STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: California

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount of Basis for Determination
Physician			X	$1 per visit
Clinic/Outpatient			X	$1 per visit
Surgical center			X	$1 per visit
Optometric			X	$1 per outpatient visit
Chiropractic			X	$1 per outpatient visit
Psychology			X	$1 per outpatient visit
Podiatric			X	$1 per outpatient visit
Occupational therapy			X	$1 per outpatient visit
Physical therapy			X	$1 per outpatient visit
Speech therapy			X	$1 per outpatient visit
Audiology			X	$1 per outpatient visit
Acupuncture			X	$1 per outpatient visit
Drug Prescriptions			X	$1 per outpatient drug prescription
Dental			X	$1 per outpatient dental visit
Nonemergency services in an emergency room			X	$5 per visit (average payment for nonemergency services in an emergency room is greater than $50) All other amounts besides nonemergency services in an emergency room that meet the definition of nominal.

Exceptions:

1. Any service for which the State payment is $10 or less.
2. Any family planning service.
3. Any service provided to a person under age 19.
4. Any service furnished to a pregnant women, if the service relates to the pregnancy or to any other medical condition which may complicate the pregnancy, including counseling and pharmacotherapy for cessation of tobacco use.
5. Any service provided to an individual who is an inpatient in a hospital, long-term care facility or other medical institution who is required to spend all but a minimal amount of his income required for personal needs towards the cost of care.
6. Any children under 21 living in boarding homes or institutions for foster care.
7. Any individual who is currently or has previously used services provided by an Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) in any state and any American Indian/Alaskan Native that have received services through referral under contract health services.
8. Any preventive services and vaccines in accordance with the Affordable Care Act Section 4106.

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State: California

B. The method used to collect cost sharing charges for medically needy individuals:

[X] Providers are responsible for collecting the cost sharing charges from individuals.

[ ] The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The individual determines whether he/she can pay the copayment and informs the provider accordingly. The providers have been instructed that they may not refuse to provide services based solely on the individual's inability to copy.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Medi-Cal will exempt all applicable beneficiary groups from cost sharing by the following:

The county eligibility worker will verify that the beneficiary is part of an exempted group, then insert an "exemption indicator" in the cost sharing field of the Medi-Cal Eligibility Data System (MEDS). The indicator in MEDS will translate into a message displayed at the time the provider checks the beneficiary's Medi-Cal eligibility status. Providers will be alerted that the beneficiary is exempt from cost sharing, and that cost sharing is not permissible.

Also, the State will instruct providers via provider bulletins, and the Medi-Cal *Newsflash* of covered services, including services applicable to the Affordable Care Act, Section 4106, which are not subject to copayment and of those individuals who are exempt from copayments. The State will send notices to beneficiaries to inform them of the services and beneficiaries that are exempt from cost sharing and those services/conditions under which copayments are enforceable.

Section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447 exempts American Indian/Alaskan Native (AI/ANs) from cost sharing, if they have received an item or service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services.

Effective January 1, 2014, the State will implement the above described MEDS system changes for exempting AI/ANs from cost sharing. If the AI/AN self attests that he/she has received a service from an Indian Health Service (IHS)/Tribal 638/Urban Indian Health Program (UIHP) (I/T/U) or through a referral under contract health services, the AI/AN is exempt from cost sharing. If the AI/AN does not provide self-attestation, then they must submit a letter to the county on I/T/U letterhead that exempts the AI/AN under section 5006(a) of the American Recovery and Reinvestment Act and 42 CFR Part 447. The county will, upon receipt of the letter or self-attestation, submit a transaction with an indicator to identify AI/ANs on the State's MEDS. This indicator along with the premium aid code identifies the AI/AN as exempt from cost sharing.

E. Cumulative maximums on charges:

[X] State policy does not provide for cumulative maximums.
[ ] Cumulative maximums have been established as described below.