Reserved]
447.505 Determination of best price.
447.506 Authorized generic drugs.
447.508 Exclusion from best price of certain sales at a nominal price.
447.510 Requirements for manufacturers.
447.512 Drugs: Aggregate upper limits of payment.
447.514 [Reserved]
447.516 Upper limits for drugs furnished as part of services.
447.518 State plan requirements, findings and assurances.
447.520 FFP: Conditions relating to physician-administered drugs.

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

SOURCE: 43 FR 45253, Sept. 29, 1978, unless otherwise noted.

Subpart A—Payments: General Provisions

§ 447.1 Purpose.

This subpart prescribes State plan requirements, FFP limitations and procedures concerning payments made by State Medicaid agencies for Medicaid services.

§ 447.10 Prohibition against reassignment of provider claims.

(a) Basis and purpose. This section implements section 1902(a)(32) of the Act which prohibits State payments for Medicaid services to anyone other than a provider or recipient, except in specified circumstances.
(b) Definitions. For purposes of this section:

Facility means an institution that furnishes health care services to inpatients.

Factor means an individual or an organization, such as a collection agency or service bureau, that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. Factor does not include a business representative as described in paragraph (f) of this section.

Organized health care delivery system means a public or private organization for delivering health services. It includes, but is not limited to, a clinic, a group practice prepaid capitation plan, and a health maintenance organization.

(c) State plan requirements. A State plan must provide that the requirements of paragraphs (d) through (h) of this section are met.

(d) Who may receive payment. Payment may be made only—

(1) To the provider; or

(2) To the recipient if he is a noncash recipient eligible to receive the payment under §447.25; or

(3) In accordance with paragraphs (e), (f), and (g) of this section.

(e) Reassignments. Payment may be made in accordance with a reassignment from the provider to a government agency or reassignment by a court order.

(f) Business agents. Payment may be made to a business agent, such as a billing service or an accounting firm, that furnishes statements and receives payments in the name of the provider, if the agent’s compensation for this service is—

(1) Related to the cost of processing the billing;

(2) Not related on a percentage or other basis to the amount that is billed or collected; and

(3) Not dependent upon the collection of the payment.

(g) Individual practitioners. Payment may be made to—

(1) The employer of the practitioner, if the practitioner is required as a condition of employment to turn over his fees to the employer;

(2) The facility in which the service is provided, if the practitioner has a contract under which the facility submits the claim; or

(3) A foundation, plan, or similar organization operating an organized health care delivery system, if the practitioner has a contract under which the organization submits the claim.

(h) Prohibition of payment to factors. Payment for any service furnished to a recipient by a provider may not be made to or through a factor, either directly or by power of attorney.


§447.15 Acceptance of State payment as payment in full.

A State plan must provide that the Medicaid agency must limit participation in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or copayment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual’s inability to pay the cost sharing amount imposed by the plan in accordance with §431.55(g) or §447.53. The previous sentence does not apply to an individual who is able to pay. An individual’s inability to pay does not eliminate his or her liability for the cost sharing charge.

[50 FR 23013, May 30, 1985]

§447.20 Provider restrictions: State plan requirements.

A State plan must provide for the following:

(a) In the case of an individual who is eligible for medical assistance under the plan for service(s) for which a third party or parties is liable for payment, if the total amount of the established liability of the third party or parties for the service is—

(1) Equal to or greater than the amount payable under the State plan (which includes, when applicable, cost-sharing payments provided for in §§447.53 through 447.56), the provider
Centers for Medicare & Medicaid Services, HHS § 447.21 Reduction of payments to providers.

If a provider seeks to collect from an individual (or any financially responsible relative or representative of that individual) an amount that exceeds an amount specified under §447.20(a)—

(a) The Medicaid agency may provide for a reduction of any payment amount otherwise due to the provider in addition to any other sanction available to the agency; and

(b) The reduction may be equal to up to three times the amount that the provider sought to collect in violation of §447.20(a).

[55 FR 1433, Jan. 16, 1990]

§ 447.25 Direct payments to certain recipients for physicians’ or dentists’ services.

(a) Basis and purpose. This section implements section 1905(a) of the Act by prescribing requirements applicable to States making direct payments to certain recipients for physicians’ or dentists’ services.

(b) State plan requirements. Except for groups specified in paragraph (c) of this section, a State may make direct payments to recipients for physicians’ or dentists’ services. If it does so, the State plan must—

(1) Provide for direct payments; and

(2) Specify the conditions under which payments are made.

(c) Federal financial participation. No FFP is available in expenditures for direct payment for physicians’ or dentists’ services to any recipient—

(1) Who is receiving assistance under the State’s approved plan under title I, IV-A, X, XIV or XVI (AABD) of the Act; or

(2) To whom supplemental security benefits are being paid under title XVI of the Act; or

(3) Who is receiving or eligible for a State supplementary payment or would be eligible if he were not in a medical institution, and who is eligible for Medicaid as a categorically needy recipient.

(d) Federal requirements. (1) Direct payments to recipients under this section are an alternative to payments directly to providers and are subject to the same conditions; for example, the State’s reasonable charge schedules are applicable.

(2) Direct payments must be supported by providers’ bills for services.

§ 447.26 Prohibition on payment for provider-preventable conditions.

(a) Basis and purpose. The purpose of this section is to protect Medicaid beneficiaries and the Medicaid program by prohibiting payments by States for services related to provider-preventable conditions.

(b) State plan requirements. Except for paragraphs (c) and (d) of this section, a State may make direct payments to individuals who are eligible for Medicaid by reason of receiving care for a condition that is preventable by economic, social, or behavioral factors.

(c) Federal financial participation. Federal financial participation is available in expenditures for direct payment for services related to provider-preventable conditions for certain recipients.

(d) Federal requirements. (1) Direct payments for services related to provider-preventable conditions must be supported by providers’ bills for services.

(2) Direct payments must be subject to the same conditions; for example, the State’s reasonable charge schedules are applicable.

(3) State payments must be approved by the Secretary.

[55 FR 1433, Jan. 16, 1990]
must be consistent with efficiency, economy, and quality of care.

(b) Definitions. As used in this section—

Health care-acquired condition means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other provider-preventable condition means a condition occurring in any health care setting that meets the following criteria:

(i) Is identified in the State plan.
(ii) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
(iii) Has a negative consequence for the beneficiary.
(iv) Is auditable.
(v) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Provider-preventable condition means a condition that meets the definition of a “health care-acquired condition” or an “other provider-preventable condition” as defined in this section.

(c) General rules.

(1) A State plan must provide that no medical assistance will be paid for “provider-preventable conditions” as defined in this section; and as applicable for individuals dually eligible for both the Medicare and Medicaid programs.

(2) No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

(3) Reductions in provider payment may be limited to the extent that the following apply:

(i) The identified provider-preventable conditions would otherwise result in an increase in payment.
(ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider-preventable conditions.

(4) FFP will not be available for any State expenditure for provider-preventable conditions.

(5) A State plan must ensure that non-payment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

(d) Reporting. State plans must require that providers identify provider-preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available.

[76 FR 32837, June 6, 2011]

§ 447.30 Withholding the Federal share of payments to Medicaid providers to recover Medicare overpayments.

(a) Basis and purpose. This section implements section 1914 of the Act, which provides for withholding the Federal share of Medicaid payments to a provider if the provider has not arranged to repay Medicare overpayments or has failed to provide information to determine the amount of the overpayments. The intent of the statute and regulations is to facilitate the recovery of Medicare overpayments. The provision enables recovery of overpayments when institutions have reduced participation in Medicare or when physicians and suppliers have submitted few or no claims under Medicare, thus not receiving enough in Medicare reimbursement to permit offset of the overpayment.

(b) When withholding occurs. The Federal share of Medicaid payments may be withheld from any provider specified in paragraph (c) of this section to recover Medicare overpayments that CMS has been unable to collect if the provider participates in Medicaid and—
(1) The provider has not made arrangements satisfactory to CMS to repay the Medicare overpayment; or
(2) CMS has been unable to collect information from the provider to determine the existence or amount of Medicare overpayment.

(c) The Federal share of Medicaid payments may be withheld with respect to the following providers:

(1) An institutional provider that has or previously had in effect a Medicare provider agreement under section 1866 of the Act; and
(2) A Medicaid provider who has previously accepted Medicare payment on the basis of an assignment under section 1842(b)(3)(B)(ii) of the Act; and during the 12 month period preceding the quarter in which the Federal share is to be withheld for a Medicare overpayment, submitted no claims under Medicare or submitted claims which total less than the amount of overpayment.

(d) Order to reduce State payment. (1) CMS may, at its discretion, issue an order to the Medicaid agency of any State that is using the provider’s services, to reduce its payment to the provider by the amount specified in paragraph (f) of this section.

(2) The order to reduce payment to the provider will remain in effect until—

(i) The Medicaid agency determines that the overpayment has been completely recovered; or
(ii) CMS terminates the order.

(3) CMS may withhold FFP from any State that does not comply with the order specified in paragraph (d)(1) of this section to reduce payment to the provider and claims FFP for the expenditure on its quarterly expenditure report.

(e) Notice of withholding. (1) Before the Federal share of payments may be withheld under this section, CMS will notify the provider and the Medicaid agency of each State that CMS believes may use the overpaid provider’s services under Medicaid.

(2) The notice will include the instruction to reduce State payments, as provided under paragraph (d) of this section.

(3) CMS will send the notice referred to in paragraph (e)(1) by certified mail, return receipt requested.

(4) Each Medicaid agency must identify the amount of payment due the provider under Medicaid and give that information to CMS in the next quarterly expenditure report.

(5) The Medicaid agency may appeal any disallowance of FFP resulting from the withholding decision to the Grant Appeals Board, in accordance with 45 CFR part 16.

(f) Amount to be withheld. CMS may require the Medicaid agency to reduce the Federal share of its payment to the provider by the lesser of the following amounts.

(1) The Federal matching share of payments to the provider; or
(2) The total Medicare overpayment to the provider.

(g) Effective date of withholding. Withholding of payment will become effective no less than 60 days after the day on which the agency receives notice of withholding.

(h) Duration of withholding. No Federal funds are available in expenditures for services that are furnished by a provider specified in paragraph (e) of this section from the date on which the withholding becomes effective until the termination of withholding under paragraph (i) of this section.

(i) Termination of withholding. (1) CMS will terminate the order to reduce State payment if it determines that any of the following has occurred:

(i) The Medicare overpayment is completely recovered;
(ii) The institution or person makes an agreement satisfactory to CMS to repay the overpayment; or
(iii) CMS determines that there is no overpayment based on newly acquired evidence or a subsequent audit.

(2) CMS will notify each State that previously received a notice ordering the withholding that the withholding has been terminated.

(j) Procedures for restoring excess withholding. If an amount ultimately determined to be in excess of the Medicare overpayment is withheld, CMS will restore any excess funds withheld.

(k) Recovery of funds from Medicaid agency. A provider is not entitled to recover from the Medicaid agency the
§ 447.31 Withholding Medicare payments to recover Medicaid overpayments.

(a) Basis and purpose. Section 1885 of the Act provides authority for CMS to withhold Medicare payments to a Medicaid provider in order to recover Medicaid overpayments to the provider. Section 405.377 of this chapter sets forth the Medicare rules implementing section 1885, and specifies under what circumstances withholding will occur and the providers that are subject to withholding. This section establishes the procedures that the Medicaid agency must follow when requesting that CMS withhold Medicare payments.

(b) Agency notice to providers. (1) Before the agency requests recovery of a Medicaid overpayment through Medicare, the agency must send either or both of the following notices, in addition to that required under paragraph (b)(2) of this section, to the provider.

(i) Notice that—
   (A) There has been an overpayment;
   (B) Repayment is required; and
   (C) The overpayment determination is subject to agency appeal procedures, but we may withhold Medicare payments while an appeal is in progress.

(ii) Notice that—
   (A) Information is needed to determine the amount of overpayment if any; and
   (B) The provider has at least 30 days in which to supply the information to the agency.

(2) Notice that, 30 days or later from the date of the notice, the agency intends to refer the case to CMS for withholding of Medicare payments.

(c) Documentation to be submitted to CMS. The agency must submit the following information or documentation to CMS (unless otherwise specified) with the request for withholding of Medicare payments.

(1) A statement of the reason that withholding is requested.
(2) The amount of overpayment, type of overpayment, date the overpayment was determined, and the closing date of the pertinent cost reporting period (if applicable).
(3) The quarter in which the overpayment was reported on the quarterly expenditure report (Form CMS 64).
(4) As needed, and upon request from CMS, the names and addresses of the provider’s officers and owners for each period that there is an outstanding overpayment.
(5) A statement of assurance that the State agency has met the notice requirements under paragraph (b) of this section.
(6) As needed, and upon request for CMS, copies of notices (under paragraph (b) of this section), and reports of contact or attempted contact with the provider concerning the overpayment, including any reduction or suspension of Medicaid payments made with respect to that overpayment.
(7) A copy of the provider’s agreement with the agency under §431.107 of this chapter.

(d) Notification to terminate withholding. (1) If an agency has requested withholding under this section, it must notify CMS if any of the following occurs:

(i) The Medicaid provider makes an agreement satisfactory to the agency to repay the overpayment;
(ii) The Medicaid overpayment is completely recovered; or
(iii) The agency determines that there is no overpayment, based on newly acquired evidence or subsequent audit.

(2) Upon receipt of notification from the State agency, CMS will terminate withholding.

(e) Accounting for returned overpayment. The agency must treat as a recovered overpayment the amounts received from CMS to offset Medicaid overpayments.

(f) Procedures for restoring excess withholding. The agency must establish procedures satisfactory to CMS to assure the return to the provider of amounts withheld under this section that are ultimately determined to be in excess of

[50 FR 19688, May 10, 1985; 50 FR 23307, June 3, 1985]
overpayments. Those procedures are subject to CMS review.


§ 447.40 Payments for reserving beds in institutions.

(a) The Medicaid agency may make payments to reserve a bed during a recipient’s temporary absence from an inpatient facility, if—

(1) The State plan provides for such payments and specifies any limitations on the policy; and

(2) Absences for purposes other than required hospitalization (which cannot be anticipated and planned) are included in the patient’s plan of care.

(b) An agency that pays for reserved beds in an inpatient facility may pay less for a reserved bed than an occupied bed if there is a cost differential between the two beds. (Section 1102 of the Act.)


§ 447.45 Timely claims payment.

(a) Basis and purpose. This section implements section 1902(a)(37) of the Act by specifying—

(1) State plan requirements for—

(i) Timely processing of claims for payment;

(ii) Prepayment and postpayment claims reviews; and

(2) Conditions under which the Administrator may grant waivers of the time requirements.

(b) Definitions. Claim means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State’s claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

A shared health facility means any arrangement in which—

(1) Two or more health care practitioners practice their professions at a common physical location;

(2) The practitioners share common waiting areas, examining rooms, treatment rooms, or other space, the services of supporting staff, or equipment;

(3) The practitioners have a person (who may himself be a practitioner)—

(i) Who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at the common physical location other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) Who makes available to the practitioners the services of supporting staff who are not employees of the practitioners; and

(iii) Who is compensated in whole or in part, for the use of the common physical location or related support services, on a basis related to amounts charged or collected for the services rendered or ordered at the location or on any basis clearly unrelated to the value of the services provided by the person; and

(4) At least one of the practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding $40,000 during the preceding 12 months.

The term does not include a provider of services (as specified in § 489.2(b) of this chapter), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

Third party is defined in § 433.135 of this chapter.

(c) State plan requirements. A State plan must (1) provide that the requirements of paragraphs (d), (e)(2), (f) and (g) of this section are met; and

(2) Specify the definition of a claim, as provided in paragraph (b) of this section, to be used in meeting the requirements for timely claims payment. The definition may vary by type of service (e.g., physician service, hospital service).

(d) Timely processing of claims. (1) The Medicaid agency must require providers to submit all claims no later
than 12 months from the date of service.

(2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.

(3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 90 days of the date of receipt.

(4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances:
   (i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in §447.272 of this part.
   (ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim.
   (iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse.
   (iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

(5) The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim.

(6) The date of payment is the date of the check or other form of payment.

(e) Waivers. (1) The Administrator may waive the requirements of paragraphs (d) (2) and (3) of this section upon request by an agency if he finds that the agency has shown good faith in trying to meet them. In deciding whether the agency has shown good faith, the Administrator will consider whether the agency has received an unusually high volume of claims which are not clean claims, and whether the agency is making diligent efforts to implement an automated claims processing and information retrieval system.

(2) The agency’s request for a waiver must contain a written plan of correction specifying all steps it will take to meet the requirements of this section.

(3) The Administrator will review each case and if he approves a waiver, will specify its expiration date, based on the State’s capability and efforts to meet the requirements of this section.

(f) Prepayment and postpayment claims review. (1) For all claims, the agency must conduct prepayment claims review consisting of—
   (i) Verification that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished;
   (ii) Checks that the number of visits and services delivered are logically consistent with the recipient’s characteristics and circumstances, such as type of illness, age, sex, service location;
   (iii) Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed;
   (iv) Verification that a payment does not exceed any reimbursement rates or limits in the State plan; and
   (v) Checks for third party liability within the requirements of §433.137 of this chapter.

(2) The agency must conduct postpayment claims review that meets the requirements of parts 455 and 456 of this chapter, dealing with fraud and utilization control.

(g) Reports. The agency must provide any reports and documentation on compliance with this section that the Administrator may require.

(b) Definitions. “Claim” and “clean claim” have the meaning given those terms in §447.45.

(c) Contract requirements—(1) Basic rule. A contract with an MCO must provide that the organization will meet the requirements of §§447.45(d)(2) and (d)(3), and abide by the specifications of §§447.45(d)(5) and (d)(6).

(2) Exception. The MCO and its providers may, by mutual agreement, establish an alternative payment schedule.

(3) Alternative schedule. Any alternative schedule must be stipulated in the contract.

[67 FR 41115, June 14, 2002]

COST SHARING

§ 447.50 Cost sharing: Basis and purpose.

(a) Section 1902(a)(14) of the Act permits States to require certain recipients to share some of the costs of Medicaid by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, cost-payments, or similar cost sharing charges. For States that impose cost sharing payments, §§447.51 through 447.59 prescribe State plan requirements and options for cost sharing, specify the standards and conditions under which States may impose cost sharing, set forth minimum amounts and the methods for determining maximum amounts, and prescribe conditions for FFP that relate to cost sharing requirements.

(b) Definitions. For the purposes of this subpart:

(1) Indian means any individual defined at 25 USC 1603(c), 1603(f), or 1679(b), or who has been determined eligible as an Indian, pursuant to §136.12 of this part. This means the individual:

(i) Is a member of a Federally-recognized Indian tribe;

(ii) Resides in an urban center and meets one or more of the following four criteria:

(A) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member;

(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;

(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;

(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).


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)(i)(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.


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

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

(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.


§ 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.

Centers for Medicare & Medicaid Services, HHS § 447.54

(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.

(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.

§ 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 of the CPI-U for the period of September to September ending in the preceding calendar year, and then rounded to the next higher 5-cent increment.

(2) Any coinsurance rate it imposes does not exceed 5 percent of the payment the agency makes for the services; and

(3)(i) For Federal FY 2009, any co-payments it imposes under a fee-for-service delivery system do not exceed the amounts shown in the following table:

<table>
<thead>
<tr>
<th>State payment for the service</th>
<th>Maximum copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10 or less</td>
<td>$0.60</td>
</tr>
</tbody>
</table>
(ii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(iii) Thereafter, any copayments may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(iv) For Federal FY 2009, any copayment that the State imposes for services provided by a managed care organization (MCO) may not exceed the copayment permitted under paragraph (a)(3)(i) of this section for comparable services under a fee-for-service delivery system. When there is no fee-for-service delivery system, the copayment may not exceed $3.40 per visit. In succeeding years, any copayment may not exceed these amounts as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next higher 5-cent increment.

(b) Waiver of the requirement that cost sharing amounts be nominal. Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with sections 1916(a)(3) and 1916(b)(3) of the Act and §411.57 of this chapter, for nonemergency services furnished in a hospital emergency department, if the State establishes to the satisfaction of the Secretary that alternative sources of nonemergency, outpatient services are actually available and accessible to Medicaid beneficiaries in a timely manner.

(c) Waiver of the requirement that cost sharing amounts be nominal. Upon approval from CMS, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 1916(a)(3) of the Act and §411.57 of this chapter, for nonemergency services furnished in a hospital emergency department.

(c) Institutional services. For institutional services, the plan must provide that the maximum deductible, coinsurance or co-payment charge for each admission does not exceed 50 percent of the payment the agency makes for the first day of care in the institution.

(d) Cumulative maximum. The plan may provide for a cumulative maximum amount for all deductible, coinsurance or co-payment charges that it imposes on any family during a specified period of time.

§447.55 Standard copayment.

(a) The plan may provide for a standard, or fixed, co-payment amount for any service.

(b) This standard copayment amount for any service may be determined by applying the maximum copayment amounts specified in §447.54(a) and (c) to the agency’s average or typical payment for that service. For example, if the agency’s typical payment for prescribed drugs is $4 to $5 per prescription, the agency might set a standard copayment of $.60 per prescription. This standard copayment may be adjusted based on updated copayments as permitted under §447.54(a)(3).

§447.56 Income-related charges.

Subject to the maximum allowable charges specified in §447.54(a) and (b), the plan may provide for income-related deductible, coinsurance or copayment charges. For example, an agency may impose a higher charge on medically needy recipients than it imposes upon categorically needy recipients.

§447.57 Restrictions on payments to providers.

(a) The plan must provide that the agency does not increase the payment it makes to any provider to offset uncollected amounts for deductibles, coinsurance, copayments or similar charges that the provider has waived or are uncollectable, except as permitted under paragraph (b) of this section.

(b) For those providers that the agency reimburses under Medicare reasonable cost reimbursement principles, in accordance with subpart B of this part, an agency may increase its payment to
offset uncollected deductible, coinsurance, copayment, or similar charges that are bad debts of providers.

(c) Payment under Medicaid due to an Indian health care provider or a health care provider through referral under contract health services for directly furnishing an item or service to an Indian may not be reduced by the amount of any enrollment fee, premium, or similar charge, or any deductible, copayment, cost sharing, or similar charge that otherwise would be due from the Indian.

§ 447.58 Payments to prepaid capitation organizations.

If the agency contracts with a prepaid capitation organization that does not impose the agency’s deductibles, coinsurance, co-payments or similar charges on its recipient members, the plan must provide that the agency calculates its payments to the organization as if those cost sharing charges were collected.

§ 447.59 FFP: Conditions relating to cost sharing.

No FFP in the State’s expenditures for services is available for—

(a) Any cost sharing amounts that recipients should have paid as enrollment fees, premiums, deductibles, coinsurance, copayments, or similar charges under §§ 447.50 through 447.58 (except for amounts that the agency pays as bad debts of providers under § 447.57); and

(b) Any amounts paid by the agency on behalf of ineligible individuals, whether or not the individual had paid any required premium or enrollment fee.

§ 447.60 Cost-sharing requirements for services furnished by MCOs.

Contracts with MCOs must provide that any cost-sharing charges the MCO imposes on Medicaid enrollees are in accordance with the requirements set forth in §§ 447.50 and 447.53 through 447.58 for cost-sharing charges imposed by the State agency.

§ 447.62 Alternative premiums and cost sharing: Basis, purpose and scope.

(a) Section 1916A of the Act sets forth options for a State through a Medicaid State plan amendment to impose alternative premiums and cost sharing, which are premiums and cost sharing that are not subject to the limitations under section 1916 of the Act as described in §§ 447.51 through 447.56. For States that impose alternative premiums or cost sharing, §§ 447.64, 447.66, 447.68, 447.70, 447.71, 447.72, 447.74, § 447.76, 447.78, 447.80, and 447.82 prescribe State plan requirements and options for alternative premiums and cost sharing for a group or groups of individuals (as specified by the State) for services or items (as specified by the State) and the standards and conditions under which States may impose them. The State may vary the premiums and cost sharing among groups of individuals or types of services or items, consistent with the limitations specified in this subpart and section 1916A(a)(1) of the Social Security Act. Otherwise, premiums and cost sharing must comply with the requirements described in §§ 447.50 through 447.60.

(b) Waivers of the limitations described in this subpart on deductions, cost sharing, and similar charges may be granted only in accordance with the provisions of section 1916(f) of the Act.

§ 447.64 Alternative premiums, enrollment fees, or similar fees: State plan requirements.

When a State imposes alternative premiums, enrollment fees, or similar fees on individuals, the State plan must describe the following:

(a) The group or groups of individuals that may be subject to the premiums, enrollment fees, or similar charges.
§ 447.66 General alternative premium protections.

(a) States may not impose alternative premiums upon the following individuals:

(1) Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i) of the Act, and including individuals with respect to whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(2) Pregnant women.

(3) Any terminally ill individual receiving hospice care, as defined in section 1905(o) of the Act.

(4) Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, 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.

(5) Women who are receiving Medicaid on the basis of the breast or cervical cancer eligibility group under sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

(6) Disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act.

(7) An Indian who 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) States may exempt additional classes of individuals from premiums.

(c) Nothing in this subsection shall be construed as restricting the application of any other limitations on the imposition of premiums that may apply to an individual receiving Medicaid who is an Indian.


§ 447.68 Alternative copayments, coinsurance, deductibles, or similar cost sharing charges: State plan requirements.

When a State imposes alternative copayments, coinsurance, deductibles, or similar cost sharing charges, the State plan must describe the following:

(a) The group or groups of individuals that may be subject to the cost sharing charge.

(b) The methodology used to determine family income, for purposes of the limitations on cost sharing related
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 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.

(g) The notice of, time frame for, and manner of required cost sharing and the consequences for failure to pay.

§447.70 General alternative cost sharing protections.

(a) States may not impose alternative cost sharing for the following items or services. Except as indicated, these limits do not apply to alternative cost sharing for prescription drugs identified by a State's Medicaid program as non-preferred within a class of such drugs or for non-emergency use of the emergency room.

(1) Services furnished to individuals under 18 years of age who are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, including services furnished to individuals with respect to whom child welfare services are being made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals with respect to whom adoption or foster care assistance is made available under Part E of that title, without regard to age.

(2) Preventive services, at a minimum the services specified at §457.520, provided to children under 18 years of age regardless of family income, which reflect the well baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.

(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 §438.114(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
§ 447.71

not need emergency services consistent with the requirements of paragraph (b) of this section.

(7) Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and other pharmaceuticals for which the State claims or could claim Federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.

(8) Services furnished to women who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act (breast or cervical cancer provisions).

(9) Services furnished to disabled children who are receiving medical assistance by virtue of the application of sections 1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act, in accordance with the Family Opportunity Act.

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

(11) Preferred drugs within a class, or drugs not identified by the State’s Medicaid program as a non-preferred drug within a class, for individuals for whom cost sharing may not otherwise be imposed as described in paragraphs (a)(1) through (10) of this section.

(b) For the exempt populations specified in paragraph (a) of this section, a State may impose nominal cost sharing as defined in §447.54 of this chapter for services furnished in a hospital emergency department, other than those required under §489.24, if the hospital has determined based on the medical screening required under §489.24 that the individual does not need emergency services as defined at section 1932(b)(2) of the Act and §438.114(a), the requirements of §447.80(b)(1) are met, and 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.

(75 FR 30263, 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 other alternative non-emergency services health care provider in the geographic...
area of the hospital emergency department involved.

(c) Aggregate cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under §447.78(b).

(d) The State may not impose alternative premiums and cost sharing in accordance with section 1916A of the Act on individuals whose family income is at or below 100 percent of the FPL, but may impose cost sharing that does not exceed the nominal amount as defined at §447.54 and section 1916 of the Act.


§ 447.72 Alternative premium and cost sharing exemptions and protections for individuals with family incomes above 100 percent but at or below 150 percent of the FPL.

(a) The State may not impose premiums under the State plan on individuals whose family income exceeds 100 percent, but does not exceed 150 percent, of the FPL.

(b) Cost sharing may be imposed under the State plan for individuals whose family income exceeds 100 percent, but does not exceed 150 percent, of the FPL if the cost sharing does not exceed 10 percent of the payment the agency makes for the item or service, with the following exceptions:

(1) Cost sharing for non-preferred drugs cannot exceed the nominal amount as defined in §447.54.

(2) Cost sharing for non-emergency services furnished in the hospital emergency department cannot exceed twice the nominal amount as defined in §447.54. A hospital must meet the requirements described at §447.80(b)(2) before the cost sharing can be imposed.

(3) In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO to a Medicaid beneficiary, including a child covered under a Medicaid expansion program for whom enhanced match is claimed under title XXI of the Act, may not exceed $3.40 per visit for Federal FY 2009. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 5-cent increment.

(c) Aggregate cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under §447.78(a).


§ 447.74 Alternative premium and cost sharing protections for individuals with family incomes above 150 percent of the FPL.

(a) States may impose premiums under the State plan consistent with the aggregate limits set forth in §447.78(a) on individuals whose family income exceeds 150 percent of the FPL.

(b) Cost sharing may be imposed under the State plan on individuals whose family income exceeds 150 percent of the FPL if the cost sharing does not exceed 20 percent of the payment the agency makes for the item or service (including a non-preferred drug but not including non-emergency services furnished in a hospital emergency department), with the following exception: In the case of States that do not have fee-for-service payment rates, any copayment that the State imposes for services provided by an MCO to a Medicaid beneficiary, including a child covered under a Medicaid expansion program for whom enhanced match is claimed under title XXI of the Act, may not exceed $3.40 per visit for Federal FY 2009. Thereafter, any copayment may not exceed this amount as updated each October 1 by the percentage increase in the medical care component of the CPI-U for the period of September to September ending in the preceding calendar year and then rounded to the next highest 5-cent increment.

(c) Aggregate premiums and cost sharing under sections 1916 and 1916A of the Act for all individuals in the family enrolled in Medicaid may not exceed the maximum permitted under §447.78(a).

[75 FR 30264, May 28, 2010, as amended at 75 FR 38749, July 1, 2010]
§ 447.76 Public schedule.

(a) The State must make available to the groups in paragraph (b) of this section a public schedule that contains the following information:

(1) Current premiums, enrollment fees, or similar fees.
(2) Current cost sharing charges.
(3) The aggregate limit on premiums and cost sharing or just cost sharing.
(4) Mechanisms for making payments for required premiums and charges.
(5) The consequences for an applicant or recipient who does not pay a premium or charge.
(6) A list of hospitals charging alternative cost sharing for non-emergency use of the emergency department.
(7) Either a list of preferred drugs or a method to obtain such a list upon request.

(b) The State must make the public schedule available to the following:

(1) Beneficiaries, at the time of their enrollment and reenrollment after a redetermination of eligibility, and when premiums, cost sharing charges, or aggregate limits are revised.
(2) Applicants, at the time of application.
(3) All participating providers.
(4) The general public.

(c) Prior to submitting to the Centers for Medicare & Medicaid Services for approval a State plan amendment (SPA) to establish alternative premiums or cost sharing under section 1916A of the Act or an amendment to modify substantially an existing plan for alternative premiums or cost sharing, the State must provide the public with advance notice of the amendment and reasonable opportunity to comment with respect to such amendment in a form and manner provided under applicable State law, and must submit documentation with the SPA to demonstrate that this requirement was met.


§ 447.78 Aggregate limits on alternative premiums and cost sharing.

(a) The total aggregate amount of premiums and cost sharing imposed under sections 1916 and 1916A of the Act for all individuals in a family enrolled in Medicaid with family income above 100 percent of the FPL may not exceed 5 percent of the family’s income for the monthly or quarterly period, as specified by the State in the State plan.

(b) The total aggregate amount of cost sharing imposed under sections 1916 and 1916A of the Act for all individuals in a family enrolled in Medicaid with family income at or below 100 percent of the FPL may not exceed 5 percent of the family’s income for the monthly or quarterly period, as specified by the State in the State plan.

(c) Family income shall be determined in a manner, for such period, and at such periodicity as specified by the State in the State plan, including the use of such disregards as the State may provide and the process for individuals to request a reassessment of the family’s aggregate limit if the family’s income is reduced or if eligibility is being terminated due to nonpayment of a premium.

(1) States may use gross income or any other methodology.

(2) States may use a different methodology for determining the family’s income to which the 5 percent aggregate limit is applied than is used for determining income eligibility.

[75 FR 30264, May 28, 2010]

§ 447.80 Enforceability of alternative premiums and cost sharing.

(a) With respect to alternative premiums, a State may do the following:

(1) Require a group or groups of individuals to prepay.

(2) Terminate an individual from medical assistance on the basis of failure to pay for 60 days or more.

(3) Waive payment of a premium in any case where the State determines that requiring the payment would create an undue hardship for the individual.

(b) With respect to alternative cost sharing, a State may amend its Medicaid State plan to permit a provider, including a pharmacy or hospital, to require an individual, as a condition for receiving the item or service, to pay the cost sharing charge, except as specified in paragraphs (b)(1) through (3) of this section.

(1) A provider, including a pharmacy and a hospital, may not require an individual whose family income is at or
below 100 percent of the FPL to pay the cost sharing charge as a condition of receiving the service.

(2) A hospital that has determined after an appropriate medical screening pursuant to §489.24 of this chapter, that an individual does not need emergency services as defined at section 1932(b)(2) of the Act and §438.114(a), before providing treatment and imposing alternative cost sharing on an individual in accordance with §447.72(b)(2) and §447.74(b) of this chapter for non-emergency services as defined in section 1916A(e)(4)(A) of the Act, must provide:

(i) The name and location of an available and accessible alternate non-emergency services provider, as defined in section 1916A(e)(4)(B) of the Act.

(ii) Information that the alternate provider can provide the services in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing.

(iii) A referral to coordinate scheduling of treatment by this provider.

(3) The provider is not prohibited by this authority from choosing to reduce or waive cost sharing on a case-by-case basis.

(c) Nothing in paragraph (b)(2) of this section shall be construed to:

(1) Limit a hospital's obligations with respect to screening and stabilizing treatment of an emergency medical condition under section 1867 of the Act; or

(2) Modify any obligations under either State or Federal standards relating to the application of a prudent-layperson standard with respect to payment or coverage of emergency medical services by any managed care organization.

§ 447.88 Options for claiming FFP payment for section 1920A presumptive eligibility medical assistance payments.

(a) The FMAP rate for medical assistance payments made available to a child during a presumptive eligibility period under section 1920A of the Act is the regular FMAP under title XIX, based on the category of medical assistance; that is, the enhanced FMAP is not available for section 1920A presumptive eligibility expenditures.

(b) States have the following 3 options for identifying Medicaid section 1920A presumptive eligibility expenditures in the quarter expended with no further adjustment based on the results of a subsequent actual eligibility determination (if any).

(1) A State may identify Medicaid section 1920A presumptive eligibility expenditures in the quarter expended with no further adjustment based on the results of a subsequent actual eligibility determination (if any).
§ 447.90 FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program.

(a) Basis and purpose. This section implements section 1903(i)(2)(C) of the Act which prohibits payment of FFP with respect to items or services furnished by an individual or entity with respect to which there is pending an investigation of a credible allegation of fraud except under specified circumstances.

(b) Denial of FFP. No FFP is available with respect to any amount expended for an item or service furnished by any individual or entity to whom a State has failed to suspend payments in whole or part as required by §455.23 of this chapter unless—

(1) The item or service is furnished as an emergency item or service, but not including items or services furnished in an emergency room of a hospital; or

(2) The State determines and documents that good cause as specified at §455.23(e) or (f) of this chapter exists not to suspend such payments, to suspend payments only in part, or to discontinue a previously imposed payment suspension.

[76 FR 5965, Feb. 2, 2011]

Subpart B—Payment Methods: General Provisions

§ 447.200 Basis and purpose.

This subpart prescribes State plan requirements for setting payment rates to implement, in part, section 1902(a)(30) of the Act, which requires that payments for services be consistent with efficiency, economy, and quality of care.

[46 FR 48560, Oct. 1, 1981]

§ 447.201 State plan requirements.

(a) A State plan must provide that the requirements in this subpart are met.

(b) The plan must describe the policy and the methods to be used in setting payment rates for each type of service included in the State’s Medicaid program.

§ 447.202 Audits.

The Medicaid agency must assure appropriate audit of records if payment is based on costs of services or on a fee plus cost of materials.

§ 447.203 Documentation of payment rates.

(a) The agency must maintain documentation of payment rates and make it available to HHS upon request.

(b) The agency must record, in State manuals or other official files, the following information for increases in payment rates for individual practitioner services:

(1) An estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used to make the estimate.

(2) An estimate of the composite average percentage increase of the revised payment rates over the preceding rates.

§ 447.204 Encouragement of provider participation.

The agency’s payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

§ 447.205 Public notice of changes in Statewide methods and standards for setting payment rates.

(a) When notice is required. Except as specified in paragraph (b) of this section, the agency must provide public notice of any significant proposed