



An Advocate's Guide to Medi-Cal Services

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**Chapter I:
Overview of Medicaid and Medi-Cal**

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Medicaid is the nation’s largest public health coverage program covering nearly 73 million people, including 13 million—or one in three—people in California. Medicaid covers a wide range of health services which, taken together, are intended to provide a comprehensive package of health care services from infancy to end of life. This chapter provides an overview of the federal Medicaid program, including the structural framework and program requirements, and how they are applied in California. The chapter also describes Medicaid’s general services categories and the legal protections afforded to applicants and beneficiaries who receive Medicaid services through California’s Medicaid program.

A. Framework

1. Legal Framework for Medicaid and Medi-Cal

The Medicaid Act is part of the larger Social Security Act (SSA). Medicaid provisions can be found in section 1902 of the SSA, codified in 42 United States Code (U.S.C) Section 1396 et seq. Appendix B in this Guide outlines where major provisions of the Medicaid Act may be found and other relevant resources. States are not required to participate in the Medicaid Program but when they choose to do so, they must agree to follow a set of federal laws and rules and develop a state Medicaid plan. Much of the guidance provided to states about how they must run their Medicaid programs is found in federal Medicaid regulations at 42 Code of Federal Regulations (CFR) Section 430 et seq. Additional policy guidance from the federal government is found in policy manuals such as the State Medicaid Manual and policy letters to state health officials.¹ These materials are issued by the Centers for Medicare & Medicaid Services (CMS) within the United States Department of Health and Human Services (HHS). CMS regularly publishes subregulatory guidance including Dear State Medicaid Director letters and Dear State Health Official letters to alert Medicaid directors to news that may affect their state’s administration of the Medicaid program and changes in federal law or policy. The Medicaid Act, its implementing regulations, and accompanying guidance must comply with the U.S. Constitution. The program must also comport with laws related to the Federal Spending Clause, such as those prohibiting discrimination in federally funded programs.

While the federal laws, regulations, and policy guidance provide general directives to all states, California has its own state laws, regulations, and policy guidance governing its Medicaid program, called “Medi-Cal” in California. The Medi-Cal laws can be found in California Welfare and Institutions Code Section 14000 et seq. and the most of the regulations at Title 22 of the California Code of Regulations Section 50000 et seq. The California Department of Health Care Services (DHCS) is the state agency that administers the Medi-Cal program. DHCS provides policy guidance in the form of All County Welfare Directors Letters (ACWDLs), All Plan Letters (APLs) to Medi-Cal Managed Care Plans, Mental Health and Substance Use (MHSUDs) Information Notices to Mental Health Plans and SUD Programs, Provider Bulletins, and various manuals such as the Medi-Cal Provider Manual. The Medi-Cal program, as a governmental entitlement program, is also governed by California’s constitutional protections and other state laws. Laws prohibiting discrimination also apply.

2. Structural Framework for Medicaid and Medi-Cal

Medicaid is a federal and state cooperative program. This means that both the federal government and the state government provide payment for the administration of the program and provision of services covered under the state’s Medicaid plan. The federal portion is called “federal financial participation” (FFP) and the rate at which it is paid, which varies state to state, is called the Federal Medical Assistance Percentage (FMAP).² Currently, California receives FMAP at the rate of 50 percent for most services covered under Medi-Cal.³ This means that for each dollar the state pays for Medi-Cal costs, the federal government pays another dollar of the cost of the program. California also receives an “enhanced match” for certain services, where the federal government pays for a higher portion of Medi-Cal costs. There are also state-only funded Medi-Cal programs in which the state bears the cost for the entirety of services.

Additionally, both federal and state laws govern the Medicaid program. Federal law sets some broad standards and requires states to cover certain mandatory groups and offer a basic set of mandatory services, while also offering states matching funds to cover optional groups of beneficiaries and optional services. States with Medicaid programs must follow the federal requirements in implementing their programs, including adoption of minimum standards regarding administration, eligibility, scope, and procedural protections. Both federal and state government agencies establish and implement Medicaid policy. At the federal level, CMS is responsible for enforcing the federal laws and developing regulations and guidance for the Medicaid program.

To receive federal funding, each state must have in effect a comprehensive, written state plan that has been approved by the HHS Secretary.⁴ The state Medicaid plan describes the nature and scope of the state’s Medicaid program and includes assurances that the program will be operated in conformity with

the federal statute, regulations, and other requirements. To modify a state's Medicaid program, the state must submit a state plan amendment (SPA) to the HHS Secretary for approval to reflect changes in federal statute, regulations, or court decisions, as well as material changes in state law, policy, organization, or operation of the program.⁵ States may also seek authority to waive some provisions of the Medicaid requirements through receiving approval from the HHS Secretary. There are different types of waivers as discussed below. After reasonable notice and opportunity for a hearing, HHS may delay or withhold federal Medicaid reimbursements if the state plan no longer complies with federal requirements or if the state administers its approved plan in a way that fails to comply with federal provisions.⁶

a. Single State Agency

A state plan must specify a single state agency established or designated to administer or supervise the administration of the Medicaid state plan.⁷ That agency must have legal authority to administer or supervise the administration of the plan and make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan. For an agency to qualify as the Medicaid single state agency, it must not delegate its authority to exercise this legal authority to anyone other than its own officials. In addition, the authority of the Medicaid single state agency must not be impaired. This means that other offices or agencies performing services for the Medicaid single state agency may review rules, regulations, or decisions from the Medicaid single state agency. However, these offices must not have the authority to change or disapprove any administrative decision of the Medicaid single state agency, or otherwise substitute their judgment for that of the Medicaid single state agency with respect to the applications of policies, rules, and regulations issued by the Medicaid agency.⁸ In California, the Medicaid single state agency is DHCS.

b. Waivers

The HHS Secretary may waive a limited number of federal statutory and regulatory requirements to allow states to adopt special programs, known generally as "waiver programs." There are three primary types of federal Medicaid waivers: 1) managed care waivers, 2) home and community-based services waivers (known as HCBS waivers), and 3) experimental demonstration project waivers (known as Section 1115 demonstration waivers). Approvals typically indicate that Medicaid Act provisions not specifically waived continue in full force and effect. California currently has twelve active Medi-Cal waiver programs, including various HCBS waiver programs among others.⁹

Managed care waivers, authorized through Section 1915(b) of the SSA, allow the HHS Secretary to waive provisions of the Medicaid Act to promote cost-effectiveness and efficiency.¹⁰ 1915(b) waivers are often referred to as freedom-of-choice waivers because the program designs restrict enrollees' freedom of choice. For example, California operates the Medi-Cal Specialty Mental Health Services program through a 1915(b)(4) waiver that restricts beneficiaries' choice as they can only access certain mental health services from specified providers who contract directly with a Mental Health Plan. See Chapter III on mental health services for additional information about this program.

HCBS waivers, authorized through Section 1915(c) of the Social Security Act, allow states to provide home and community based services to certain groups of individuals who 1) would be eligible for Medicaid if living in an institution, and 2) but for the services provided through a waiver, would require the level of care provided in a hospital, nursing facility, or intermediate care facility.¹¹

Section 1115 demonstration waivers allow the Secretary of HHS to grant states waivers of limited, otherwise mandatory Medicaid requirements in order to test experimental projects that promote the objectives of the Medicaid program.¹² Medicaid's objectives are to help states furnish medical assistance, rehabilitation, and other services to individuals with incomes and resources that are insufficient to meet the costs of needed medical care.¹³ In addition to meeting program objectives, the demonstration requests should have robust evaluation components and must be budget neutral. CMS' authority to approve 1115 waivers is limited and must meet the following criteria:

- The waiver must implement an “experimental, pilot, or demonstration” project;
- The experiment must be likely to promote Medicaid's objectives;
- The waiver must be limited to Medicaid provisions in 42 U.S.C. §1396a, which pertain to mandatory and optional components of a state Medicaid plan; and
- The waiver must be limited to the extent and period needed to carry out the experiment.¹⁴

3. Service Delivery Models

a. Fee-For-Service

Traditionally, Medicaid operated using “fee-for-service” payment and services delivery model. Each provider contracts individually with the state to furnish services to Medicaid beneficiaries. After the provider furnishes the covered service to the beneficiary, the provider submits a

claim to the state, and the state pays a fee for that particular claim. Health care providers who participate in Medicaid must accept Medicaid payment as payment in full; they may not collect additional payment from Medicaid patients, with the exception of cost sharing authorized under federal law and the state plan.¹⁵ In fee-for-service Medicaid, a beneficiary may obtain services from any health care provider who participates in the Medicaid program.¹⁶ Over the past few decades, many states including California have been transitioning away from this model, however there is a limited fee-for-service system that continues - mostly for populations who are not subject to managed care enrollment or select services that are not part of the managed care delivery system. In California, less than 20 percent of Medi-Cal beneficiaries remain in the non-managed care FFS Medi-Cal delivery system.

b. Managed Care

Today, the majority of Medicaid beneficiaries (10.5 million) receive services through some type of managed care arrangement.¹⁷ Most Medicaid beneficiaries are enrolled in capitated managed care plans, including Managed Care Organizations (MCOs), which receive a fixed per-member, per-month “capitated” fee, regardless of how many services an enrollee may actually need. MCOs bear the financial risk if the cost of providing services exceeds the capitated payment. On the other hand, if enrollees use fewer services, the plan keeps the excess payment. Because managed care companies have a financial incentive to manage costs and care, federal law and newly updated regulations provide an important array of consumer protections for enrollees.¹⁸

Over the past 30 years, California has increasingly moved more beneficiaries into a capitated managed care delivery system. Medi-Cal managed care models are available statewide and over 80 percent of Medi-Cal beneficiaries receive services through a managed care plan, including high-risk and vulnerable groups like seniors, people with disabilities, pregnant women, and children.¹⁹ In Medi-Cal, managed care is delivered using six different models in various counties.²⁰ Under the Two-Plan model, enrollees have two health plans, one a publicly run entity, a “local initiative,” and a privately-run entity, a “commercial plan,” from which to choose their care. Under the Geographic Managed Care (GMC) model, several commercial plans compete to provide services to Medi-Cal beneficiaries. Under the Regional and Imperial Models, two privately run plans compete to provide services to beneficiaries; these plans cover an entire region of the state as if it were one county. In San Benito County, one commercial plan is available to Medi-Cal beneficiaries who wish to enroll in managed care on a

voluntary basis. And under the County Organized Health System (COHS) model, a county forms an agency which contracts with the state Medi-Cal program to provide services to almost all Medi-Cal beneficiaries living in that county.

Medi-Cal managed care plans are governed by both state and federal law, and are regulated by a number of federal and state agencies. Medi-Cal plans are regulated by CMS and DHCS. In 2016, CMS made major revisions to the federal regulations that govern Medi-Cal plans; pursuant to the new regulations, California added significant new statutory provisions to implement the new rules in California. In addition, most—but not all—Medi-Cal managed care plans are also licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the California Knox-Keene Act.²¹ Because COHS Medi-Cal plans are exempt from DMHC licensure, currently only one COHS, Health Plan of San Mateo, is Knox-Keene licensed.²² Medi-Cal Managed Care Plans licensed under the Knox-Keene Act are also regulated by DMHC.

i. Network Adequacy

As previously mentioned, Medi-Cal managed care plans are capitated—i.e. they receive a set payment per enrollee per month in exchange for providing services.²³ The plans contract on a “comprehensive risk” basis, meaning they accept the risk of incurring a loss if they spend more on services than they receive through the capitated payments, but they will make a profit if providing services costs less than the payments.²⁴

Both federal and state laws require Medi-Cal managed care plans to have adequate provider networks to serve their enrollees. But the rules differ somewhat depending on whether a plan is regulated by DMHC and DHCS, or only DHCS. Federal Medicaid law requires that each Medi-Cal Managed Care plan ensure that all services covered under the State Plan are available and accessible to managed care enrollees.²⁵ The updated federal Medicaid regulations require states to develop and publish network adequacy standards, including specific time and distance requirements, for certain types of providers, effective July 1, 2018.²⁶ The regulations further require managed care plans that participate in Medi-Cal to ensure and annually document their capacity to serve the health care needs of their enrollees in each service area in accordance with state access-to-care standards.²⁷ The regulations require the state to annually certify to CMS that its plans are in compliance with state standards for service availability, after the state’s review of each plan’s

documents.²⁸ California Medi-Cal law complies with the federal rules in part by requiring plans to “[e]nsure and monitor an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel, and an adequate number of accessible facilities within each service area.”²⁹ For information about California’s specific requirements for Medi-Cal plans, see National Health Law Program’s Medi-Cal Managed Care Series, which includes an issue brief on *Network Adequacy Laws in Medi-Cal Managed Care Plans*.³⁰

B. Services

In general, the Medicaid Act requires states to provide coverage for broad categories of services, but does not explicitly define the minimum level of each service to be provided. For example, prenatal care is a mandatory service, however states have some leeway to determine the extent to which a particular service is covered.³¹ Instead, the Medicaid Act requires states to establish reasonable standards, comparable for all eligibility groups, for determining the extent of medical assistance. These standards must be consistent with the objectives of the Medicaid Act and are described in more detail below.

1. General

Medicaid offers comprehensive services that address the health needs of the populations served. Low-income individuals and families tend to have worse health outcomes than their higher income counterparts, and are more likely to have chronic health conditions and disabilities.³² The service package offered through Medicaid was developed to help address these health care needs.

a. Mandatory Services for Categorically Needy Enrollees

The mandatory categorically needy qualify automatically for Medicaid because they fit into a specified category. Currently, individuals must fit into one or more of groups of low-income families and children or low-income aged, blind, or disabled individuals.³³ Individuals covered by their state Medicaid expansion program under the ACA (including California), are also included in this category.³⁴ The Medicaid Act requires states to cover a broad array of services for all categorically needy enrollees, including, but not limited to:

- Inpatient hospital services (other than services in an institution for people with mental health diagnoses);³⁵
- Outpatient hospital services;³⁶
- Physician services;³⁷
- Rural health clinic services, including ambulatory services offered by a rural health clinic and otherwise included in the state’s Medicaid plan;³⁸
- Federally-qualified health center services;³⁹

- Laboratory and X-ray services;⁴⁰
- Nursing facility services (other than in an institution for people with mental health diagnoses) for individuals 21 or older;⁴¹
- EPSDT services for recipients under age 21;⁴²
- Pregnancy-related services and services for conditions that might complicate pregnancy;⁴³
- Family planning services and supplies;⁴⁴

b. Optional Services for Categorically Needy Enrollees

The Medicaid Act provides that states may cover additional services. Once a state chooses to provide an optional service, the state must fully adhere to applicable requirements. Optional services include, but are not limited to:

- Clinic services furnished by or under the direction of a physician, including such services furnished by clinic personnel outside the clinic to enrollees who do not reside in a permanent dwelling or have a fixed mailing address;⁴⁵
- Physical therapy and related services;⁴⁶
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses;⁴⁷
- Other diagnostic, screening, preventive, and rehabilitative services;⁴⁸
- Dental services;⁴⁹ and
- Intermediate care facility services for the developmentally disabled (other than institutions for people with mental health diagnoses).⁵⁰

c. Services for Medically Needy Enrollees (Optional Coverage Groups)

States with medically needy Medicaid programs can offer this group the same or a more limited package of services than it offers the categorically needy. At a minimum, if a state chooses to cover the medically needy, it must provide prenatal and delivery services.⁵¹ If a pregnant person applies for and receives medically needy Medicaid during their pregnancy, the state must continue to cover pregnancy-related care services through the end of the month in which the 60-day postpartum period falls.⁵² The state must also cover ambulatory services for children under age 18 and for individuals entitled to institutional services.⁵³ Individuals entitled to nursing facility services must also have access to home health services.⁵⁴

2. Medi-Cal Services

In addition to the mandatory benefit categories described previously, California has opted to cover many additional benefits in its Medi-Cal program such as prescription drugs, adult dental benefits, long-term services and supports for

older adults and individuals with disabilities, family planning services, non-emergency medical transportation, and a wide range of mental health and substance use disorder services.⁵⁵ These services are described in detail in subsequent chapters of the Guide.

a. Limited Scope Services for Immigrant Adults

Adults seeking to enroll in full-scope Medi-Cal must be U.S. citizens or have a qualifying immigration status.⁵⁶ Those immigrants who are not eligible for full-scope Medi-Cal can still receive certain services under restricted or emergency Medi-Cal. Immigrants not eligible for full-scope Medi-Cal may also be able to access other types of limited scope and/or state publicly-funded services and programs, including:⁵⁷

- State Breast and Cervical Cancer Treatment Program (BCCTP)
- Family Planning, Access, Care, and Treatment (Family PACT)
- Medi-Cal Access Program
- Medi-Cal Minor Consent services
- Long-term care and kidney dialysis
- Child Health and Disability Prevention Program
- Refugee Medical Assistance
- Hill-Burton Act funded services
- Services provided at Federally Qualified Health Centers
- Public Health Programs
- County Health Programs

Children under 19 years of age are eligible for full-scope Medi-Cal services regardless of immigration status as a result of the enactment of Full Scope Medi-Cal for All Children (SB 75), which went into effect on May 1, 2016.⁵⁸ Starting January 1, 2020, young adults up to age 26 years of age are also eligible for full-scope Medi-Cal coverage under California's state-funded Young Adult Expansion program.⁵⁹

3. Medicaid Protections That Help Ensure Coverage and Access to Services

Congress mandated the inclusion of certain benefits and services states must offer in their Medicaid programs.⁶⁰ However, it did not explicitly define the minimum level of each service to be provided. Instead, Congress, through the Medicaid Act, required states to establish reasonable standards, comparable for all eligibility groups, for determining the extent of medical assistance.⁶¹ These standards must be consistent with the objectives of the Medicaid Act.⁶² While enforcing these rights may only happen through a legal challenge in the courts, these consumer protections are key features to the Medicaid program.

a. Amount, Duration, and Scope of services

Federal Medicaid law and regulations require that the services be “sufficient in amount, duration and scope to reasonably achieve their

purpose.”⁶³ These rules also require that states not “arbitrarily deny or reduce the amount, duration, or scope of such services to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.”⁶⁴ There is no concrete rule as to what constitutes a sufficient amount of services, and states have a leeway about how they impose limits on services. It is generally understood to mean that all medically necessary treatment within a covered service must be provided, that service must be covered in an amount sufficient to achieve its intended purpose (meets most people’s need for that service), and particular illnesses cannot be singled out for restricted coverage. States must also use reasonable standards in administering their Medicaid program, meaning that they cannot have policies or practices that arbitrarily deny a particular service or item within a category of benefits, such as durable medical equipment. All these consumer protections are critical to ensure beneficiaries have access to services that are medically necessary.

b. Comparability

Medicaid benefits must not only be “sufficient” in amount, duration, and scope, they must also be comparable. Generally, states must ensure that services available to categorically needy beneficiaries are not less in amount, duration, and scope than those services available to medically needy beneficiaries.⁶⁵ Additionally states are required to provide services equal in amount, duration and scope for all beneficiaries within the categorically needy and medically needy groups respectively.⁶⁶ Some exceptions exist, for example, children are entitled to receive additional services.⁶⁷ A state may also operate a home and community-based services program for people with disabilities under a Medicaid waiver program which can provide additional services.⁶⁸ Essentially, comparability is about fairness: one person who has the same type of needs as another person should be able to access the same services. Comparability does not require states to provide any particular service, but requires the state to provide the services it offers in a manner that does not deny it to individuals who have the same types of needs. Some states have been found by courts to violate this requirement when they arbitrarily provide a service or benefit to one individual or group of individuals but do not provide the service or benefit to another group with a similar need.⁶⁹

c. Reasonable Promptness

The Medicaid Act requires that state “medical assistance . . . be furnished with reasonable promptness to all eligible individuals.”⁷⁰ Federal regulations direct state agencies to determine an applicant’s eligibility for Medicaid within forty-five days of the date of application

and to “[f]urnish Medicaid promptly to beneficiaries without any delay caused by the agency’s administrative procedures.”⁷¹ This requirement arises both in the state’s obligation to determine Medicaid eligibility of an applicant in a timely manner and in the duty to provide services or benefits to a Medicaid beneficiary.⁷² For example, if a state (or county) fails to determine individuals’ eligibility for Medicaid in a timely manner (i.e. 45 days for most applicants) due to a backlog of applications in the system, that delay would very likely violate the state’s obligation to furnish assistance with reasonable promptness. In the case of services or benefits, the existence of a waitlist for beneficiaries to access a particular service due to a lack of providers available to provide services would likely violate their right to get medically necessary services in a reasonable prompt time frame. Other similar examples that could violate the reasonable promptness standard are a cap on services, or a state imposing an arbitrary waiting period before a beneficiary can access particular services. If a state fails to determine Medicaid eligibility or provide needed services with reasonable promptness, beneficiaries can appeal. See Section G later in the chapter for information on Medicaid Due Process.

d. Statewideness

Another consumer protection provision of the Medicaid law is the requirement that a state plan for medical assistance “shall be in effect in all political subdivisions of the state.”⁷³ The state Medicaid plan must be continuously in operation throughout the state.⁷⁴ In general, states are required to make their Medicaid benefits available to all eligible individuals, regardless of the location of their residence within the state. This requirement does not mean that a Medicaid provider must offer the services throughout the state, but rather that services covered under the Medicaid state plan must be available throughout the state.⁷⁵ So, for example, a state can contract with a managed care plan to serve a particular population, or beneficiaries residing within a particular region of the state, and the contract can exclude beneficiaries outside of that population or region of the state. The statewideness rule applies to both mandatory and optional benefits. For example, a state that covers optional prescription drugs must make that benefit available in both rural and urban areas of the state. There are exceptions to this general rule, as states are allowed to limit coverage of some services (e.g. “targeted” case management services) to a particular subpopulation of Medicaid beneficiaries or to particular geographic areas within the state. Similarly, certain HCBS waiver services can be restricted to certain target populations residing in particular areas within the state or to beneficiaries that meet certain qualifications. States may also obtain waivers of this “statewideness” requirement to conduct 1115 demonstrations.⁷⁶

e. Free Choice of Provider

Any individual eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them.⁷⁷ This provision is often referred to as the “free choice of provider” provision. This important consumer protection allows Medicaid beneficiaries to seek care and services from a Medicaid provider that they elect as long as such provider is willing to provide these services (and accept them as a patient). There is an exception for beneficiaries enrolled in certain managed care plans (to permit such plans to restrict beneficiaries to providers in the managed care plan’s network).⁷⁸ However, Medicaid managed plans cannot restrict free choice of *family planning* providers, even if the plan otherwise restricts enrollees’ coverage to a network of providers.⁷⁹ The provider must also meet Medicaid qualifications or standards set forth by the state.

Additionally, states cannot set unreasonable standards to unfairly target certain providers. A state’s action against a provider affecting beneficiary access to the provider must be supported by evidence of fraud or criminal action, material noncompliance with relevant requirements, or material issues concerning the fitness of the provider to perform covered services or appropriately bill for them.⁸⁰ Taking such action against a provider without such evidence would not be in compliance with the free choice of provider requirement. If a state does not have evidence supporting its finding that a provider failed to meet a state standard, that provider remains “qualified to furnish” Medicaid services.⁸¹ Within the family planning context, the free choice of provider protection prevents states from denying qualification to family planning providers, or taking other action against qualified family planning providers that impedes beneficiaries’ access to those providers. A qualified provider includes individual providers, physician groups, outpatient clinics, and hospitals, even if they separately provide family planning services or the full range of legally permissible gynecological and obstetric care, including abortion services (as permitted by state and federal law), as part of their scope of practice.⁸² The “freedom of choice” protection is critical for beneficiaries who want to receive care from a provider with whom they are comfortable, is familiar with their health history, and can provide immediate and time-sensitive care.

f. Language Access and Communication Assistance

Many Medi-Cal beneficiaries are limited English speakers or may not speak English at all. Others may be able to understand English but feel more comfortable communicating verbally or reading written materials in another language. Medi-Cal entities including managed care plans, health facilities, and providers must comply with a number of federal

and state legal requirements when providing health care services or communicating with Medi-Cal beneficiaries who are limited-English proficient (LEP) and/or deaf, hard of hearing, blind, or require communication assistance. These laws and their implementing regulations help ensure Medi-Cal beneficiaries can meaningfully communicate with their providers and access needed health care services.

Federal Laws Requiring Language Access and Communication Assistance

Title VI of the Civil Rights Act of 1964 (“Title VI”) – ensures that all federal fund recipients cannot discriminate on the basis of race, color, or national origin. Title VI’s implementing regulations also prohibit “disparate impact” discrimination.⁸³ Through Executive Order 13166, Title VI applies to federal agencies themselves.⁸⁴

Section 1557 of the Affordable Care Act (ACA) – applies both to federal fund recipients as well as all programs and activities administered by the federal agencies and entities created under Title I of the ACA, primarily federal and state marketplaces and qualified health plans.⁸⁵ The regulations implementing Section 1557 outline requirements for notifying clients/ patients of language services, providing oral interpreting and including taglines on significant written documents.⁸⁶ Section 1557 also incorporates existing Americans with Disabilities Act requirements for covered entities to take appropriate steps to ensure effective communications with individuals with disabilities.

Hill-Burton Act – hospitals that received funding under this Act have an ongoing “community service” obligation which includes non-discrimination in the delivery of services.⁸⁷ These hospitals must post notices of this obligation in English, Spanish, and other languages spoken by ten percent or more of the households in the service area.⁸⁸

Emergency Medical Treatment and Active Labor Act (EMTALA) – requires screening, treatment and transfer requirements which would be challenging to meet without effective communication with a LEP patient.⁸⁹

Americans with Disabilities Act (ADA) – hospitals and medical offices are required to take steps to ensure that their communications with people with disabilities are as effective as communications with others.⁹⁰

Section 504 of the Rehabilitation Act (Section 504) – requires effective communication, including auxiliary aids and services, such as the provision of sign language interpreters or written materials in alternative formats.

Recipients of federal funding, such as DHCS and any Medi-Cal participating facility or provider, must comply with Title VI, ACA Section 1557, Section 504, and a number of Medicaid provisions to ensure services are rendered in a linguistically appropriate and accessible manner. For example, DHCS must effectively communicate with applicants and recipients, and publish and make available bulletins that explain the rules about eligibility and appeals “in plain language and in a manner that is accessible and timely.”⁹¹ The Medicaid statute also requires that DHCS provide all managed care enrollment notices, information, and instructional materials in a manner and form which may be easily understood by existing and potential beneficiaries.⁹² Medicaid regulations also provide heightened protections for LEP individuals who reside in long-term care facilities, and children and adolescents who use or are eligible for EPSDT services.⁹³

In addition to the federal requirements, Medi-Cal participating providers and Medi-Cal managed plans must also comply with state requirements.⁹⁴ For those who receive their health care through managed care plans, there are added requirements to ensure access to language assistance services.⁹⁵ Medi-Cal managed care plans are also required to conduct Health Education and Cultural and Linguistic Population Needs Assessment to identify the needs of their enrollees (including the needs of LEP individuals, seniors, persons with disabilities, and children and adults with special healthcare needs), available health education and cultural and linguistic programs and resources, and gaps in services.⁹⁶

g. Due Process

One of the most important consumer protections of the Medicaid program are the rights of applicants and beneficiaries to receive a notice and obtain a hearing when benefits are denied, terminated or reduced. Medicaid is an entitlement program, meaning any individuals who meets the program’s eligibility requirements has a right to enroll. Medicaid applicants and beneficiaries therefore have a property interest in Medicaid benefits. This property interest is protected by the Due Process Clause of the U.S. Constitution.⁹⁷

The two fundamental elements of these constitutionally required protections are the right to adequate notice of the state Medicaid agency’s actions and a meaningful opportunity to seek a hearing to appeal the state’s actions or decisions. These rights were articulated by the U.S. Supreme Court in its landmark decision of *Goldberg v. Kelly*.⁹⁸ In *Goldberg*, the Court acknowledged that beneficiaries rely on programs like Medicaid to meet basic needs, without any other options,

and therefore beneficiaries are entitled to effective notice and a pre-termination hearing when these benefits are being terminated. The notice must inform the individual of the action being taken, reasons for the action, specific legal support for the action, and an explanation of the individual's hearing rights, rights to representation and to continued benefits.⁹⁹

Federal law also provides protections for Medicaid beneficiaries. The federal Medicaid Act and implementing regulations require states to provide beneficiaries with the opportunity to request a State Fair Hearing whenever a request for benefits is denied or is not acted upon with reasonable promptness.¹⁰⁰ A beneficiary who requests a hearing prior to the effective date of the adverse action generally has the right to receive continued benefits at the previously authorized level pending the outcome of the hearing.¹⁰¹ Applicants and beneficiaries are also entitled to cross-examine witnesses, have access to their case file, and to present a case without interference.

Recent federal regulations on managed care provide additional protections for Medicaid enrollees. States must comply with these requirements for Medicaid managed care contracts starting on or after July 1, 2017.¹⁰² The regulations require states to ensure (through contracts) that these entities have a grievance and appeal system and provide adequate notice to enrollees of decisions about or changes to their benefits.¹⁰³ The regulations provide specifics as to the requirements for notice of an adverse benefit determination.¹⁰⁴ They also specify procedures for the opportunity for a hearing if a state agency or plan makes an adverse benefit determination.¹⁰⁵ California has specific state laws, regulations and guidance that govern managed care plans obligations concerning notice and appeal rights involving benefit determinations.¹⁰⁶

4. Utilization Controls, Prior Authorization, Limits to Services

The Medicaid Act allows states to impose utilization controls on the delivery of services.¹⁰⁷ Utilization controls are management techniques designed to steer Medicaid beneficiaries toward or away from certain drugs or medical procedures. The stated aims are to ensure that beneficiaries receive the most cost-effective, medically necessary services and to avoid unnecessary program costs. The federal statute does not define "utilization controls," however there are limits.¹⁰⁸ Permissible utilization controls include: 1) medical necessity requirements, 2) prior authorization for prescription drugs, devices or health services, 3) obtaining a second opinion prior to surgery, 4) lock-in programs requiring a beneficiary to receive services from particular providers, and 5) for adults, limits on the number or frequency of services. Prior authorization is not a

permissible utilization control for emergency services and EPSDT screens.¹⁰⁹ Medicaid managed care plans may adopt their own utilization controls, subject to certain limitations.¹¹⁰ States and Medicaid managed care plans are not permitted to impose utilization controls that interfere with a beneficiary's freedom to choose the method of family planning to be used.¹¹¹ DHCS does place some limits of Medi-Cal plans authorization of services.¹¹²

ADVOCACY TIPS:

- ✓ Medi-Cal beneficiaries can remain eligible for Medi-Cal benefits even if they have other health insurance coverage. Any additional health insurance is referred to as other health coverage (OHC). OHC includes private insurance 1) through an employer; 2) as a spouse or dependent covered through another person's employer-sponsored coverage; or 3) individual insurance that the beneficiary or the family purchases through Covered California.
- ✓ Medi-Cal managed care plans must have an adequate network of providers, provide timely access to services, and meet certain time and distance standards to access services. This guide does not address those requirements but see NHeLP's issue brief on [Network Adequacy in Medi-Cal Managed Care Plans](#) for more information on these requirements.

Endnotes

¹ See generally CMS, STATE MEDICAID MANUAL.

² See 42 U.S.C. § 1301(a)(8).

³ 89 Fed. Reg. 61,157, 61,159 (Nov. 28, 2018). Some Medi-Cal services are eligible for an enhanced FMAP.

⁴ 42 C.F.R. § 430.10; see also, generally 42 U.S.C. § 1396a.

⁵ 42 C.F.R. § 430.12(c).

- ⁶ See 42 U.S.C. § 1396c; 42 C.F.R. §§ 430.15, 430.35.
- ⁷ 42 U.S.C. §1396a(a)(5) 42 C.F.R. § 431.10.
- ⁸ For more information on consumer protections in Medicaid, see Kim Lewis & Wayne Turner, Nat'l Health L. Prog. *What Makes Medicaid, Medicaid? – Consumer Protections and Due Process* (2017) [hereinafter NHeLP, *What Makes Medicaid*], <https://healthlaw.org/resource/what-makes-medicaid-medicaid-consumer-protections-and-due-process/>.
- ⁹ Cal. Dep't Health Care Servs, *Medi-Cal Waivers*, <https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx>.
- ¹⁰ See 42 U.S.C. § 1396n(b).
- ¹¹ See 42 U.S.C. § 1396n(c); *id.* §§ 1396a(a)(10)(A)(ii)(VI), 1396n(b)-(e).
- ¹² *Id.* § 1315(a).
- ¹³ See *id.* § 1396.
- ¹⁴ *Id.* § 1315(a).
- ¹⁵ *Id.* § 1396a(a)(25)(C); 42 C.F.R. §§ 447.15, 447.20.
- ¹⁶ 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51.
- ¹⁷ Cal. Dep't Health Care Servs., *Medi-Cal Managed Care Performance Dashboard 2* (2019) [hereinafter *Medi-Cal Dashboard*], <https://www.dhcs.ca.gov/services/Documents/MMCD/Sept24-2019-Release.pdf> (nearly 11 Million beneficiaries receive care from a managed care plan as of March, 2019). For more information, see also Abbi Coursolle, Nat'l Health L. Prog., *Network Adequacy Rules for Medi-Cal Managed Care Plans, Managed Care in California Series* (2d. Ed., 2018), <https://healthlaw.org/resource/managed-care-in-ca-series-issue-1-network-adequacy-laws-revised-may-7-2018/>.
- ¹⁸ NHeLP, *What Makes Medicaid*, *supra* note 8.
- ¹⁹ *Medi-Cal Dashboard*, *supra* note 17, at 2 (managed care enrollment at 81% as of March, 2019).
- ²⁰ For a chart of the different county models, see Cal. Dep't Health Care Servs., *Medi-Cal Managed Care Program Fact Sheet – Managed Care Models* (2018), <https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf>.
- ²¹ See generally CAL. WELF. & INST. CODE §§ 1340-1399.818.
- ²² CAL. WELF. & INST. CODE § 14087.95; see also, e.g., Cal. Health Benefits Rev. Prog., *The California Cost and Coverage Model*, App'x 13 at 7 (2013), http://www.chbrp.org/other_publications/docs/ap_13.pdf.

- ²³ In Medi-Cal, the capitation rate is paid by the state to the plans directly. See Cal. Health Care Found., *Medi-Cal Facts and Figures: A Program Transforms* 26 (2013), <https://www.chcf.org/wp-content/uploads/2017/12/PDFMediCalFactsAndFigures2013.pdf>. There are a few very small managed care programs in Medi-Cal for enrollees with particular chronic conditions that are not capitated; this Guide will not discuss them. See Medi-Cal Performance Dashboard, *supra* note 17, at 2. See also Cal. Dep’t Health Care Servs., *External Quality Review Technical Report* 17 (2019), https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2017-18_EQR_Technical_Report_F1.pdf.
- ²⁴ See 42 C.F.R. § 438.2 (defining “comprehensive risk contract” and “capitation payment” for Medi-Cal plans).
- ²⁵ 42 U.S.C. § 1396u-2(b)(5).
- ²⁶ 42 C.F.R. § 438.62.
- ²⁷ *Id.* § 438.207(a).
- ²⁸ *Id.* § 438.207(d).
- ²⁹ CAL. WELF. & INST. CODE § 14182(c)(2); see also, e.g., Cal. Dep’t Health Care Servs., *Sample Contract Boilerplate for COHS Counties*, Ex. A, Att. 6 (2014), <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.
- ³⁰ See generally Coursolle, *supra* note 17.
- ³¹ See generally Nat’l Health Law Program, *An Advocate’s Guide to the Medicaid Program* (2013) [hereinafter NHeLP, Advocate’s Guide] (giving additional information about mandatory and optional Medicaid covered services, including citations to the Act and the Code of Federal Regulations).
- ³² Steven H. Woolf et al., Urban Inst. & Ctr. on Society & Health, *How are Income and Wealth Linked to Health and Longevity* (2015), <https://www.urban.org/sites/default/files/publication/49116/2000178-How-are-Income-and-Wealth-Linked-to-Health-and-Longevity.pdf>.
- ³³ For a comprehensive list of groups covered under the mandatory categorically needy, see NHeLP, Advocate’s Guide, *supra* note 31.
- ³⁴ 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (added by ACA § 2001(a)(1)). The U.S. Supreme Court’s decision in *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 576 U.S. 519 (2012), upheld the ACA’s adult expansion group as a new mandatory coverage group, however the Court ruled that HHS cannot penalize states that do not cover newly eligible individuals, rendering the expansion optional to the states. *Id.* at 585.
- ³⁵ 42 U.S.C. § 1396d(a)(1); 42 C.F.R. §§ 440.2(a) (defining inpatient as one who is admitted and expected to need services for a 24 hour period or longer), 440.10 (defining inpatient hospital services), 456.50-456.145 (prescribing requirements for utilization control of inpatient hospital services, including individual written plans of care).

- ³⁶ 42 U.S.C. § 1396d(a)(2)(A); 42 C.F.R. §§ 440.2(a) (defining outpatient), 440.20(a) (defining outpatient hospital service); CMS, STATE MEDICAID MANUAL § 4221 (discussing outpatient psychiatric services as outpatient hospital or clinic service).
- ³⁷ 42 U.S.C. § 1396d(a)(5)(A); *see also* 42 U.S.C. § 1396d(e) (discussing physician's services as including optometrist services); 42 C.F.R. § 440.50. Services may be furnished by a physician in an office, the patient's home, a hospital, a nursing facility, or elsewhere.
- ³⁸ 42 U.S.C. §§ 1396d(a)(2)(B), 1396d(l)(1); 42 C.F.R. § 440.20(b), (c).
- ³⁹ 42 U.S.C. §§ 1396d(a)(2)(C); 1396d(l)(2); 1396a(bb) (establishing payment requirements); *see* CHIPRA § 501 (allowing provision of dental benefits for Medicaid and CHIP beneficiaries through FQHCs). *See* CMS, STATE MEDICAID MANUAL §§ 4231, 6303.
- ⁴⁰ 42 U.S.C. § 1396d(a)(3); 42 C.F.R. § 440.30.
- ⁴¹ 42 U.S.C. §§ 1396d(a)(4)(A), 1396d(f) (defining nursing facility), 1396r (defining nursing facility and establishing certification, quality of care, and residents rights requirements); 42 C.F.R. §§ 440.40(a), 440.155, pt. 442 (standards for payment).
- ⁴² 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (as added and amended by Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101--239, § 6403, 103 Stat. 2106, 2262-64); *see* 42 U.S.C. §§ 1396r-6(a)(4), (b)(4) (EPSDT applies during extended benefit period).
- ⁴³ 42 U.S.C. §§ 1396a(a)(10)(A), (C), 1396a(l), 1396d(n) (defining qualified pregnant woman); 42 C.F.R. §§ 440.210(a)(2) (allowing greater amount, duration and scope of pregnancy services); CMS, STATE MEDICAID MANUAL §§ 3311.2, 3571.2, 4421.
- ⁴⁴ 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20; *see* CMS, STATE MEDICAID MANUAL § 4270; CMS, *Dear State Medicaid Director* (July 2, 2010) (discussing family planning and family planning related services in context of new eligibility option under ACA § 2303).
- ⁴⁵ 42 U.S.C. § 1396d(a)(9); 42 C.F.R. § 440.90 (coverage extends to preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided to outpatients); CMS, STATE MEDICAID MANUAL § 4221 (discussing outpatient psychiatric services as clinic or outpatient hospital service); *Id.* § 4320.
- ⁴⁶ 42 U.S.C. § 1396d(a)(11); 42 C.F.R. § 440.110 (coverage for physical therapy (including necessary supplies and equipment), occupational therapy, and services for persons with speech, hearing and language disorders).
- ⁴⁷ 42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.120.
- ⁴⁸ 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130; CMS, STATE MEDICAID MANUAL § 4385 (preventive services).
- ⁴⁹ 42 U.S.C. § 1396d(a)(10); 42 C.F.R. § 440.100; *see* CMS, *Dear State Health Official* (Jul. 5, 2001) (regarding use of American Dental Association's Current Dental Terminology codes).

- ⁵⁰ 42 U.S.C. §§ 1396d(a)(15), 1396d(d) (an institution (or distinct part thereof) for the “mentally retarded” or “persons with related conditions”), 1396a(a)(31) (requiring written plans of care); 1396a(i) (explaining termination of certification); see 42 C.F.R. §§ 440.150 (defining ICF, including requirements for certification and “active treatment”); CMS, STATE MEDICAID MANUAL §§ 4395-4397, 4398 (discussing persons with related conditions and regulatory history of including individuals with developmental disabilities).
- ⁵¹ 42 U.S.C. §§ 1396a(a)(10)(C)(iii); 42 C.F.R. § 440.220(a)(1).
- ⁵² 42 C.F.R. § 440.220(a)(5).
- ⁵³ 42 U.S.C. § 1396a(a)(10)(C)(iii); 42 C.F.R. § 440.220(a)(2)(i) (designating ambulatory services as a required service).
- ⁵⁴ 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 440.220(a)(3)(designating home health services as a required service).
- ⁵⁵ See CAL. WELF. & INST. CODE § 14132.
- ⁵⁶ 42 U.S.C. §§ 1320b-7(d), 1396a(b)(3); CAL. WELF. & INST. CODE § 14011.2(d); CAL. CODE REGS. tit. 22, § 50301. See Jen Flory et al., Western Ctr. on L. & Poverty, *Getting and Keeping Health Coverage for Low-Income Californians* (2016), https://wclp.org/wp-content/uploads/2016/06/Western_Center_2016_Health_Care_Eligibility_Guide_Full_rev.1.pdf.
- ⁵⁷ For more details on the scope of these programs, and detailed eligibility requirements, see, e.g., Flory et al., *supra* note 56, at § 3.111-19, Ch. 7.
- ⁵⁸ CAL. WELF. & INST. CODE § 14007.8.
- ⁵⁹ See *id.* § 14007.8(b); see also Cal. Dep’t Health Care Servs., Young Adult Expansion, <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/YoungAdultExp.aspx> (last accessed Dec. 23, 2019).
- ⁶⁰ See 42 U.S.C. § 1396a(a)(10)(including text following subsection (G) of a(a)(10).
- ⁶¹ 42 U.S.C. § 1396a(a)(17). See S. Rep. No. 89-404 (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1986 (“Congress intended medical judgments to play a primary role in determining medical necessity. . . . The Committee’s bill provides that the physician is to be the key figure in determining utilization of health services -- and provides that it is a physician who is to decide upon admission to a hospital, order tests, drugs, and treatments, and determine the length of stay.”).
- ⁶² 42 U.S.C. § 1396a(a)(17).
- ⁶³ 42 C.F.R. § 440.230(b); see 42 U.S.C. § 1396a(a)(10)(B).
- ⁶⁴ 42 C.F.R. § 440.230(c); see 42 U.S.C. § 1396a(a)(10)(B).
- ⁶⁵ 42 U.S.C. § 1396a(a)(10)(B)(ii).
- ⁶⁶ *Id.* § 1396a(a)(10)(B)(i).
- ⁶⁷ See 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (Medicaid’s Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards).

- ⁶⁸ See 42 U.S.C. § 1396n(c); *id.* §§ 1396a(a)(10)(A)(ii)(VI), 1396n(b)-(e).
- ⁶⁹ Some examples of violating this requirement include: providing orthopedic shoes and compression stockings to some people who needed them, but not to others, *see, e.g. Davis v. Shah*, 821 F.3d 231, 256 (2d Cir. 2016); and providing certain surgical procedures to individuals with cancer, but not those with gender dysphoria, *see, e.g., Flack v. Wisconsin Dep't of Health Servs.*, 395 F. Supp. 3d 1001, 1019 (W.D. Wis. 2019).
- ⁷⁰ 42 U.S.C. § 1396a(a)(8).
- ⁷¹ 42 C.F.R. § 435.930(a).
- ⁷² See *id.* §§ 435.912, 435.930.
- ⁷³ 42 U.S.C. §1396a(a)(1); *see also* 42 CFR § 431.50.
- ⁷⁴ 42 CFR § 431.50(b)(3).
- ⁷⁵ See *id.* § 431.50(c).
- ⁷⁶ See 42 U.S.C. § 1315; *see also, e.g.,* Leo Cuello, Nat'l Health Law Prog., *Health Advocate: Section 1115 Waivers: More than Meets the Eye* (2013), <http://healthlaw.org/resource/health-advocate-section-1115-waivers-more-than-meets-the-eye>.
- ⁷⁷ 42 U.S.C. § 1396a(23); 42 CFR § 431.51.
- ⁷⁸ See 42 U.S.C. § 1396u-2(a)(1).
- ⁷⁹ *Id.* § 1396a(23); 42 C.F.R. § 431.51(a)(3).
- ⁸⁰ CMS, Dear State Medicaid Director Letter 2 (Apr. 19, 2016) (SMD # 16-005).
- ⁸¹ *Id.*
- ⁸² *Id.*
- ⁸³ 42 U.S.C. § 2000d (Title VI of the Civil Rights Act of 1964); *see also* Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, 65 Fed. Reg. 52762 (Aug. 30, 2000), <https://www.govinfo.gov/content/pkg/FR-2000-08-30/pdf/00-22140.pdf>. For additional information on federal requirements, *see* Mara Youdelman, Nat'l Health Law Prog., *Federal Laws and Policies to Ensure Access to Health Care Services for People with Limited English Proficiency* (2004), <http://healthlaw.org/resource/federal-laws-and-policies-to-ensure-access-to-health-care-services-for-people-w>.
- ⁸⁴ See Exec. Order No. 13166, 65 Fed. Reg. 50121 (Aug. 16, 2000) ("Improving Access to Services for Persons with Limited English Proficiency"), <https://www.govinfo.gov/content/pkg/FR-2000-08-16/pdf/00-20938.pdf>.
- ⁸⁵ 42 U.S.C. § 18116.
- ⁸⁶ See 45 C.F.R. §§ 92.8(f)(1), 92.201.
- ⁸⁷ 42 U.S.C. § 291c(e); *see also* 42 C.F.R. § 124.603(a)(1).

- ⁸⁸ See U.S. Dep't Health & Hum. Servs., *Know Your Rights Under the Community Service Assurance Provisions of the Hill-Burton Act* 1 (1990), <https://www.hhs.gov/sites/default/files/knowyourrightshillburtonfactsheet.pdf>.
- ⁸⁹ See 42 U.S.C. § 1395dd; see also 42 C.F.R. § 489.24.
- ⁹⁰ See 28 C.F.R. § 35.160
- ⁹¹ 42 C.F.R. § 435.905(b).
- ⁹² 42 U.S.C. § 1396u-2(a)(5)(A).
- ⁹³ See 42 C.F.R. § 483.10(g) (residents of long-term care facilities); 42 U.S.C. § 1396a(a)(43)(A) (ESPDT).
- ⁹⁴ As of September 2018, there were 257 provisions in statutes and regulations governing language requirements in California. See Mara Youdelman, Nat'l Health Law Prog., *Summary of State Law Requirements Addressing Language Needs in Health Care* 4 (2019), <https://healthlaw.org/resource/summary-of-state-law-requirements-addressing-language-needs-in-health-care-2/>.
- ⁹⁵ See generally Cal. Dep't Health Care Servs., All Plan Letter 17-011 (June 30, 2017), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-011.pdf>.
- ⁹⁶ See generally Cal. Dep't Health Care Servs., MMCD Policy Letter 19-011 (Sept. 30, 2019), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-011.pdf>.
- ⁹⁷ See U.S. CONST., AMEND. XIV, § 1.
- ⁹⁸ 397 U.S. 254 (1970) (holding that when welfare benefits are terminated, the beneficiary has due process rights to an effective notice and pre-termination hearing); see also 42 C.F.R. § 431.205(d) (implementing these protections in Medicaid).
- ⁹⁹ 42 C.F.R. §§ 431.206, 431.210.
- ¹⁰⁰ See 42 U.S.C. § 1396a(a)(3); 42 C.F.R. SubPart E (Medicaid fair hearing provisions); *id.* § 438, SubPart F (dispute resolution requirements for managed care systems); see also *id.* at § 431.205(d) (explicitly requiring hearing system to meet Goldberg standards).
- ¹⁰¹ *Goldberg*, 397 U.S. at 267; see also 42 C.F.R. § 431.230.
- ¹⁰² 42 C.F.R. § 438.400(c).
- ¹⁰³ *Id.* §§ 438.228, 438.400-24. These provisions have been implemented in state law at CAL. WELF. & INST. CODE § 14197.3; see also Cal. Dep't Health Care Servs., All Plan Letter 17-006 at 2 (May 9, 2017) [hereinafter APL 17-006], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>; Cal. Dep't of Health Care Servs., MHSUDS Information Notice 18-010E at 5 (Mar. 27, 2018) [hereinafter MHSUDS 18-010E], https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf.

¹⁰⁴ 42 C.F.R. § 438.404.

¹⁰⁵ 42 C.F.R. §§ 438.402(c), 431.220, 431.244.

¹⁰⁶ CAL. WELF. & INST. CODE § 14197.3; APL 17-006, *supra* note 103; MHSUDS 18-010E, *supra* note 103.

¹⁰⁷ 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 440.230(d); *id.* § 456.1-456.6.

¹⁰⁸ Courts have placed limits on the extent to which a state Medicaid agency can impose utilization controls to restrict the use of medically necessary services. *See, e.g., Bontrager v. Indiana Fam. & Soc. Servs. Admin.*, 697 F.3d 604 (7th Cir. 2012) (holding that Indiana violated the Medicaid Act when it denied medically necessary dental work because the enrollee had exceeded the annual cap on dental services).

¹⁰⁹ *See* 42 U.S.C. § 1396u-2(b)(2)(A)(i) (emergency services); 42 C.F.R. § 441.59(a) (EPSDT screens).

¹¹⁰ 42 C.F.R. § 438.210(a)(4).

¹¹¹ 42 C.F.R. § 438.210(a)(4)(ii)(C); *see also* CMS, State Health Official Letter (June 14, 2016) (SHO # 16-008). Cal. Dep't Health Care Servs., All Plan Letter 18-019 at 1 (Nov. 21, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-019.pdf>.

¹¹² *See, e.g.,* Cal. Dep't Health Care Servs., MHSUDS Info. Notice 19-026 (May 31, 2019), https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_IN_19-026_Authorization_of_SMHS.pdf.