

**§ 447.54**

**42 CFR Ch. IV (10-1-99 Edition)**

required for personal needs, for medical care costs are excluded from cost sharing.

(4) *Emergency services.* Services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in—

- (i) Placing the patient's health in serious jeopardy;
- (ii) Serious impairment to bodily functions; or
- (iii) Serious dysfunction of any bodily organ or part.

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

(6) *HMO Enrollees.* Services furnished by a health maintenance organization (HMO) to categorically needy individuals enrolled in the HMO are excluded from cost sharing. States may further exclude copayment charges for HMO services furnished to medically needy individuals.

(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.

[43 FR 45253, Sept. 29, 1978, as amended at 47 FR 21051, May 17, 1982; 48 FR 5736, Jan. 8, 1983; 50 FR 23013, May 30, 1985; 55 FR 48611, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990]

**§ 447.54 Maximum allowable charges.**

(a) *Non-institutional services.* Except as specified in paragraph (b), for non-institutional services, the plan must provide that—

(1) Any deductible it imposes does not exceed \$2.00 per month per family for each period of Medicaid eligibility. For example, if Medicaid eligibility is certified for a 3-month period, the maximum deductible which may be imposed on a family for that period of eligibility is \$6.00;

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

(3) Any co-payments it imposes do not exceed the amounts shown in the following table:

States payment for the service	Maximum copayment chargeable to recipient
\$10 or less .....	\$.50
\$10.01 to \$25 .....	1.00
\$25.01 to \$50 .....	2.00
\$50.01 or more .....	3.00

(b) *Waiver of the requirement that cost sharing amounts be nominal.* Upon approval from HCFA, the requirement that cost sharing charges must be nominal may be waived, in accordance with section 431.55(g) for nonemergency services furnished in a hospital emergency room.

(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.

[48 FR 5736, Jan. 8, 1983]

**§ 447.55 Standard co-payment.**

(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