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

A. The following charges are imposed on the categorically needy for services other than those provided under Section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge Deduct. Coins. Copay.	Amount of Basis for Determination
Clinic	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
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 preventive services and vaccines.

2. Disabled or blind individuals under age 18 eligible for the following eligibility groups:
   - SSI Beneficiaries.
   - Blind and Disabled Individuals in 209(b) States.
   - Individuals Receiving Mandatory State Supplements.

3. Children for 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 receiving benefits under Part E of that title, without regard to age.

4. Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).

5. Pregnant women, during pregnancy and through the 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, except for cost sharing for services specified in the state plan as not pregnancy-related.

6. Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.

7. An individual receiving hospice care, as defined in section 1905(o) of the Act.

8. Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.

9. Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

10. The state elects to exempt individuals under age 19.

11. The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs.

12. Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).

13. Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and 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.

14. Preventive services, at a minimum the services specified at 42 CFR 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.

15. Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specifically identified in the state plan as not being related to pregnancy.

16. Provider-preventable services as defined in 42 CFR 447.26(b).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

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

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

/ / The agency reimburses providers the full Medicaid rate for a 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. Providers have been instructed that they may not refuse to provide services based solely on the individual's inability to copay.

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

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.