



An Advocate's Guide to Medi-Cal Services

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By: Abbi Coursolle, Alicia Emanuel, Héctor Hernández-Delgado, Priscilla Huang,
Kim Lewis, Michelle Lilienfeld, Hayley Penan



Foreword

The National Health Law Program (NHeLP) is pleased to present *An Advocate's Guide to Medi-Cal Services* ("Guide"). The Guide is a new and updated version of a July 2008 NHeLP publication, *Overview of the Medi-Cal Program*, which provided a basic overview of the Medi-Cal program. The 2020 update is intended to be a resource for health care and low-income advocates, legal aid attorneys, and other health care stakeholders in California. The Guide focuses on some of the most important benefits in Medi-Cal, many of which have been added or significantly expanded since the 2008 publication was released. We hope that this publication will serve to improve your understanding of the benefits covered by Medi-Cal and the important role that Medi-Cal plays in improving the health and well-being of low-income individuals and families in California.

About NHeLP

Founded in 1969, the National Health Law Program (NHeLP) protects and advances the health rights of low-income and marginalized people to access high quality health care, particularly in publicly funded health programs. We advocate, educate, and litigate at the federal and state levels to advance health and civil rights in the U.S.



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

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Overview of Medicaid and Medi-Cal

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/knownyourrightshillburtonfactsheet.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.



An Advocate's Guide to Medi-Cal Services

January 2020



**Chapter II:
Prescription Drugs**

Chapter II: Prescription Drugs

Prescription Drug Services Covered in this Chapter*

- Prescription Drugs Covered by Medi-Cal
 - Coverage of every Food and Drug Administration approved drug
 - Excluded drugs
- Medi-Cal Contract Drug List (CDL)
 - No prior authorization required, although some exceptions
 - Removal of a drug from CDL
 - State fair hearing rights
 - Continuing care status
- Prior Authorization
 - Department of Health Care Services (DHCS) establishes prior authorization criteria
 - Cannot be so restrictive that denies access to drug for “medically accepted indication”
 - Beneficiary’s prescriber/pharmacist submits Treatment Authorization Request
 - DHCS or health plan must respond within 24 hours of request, and
 - Dispense a 72-hour supply of covered outpatient drug in an emergency situation pending TAR response
- Other Utilization Controls
 - No more than 100 calendar day supply
 - Six prescriptions per month limit
 - Generic drugs
- Prescription Drug Coverage Under Managed Care
 - Same right to access to covered Medi-Cal drugs
 - Some drug coverage carved out of managed care
 - Per Executive Order N-01-19, DHCS will transition Medi-Cal pharmacy services for Medi-Cal managed care to fee-for-service

Prescription Drug Services Covered in this Chapter* (continued)

- Prescription Drugs for Dual Eligibles
 - Must receive most prescription drugs through Medicare Part D plan
 - Drug categories excluded from Part D may be covered by Medi-Cal

*This is a non-exhaustive list of services. It may not include all available services.

Medi-Cal benefits include coverage of prescription drugs, which are an optional service under the federal Medicaid Act.¹ Subject to certain narrow limitations, Medi-Cal must cover nearly every drug approved by the Food and Drug Administration (FDA). Nevertheless, Medi-Cal beneficiaries may face barriers to obtain a drug even if they have a prescription for it. For example, a beneficiary may need prior authorization for the drug. Also, additional limitations apply to any drug that is not on the state’s “Contract Drugs List.”

A. Prescription Drugs Covered by Medi-Cal²

Under federal law, Medi-Cal typically must cover every FDA approved drug sold by a manufacturer that has entered into a drug rebate agreement with the federal government.³ Since nearly all manufacturers have entered into such rebate agreements, the effect of this statute is that Medi-Cal has an “open formulary”, i.e., Medi-Cal beneficiaries can receive coverage of almost any FDA approved drug.

However, federal law allows states to exclude coverage of certain categories of drugs, and Medi-Cal has adopted some coverage restrictions. For example, Medi-Cal does not cover over-the-counter cough and cold products, unless provided to a beneficiary under 21 years of age through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.⁴

Medi-Cal does cover some classes of drugs even though federal law allows for their exclusion. For example, federal law allows states to exclude coverage of smoking cessation products provided to adults who are not pregnant women.⁵ Medi-Cal, however, covers both prescription and over-the-counter tobacco cessation products for all beneficiaries.⁶

B. Medi-Cal Contract Drug List

Not every covered Medi-Cal drug appears on Medi-Cal’s “Contract Drugs List.”⁷ The Contract Drugs List (CDL) is a type of preferred drug list. Drugs on the list are preferred because they are generally available to a beneficiary without prior authorization, meaning that a beneficiary only needs a prescription – and not

pre-approval from the Department of Health Care Services (DHCS) – in order to obtain a drug.⁸ Manufacturers sometimes get their drugs placed on the list by signing a contract with Medi-Cal in which they agree to provide additional rebates to Medi-Cal in addition to the rebates required under federal law. Ultimately, DHCS, as advised by the Medi-Cal Contract Drug Advisory Committee, determines which drugs get placed on the CDL based on a drug’s safety, efficacy, cost, and potential misuse, as well as whether there is an “essential need” for the drug.⁹

Although a beneficiary typically can obtain a drug on the CDL without having to obtain prior authorization, there are circumstances in which this is not the case:

- Some drugs on the list are subject to prior authorization if they are being prescribed for certain conditions, but are not subject to prior authorization if they are prescribed for other conditions.¹⁰
- Enbrel, which is used to treat a variety of conditions such as rheumatoid arthritis, is subject to prior authorization even though it appears on the CDL.¹¹
- Celebrex, a COX-2 inhibitor, is subject to step therapy even though it appears on the CDL.¹² This means that the Medi-Cal beneficiary must try another COX-2 inhibitor prior to receiving Celebrex.¹³

All drugs not listed on the CDL require prior authorization from Medi-Cal.¹⁴

Sometimes, a Medi-Cal beneficiary may be taking a drug that Medi-Cal seeks to remove from the CDL. In that case, Medi-Cal must provide beneficiaries with notice about the proposed removal, and such notice must inform beneficiaries of the right to a fair hearing to challenge such removal.¹⁵ Even if the drug is removed from the CDL, a Medi-Cal beneficiary may still receive the drug without prior authorization if the beneficiary is granted continuing care status. Continuing care status is for beneficiaries who are taking a drug at the time that DHCS removes the drug from the CDL and continue to seek prescriptions for the drug at least once every 100 days.¹⁶

C. Prior Authorization

DHCS establishes prior authorization criteria for drugs not on the CDL, as well as drugs on the CDL when not used for the indications specified on the CDL. In the case where a beneficiary is seeking access to a drug that is not on the CDL, prior authorization may be granted when the clinical condition of the beneficiary requires the use of an unlisted drug and listed drugs have been adequately considered or tried and do not meet their medical needs, or the use of an unlisted drug results in a less expensive treatment than would otherwise occur.¹⁷

Federal law prohibits state Medicaid programs from making their criteria so restrictive that they deny access to a drug when a beneficiary is seeking the drug for a “medically accepted indication.”¹⁸ A “medically accepted indication” is

any indication set forth on a drug's FDA label, as well as off-label indications that are recognized in three different drug compendia.¹⁹ Thus, Medi-Cal is prohibited from imposing prior authorization criteria for a particular drug that would result in a denial of coverage when a drug is prescribed for a medically accepted indication.

In cases where prior authorization of a drug is required, the beneficiary's prescriber or pharmacist should submit a Treatment Authorization Request (TAR) to DHCS, or, for managed care enrollees, the Medi-Cal managed care plan (MCP), in order to obtain such prior authorization. DHCS or the plan must: 1) provide a response by telephone or other telecommunication device within 24 hours of the request or receipt of the TAR; and 2) provide for the dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation pending a response on the TAR.²⁰ If DHCS or a Medi-Cal MCP denies the TAR, both the beneficiary and the beneficiary's provider should receive a notice explaining why the TAR was denied, and the beneficiary may request an expedited fair hearing.²¹

When a provider has verified a Medi-Cal beneficiary's eligibility for services, the provider may not deny services because the service requires the provider to obtain authorization.²² A pharmacist may not make the Medi-Cal beneficiary pay for the medication by claiming that Medi-Cal does not cover it. Such a statement may constitute fraud if Medi-Cal could pay for the drug if a TAR were submitted.²³

ADVOCACY TIP:

- ✓ California state law prohibits providers from imposing medical management techniques, including prior authorization and step therapy, on beneficiaries seeking contraceptive drugs and devices.²⁴

D. Other Utilization Controls

In addition to the imposition of prior authorization for drugs not on the CDL, Medi-Cal imposes additional drug utilization controls:

- Beneficiaries typically can obtain no more than a 100-calendar day supply of a drug, except for sodium fluoride tablets, drops, or when necessary to comply with minimum quantities otherwise specified in the regulation.²⁵
- Prior authorization is needed for prescription drugs that exceed a six prescriptions-a-month limit (family planning drugs and patients receiving care in a nursing facility are not subject to this limit).²⁶
- California has adopted policies to promote the use of generic drugs.²⁷ Although the Medi-Cal program does not require generic substitution, the program is required to purchase the most cost-effective drug.²⁸

Medi-Cal also imposes a copayment of one dollar per each prescription or refill, although in practice, beneficiaries are generally not charged any copayments for their prescriptions.²⁹ Co-payments are not permitted for contraceptive drugs and devices.³⁰

E. Prescription Drug Coverage Under Managed Care

Medi-Cal enrollees in managed care have the same right to access covered Medi-Cal drugs as beneficiaries in the fee-for-service (FFS) system. Medi-Cal MCP enrollees have the right to coverage of nearly all FDA approved drugs, just as those enrolled in FFS do. Similarly, MCPs must provide a response to a prior authorization request within 24 hours and must provide a 72-hour supply of a drug when an enrollee is seeking a drug in case of an emergency.³¹ Medi-Cal managed care plans must also allow new enrollees to continue to receive brand name (single-source) drugs, which they were taking prior to the date of enrollment in the plan.³² This applies whether or not the drug is covered by the plan, until the plan's doctor decides it is no longer necessary.³³ Also, Medi-Cal MCP enrollees seeking contraceptives may see any qualified family planning provider of their choice, even if the provider is out of network, without a referral, prior authorization and with no cost sharing.³⁴

However, there can be differences in how MCP enrollees access drugs. Several types of drugs – such as HIV drugs, certain psychiatric drugs, drugs to treat alcohol and other substance use disorders, and blood coagulation factors – are carved out of managed care and not covered by MCPs under Medi-Cal.³⁵ Enrollees in these plans are still entitled to coverage of such drugs, but it is the Medi-Cal program itself, not the managed care plan, that covers and pays for such drugs, even though the drugs may be prescribed by a MCP provider.³⁶

Medi-Cal MCPs can also develop their own formularies, and those formularies are not required to include every drug that appears on the Contract Drug List.³⁷ However, underlying federal drug coverage protections continue to apply. If an enrollee needs access to a drug that is not on the formulary, then the managed care plan must cover such drug through prior authorization, and the prior authorization criteria cannot be so strict that they deny coverage for medically accepted indications.³⁸ In addition, managed care plans develop their own pharmacy networks, so in some cases managed care enrollees may be required to receive their drugs from different pharmacies than FFS beneficiaries.

In January 2019, Governor Newsom issued Executive Order N-01-19, calling for an end of Medi-Cal managed care coverage of prescription drugs and requiring DHCS to transition Medi-Cal pharmacy services to FFS with the aim of obtaining greater discounts from manufacturers.³⁹ The Executive Order calls for the transition to occur by January 2021. In August 2019, DHCS solicited proposals from firms that are able to provide administrative services for managing the FFS

pharmacy benefit. DHCS announced it planned to make a single contract award for Medi-Cal prescription drug services to the firm earning the highest evaluation score.⁴⁰ On November 7, 2019, DHCS announced it intends to award a contract to Magellan Medicaid Administration, Inc.⁴¹

F. Prescription Drugs for Dual Eligibles

Medi-Cal beneficiaries who are also eligible for Medicare, known as “dual eligibles”, must receive most of their prescription drugs from a Medicare Part D plan rather than through Medi-Cal.⁴² These beneficiaries are entitled to and should be automatically enrolled in the Low-Income Subsidy (LIS) program.⁴³ Dual eligibles may receive Medi-Cal coverage for medications that are categorically excluded under Medicare Part D but are covered by Medi-Cal.⁴⁴ If a drug is a coverable drug under Medicare Part D, but the beneficiary’s Part D plan does not cover the medication, the beneficiary cannot turn to Medi-Cal for coverage of that drug.⁴⁵

Endnotes

- ¹ CAL. WELF. & INST. CODE § 14132(d); CAL. CODE REGS. tit. 22, § 51313. See also 42 U.S.C. §§ 1396d(a)(12) (prescription drugs), 1396a(a)(54) (outpatient drugs), 1396r-8 (outpatient drugs); 1396b(i)(5) and (10) (federal payments); 42 C.F.R. § 440.120(a) (defining prescribed drugs).
- ² California elected to align benefits offered to both the traditional and expansion Medi-Cal populations, and thus provides the same scope of services to all Medi-Cal beneficiaries. CMS, Approval Letter for Cal. State Plan Amendment # 13-035, <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-035.pdf>.
- ³ 42 U.S.C. § 1396r-8(d)(1)(B), (4).
- ⁴ CAL. WELF. & INST. CODE § 14132(d)(4); Cal. Dep’t Health Care Servs., *Drugs: Contract Drug List Introduction 2* (May 2016), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/drugscdlintr_p00.doc; 42 U.S.C. § 1396r-8(42 U.S.C. § 1396r-8(a)(1).
- ⁵ 42 U.S.C § 1396r-8(d)(2). CMS, Dear State Medicaid Director (June 24, 2011) (SMD # 11-007) (New Medicaid Tobacco Cessation Services), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-007.pdf>.
- ⁶ CAL. WELF. & INST. CODE § 14134.25(b)(2).

- ⁷ See Cal. Dep't Health Care Servs., *Contract Drugs List*, <http://files.medi-cal.ca.gov>. Medications are listed by their generic name.
- ⁸ Cal. Dep't Health Care Servs., *Pharmacy Benefits Frequently Asked Questions*, <https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/PharmFAQ.aspx> (last viewed Dec. 19, 2019).
- ⁹ CAL. WELF. & INST. CODE § 14105.39(c)(1); CAL. CODE REGS. tit. 22, § 51313.6(a).
- ¹⁰ CAL. CODE REGS. tit. 22, § 51313.3(b).
- ¹¹ Cal. Dep't Health Care Servs., *Drugs: Contract Drug List Part 7 – Preferred Prior Authorization Drug List 1*, <http://files.medi-cal.ca.gov>.
- ¹² Cal. Dep't Health Care Servs., *Drugs: Contract Drug List Part 8 – Step Therapy 2*, <http://files.medi-cal.ca.gov>.
- ¹³ In addition, state law allows HIV and cancer drugs to be placed on the Contract Drug List even if their manufacturer has not signed a contract with Medi-Cal. CAL. WELF. & INST. CODE §§ 14105.43, 14133.2. If a manufacturer for such drugs refuses to provide a supplemental rebate to Medi-Cal for such drugs, then those drugs become subject prior authorization even though they appear on the Contract Drug List. CAL. WELF. & INST. CODE § 14105.436(i).
- ¹⁴ CAL. CODE REGS. tit. 22, § 51313(c).
- ¹⁵ CAL. WELF. & INST. CODE § 14105.33(i).
- ¹⁶ CAL. WELF. & INST. CODE § 14105.33(r), (s).
- ¹⁷ CAL. CODE REGS. tit. 22, § 51313(c)(1).
- ¹⁸ 42 U.S.C. § 1396r-8(d)(1)(B)(i), (5).
- ¹⁹ 42 U.S.C. § 1396r-8(k)(6). 42 U.S.C. § 1396r-8(k)(g)(1)(B)(i). See also CAL. CODE REGS. tit. 22, § 51313(c)(4) (allowing authorization for unlabeled use of drugs if the use represents “reasonable and current prescribing practices” based on: a) reference to current medical literature, and b) consultation with provider organizations, academic and professional specialists).
- ²⁰ CAL. WELF. & INST. CODE § 14133.37(a) & (b), 42 U.S.C. § 1396r-8(d)(5)(A) & (B); 42 C.F.R. §§ 438.3(s)(6), 438.210(d)(3) (managed care).
- ²¹ See Cal. Dep't Health Care Servs., TAR Overview, <https://www.dhcs.ca.gov/provgovpart/Pages/TAROverview.aspx> (last visited Dec. 19, 2019) See Cal. Dep't Health Care Servs., Medi-Cal Fair Hearing, <https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx>; see also Cal. Dep't Health Care Servs., All Plan Letter 17-006 (May 9, 2017) (describing notice requirements for Medi-Cal managed care plans), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>.
- ²² See Cal. Dep't Health Care Servs., *Medi-Cal Provider Guidelines 7-8*, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/provguide_z01.doc.
- ²³ Medi-Cal fraud by providers or beneficiaries may be reported by calling the statewide Medi-Cal Fraud Hotline at 1-800-822-6222.

- ²⁴ S.B. 1053, Contraceptive Coverage Equity Act (2014), CAL. HEALTH & SAFETY CODE § 1367.25.
- ²⁵ CAL. CODE REGS. tit. 22, § 51313(b).
- ²⁶ CAL. WELF. & INST. CODE § 14133.22.
- ²⁷ CAL. BUS. & PROF. CODE § 4073; CAL. HEALTH & SAFETY CODE § 1367.22(a).
- ²⁸ CAL. CODE REGS. tit. 22, § 51313(c)(1)(B); *see also* Cal. Dep't Health Care Servs., *California Medi-Cal Drug Use Review (DUR) Program Federal Fiscal Year (FFY) 2016 Annual Report*, Attachment 4-42, http://files.medi-cal.ca.gov/pubsdoco/dur/Articles/packet20170516_25904.pdf.
- ²⁹ CAL. WELF. & INST. CODE § 14134(a)(3); Cal. Health Care Found., *The Medi-Cal Prescription Drug Benefit*, at 3 (2009) (noting that all Medi-Cal managed care plans decline to charge copayments for prescription drugs), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-MediCalPrescriptionDrugBenefitOverview.pdf>.
- ³⁰ 42 U.S.C. §§ 1396o(a)(2), (b)(2); 42 C.F.R. § 447.56(a)(2)(ii).
- ³¹ 42 C.F.R. § 438.3(s)(6).
- ³² CAL. WELF. & INST. CODE § 14185(b).
- ³³ *Id.*
- ³⁴ This federal protection is known as “freedom of choice” in family planning and was codified in state law with the enactment of the “Protection of Choice for Family Planning Act.” *See* Chapter 6 on Reproductive and Sexual Health Services of this Guide for more information about freedom of choice requirements.
- ³⁵ *See* Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, MCP: County Organized Health System (COHS)* 6-11, http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpcohs_z01.doc. For more information on carved-out behavioral health medications, *see* Chapter III on Mental Health Services and Chapter IV on Substance Use Disorder services of this Guide.
- ³⁶ 81 Fed. Reg. 27497, 27544 (May 6, 2016).
- ³⁷ Cal. Dep't Health Care Servs., *County Organized Health Systems Boilerplate Contract*, Exhibit A, Attachment 10, § F(2), <https://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.
- ³⁸ “The MCO, PIHP, or PAHP may be permitted to maintain its own formularies for covered outpatient drugs, but when there is a medical need for a covered outpatient drug that is not included in their formulary but that is within the scope of the contract, the MCO, PIHP, or PAHP must cover the covered outpatient drug under a prior authorization process.” 81 Fed. Reg. 27497, 27544 (May 6, 2016).
- ³⁹ Cal. Executive Dep't, Executive Order N-01-19, <https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf>.

- ⁴⁰ Cal. Dep't Health Care Servs., *Request for Proposal # 19-96125*, https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Pages/CSBmcrxHome.aspx.
- ⁴¹ Cal. Dep't Health Care Servs., *Notice of Intent to Award*, https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/MCRx-NOIA.pdf.
- ⁴² CAL. WELF. & INST. CODE § 14133.23(a).
- ⁴³ 42 C.F.R. §§ 423.772, 423.773(c)(1)(i), 423.780, 423.782.
- ⁴⁴ CAL. WELF. & INST. CODE § 14133.23(b) & (c).
- ⁴⁵ See Randolph T. Boyle, Nat'l Health Law Prog., *Medicare Part D and Dual Eligibles: A Guide for California Advocates* (2008), https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/medicare_ptD_dualsadvocates_guide.



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter III:
Mental Health Services**

Chapter III: Mental Health Services

Mental Health Services Covered in the Chapter*

- Specialty Mental Health Services
 - Rehabilitative mental health services
 - Medication support
 - Day treatment intensive care and rehabilitation
 - Crisis intervention, stabilization, and residential treatment
 - Adult residential treatment
 - Psychiatric health facility services
 - Inpatient mental health services
 - Psychiatric inpatient hospital services
 - Acute psychiatric inpatient hospital services
 - Psychiatric health facility services
 - Psychiatric inpatient hospital professional services
 - Targeted case management
 - Psychiatric services
 - Psychologist services
 - Psychiatric nursing facility services
 - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Specialty Mental Health Services services (including intensive care coordination, intensive home-based services, therapeutic behavioral services, and therapeutic foster care).
- Non-specialty Mental Health Services
 - Individual and group mental health evaluation and treatment (psychotherapy)
 - Psychological testing
 - Outpatient services for monitoring drug therapy and for beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning
 - Outpatient laboratory, drugs, supplies, and supplements
 - Psychiatric consultation
- Psychotherapeutic/Psychiatric Medications

*This is a non-exhaustive list of services. It may not include all available services.

Under federal Medicaid law, mental health services are an optional benefit for most populations.¹ However, all state Medicaid programs must provide mental health services to beneficiaries under age 21 pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medicaid Act.² In California, Medi-Cal covers mental health services through different delivery systems: 1) specialty mental health services are delivered by County Mental Health Plans (MHPs); 2) non-specialty mental health services are delivered by Medi-Cal Managed Care Health Plans (MCPs); and 3) some services, such as psychotherapeutic medications, are delivered by Fee-for-Service (FFS) Medi-Cal. The Affordable Care Act (ACA) also requires MCPs to provide mental health services in compliance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).³ As a result, mental health services cannot be subject to limitations that are more onerous than those limitations typically imposed on physical and surgical benefits.⁴

A. Specialty Mental Health Services in Medi-Cal

Since 1995, California has offered some Medi-Cal covered mental health services to beneficiaries through a prepaid inpatient health plan (PIHP) administered by each county.⁵ These PIHPs are known as MHPs in California. Specialty mental health services covered by MHPs include:⁶

- rehabilitative mental health services (which includes mental health, medication support, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment, crisis residential treatment, and psychiatric health facility services);
- psychiatric inpatient hospital services;
- targeted case management;
- psychiatrist services;
- psychologist services;
- psychiatric nursing facility services; and
- EPSDT specialty mental health services (including intensive care coordination, intensive home-based services, therapeutic behavioral services, and therapeutic foster care).

ADVOCACY TIPS:

- ✓ For Medi-Cal beneficiaries who are not enrolled in a Medi-Cal MCP, non-specialty mental health services are delivered through FFS Medi-Cal.
- ✓ While there are regulations governing specialty mental health services in Title 9 of the California Code of Regulations, they have not been updated in many years and some of the regulations have been superseded by state or federal law. More up-to-date information can often be found in Mental Health/ Substance Use Disorder Services Information Notices or other state guidance documents.

MHPs must make specialty mental health services available 24 hours a day, seven days a week, as needed to treat a beneficiary's urgent condition.⁷ An urgent psychiatric condition exists when, without timely intervention, the beneficiary's condition is "highly likely to result in an immediate emergency psychiatric condition."⁸ In addition, each MHP is required to maintain a 24-hour toll-free telephone number with language capabilities for all languages spoken in the county to provide general information about specialty mental health services to beneficiaries and providers, and to facilitate authorization of urgent specialty mental health services.⁹

Each MHP is financially responsible for payment of emergency psychiatric services provided to its enrollees.¹⁰ MHPs may not require prior authorization for emergency services.¹¹ Emergency psychiatric services are covered by the MHP when the recipient has been admitted to a hospital or a psychiatric health facility due to a mental disorder that is either creating a current danger to self or others, or causing the person to be immediately unable to provide for, or utilize, food, shelter or clothing.¹²

To receive inpatient and outpatient specialty mental health services from a MHP, a person must have a listed diagnosis, and meet specified impairment and intervention criteria. The specific diagnoses and impairment criteria vary depending on whether someone is being treated on an inpatient or outpatient basis, as detailed below.

1. Inpatient Specialty Mental Health Services

MHPs cover the following inpatient specialty mental health services: acute psychiatric inpatient hospital services, psychiatric health facility services, and psychiatric inpatient hospital professional services.¹³ In general, MHPs only provide inpatient care in hospitals that participate in FFS Medi-Cal.¹⁴

Beneficiaries with the following diagnoses are eligible for Medi-Cal inpatient specialty mental health services:¹⁵

- Pervasive Developmental Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Tic Disorders
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Cognitive Disorders (only Dementias with Delusions, or Depressed Mood)
- Substance Induced Disorders, only with Psychotic, Mood, or Anxiety Disorder
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders

- Dissociative Disorders
- Eating Disorders
- Intermittent Explosive Disorder
- Pyromania
- Adjustment Disorders
- Personality Disorders

To receive inpatient specialty mental health services, beneficiaries must also show that they meet applicable impairment criteria. For inpatient specialty mental health services, beneficiaries must demonstrate a need for psychiatric inpatient hospital services by showing that either:¹⁶

- The beneficiary has symptoms or behaviors due to a mental disorder that meet one of one of the following:
 - Represent a current danger to self or others, or significant property destruction;
 - Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;
 - Present a severe risk to the beneficiary's physical health; or
 - Represent a recent, significant deterioration in ability to function.

OR

- The beneficiary requires an in-patient admission for one of the following:
 - Further psychiatric evaluation;
 - Medication treatment; or
 - Other treatment that can reasonably be provided only if the patient is hospitalized.

2. Outpatient Specialty Mental Health Services

To receive outpatient specialty mental health services, a person must have a listed diagnosis, and meet specified impairment and intervention criteria, as detailed below.¹⁷

Beneficiaries with the following diagnoses are eligible for Medi-Cal outpatient specialty mental health services:

- Pervasive Development Disorders
- Disruptive Behavior and Attention Deficit Disorders
- Feeding and Eating Disorders of Infancy or Early Childhood
- Elimination Disorders
- Other Disorders of Infancy, Childhood, or Adolescence
- Schizophrenia and other psychotic disorders, except psychotic disorders due to a general medical condition
- Mood disorders, except mood disorders due to a general medical condition
- Anxiety disorders, except anxiety disorders due to a general medical condition
- Somatoform disorders
- Factitious disorders

- Dissociative disorders
- Paraphilias
- Gender Identity Disorder
- Eating disorders
- Impulse control disorders not elsewhere classified
- Adjustment disorders
- Personality disorders, excluding antisocial personality disorder
- Medication-induced movement disorders related to other included diagnoses

To receive inpatient specialty mental health services, beneficiaries must also show that they meet applicable impairment and intervention criteria. For outpatient specialty mental health services, beneficiaries age 21 and over must demonstrate a need for specialty mental health services by showing that their included mental health diagnosis either:¹⁸

- Causes significant impairment in an important area of life functioning; or
- Creates a reasonable probability of significant deterioration in an important area of life functioning.

In addition, a beneficiary age 21 or over must show that the proposed specialty mental health services will address their included diagnosis, and either significantly diminish the impairment it causes, or prevent significant deterioration in an important area of life functioning, and that the beneficiary's condition could not be treated by a physical health intervention.¹⁹ MHPs may place limits on services only when such limits are consistent with medical necessity consistent with current clinical standards and practices.²⁰

3. Specialty Mental Health Services for Children and Youth Under Age 21

Consistent with the EPSDT benefit, MHPs must use less stringent medical necessity criteria, and must provide a broader array of services to beneficiaries under age 21. Specifically, MHPs must comply with federal and state law that requires state Medicaid programs to provide services when they are necessary to correct or ameliorate a child or adolescent's illness or condition.²¹ Compared to the adult medical necessity standard, which requires a more narrow showing that a person's mental health condition is causing substantial impairment, and that the requested intervention is likely to significantly diminish the level of impairment, or prevent further deterioration, the EPSDT standard requires that services be delivered whenever they are necessary to address or improve a child or adolescent's mental health condition, and cannot be addressed by a physical health intervention.

In addition, MHPs must provide mental health diagnostic services and treatment to beneficiaries under 21 when they meet those medical necessity criteria, even when requested services are "not otherwise covered... specialty mental health services."²² Some specialty mental health services under EPSDT

for children and adolescents have been established through litigation, including intensive care coordination, intensive home-based services, therapeutic behavioral services, and therapeutic foster care.²³

B. Non-Specialty Mental Health Services in Medi-Cal

For many years, adult beneficiaries with a mental health condition who were not eligible to receive specialty mental health services had few options to receive non-specialty mental health services. Then starting in 2014, MCPs were required to deliver non-specialty mental health services to their enrollees. As part of the ACA, starting on January 1, 2014, California was required to provide behavioral health services, including mental health services, to the Medicaid Expansion population.²⁴ California elected to align the mental health benefits offered to both the traditional and expansion Medi-Cal populations, and thus provides the same scope of behavioral health services to all Medi-Cal beneficiaries.²⁵ To implement the alignment, California requires MCPs to cover the following mental health services:²⁶

- Individual and group mental health evaluation and treatment (psychotherapy);
- Psychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for the purposes of monitoring drug therapy;
- Outpatient laboratory, drugs, supplies, and supplements; and
- Psychiatric consultation.

ADVOCACY TIPS:

- ✓ MHPs must work to coordinate services for children who move to a different county as a result of an adoption or child welfare placement. If you are working with families of such children, make sure both the sending MHP and the receiving MHP are working together to ensure the child is receiving all medically necessary specialty mental health services.
- ✓ When a Medi-Cal beneficiary has co-occurring diagnoses, i.e. an included and an excluded diagnosis, the beneficiary will be eligible to receive specialty mental health services from the MHP for the included diagnosis provided that the other components of the specialty mental health services medical necessity criteria are also met. MHPs must coordinate care with other providers delivering services for excluded diagnoses, including primary care physicians, regional centers, community-based organizations, etc., depending on the beneficiary's unique needs, to ensure that the beneficiary receives appropriate services to address all aspects of general health and well-being.

While the Department of Health Care Services (DHCS) has been clear that “eligibility and medical necessity criteria for Medi-Cal specialty mental health services provided by MHPs have not changed pursuant to this policy, MCPs are obligated to cover outpatient mental health services to adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning.”²⁷ For this reason, the scope of services provided by the Medi-Cal plans to adult enrollees is sometimes referred to as “mild to moderate.” These services must be provided to adult beneficiaries when they are “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”²⁸

As described above, however, both specialty and non-specialty mental health services must be provided through EPSDT to beneficiaries under age 21 when they are necessary to correct or ameliorate a child’s or adolescent’s illness or condition.²⁹ Therefore, children and youth are entitled to non-specialty and specialty mental health services regardless of the severity of their condition.³⁰

C. Psychotherapeutic Medications

Most psychotherapeutic medications in Medi-Cal are provided on a fee-for-service basis.³² These medications may be prescribed by either an MCP or MHP provider, and fulfilled by a participating pharmacy.³³ In general, MCPs are responsible for coordinating the provision of these carved-out medications to their enrollees.³⁴ Prescription and administration of psychotropic medications requires specific procedures and informed consent from the beneficiary or appropriate authorizing entity.³⁵

ADVOCACY TIPS:

- ✓ While plans are responsible for different services, they still have a responsibility to coordinate services between plans.³¹ These coordination obligations are spelled out in Memoranda of Understanding (MOUs) between plans. Advocates should review those MOUs when assisting clients who are receiving both specialty and non-specialty mental health services, or who are moving from one plan type to the other.
- ✓ When there is a dispute between an MHP and an MCP over who is responsible for providing a medically necessary mental health service, the plans must have a process for resolving such disputes, and may submit disputes to DHCS for resolution if they are unable to resolve them on their own. The dispute resolution process between plans is required to ensure that beneficiaries have continued access to medically necessary services while the dispute is pending.

Endnotes

- ¹ Most mental health services are provided pursuant to the rehabilitative services option (42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130) or other licensed practitioner option (42 U.S.C. § 1396d(a)(6); 42 C.F.R. 440.60). Some services may also be delivered as part of broader optional benefits, such as pharmacy benefits (42 U.S.C. §§ 1396d(a)(12), 1396r-8; 42 C.F.R. § 440.120), or targeted case management (42 U.S.C. § 1396n(g)).
- ² 42 U.S.C. 1396d(r); CAL. WELF. & INST. CODE § 14132(v); see also Cal. Dep’t Health Care Servs., All Plan Letter 14-017 (Dec. 12, 2014), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>; Cal. Dep’t Health Care Servs., MHSUDS Information Notice 16-061 (Dec. 9, 2016) [hereinafter MHSUDS Info. Notice 16-061], https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-061.pdf.
- ³ For the requirement to comply with parity with regards to Medicaid MCPs, see 42 U.S.C. § 1396u-2(b)(8). See also 42 C.F.R. §§ 438.900–438.930.
- ⁴ 42 U.S.C. § 300gg-26.
- ⁵ The PIHP model was phased in between 1995 and 1998 as part of a Medicaid Waiver, known as a 1915b “Freedom of Choice” Waiver (“1915b Waiver”), which allowed the State to require beneficiaries to receive covered mental health services through one plan per county. See Sarah Arnquist & Peter Harbage, Cal. Health Care Found., *A Complex Case: Public Mental Health Delivery and Financing in California* 15–18 (2013), <https://www.chcf.org/wp-content/uploads/2017/12/PDF-ComplexCaseMentalHealth.pdf> (describing this history). California most recently renewed its 1915b Waiver for a five-year period starting on July 1, 2015. CMS, Approval Letter for California’s Medi-Cal Specialty Mental Health Services (SMHS) Waiver Renewal (June 24, 2015), http://www.dhcs.ca.gov/services/MH/Documents/Ltr_1915-b_Waiver_Amend_01_10_14.pdf.
- ⁶ CAL. CODE REGS., tit. 9, § 1810.247; see also Cal. Dep’t Health Care Servs., MHSUDS Information Notice 18-054, Enclosure 1, at 3 (Nov. 2, 2018) [hereinafter MHSUDS Info. Notice 18-054], https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN-18-054_Annual_Review_Protocol/Enclosure_1-Annual_Review_Protocol_for_SMHS_and_Other_Funded_%20Programs_FY_18-19.pdf; Cal. Dep’t Health Care Servs., All Plan Letter 17-018 (Oct. 17, 2017) [hereinafter All Plan Letter 17-018], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-018.pdf>.
- ⁷ CAL. CODE REGS., tit. 9, § 1810.405(c); MHSUDS Info. Notice 18-054, *supra* note 6, at 4.
- ⁸ CAL. CODE REGS., tit. 9, § 1810.253.
- ⁹ CAL. CODE REGS., tit. 9, § 1810.405(d).

- ¹⁰ 42 C.F.R. § 438.114(b); Cal. Dep't Mental Health, DMH Letter 03-08 (Dec. 2, 2003), <https://www.dhcs.ca.gov/formsandpubs/MHArchiveLtrs/MH-Ltr03-08.pdf>.
- ¹¹ CAL. CODE REGS., tit. 9, § 1820.220(l)(2); Cal. Dep't Health Care Servs., MHSUDS Info. Notice 19-026 (May 31, 2019) [hereinafter MHSUDS Info. Notice 19-026], https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_IN_19-026_Authorization_of_SMHS.pdf.
- ¹² CAL. CODE REGS., tit. 9, §§ 1820.225(b), 1820.200(d); *see also* MHSUDS Info. Notice 19-026, *supra* note 11, at 8; MHSUDS Info. Notice 18-054, *supra* note 6, Enclosure 1, at 3.
- ¹³ CAL. CODE REGS., tit. 9, §§ 1810.201, .237, .237.1, .238, .239, .345, .350. *see also* Cal. Dep't Health Care Servs., MHSUDS Info. Notice 18-008 (Feb. 7, 2018), https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_Information_Note_18-008-IMD-FINAL.pdf.
- ¹⁴ *See* CAL. CODE REGS., tit. 9, § 1820.100(a); *see also* All Plan Letter 17-018, *supra* note 6, at 10.
- ¹⁵ Cal. Dept. Health Care Servs., *Section 1915(b) Waiver Proposal For MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs* 21 (June 10, 2015) [hereinafter *Section 1915(b) Waiver Proposal*], <https://www.dhcs.ca.gov/services/MH/Documents/1915-b-SMHS-Waiver.pdf>; CAL. CODE REGS., tit. 9, § 1820.205(a)(1).
- ¹⁶ CAL. CODE REGS., tit. 9, § 1820.205(a)(2); *see also* MHSUDS Info. Notice 19-026, *supra* note 11, at 6–7.
- ¹⁷ *Section 1915(b) Waiver Proposal*, *supra* note 15, at 21–24.
- ¹⁸ CAL. CODE REGS., tit. 9, § 1830.205(b)(2); *see also* MHSUDS Info. Notice 19-026, *supra* note 11, at 6–7.
- ¹⁹ CAL. CODE REGS., tit. 9, § 1830.205(b)(3).
- ²⁰ MHSUDS Info. Notice 19-026, *supra* note 11, at 4. For more information on the requirements for limits based on medical necessity, *see id.*
- ²¹ *See* CAL. WELF. & INST. CODE § 14059.5(b)(1) (incorporating by reference 42 U.S.C. § 1396d(r)(5)); CAL. CODE REGS., tit. 9, § 1810.215 (requiring MHPs to comply with CAL. CODE REGS. tit. 22, §§ 51340(e)(3) & (f) and 42 U.S.C. § 1396d(r)); *see also* MHSUDS Info. Notice 16-061, *supra* note 2, at 2–3.
- ²² CAL. CODE REGS., tit. 9, § 1810.215. For more information on covered SMHS for beneficiaries under 21, *see* MHSUDS Info. Notice 16-061, *supra* note 2.

- ²³ See generally Cal. Dep't Health Care Servs., *Medi-Cal Manual: For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries* (3d ed. 2018), https://www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf; see also Cal. Dep't Health Care Servs., MHSUDS Info. Notice 17-055 (Oct. 16, 2017), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/MHSUDS_Information_Notece_17-055_ICC_and_IHBS_Lockout_Removal.pdf (describing requirements for intensive care coordination and intensive home-based services); Cal. Dep't Health Care Servs., MHSUDS Info. Notice 17-021 (May 24, 2017), https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/MHSUDS_Information_Notece_17-021_TFC_Claiming.pdf (providing information on therapeutic foster care); Cal. Dep't Mental Health., DMH Info. Notice 08-38 (Dec. 22, 2008), <https://www.dhcs.ca.gov/formsandpubs/MHArchives/InfoNotice08-38.pdf>. For more information about the EPSDT requirements, see Chapter VIII of the National Health Law Program's Medi-Cal Services Guide on Children and Adolescents Services.
- ²⁴ 42 U.S.C. §§ 1396a(k)(1), 1396u-7(b)(5) (benefits for expansion population must include essential health benefits and behavioral health services are an essential health benefit per 42 U.S.C. § 18022(b)(1)(E)); see also Michelle Lilienfeld, Nat'l Health Law Prog., *Alternative Benefit Plans for the Medicaid Expansion Population* (2014), <https://healthlaw.org/resource/alternative-benefit-plans-for-the-medicaid-expansion-population/>.
- ²⁵ CMS, Approval Letter for Cal. State Plan Amendment # 13-035 (March 28, 2014), <https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-035.pdf>; see also Lilienfeld, *supra* note 25, at 2-3 (discussing benefit alignment).
- ²⁶ All Plan Letter 17-018, *supra* note 6, at 4. These services are also covered in fee-for-service for beneficiaries who are not enrolled in a Medi-Cal plan. See CAL. WELF. & INST. CODE § 14132.03.
- ²⁷ All Plan Letter 17-018, *supra* note 6, at 4.
- ²⁸ CAL. WELF. & INST. CODE § 14059.5(a).
- ²⁹ See CAL. WELF. & INST. CODE § 14059.5(b)(1) (incorporating by reference 42 U.S.C. § 1396d(r)(5)); CAL. CODE REGS., tit. 9, § 1810.215 (requiring MHPs to comply with 22 CCR §§ 51340(e)(3) & (f)) and 42 U.S.C. § 1396d(r)); see also MHSUDS Info. Notice 16-061, *supra* note 2, at 2-3; Cal. Dep't Health Care Servs., All Plan Letter 18-007, at 5 (March 2, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-007.pdf>.

- ³⁰ MHSUDS Info. Notice 16-061, *supra* note 2, at 2–3. For additional information about mental health services and eligibility for beneficiaries under 21, see All Plan Letter 17-018, *supra* note 6, and Cal. Dep’t Health Care Servs., All Plan Letter 18-006 (March 2, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-006.pdf>.
- ³¹ Cal. Dep’t Health Care Servs., All Plan Letter 18-015 (Sept. 19, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-015.pdf>.
- ³² See, e.g., Cal. Dep’t Health Care Servs., *Two-Plan Boilerplate Contract*, Exhibit A, Attachment 10, § (8)(E)(2)(g)(iii) (2014) [hereinafter Cal. Dep’t Health Care Servs., *Two-Plan Boilerplate Contract*], <https://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf>. The following psychotherapeutic drugs are provided fee-for-service: Amantadine HCl, Aripiprazole, Asenapine (Saphris), Bzotropine Mesylate, Biperiden HCl, Biperiden Lactate, Chlorpromazine HCl, Chlorprothixene, Clozapine, Fluphenazine Decanoate, Fluphenazine Enanthate, Fluphenazine HCl, Haloperidol, Haloperidol Decanoate, Haloperidol Lactate, Iloperidone (Fanapt), Isocarboxazid, Lithium Carbonate, Lithium Citrate, Loxapine HCl, Loxapine Succinate, Lurasidone Hydrochloride, Mesoridazine Mesylate, Molindone HCl, Olanzapine, Olanzapine Fluoxetine HCl, Olanzapine Pamoate Monohydrate (Zyprexa Relprevv), Paliperidone (Invega), Paliperidone Palmitate (Invega Sustenna), Perphenazine, Phenelzine Sulfate, Pimozide, Procyclidine HCl, Promazine HCl, Quetiapine, Risperidone, Risperidone Microspheres, Selegiline (transdermal only), Thioridazine HCl, Thiothixene, Thiothixene HCl, Tranylcypromine Sulfate, Trifluoperazine HCl, Triflupromazine HCl, Trihexyphenidyl, Ziprasidone, and Ziprasidone Mesylate. All Plan Letter 17-018, *supra* note 6, Attachment 2, at 11.
- ³³ See, e.g., CAL. CODE REGS., tit. 9, § 1810.415(c); Cal. Dept. Health Care Servs., *Two-Plan Boilerplate Contract*, *supra* note 33, at Exhibit A, Attach 10 § (8)(E)(2)(g)(iii).
- ³⁴ See All Plan Letter 17-018, *supra* note 6, Attachment 2, at 11; see also Cal. Dep’t Health Care Servs., *Benefits and their Delivery System* 35 (2018), https://www.dhcs.ca.gov/services/Documents/CareCoordination/Care_Coordination_Carve_Out_Pro_Cons_All_Divisions.pdf.
- ³⁵ See generally Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 17-040 (Aug. 24, 2017), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_17-040_MHSUDS_Chart_Documentation_Information_Note.pdf.



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter IV:
Substance Use Disorder Services**

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Substance Use Disorder Services

Outline of Medi-Cal Substance Use Disorder Services*

- SUD Preventative Services
 - Screening, Brief Intervention and Referral to Treatment (SBIRT) for opioid use disorders & Alcohol Misuse Screening and Counseling (AMSC)
 - Initial evaluation & treatment
 - Routine screenings (Expanded screenings for alcohol use disorder)
 - Specialized alcohol use disorder treatment
 - Services for Prevention of Tobacco Use
 - Initial tobacco use assessment with following annual visits
 - FDA-approved tobacco cessation medications
 - Individual, group, and telephone counseling
 - One-on-one counseling services for pregnant tobacco users
- Prescription Drug Services for Alcohol and Opioid Use Disorders
- Drug Medi-Cal
 - Methadone Maintenance Treatment at Narcotic Treatment Programs
 - Outpatient Drug Free Treatment
 - Intensive Outpatient Treatment
 - Perinatal Residential SUD Services
 - Naltrexone Treatment Services
- Drug Medi-Cal Organized Delivery System
 - Additional Treatment at Narcotic Treatment Programs
 - Residential Services
 - Withdrawal Management
 - Recovery Services
 - Case Management
 - Physician Consultation
 - Partial Hospitalization
 - Additional medication-assisted treatment services
- Voluntary Inpatient Detoxification

*This is a non-exhaustive list of services. It may not include all available services.

California significantly expanded the availability of substance use disorder (SUD) services in Medi-Cal in 2014. This coverage expansion was in response to the Affordable Care Act's (ACA) Essential Health Benefits provision, which mandates all state Medicaid programs to cover mental health and SUD services.¹ The ACA also requires Medi-Cal managed care plans (MCPs) to provide these services in compliance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).² As a result, SUD services cannot be subject to limitations that are more onerous than those limitations typically imposed on physical and surgical benefits.³

A. SUD Preventive Services

1. Screening, Brief Intervention and Referral to Treatment (SBIRT)

Medi-Cal provides coverage for preventive alcohol and opioid use services for beneficiaries over 18 through the SBIRT benefit. Medi-Cal MCPs are responsible for providing SBIRT services for MCP enrollees and Medi-Cal primary care physicians (PCP) provide SBIRT to Fee-for-Service (FFS) Medi-Cal beneficiaries.

SBIRT was originally conceived as a program for individuals at risk of developing an alcohol use disorder (AUD). This alcohol use-specific benefit is now more commonly known as Alcohol Misuse Screening and Counseling (AMSC). SBIRT/AMSC consists of the following components: 1) initial evaluation, routine screening, and expanded screening for AUD; 2) initial treatment provided by the PCP and other MCP providers; and 3) specialized AUD treatment provided by the county alcohol and drug program.

PCPs must screen beneficiaries as part of initial and routine evaluations. When the beneficiary's PCP identifies a potential AUD, beneficiaries are entitled to at least one expanded screening every year.⁵ For beneficiaries screening positively for risky alcohol use or a potential AUD, Medi-Cal provides coverage for behavioral counseling interventions provided by the PCP or another MCP provider.⁶ MCPs must cover at least one, and up to three, behavioral counseling interventions per year with additional interventions covered as necessary.⁷ Finally, under the AMSC benefit, beneficiaries identified with a possible AUD must be referred to the county alcohol and drug program for additional evaluation and treatment.⁸

ADVOCACY TIP:

✓ While coverage of SBIRT services is technically available to Medi-Cal beneficiaries over 18, beneficiaries ages 18 to 21 continue to be eligible for screening and preventive SUD services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.⁴ Therefore, in practice, the more limited SBIRT benefit is available for adults over 21 while the EPSDT standard applies to beneficiaries under 21.

As part of the 2019–2020 budget approval process, the Department of Health Care Services (DHCS) has been tasked with seeking federal funding to expand SBIRT to include services related to opioid use disorders (OUD) “in order to strengthen linkages and referral pathways between primary care and specialty substance use disorder treatment.”⁹ If federal funding is approved, beginning in January 2020, the three components of SBIRT would also apply to identification and treatment of potential risks associated with misuse of opioids.

2. Services for Prevention of Tobacco Use

Medi-Cal provides coverage for all preventive services identified as United States Preventive Services Task Force (USPSTF) grade “A” and “B” recommendations.¹⁰ As a result, Medi-Cal beneficiaries have access to the following tobacco cessation services:

- **Assessment of tobacco use during initial medical visit and annually thereafter**
- **FDA-approved tobacco cessation medications:**¹¹
 - Bupropion SR (Zyban[®])
 - Varenicline (Chantix[®])
 - Nicotine gum
 - Nicotine inhaler
 - Nicotine lozenge
 - Nicotine nasal spray
 - Nicotine patch
- **Individual, group, and telephone counseling:** at least four counseling sessions of at least ten minutes are covered regardless of whether the beneficiary is also undergoing medication treatment.¹² Beneficiaries have the option of selecting between individual or group counseling, and between counseling in-person or by telephone. Coverage of counseling sessions without prior authorization extends to at least two separate attempts to quit per year.¹³
- **Services for pregnant tobacco users:** Beneficiaries who are pregnant are eligible for tailored, one-on-one counseling for tobacco cessation.¹⁴ Cessation counseling services must be covered during pregnancy and for 60 days after delivery, plus any additional days needed to end the respective month.

B. Prescription Drug Services for Alcohol and Opioid Use Disorders

Medi-Cal covers prescription drugs for treatment of alcohol and opioid use disorders on a FFS basis since these medications have been carved out of MCP contracts.¹⁵ Medi-Cal covers the following medications:¹⁶

- Methadone, buprenorphine (Subutex[®] or Suboxone[®]), and injectable naltrexone (Vivitrol[®]) for medication-assisted treatment (MAT) of OUD;
- Naloxone (Narcan[®] or Evzio[®]) as an opioid overdose reversal medication; and
- Disulfiram (Antabuse[®]), acamprosate (Campral[®]), and oral and injectable naltrexone (Vivitrol[®]) for treatment of AUD.

When these medications are administered in a provider's office or in a clinical setting, Medi-Cal pays for the medications under the medical provider benefit.¹⁷ However, under certain circumstances, providers may prescribe medications for SUD treatment for use outside of the provider's office. In these situations, Medi-Cal pays for the medications on a FFS basis under the prescription drug coverage benefit.¹⁸ Pharmacies must bill DHCS directly even if the prescription was written by a MCP provider.

ADVOCACY TIP:

- ✓ The California Department of Public Health has issued a statewide standing order for the overdose-reversal medication naloxone, which enables individuals to access the medication from participating community organizations or entities without a prescription.¹⁹ In addition, pharmacists across the state are allowed to dispense naloxone without a prescription.²⁰ Medi-Cal beneficiaries with SUD who may be at risk of overdose may access the medication at no cost and without any barriers such as prior authorization.

C. Drug Medi-Cal

Drug Medi-Cal (DMC) services are available to all Medi-Cal beneficiaries regardless of their county of residence, and are furnished by DHCS-certified SUD providers.²¹ These services have been carved out of MCP contracts. Instead, county alcohol and drug programs are responsible for contracting with DHCS-certified providers to arrange, provide, or subcontract the provision of DMC services.

The State's obligations under the EPSDT benefit apply to DMC services.²² This means that county alcohol and drug programs must ensure the availability of all DMC services for beneficiaries under 21 as long as the services are needed to correct or ameliorate an SUD condition. Prior authorization is not required when services are rendered under the EPSDT benefit, with the exception of residential SUD services, for which counties must provide authorization within 24 hours of submission of the request.²³

In addition, all DMC services are reimbursed at an enhanced rate when provided to a beneficiary during pregnancy or postpartum, as long as the provider is certified to provide perinatal Medi-Cal services.²⁴ Perinatal SUD services must address specific issues that affect treatment and recovery, such as relationships and sexual and physical abuse. Perinatal services under DMC also extend to the following services:²⁵

- Mother/child habilitative and rehabilitative services (such as development of parenting skills and training in child development);
- Transportation and service access;

- Education to reduce harmful effects of alcohol and drugs on the pregnant individual and fetus or infant; and
- Coordination of ancillary services (such as accessing dental services, accessing social and community services, and educational or vocational training).

Services covered as part of the DMC program include:

- **Methadone Maintenance Treatment (MMT) at Narcotic Treatment Programs (NTPs):** Pursuant to federal law, only specialized licensed clinics can dispense methadone for SUD treatment.²⁶ In California, these clinics are called narcotic treatment programs (NTPs) and provide “outpatient services using methadone... directed at stabilization and rehabilitation of persons [with SUD].”²⁷
- **Outpatient Drug Free Treatment:** Outpatient services directed at stabilizing and rehabilitating persons with SUD diagnoses.²⁸
- **Intensive Outpatient Treatment (IOT):** “Outpatient counseling and rehabilitation services provided at least three hours per day, three days per week...”²⁹
- **Perinatal Residential SUD Services:** “Non-institutional, non-medical residential programs which provide rehabilitation services.”³⁰
- **Naltrexone Treatment Services:** Naltrexone is a medication that, in its injectable form, blocks the euphoric effects of opiates and helps prevent relapse. Medi-Cal covers naltrexone services on an outpatient basis.³¹

The following two tables summarize the components of the DMC program services (see Figure 1 below), and provide an overview of the coverage restrictions and exclusions for each service (See Figure 2):

Figure 1

	NTPs	Outpatient Drug Free Treatment	IOT	Perinatal Residential	Naltrexone Treatment
Intake ³²	✓	✓	✓	✓	✓
Body specimen screening	✓	✓	✓	✓	✓
Admissions physical exams and laboratory tests	✓	✓	✓	✓	✓
Treatment Planning	✓	✓	✓	✓	✓
Physician/Nursing Services	✓				✓
Medical Direction	✓	✓	✓	✓	✓
Medical Psychotherapy ³³	✓				
Individual/Group Counseling ³⁴	✓ ³⁵	✓ ³⁶	✓ ³⁷	✓ ³⁸	✓ ³⁹
Medication Services ⁴⁰	✓	✓	✓	✓	✓

Figure 1 (continued)

	NTPs	Outpatient Drug Free Treatment	IOT	Perinatal Residential	Naltrexone Treatment
Provision of MMT and/ or Levomethadyl acetate (LAAM)	✓				
Crisis Intervention ⁴¹		✓	✓	✓	✓
Collateral Services ⁴²		✓	✓	✓	✓
Parenting Education				✓	
Discharge Planning		✓			

Figure 2

Services	Restrictions on Eligibility and Coverage Exclusions
Treatment at NTPs	Adults: Must have confirmed history of one year of OUD Children: Parental/legal guardian consent Confirmed history of 2 or more unsuccessful attempts in withdrawal treatment or short-term detoxification within one year. ⁴³
Outpatient Drug Free Treatment	None
IOT	None ⁴⁴
Perinatal Residential	Pregnant and postpartum individuals only. Beneficiaries must live on the premises of the facility and be supported, 24-hours and seven days a week, in an effort to “restore, maintain, and apply interpersonal and independent living skills and access community support systems.” ⁴⁵ Because of the federal Institution for Mental Diseases (IMD) exclusion, perinatal residential services under DMC must be provided in facilities with treatment capacity of 16 beds or less. ⁴⁶ In addition, Medi-Cal coverage of perinatal residential services is limited to provision of SUD services at facilities licensed by the State and excludes room and board costs. ⁴⁷
Naltrexone Treatment	Limited to beneficiaries who are at least 18 years old, have a confirmed, documented history of OUD, have undergone detoxification (i.e., they are opiate free), and are not pregnant. ⁴⁸

D. Drug Medi-Cal Organized Delivery System

In 2015 California became the first state to obtain federal approval for a demonstration program to expand access to SUD services. The Drug Medi-Cal Organized Delivery System (DMC-ODS) program is part of California's Section 1115 waiver (Medi-Cal 2020), and seeks to increase integration and coordination of SUD services.⁴⁹ The demonstration also seeks to adopt the American Society of Addiction Medicine (ASAM) continuum of care, recognizing that different interventions are necessary for individuals with SUD who have different levels of need.⁵⁰

In order to provide the whole continuum of care, the DMC-ODS waiver makes available several substance use services in addition to the services already available under the DMC program. These additional benefits are only available for Medi-Cal beneficiaries residing in counties that opt into the waiver program.⁵¹ Eligibility for DMC-ODS program services is also restricted to Medi-Cal beneficiaries who meet the ASAM medical necessity criteria.⁵² Therefore, in order to receive DMC-ODS program services, adult beneficiaries must meet: 1) a diagnosis for a substance-related and addictive disorder found in the Diagnostic and Statistical Manual of Mental Disorders, and 2) the ASAM criteria definition of medical necessity.

Despite the inclusion of this medical necessity criteria for children and adolescents as part of the DMC-ODS waiver, nothing in the waiver overrides EPSDT requirements.⁵³ This means that for a child or adolescent, if expanded SUD services are needed to correct or ameliorate an SUD condition, counties must make such service available regardless of whether the beneficiary meets the ASAM medical necessity criteria and regardless of whether the beneficiary's county of residence is participating in the DMC-ODS program.

The table below compares the SUD services available in counties participating in the DMC-ODS program with those available in the counties not participating in the demonstration:

Figure 3

Standard DMC Benefits (available to beneficiaries in all counties)	DMC-ODS Benefits (only available to beneficiaries in pilot counties)
Outpatient Drug Free Treatment	Outpatient Services
Intensive Outpatient Treatment	Intensive Outpatient Services
Naltrexone Treatment	Naltrexone Treatment
Narcotic Treatment Program (methadone)	Narcotic Treatment Program (methadone and additional medications)

Figure 3 (continued)

Standard DMC Benefits (available to beneficiaries in all counties)	DMC-ODS Benefits (only available to beneficiaries in pilot counties)
Perinatal Residential SUD services (limited by IMD exclusion)	Residential services (not restricted by IMD exclusion or limited to perinatal)
Detoxification in a Hospital	Withdrawal Management (at least one level)
	Recovery Services
	Case Management
	Physician Consultation
	Partial Hospitalization (Optional for counties)
	Additional MAT (Optional for counties)

1. Additional Treatment at Narcotic Treatment Programs

The DMC-ODS program continues to cover methadone treatment at NTPs. In addition to methadone treatment, the program also provides coverage for treatment at NTPs with the medications buprenorphine, disulfiram, and naloxone. The program also clarifies that activities covered as part of NTP include the prescribing, ordering, and monitoring of the medication regime.⁵⁴ NTPs must also now provide collateral services, crisis intervention services, and patient education services.

2. Residential Services

The DMC-ODS waiver makes residential services available to all beneficiaries who meet the ASAM medical necessity criteria for residential treatment.⁵⁵ The waiver includes a waiver of the Institution for Mental Disease (IMD) exclusion. The IMD exclusion rule is the part of the Medicaid Act that prohibits states from using federal Medicaid funds to cover treatments in mental health facilities with more than 16 beds, such as state mental hospitals. By waiving the exclusion, adult beneficiaries residing in a DMC-ODS program county who need residential SUD treatment may access these services at facilities with more than 16 beds. Medi-Cal coverage of residential SUD treatment is limited to two non-continuous 90 day stays per year for adults and two non-continuous 30 day stays for adolescents. When medically necessary, a one-time extension of up to 30 days may be authorized on an annual basis.⁵⁶

Residential SUD services under the DMC-ODS program are intended to be individualized to treat the functional deficits identified in the ASAM criteria and must be provided in DHCS-licensed residential facilities that also have DMC certification and that have been designated as capable of delivering care consistent with ASAM treatment criteria. In addition to the components of

perinatal residential treatment under DMC, residential treatment under the DMC-ODS program includes education services, family therapy, safeguarding medication services, and transportation services.⁵⁷

3. Withdrawal Management

Withdrawal management services are more commonly known as detoxification (“detox”) services. This service consists of “the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence.”⁵⁸ Counties participating in the DMC-ODS waiver must provide coverage for at least one ASAM level of withdrawal management.⁵⁹ Regardless of which ASAM level the county elects to cover, the services must include intake, observation, medication services, and discharge services.⁶⁰

4. Recovery Services

Recovery services are available under the DMC-ODS program for beneficiaries who have completed their course of treatment whether they are triggered, have relapsed or as a preventive measure to prevent relapse.⁶¹ Services may be provided face-to-face, by telephone, or by telehealth. Recovery services include the following components:⁶²

- Outpatient counseling services: individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
- Recovery Monitoring: coaching, monitoring via telephone and internet;
- Substance Abuse Assistance: Peer-to-peer services and relapse prevention;⁶³
- Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
- Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
- Support Groups: Linkages to self-help and support, spiritual and faith-based support, and peer support;
- Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination;
- Youth Peer-to-Peer Recovery Coaching/Peer Mentoring (for persons under 21);
- Technological Support Services (for persons under 21); and
- Parent/Caregiver Support (for persons under 21).⁶⁴

5. Case Management

Case management services are defined as “a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.”⁶⁵ Services may be provided by a licensed practitioner or by a certified counselor at DMC provider sites, county locations, regional centers or as otherwise outlined by the county, and focus on coordination of SUD care, integration around primary care, and interaction with

the criminal justice system. Services may be provided face-to-face, by telephone, or by telehealth with the beneficiary.⁶⁶

The specific components of the DMC-ODS program case management benefit are:⁶⁷

- Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;
- Transition to a higher or lower level SUD of care;
- Development and periodic revision of a beneficiary plan that includes service activities;
- Communication, coordination, referral and related activities;
- Monitoring service delivery to ensure that the beneficiary is accessing the service and the effectiveness of the service delivery system;
- Monitoring the beneficiary's progress; and
- Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

6. Physician Consultation

Physician consultation services allow DMC physicians to consult with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. These services are designed to assist DMC physicians seek expert advice on designing treatment plans for specific DMC-ODS program beneficiaries with complex SUD conditions. Consultation may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.⁶⁸

7. Partial Hospitalization

Partial hospitalization services are available as optional services for counties participating in the DMC-ODS waiver. These are outpatient services that are more intensive than other outpatient services, such as treatment at NTPs, outpatient drug free treatment, and IOT. The partial hospitalization benefit entitles beneficiaries to 20 or more hours of clinically intensive SUD treatment per week. Services typically include direct access to psychiatric, medical, and laboratory services. The services should also meet the needs that, while identified as requiring daily monitoring or management, can be appropriately addressed in an outpatient setting.⁶⁹

8. Additional MAT Services

Additional MAT services are available as optional services for counties participating in the DMC-ODS waiver. These services consist of the ordering, prescribing, administering, and monitoring of methadone, buprenorphine, and naltrexone treatment.⁷⁰

ADVOCACY TIP:

- ✓ Advocates should determine whether their county is participating in the DMC-ODS waiver in order to know what services are available. If you are unsure, go to <https://www.dhcs.ca.gov/provgovpart/Pages/County-Implementation-Plans-.aspx> to find out. While 35 counties are currently participating in the waiver, the waiver will terminate or need to be re-authorized in 2020 and there will certainly be changes to the program at that time. Check CMS's website and the California Advancing and Innovating Medicaid (CalAIM) website for updates.

E. Voluntary Inpatient Detoxification

Voluntary Inpatient Detoxification (VID) is a type of withdrawal management or “detox” service provided to individuals with SUD in need of inpatient stays at general acute hospitals that are not Chemical Dependency Treatment Facilities or IMDs. As with other SUD services in Medi-Cal, the VID benefit has been carved out of MCP contracts and is available only on a FFS basis.⁷¹ Both MCP enrollees and FFS beneficiaries are entitled to the service, subject to approval of a Treatment Authorization Request (TAR).⁷²

To receive the service, the beneficiary must meet at least one of the following criteria:⁷³

- Delirium tremens, with any combination of hallucinations, disorientation, tachycardia, hypertension, fever, agitation, or diaphoresis;
- Score greater than 15 on the Clinical Institute Withdrawal Assessment Scale for Alcohol, revised (CIWA-Ar) form;
- Alcohol/sedative withdrawal with CIWA score greater than 8 and one or more of the following high-risk factors:
 - Multiple substance abuse;
 - History of delirium tremens;
 - Unable to receive the necessary medical assessment, monitoring, and treatment in a setting with a lower level of care;
 - Medical co-morbidities that make outpatient detoxification unsafe;
 - History of failed outpatient treatment;
 - Psychiatric co-morbidities;
 - Pregnancy; or
 - History of seizure disorder or withdrawal seizures.
- Complications of opioid withdrawal that cannot be adequately managed in the outpatient setting due to the following factors:
 - Persistent vomiting and diarrhea from opioid withdrawal; or
 - Dehydration and electrolyte imbalance that cannot be managed in a setting with a lower level of care.

While VID is provided on a FFS basis, MCPs retain the responsibility of referring enrollees to providers at acute care hospitals for provision of the service when enrollees have symptoms meeting the medical necessity criteria. Beneficiaries may also self-refer to an acute care hospital for a medical necessity assessment to access VID. In addition, MCPs must provide care coordination with the VID service provider as needed. Finally, when an enrollee goes to an acute care hospital for VID services but the medical necessity criteria is not met, MCPs are responsible for referring the enrollee to the county alcohol and drug program for provision of other SUD services, as appropriate.⁷⁴

Endnotes

¹ 42 U.S.C. § 18022(b)(10)(E). *See also* 42 C.F.R. § 440.347(a)(5).

² For the requirement to comply with parity with regards to Medicaid MCPs, *see* 42 U.S.C. § 1396u-2(b)(8). *See also* 42 C.F.R. §§ 438.900–930.

³ 42 U.S.C. § 300gg-26.

⁴ *Id.*

⁵ Cal. Dep't Health Care Servs., All Plan Letter 18-014, at 3 (Sept. 14, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-014.pdf>. Additional expanded screenings may be covered if medically necessary.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ CAL. WELF. & INST. CODE § 14021.37. Pursuant to the approved budget and relevant statutory provisions, the expanded benefit will be suspended on December 31, 2021, unless the State determines through the 2021 budget process that there is sufficient General Fund revenue to support coverage of the benefit. *See also* Cal. State Budget 2019–2020 Summary, at 57, <http://www.ebudget.ca.gov/2019-20/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf>

¹⁰ CAL. WELF. & INST. CODE § 14134.25(a); Cal. Dep't Health Care Servs., All Plan Letter 16-014, at 1–2 (Nov. 30, 2016) [hereinafter All-Plan Letter 16-014], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf>.

- ¹¹ CAL. WELF. & INST. CODE § 14134.25(b)(2); All Plan Letter 16-014, *supra* note 10, at 3–4. In addition to the medications listed, any other medication approved by the FDA in the future is also covered. Coverage of tobacco cessation medications is not subject to proof of counseling and beneficiaries may not be required to receive a particular form of tobacco cessation service as a condition of receiving another tobacco cessation service. Coverage of cessation medications extends to 90-day treatment regimens without restrictions or barriers.
- ¹² CAL. WELF. & INST. CODE § 14134.25(b)(1); All Plan Letter 16-014, *supra* note 10, at 4–5.
- ¹³ All Plan Letter 16-014, *supra* note 10, at 5.
- ¹⁴ All Plan Letter 16-014, *supra* note 10, at 5–6.
- ¹⁵ For information on carved-out medications, see Cal. Dep’t Health Care Servs., All Plan Letter 16-004 (Feb. 19, 2016), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-004.pdf>.
- ¹⁶ See Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 15-033 (Aug. 14, 2015) [hereinafter MHSUDS Info. Notice 15-033], https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_15-033_MAT.pdf.
- ¹⁷ See Cal. Dep’t Health Care Servs., *Medication Assisted Treatment for Substance Use Disorders and the Drug Medi-Cal Organized Delivery System Pilot Program: Frequently Asked Questions 3–5* (2018), <https://www.rcdmh.org/Portals/0/PDF/Substance%20Use/DHCS%20-%20DMC-ODS%20MAT%20FAQ%20Update%208-2016%20Final.pdf?ver=2016-09-15-151405-663>.
- ¹⁸ *Id.* See also MHSUDS Info. Notice 15-033, *supra* note 16.
- ¹⁹ For more information about the naloxone statewide standing order, see Cal. Dep’t Pub. Health, *Naloxone Statewide Standing Order Frequently Asked Questions (FAQs)*, <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Naloxone/Naloxone%20FAQs%20062118.pdf>.
- ²⁰ CAL. BUS. & PROF. CODE § 4052.01.
- ²¹ Most SUD services are provided pursuant to the rehabilitative services option (42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130) or other licensed practitioner option (42 U.S.C. § 1396d(a)(6); 42 C.F.R. § 440.60). Some services may also be delivered as part of broader optional benefits, such as pharmacy benefits (42 U.S.C. §§ 1396d(a)(12), 1396r-8; 42 C.F.R. § 440.120), or targeted case management (42 U.S.C. § 1396n(g)).
- ²² Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 16-063 (Dec. 21, 2016) [hereinafter MHSUDS Info. Notice 16-063], https://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/MHSUDS_IN_16-063.pdf. For more information about the scope and accessibility of mental health services in Medi-Cal, see Chapter III of the National Health Law Program’s Medi-Cal Services Guide on Mental Health Services.
- ²³ *Id.* at 2.
- ²⁴ CAL. CODE REGS. tit. 22, § 51341.1(c).

- ²⁵ *Id.*
- ²⁶ 42 C.F.R. § 8.12.
- ²⁷ CAL. CODE REGS. tit. 22, § 51341.1(b)(17). *See also* CAL. CODE REGS. tit. 22, § 51341.1(d)(1).
- ²⁸ CAL. CODE REGS. tit. 22, § 51341.1(b)(18). *See also* CAL. CODE REGS. tit. 22, § 51341.1(d)(2).
- ²⁹ CAL. CODE REGS. tit. 22, § 51341.1(b)(8). *See also* CAL. CODE REGS. tit. 22, § 51341.1(d)(3). Service was formerly known as day care habilitative services.
- ³⁰ CAL. CODE REGS. tit. 22, § 51341.1(b)(20). *See also* CAL. CODE REGS. tit. 22, § 51341.1(d)(4).
- ³¹ CAL. CODE REGS. tit. 22, § 51341.1(b)(16). *See also* CAL. CODE REGS. tit. 22, § 51341.1(d)(5).
- ³² Intake is “the process of admitting a beneficiary into [an SUD] treatment program, [including] the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and [SUD]; the diagnosis of [SUD]...; and the assessment of treatment needs to provide medically necessary treatment services...” CAL. CODE REGS. tit. 22, § 51341.1(b)(13).
- ³³ Medical Psychotherapy consists of “face-to-face discussion conducted by the medical director on a one-on-one basis with the patient, on issues identified in the patient’s treatment plan.” CAL. CODE REGS. tit. 22, § 51341.1(b)(14); CAL. CODE REGS. tit. 9, § 10345(b)(3)(C).
- ³⁴ Individual counseling is defined as “face-to-face contacts between a beneficiary and a therapist or counselor...conducted in a confidential setting.” CAL. CODE REGS. tit. 22, § 51341.1(b)(12). Group counseling consists of “face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time...conducted in a confidential setting...” Beneficiaries under 18 shall not participate with beneficiaries 18 or older unless the counseling takes place at a certified school site. CAL. CODE REGS. tit. 22, § 51341.1(b)(11).
- ³⁵ At least 50 hours of counseling sessions per month. CAL. CODE REGS. tit. 22, § 51341.1(h)(4)(B). These sessions may be individual sessions, medical psychotherapy sessions, or group sessions with four to ten patients and must have “a clear goal and/or purpose that is a common issue identified in the treatment plans of all participating patients.” CAL. CODE REGS. tit. 22, § 51341.1(b)(11)(A); CAL. CODE REGS. tit. 9, § 10345.
- ³⁶ At least two group counseling sessions per month. CAL. CODE REGS. tit. 22, § 51341.1(h)(4)(A). Groups must be composed of between four to ten patients and must focus on “short-term personal, family, job/school and other problems and their relationship to substance use.” Individual counseling sessions under outpatient drug free treatment are limited to intake, crisis intervention, collateral services, and treatment and discharge planning. CAL. CODE REGS. tit. 22, § 51341.1(b)(11)(A); CAL. CODE REGS. tit. 22, § 51341.1(d)(2)(A)-(B).
- ³⁷ At least two counseling sessions per month. CAL. CODE REGS. tit. 22, § 51341.1(h)(4)(A). Group counseling as part of IOT is limited to groups of between two to twelve patients. CAL. CODE REGS. tit. 22, § 51341.1(b)(11)(B).

- ³⁸ At least two counseling sessions per month. CAL. CODE REGS. tit. 22, § 51341.1(h)(4)(A).
- ³⁹ At least two counseling sessions per month. CAL. CODE REGS. tit. 22, § 51341.1(h)(4)(A).
- ⁴⁰ Medication services are defined as “the prescription or administration of medication related to [SUD] treatment services, or the assessment of the side effects or results of that medication...” CAL. CODE REGS. tit. 22, § 51341.1(b)(15).
- ⁴¹ Crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services are “face-to-face contact between a therapist or counselor and a beneficiary in crisis, [which] focus on alleviating crisis problems.” CAL. CODE REGS. tit. 22, § 51341.1(b)(7).
- ⁴² Collateral services are defined as “face-to-face sessions with therapists or counselors and significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary’s treatment goals.” CAL. CODE REGS. tit. 22, § 51341.1(b)(4).
- ⁴³ CAL. CODE REGS. tit. 9, § 10270; CAL. CODE REGS. tit. 22, § 51341.1(h)(1)(B). See also Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 18-061 (Dec. 28, 2018), https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_18-061_-_Treating_Youth_in_NTPs.pdf.
- ⁴⁴ IOT was originally available only for pregnant individuals and individuals under 21 as part of EPSDT. State Plan Amendment # 13-038 made the service available to all beneficiaries.
- ⁴⁵ CAL. CODE REGS. tit. 22, § 51341.1(b)(20).
- ⁴⁶ CAL. CODE REGS. tit. 22, § 51341.1(d)(4)(B). In order to prevent institutionalization, the federal Medicaid Act prohibits federal financial participation from going to facilities that treat individuals with mental health and SUDs if these facilities have more than 16 beds. 42 U.S.C. § 1396d(a)(B).
- ⁴⁷ CAL. CODE REGS. tit. 22, § 51341.1(d)(4)(A).
- ⁴⁸ CAL. CODE REGS. tit. 22, § 51341.1(d)(5).
- ⁴⁹ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend. (Aug. 13, 2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/Bridge-to-Health-Reform/ca-bridge-to-health-reform-2015-cms-amend-appvl-08132015.pdf>; See also Cal. Dep’t Health Care Servs., Drug Medi-Cal Organized Delivery System, <https://www.dhcs.ca.gov/provgovpart/pages/drug-medi-cal-organized-delivery-system.aspx> (last visited Nov. 12, 2019).
- ⁵⁰ For more information on the ASAM criteria, see Am. Soc. Addiction Med., What is the ASAM Criteria?, <https://www.asam.org/resources/the-asam-criteria/about> (last visited Nov. 12, 2019).

- ⁵¹ Under federal law, unless the Centers for Medicare and Medicaid Services (CMS) waives the requirement through approval of a Section 1115 waiver, Medicaid benefits must be available statewide and must be available in similar amount, scope, and duration to all beneficiaries, regardless of categories of eligibility. See 42 C.F.R. §§ 431.50, 440.240. California’s Section 1115 waiver waives these requirements and allows the State to provide different services depending on whether the county of residence opts to participate in the demonstration. CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Waiver Authority.
- ⁵² CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 121–122.
- ⁵³ See CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 121.
- ⁵⁴ Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 16-048 (Sept. 27, 2016), https://www.dhcs.ca.gov/formsandpubs/ADPBulletins/MHSUDS-IN_16-048-MAT_NTPS_WAIVER.pdf.
- ⁵⁵ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, at 130. Counties are required to provide at least one ASAM level of residential treatment services initially and all ASAM levels within three years of participating in the program. See also Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 16-042 (Aug. 11, 2016), https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_IN_16-042.pdf.
- ⁵⁶ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 130.
- ⁵⁷ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Expenditure Authority, at 4.
- ⁵⁸ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 131.
- ⁵⁹ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 125–126.
- ⁶⁰ See Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 16-037 (July 20, 2016), https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_16-037.pdf.
- ⁶¹ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 133.
- ⁶² *Id.*
- ⁶³ For more information on peer support services under DMC-ODS, see Cal. Dep’t Health Care Servs., MHSUDS Info. Notice 17-008 (Feb. 14, 2017), https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20IN_17-008.pdf.

- ⁶⁴ MHSUDS Info. Notice 16-063, *supra* note 22. See also CMS & SAMHSA, Joint Informational Bulletin: Coverage of Behavioral Health Services for Youth with Substance Use Disorders (Jan. 26, 2015), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>.
- ⁶⁵ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 133–134.
- ⁶⁶ *Id.*
- ⁶⁷ *Id.*
- ⁶⁸ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 134.
- ⁶⁹ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 129.
- ⁷⁰ CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amend., *supra* note 49, Special Terms and Conditions, at 132.
- ⁷¹ Cal. Dep’t Health Care Servs., All Plan Letter 18-001 (January 11, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-001.pdf>.
- ⁷² *Id.*
- ⁷³ *Id.*
- ⁷⁴ *Id.*



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter V:
Gender-Affirming Services**

Chapter V: Gender-Affirming Services

Outline of Medi-Cal Gender Affirming Services*

- Mental Health Services (in addition to other Mental Health services, see *Chapter 3*)
 - Gender dysphoria assessments
 - Counseling regarding gender expression and transition options
 - Diagnosis and treatment of co-occurring mental health conditions
 - Referrals
- Hormone Therapy
 - Covered when medically necessary under Fee-For-Service Medi-Cal and Medi-Cal Managed Care
- Surgical Care
 - Variety of medically necessary procedures that bring primary and secondary gender characteristics in conformity with the individual's identified, including gender:
 - Chest reconstruction surgery
 - Genital reconstruction surgeries
 - Other surgeries to feminize/masculinize the body

*This is a non-exhaustive list of services. It may not include all available services.

Transgender and non-binary people may be diagnosed with gender dysphoria, a condition that manifests as significant distress when people experience conflict between their assigned gender and the gender with which they identify.¹ Some transgender and non-binary people experience a conflict between their assigned gender and gender identity without distress. But when people do experience clinically significant distress, they may require treatment to alleviate the distress. The standards of care for treating gender dysphoria involve a range of options depending on the needs and desires of the person seeking treatment.² Together, these interventions are known as gender-affirming care.

Gender-affirming health care interventions may include hormone therapy, surgical interventions, speech and language interventions, and behavioral health services. Not all transgender or non-binary people seek all health care interventions, and some seek none. When people seek these interventions to treat gender dysphoria, they are considered medically necessary when treatment is consistent with the standard of care. Treatment of gender dysphoria, including gender-affirming care, is a covered Medi-Cal benefit when medically necessary. Medi-Cal requires requests for such care to be made by “specialists experienced in providing care to transgender individuals.”³ Care must be provided according to nationally recognized clinical guidelines; the most commonly used source for the standards of care is the “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People,” published by the World Professional Association for Transgender Health, or the WPATH Standards of Care.⁴

ADVOCACY TIP:

- ✓ The standards of care for transgender and non-binary individuals in health care settings generally reflect the standards of care recommended for non-transgender and binary individuals, however transgender and non-binary individuals may face barriers in accessing care, insurance coverage, and discrimination.⁵ Advocates should ensure that their local provider communities receive training about how they can be culturally sensitive and provide appropriate care to transgender and non-binary people, and address specific problems of cultural competence when they arise.

A. Mental health services for transgender and non-binary beneficiaries

Transgender and non-binary people may seek mental health services for a wide variety of reasons. For many transgender and non-binary individuals, but not all, mental health services may be a component of their gender-affirming care.⁶ Medi-Cal coverage of many gender-affirming procedures requires a person to present with a diagnosis of gender dysphoria.⁷ Gender dysphoria is a mental health condition defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).⁸ As defined in the DSM-5, gender dysphoria is the distress a person experiences as a result of the sex and gender they were assigned at birth, such as when a person’s assigned sex and gender do not match that person’s gender identity.⁹

Medi-Cal considers behavioral health services a “core component” of treatment for gender dysphoria.¹⁰ For transgender and non-binary beneficiaries seeking surgical interventions, “[t]he determination of whether a service requested by a transgender [or non-binary] beneficiary is medically necessary and/or

constitutes reconstructive surgery must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary's primary care provider."¹¹ In pursuing gender-affirming services, transgender and non-binary Medi-Cal beneficiaries may seek mental health services such as gender dysphoria assessments, counseling regarding gender expression and transition options, diagnosis and treatment of co-occurring mental health conditions, and referrals to other treatments.¹²

B. Hormone Therapy

Hormone therapy is a covered benefit under Medi-Cal when medically necessary to treat gender dysphoria, and should be available regardless of whether the beneficiary has Fee-for-Service (FFS) or is enrolled in a Medi-Cal Managed Care Plan (MCP).

Medi-Cal generally follows the WPATH Standard of Care, which sets forth criteria for initiation of hormone therapy. For adults seeking hormone therapy, the criteria are:¹³

- The patient has the capacity to make fully informed decisions and to consent for treatment;
- If the patient has other significant medical or mental health concerns, they are reasonably well controlled;
- The patient has persistent gender dysphoria as documented by a qualified health professional; and
- The patient has received a psychosocial assessment.

There are separate criteria for initiation of hormone therapy if the individual is a child or adolescent. The criteria for children and adolescents seeking puberty-suppressing hormones are:¹⁴

- The patient has begun puberty. It is recommended that the adolescent experience the onset of puberty to at least the second stage on the Tanner scale (this usually occurs around 12 years old, but can occur earlier);¹⁵
- The patient has a long-lasting and intense pattern of gender nonconformity or gender dysphoria;
- Any coexisting medical, social, or psychological problems that may interfere with treatment have been addressed to the extent that the adolescent's situation and functioning are stable; and
- The patient has given informed consent for treatment, and particularly when the adolescent has not reached the age of medical consent, the parents or guardians have consented to treatment and are involved in supporting the patient's treatment.

1. Fee-for-Service Medi-Cal

Hormone therapy is covered for treatment of gender dysphoria under FFS Medi-Cal when medically necessary. Requests for hormone therapy should be made

by “specialists experienced in providing care to transgender individuals.”¹⁶ Medical necessity should be determined by “treating licensed mental health professionals and physicians and surgeons experienced in treating gender dysphoria.”¹⁷ The frequency of hormone therapy services to treat gender dysphoria cannot be categorically limited and must be provided timely as needed for treatment of gender dysphoria. Any limitations or exclusions, medical necessity determinations, and utilization management criteria must be applied in a non-discriminatory fashion (i.e. cannot be applied to transgender or non-binary beneficiaries if not applied to all beneficiaries in need of hormone therapy).¹⁸

The most common categories of hormone medications used to treat gender dysphoria are testosterone, estrogen, and anti-androgens.¹⁹ Medi-Cal covers at least some preparations of each of these categories of hormone drugs.²⁰

2. Medi-Cal Managed Care

Hormone therapy is also a covered benefit for treating gender dysphoria for beneficiaries enrolled in MCPs. MCPs and their subcontractors and network providers cannot discriminate against transgender or non-binary individuals. MCPs are responsible for ensuring that their subcontractors and network providers are complying with the law, state guidance, and their contractual obligations, including protections for transgender and non-binary individuals.²¹

Transgender and non-binary individuals must be provided with the “same level of health care benefits that are available to non-transgender beneficiaries.”²² Further, MCPs must “treat beneficiaries consistent with their gender identity” and are prohibited from “categorically excluding or limiting coverage for health care services related to gender transition.”²³ This prevents MCPs from limiting either the type or frequency of hormone therapy when medically necessary to treat gender dysphoria, as it is a core service in bringing “primary and secondary gender characteristics into conformity with the individual’s identified gender” for those with gender dysphoria.²⁴ MCPs may impose non-discriminatory limitations and exclusions, medical necessity determinations, and apply appropriate utilization management criteria so long as they are applied to all beneficiaries and not specific to transgender and non-binary beneficiaries.²⁵ The determination of whether hormone therapy is medically necessary for the treatment of gender dysphoria “must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary’s primary care provider.”²⁶

ADVOCACY TIP:

- ✓ Look out for situations where MCPs deny medically necessary treatments for gender dysphoria as cosmetic, and appeal such denials as appropriate, including through Independent Medical Review where available.

C. Surgical Care

Some transgender and non-binary Medi-Cal beneficiaries will seek surgical procedures to align their primary and/or secondary sex characteristics with their gender identity.²⁷ Surgery is often the last and most considered of the treatment options for gender dysphoria in transgender and non-binary individuals. Not every transgender or non-binary person wants, requires, or qualifies for every available surgical procedure. Rather, the number, type, and sequence of surgical interventions often varies widely from one person to another, depending on their particular clinical needs.²⁸ Medi-Cal typically follows the WPATH Standard of Care criteria for initiation of surgical treatment. For adults seeking chest and/or genital reconstruction procedures, the criteria are:²⁹

- The person has the capacity to make fully informed decisions and to consent for treatment;
- If the person has other significant medical or mental health concerns, they are reasonably well-controlled prior to surgery;
- The person has persistent gender dysphoria as documented by at least one mental health professional for chest reconstruction surgeries and two such professionals for genital reconstruction surgeries;
- Prior to genital reconstruction surgery, the person has undergone 12 continuous months of hormone therapy, unless hormone therapy is not clinically indicated for that patient.³⁰ The purpose of the prerequisite is to introduce a period of estrogen or testosterone suppression before the patient undergoes a surgical intervention; and
- Prior to certain genital reconstruction procedures – metoidioplasty, phalloplasty, or vaginoplasty – the person has lived for 12 continuous months in a gender role that is congruent with their gender identity. The prerequisite ensures that the patient has ample opportunity to experience and socially adjust in their desired gender role, before undergoing this surgery.³¹

1. Surgical Treatments for Gender Dysphoria

Medi-Cal policy does not identify specific surgical procedures that will be covered as part of gender-affirming treatment for beneficiaries with gender dysphoria. It merely provides that a “variety of surgical procedures that bring primary and secondary gender characteristics into conformity with the individual’s identified gender [will be covered when they] ‘are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis and treatment of disease, illness or injury.’”³²

In its letter to MCPs, DHCS differentiates between “reconstructive surgery,” which is covered by Medi-Cal, and “cosmetic surgery,” which is not.³³ DHCS notes that under state law, reconstructive surgery is defined as surgery “performed to correct or repair abnormal structures of the body . . . to create a normal appearance to the extent possible.”³⁴ DHCS then states that: “In the case of

transgender beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.”³⁵ DHCS does not explicitly delineate when a particular procedure will be considered reconstructive versus cosmetic for a transgender or non-binary beneficiary, instead noting that such determinations should be made on a case-by-case basis using “nationally recognized medical/clinical guidelines” such as the WPATH Standards of Care.³⁶ DHCS further explains that any “determination of whether a service requested by a transgender [or non-binary] beneficiary is medically necessary and/or constitutes reconstructive surgery must be made by a qualified and licensed mental health professional and the treating surgeon, in collaboration with the beneficiary’s primary care provider.”³⁷

Although DHCS does not spell out the specific gender-affirming surgical procedures that are covered in Medi-Cal, the WPATH Standards of Care does provide some guidance as to procedures that are likely to be covered. For transgender women (women who were assigned male at birth and have a female gender identity), surgical treatment options that are generally accepted in the medical community and are consistent with the WPATH Standards of Care include, but are not limited to:³⁸

- Chest reconstruction surgery: augmentation mammoplasty (breast implants);
- Genital reconstruction surgeries: penectomy (removal of the penis), orchiectomy (removal of the testes), vaginoplasty, clitoroplasty, and/or vulvoplasty (creation of female genitalia including the labia minora and majora); and
- Other surgeries to feminize the body, such as: reduction thyroid chondroplasty (reduction of the Adam’s apple), voice modification surgery, suction-assisted lipoplasty and/or lipofilling (contour modeling) of the waist, hair transplantation, and facial feminization procedures.

For transgender men (men who were assigned female at birth and have a male gender identity), surgical treatment options that are generally accepted in the medical community and are consistent with the WPATH Standards of Care include, but are not limited to:³⁹

- Chest reconstruction surgery: subcutaneous mastectomy, creation of a male chest;
- Genital reconstruction surgeries: hysterectomy/salpingo-oophorectomy (removal of the uterus and ovaries), reconstruction of the fixed part of the urethra, which can be combined with a metoidioplasty or a phalloplasty (creation of a penis), vaginectomy (removal of the vagina), scrotoplasty (creation of the scrotum), and implantation of erection and/or testicular prostheses; and
- Other surgeries to masculinize the body, such as: liposuction, lipofilling, pectoral implants, and body contouring procedures.

D. Other interventions and considerations for transgender and non-binary beneficiaries

There are a number of barriers to accessing services that transgender and non-binary beneficiaries may experience. These include issues accessing care when the individual's gender marker does not match their presupposed anatomy, issues accessing care when plans deem transition-related care as "cosmetic," issues receiving the standard of care due to religious or moral provider refusals, issues receiving culturally sensitive and appropriate care, and a lack of providers with experience and expertise in providing certain types of gender-affirming care, especially surgical procedures. These barriers can have either a direct impact on a beneficiary's ability to access care, or an indirect impact through discouraging transgender beneficiaries from seeking needed care.

1. Issues accessing services when gender marker does not match presupposed anatomy

Sometimes transgender individuals can experience issues accessing medically necessary care because their gender marker does not match their presupposed anatomy. However, this should not be happening and Medi-Cal provides information on what steps providers should take to avoid issues in accessing care in these situations. If the gender on a Medi-Cal claim conflicts with a billed procedure code, the gender limitation can be overridden either by the provider attaching an approved Treatment Authorization Request (TAR) or Service Authorization Request (SAR) or adding the modifier "KX" to the billed procedure code; the "KX" modifier is used to indicate that the provider is attesting that the service request conforms to Medi-Cal coverage criteria.⁴⁰ The beneficiary's medical record must support that the treatment is medically necessary. Under FFS Medi-Cal, there also used to be a drug-gender screening system that provided a barrier to accessing care when the gender marker and presupposed anatomy were mismatched. However, this screening system is currently inactive.⁴¹

2. Issues accessing services when plan deems care "cosmetic"

While the law and guidance clearly indicates that all procedures that are medically necessary to treat gender dysphoria are covered, sometimes MCPs will still try to deny coverage of certain treatments, deeming them "cosmetic." This is most prevalent with gender-affirming surgical treatments, including but not limited to tracheal shaves, breast or chest construction, liposuction, lipofilling, pectoral implants, other body contouring procedures, and electrolysis.⁴² However, California Courts of Appeal held in 1978 that gender-affirming surgeries are not "cosmetic" when medically necessary to treat gender dysphoria.⁴³ In practice, MCPs sometimes push back on where the line between medically necessary and cosmetic lies and there are not clear guidelines on this distinction in the law, regulations, and guidance governing Medi-Cal. The

WPATH Standards of Care provide that gender-affirming interventions—including hormone therapy, body modification surgery, facial hair removal, speech and communication modification, behavioral adaptations like genital tucking or packing, and chest binding—when sought by transgender and non-binary individuals are medically necessary.⁴⁴ Thus, any denial of services as “cosmetic” should be appealed through the proper channels.

ADVOCACY TIP:

- ✓ Providers may refuse to provide covered services to transgender and non-binary beneficiaries due to their religious or moral beliefs about gender identity. These refusals can cause delays and obstacles to transgender patients receiving the standard of care. They can also be traumatic experiences that exacerbate a transgender patient’s gender dysphoria and/or other mental health concerns. Encourage clients to report instances of discrimination at All Care Everywhere, www.allcareeverywhere.com, which is a project of the National Health Law Program and the ACLU to collect stories of religious refusals to use in broad advocacy in California.

Endnotes

- ¹ *What Is Gender Dysphoria?*, Am. Psychiatric Ass’n (Feb. 2016), <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> (last visited Nov. 13, 2019).
- ² World Prof’l Ass’n Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (2012) [hereinafter WPATH, Standards of Care], <https://www.wpath.org/publications/soc>.
- ³ Cal. Dep’t Health Care Servs., *Medi-Cal Provider Manual, Transgender Services*, at 1 (2017), http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transgender_m00o03.doc.
- ⁴ *Id.* See WPATH, *Standards of Care*, *supra* note 2.
- ⁵ See, e.g., Jamie Feldman & Madeline B. Deutsch, *Primary Care of Transgender Individuals*, UpToDate (Nov. 1, 2016), <https://www.uptodate.com/contents/primary-care-of-transgender-individuals>.
- ⁶ WPATH Standards of Care, *supra* note 2, at 24.

- ⁷ See Cal. Dep't Health Care Servs., All Plan Letter 16-013, at 2 (Oct. 6, 2016) [hereinafter All Plan Letter 16-013], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-013.pdf>.
- ⁸ See “Gender Dysphoria” in Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) (DSM-5).
- ⁹ *Id.*
- ¹⁰ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transgender Services*, *supra* note 3, at 2.
- ¹¹ See All Plan Letter 16-013, *supra* note 7, at 2 (clarifying that “core services in treating gender dysphoria [include] behavioral health services [and] psychotherapy.”).
- ¹² WPATH, *Standards of Care*, *supra* note 2, at 23–26. For more information about the scope and accessibility of mental health services in Medi-Cal, see Chapter III of the National Health Law Program’s Medi-Cal Services Guide on Mental Health Services.
- ¹³ WPATH, *Standards of Care*, *supra* note 2, at 34.
- ¹⁴ WPATH, *Standards of Care*, *supra* note 2, at 18–19.
- ¹⁵ For more details on the Tanner Scale, see generally Lawrence S. Neinstein, *Adolescent Health Care: A Practical Guide* (5th ed. 2008).
- ¹⁶ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transgender Services*, *supra* note 3.
- ¹⁷ *Id.*
- ¹⁸ *Id.*
- ¹⁹ *What are commonly used medications for transition?*, Transline, <https://transline.zendesk.com/hc/en-us/articles/229373208-What-are-commonly-used-medications-for-transition-> (last visited Nov. 16, 2019).
- ²⁰ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Drugs: Contract Drugs List Part 1 - Prescription Drugs (S through Z)* (2017) (drugs cdl p1d), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/drugscdlp1d_p00.doc; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Drugs: Contract Drugs List Part 1 - Prescription Drugs (E through M)* (2018) (drugs cdl p1b), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/drugscdlp1b_p00.doc.
- ²¹ All Plan Letter 16-013, *supra* note 7.
- ²² *Id.*
- ²³ *Id.*
- ²⁴ *Id.*
- ²⁵ *Id.*
- ²⁶ *Id.*
- ²⁷ WPATH, *Standards of Care*, *supra* note 2, at 9–10.

- ²⁸ *Id.* at 58.
- ²⁹ *Id.* at 60; see also Wylie C Hembree et al., *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLIN. ENDOCRINOLOGY & METABOLISM 3869 (2017).
- ³⁰ While not an explicit criterion, the WPATH *Standards of Care* recommends that individuals undergo 12 months of continuous hormone therapy prior to breast augmentation surgery to obtain the best possible outcome. WPATH, *Standards of Care*, *supra* note 2, at 59.
- ³¹ While not an explicit criterion, the WPATH *Standards of Care* also recommend that these individuals see a mental health or other medical professional during this 12-month period. WPATH, *Standards of Care*, *supra* note 2, at 60.
- ³² Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transgender Services*, *supra* note 3, at 2 (citing CAL. CODE REGS., tit. 22, § 51303); see also All Plan Letter 16-013, *supra* note 7, at 2.
- ³³ All Plan Letter 16-013, *supra* note 7, at 2.
- ³⁴ *Id.* (quoting CAL. HEALTH & SAFETY CODE § 1367.63(c)(1)(B)).
- ³⁵ *Id.*
- ³⁶ *Id.*
- ³⁷ *Id.*
- ³⁸ WPATH, *Standards of Care*, *supra* note 2, at 57.
- ³⁹ *Id.*
- ⁴⁰ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transgender Services*, *supra* note 3.
- ⁴¹ "The drug-gender screening system, which is currently inactive, warns of inappropriate drug use based on the patient's sex." Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, DUR: Prospective Drug Use Review* (2007), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-other/dur/20_d00.doc.
- ⁴² *Medi-Cal and Gender Reassignment Procedures*, Transgender L. Ctr. (May 2002), <https://transgenderlawcenter.org/wp-content/uploads/2012/07/Medical-Fact-Sheet.pdf>.
- ⁴³ *GB v. Lackner*, 80 Cal. App. 3d (1978); *JD v. Lackner*, 80 Cal. App. 3d 90 (1978).
- ⁴⁴ Prescribing hormones for gender affirmation is within the scope of practice of a range of providers, including primary care physicians, obstetricians-gynecologists, endocrinologists, advanced practice nurses, physician assistants, and other providers with prescriptive rights (such as, in some jurisdictions, naturopathic providers and nurse midwives). Madeline B. Deutsch, *Initiating Hormone Therapy*, UCSF Ctr. Excellence for Transgender Health (June 17, 2016), <http://transhealth.ucsf.edu/trans?page=guidelines-initiating-hormone-therapy> (last visited Nov. 16, 2019); WPATH *Standards of Care*, *supra* note 2.



An Advocate's Guide to Medi-Cal Services

January 2020

Chapter VI: Reproductive and Sexual Health Services

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Reproductive and Sexual Health Services Covered in the Chapter*

- Family Planning and Family Planning-Related Services
 - Access to Family Planning Services and Supplies
 - Patient Visits & Counseling Services
 - Contraceptives
 - Sexually Transmitted Infections
 - Sterilization
 - Other Services
- Abortion Services
 - State-only abortion coverage
 - Services and supplies incidental or preliminary to an abortion:
 - Services following an abortion
- Pregnancy Services
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- Reproductive and Sexual Health Services in EPSDT
- Limited Infertility Services
- Additional Coverage Categories for Reproductive and Sexual Health Services
 - Family PACT
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 - Pregnancy-Related Medi-Cal
 - Medi-Cal Access Program
 - Presumptive Eligibility for Pregnant Women
- Breast and Cervical Cancer Screening and Treatment Programs
 - Every Woman Counts
 - Federal BCCTP coverage
 - State BCCTP coverage
- Reproductive and Sexual Health for Dual Eligibles

*This is a non-exhaustive list of services. It may not include all available services.

A. Introduction

Medi-Cal is critical to the reproductive and sexual health of all Californians. Under federal law, all states must offer coverage to certain low-income individuals, including pregnant women and very low-income parents. In the 37 states like California that have expanded Medicaid under the Affordable Care Act, most previously uninsured, low-income women now have access to full Medicaid benefits.¹ Medi-Cal therefore plays a major role in the financing of reproductive and sexual health care services for millions of low-income women and other individuals in California.

This chapter focuses on the range of reproductive and sexual health services available to Medi-Cal beneficiaries. It highlights services such as contraceptives, pregnancy care, cancer screening and treatment, and abortion.

B. Family Planning and Family Planning-Related Services

While the Medicaid Act does not define “family planning services and supplies,” CMS provided guidance on the types of family planning services and supplies that are covered.² Similarly, the guidance describes “family planning-related services” as medical, diagnosis, and treatment services “pursuant to” a family planning visit such as screening and treatment for cervical and breast cancer, and sexual health counseling.³

1. Access to Family Planning Services and Supplies

Since 1972, the Social Security Act has required all states to cover family planning services and supplies without co-payments or cost sharing for beneficiaries of childbearing age (including sexually active minors).⁴ To promote access to family planning services and supplies, beneficiaries are entitled to receive family planning services and supplies from any qualified Medicaid provider.⁵ In the case of a Medicaid enrollee receiving services from a Medi-Cal managed care plan (MCP), this means the enrollee can obtain family planning services from a particular provider even if the provider is out-of-network.⁶ This protection is known as “freedom of choice” in family planning. California codified this requirement through the Protection of Choice for Family Planning Act (SB 743), which went into effect on January 1, 2018. SB 743 provides the same protection as the federal family planning freedom of choice provision, allowing Medi-Cal enrollees to seek services from any qualified Medi-Cal provider, even if the provider of choice is out of their Medi-Cal managed care network.⁷

Managed care plans must also guarantee direct access to a “women’s health specialist” and must ensure that family planning providers are available in network.⁸

Individuals covered under another person’s health plan—such as a parent’s or spouse’s—may also seek contraceptive services, abortions, and other “sensitive services” confidentially without notifying or involving a parent or spouse.⁹ Medi-

Cal sensitive services include services related to STIs, pregnancy, family planning, abortions, HIV, sexual assault and rape, and other minor consent services.¹⁰ The individual requesting confidential services must submit a Confidential Communication Request to their Medi-Cal managed care plan or medical provider, and the request must be implemented within seven days of receipt of an electronic or telephone request and 14 days of receipt of a request sent by mail.¹¹

2. Patient Visits and Counseling Services

Medi-Cal covers family planning patient visits and counseling without cost-sharing as part of the family planning benefit. Counseling topics may include family planning needs, pregnancy prevention, and health education. Through these visits, individuals can obtain prescriptions for contraceptives or advice about contraception.¹²

3. Contraceptives

California's Medi-Cal program provides robust contraceptive coverage. Contraceptives are designed to prevent pregnancy and also may be used to treat other medical conditions. Medi-Cal covers all types of Food and Drug Administration (FDA)-approved birth control methods, such as oral contraceptives, or "the pill"; transdermal patch hormonal contraceptive devices; injectable contraceptives; vaginal rings; diaphragms; foam, gel, jelly, and cream; male and female condoms; long acting reversible contraceptives (LARCs) including intrauterine contraception (commonly known as IUDs) and implantable subdermal contraceptives; and emergency contraception.¹³

Emergency contraception (EC) is often referred to as the "morning after pill" and is a method of pregnancy prevention. Instead of taking it before intercourse like with other oral contraception, emergency contraception is taken after sexual intercourse. EC does not cause an abortion and is not RU486 or what is commonly referred to as the "abortion pill." There are two types of EC: the copper intrauterine device and emergency contraception pills, of which there are three types.

Physicians, physician assistants, certified nurse midwives, nurse practitioners, registered nurses, and pharmacists are all authorized to dispense contraceptives in California.¹⁴ Medi-Cal MCPs must cover up to a 12-month supply of FDA approved, self-administered contraceptives, consistent with a provider's prescription. The MCP may not impose utilization controls that limit the supply of FDA approved, self-administered hormonal contraceptives dispensed or furnished by a provider, pharmacist or other authorized location that is less than a 12-month supply.¹⁵ In addition, the MCP must not impose utilization controls, such as prior authorizations and step therapy that are more restrictive than those used under fee-for-service.¹⁶

Medi-Cal requires a prescription before it will cover contraceptive supplies that are available over-the-counter (OTC) such as emergency contraception pills (also known as “Plan B”), male condoms, interior (or “female”) condoms, spermicides, and sponges.¹⁷ Medi-Cal also imposes quantity limits for OTC contraceptives. For example, enrollees are allowed up to one pack of emergency contraception per month and up to six packs total per year.¹⁸

4. Sexually Transmitted Infections

Medi-Cal covers both the testing and treatment of sexually transmitted infections (STIs) including but not limited to chlamydia, human papillomavirus (HPV), gonorrhea, genital herpes, and syphilis, as a family planning-related service.¹⁹ The treatment or diagnostic tests for the management of urinary tract infections (UTIs) is also covered when provided as part of, or as a follow-up to, a family planning visit where the UTI was identified or diagnosed.²⁰

Children and young adults up to age 21 who are enrolled in Medi-Cal can also receive STI and other preventive screenings as an Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit. See section E of this chapter for additional information.

5. Sterilization

Medi-Cal provides coverage for sterilization services, or any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing. Medi-Cal covers vasectomies, tubal ligations, as well as treatment for complications resulting from previous family planning procedures.²¹ Medi-Cal will cover a hysterectomy as a treatment option for a medical issue, however it is not covered as a sterilization procedure.²²

Coverage of sterilization is subject to stringent state and federal legal requirements that limit both who may be sterilized and establishes stringent informed consent procedures.²³ Historically, women of color, low-income women, and people with developmental disabilities have been subjected to forced sterilization throughout the United States, including in California. To protect against coercion, federal law prohibits the expenditure of federal Medicaid funds on sterilizations for individuals who are younger than 21 years of age or those who are mentally incompetent.²⁴ State law prohibits the performance of sterilization on anyone who is institutionalized, which includes those residing in prison and those who have been admitted to a hospital or psychiatric health facility due to a mental health diagnosis (even if voluntarily committed to such hospital facility).²⁵ In addition, a person who is in labor, has given birth or had an abortion within the past 24 hours, is seeking to obtain or obtaining an abortion, or is under the influence of alcohol or another substance cannot consent to sterilization.²⁶

Federal and state regulations allow for coverage of a sterilization only if the beneficiary has provided informed consent at least 30 days before the procedure is performed. In order for consent to be informed, the individual obtaining the consent must first offer to answer any questions the patient may have concerning the procedure. The individual must also provide the beneficiary with certain information, such as a description of alternative methods of family planning and a thorough explanation of the specific procedure to be performed, as well as a copy of the consent form and a booklet on sterilization prepared by the California Department of Health Care Services (DHCS).²⁷ The information must be effectively communicated in order to overcome any language or communication barrier.²⁸ If a doctor fails to comply with these requirements, they will not receive payment from DHCS, and will be reported to the Medical Board of California.²⁹

The consent form itself also must include that the person securing the consent certifies that they believed that the individual to be sterilized appeared mentally competent and voluntarily consents to the sterilization.³⁰ Consistent with federal law, Medi-Cal imposes a 30-day waiting period between the time an individual signs a consent form for sterilization and the time when the procedure may be performed.³¹

There are two exceptions to this time frame. Voluntary sterilization may be performed at the time of emergency abdominal surgery if the written informed consent to be sterilized was given at least 30 days before the individual intended to be sterilized and at least 72 hours have passed after written informed consent to be sterilized was given.³² In the case of premature delivery, a sterilization can be performed if written informed consent was given at least 30 days before the expected due date and at least 72 hours have passed after written informed consent to be sterilized was given.³³

6. Other services

Medi-Cal beneficiaries may also obtain coverage of laboratory exams and tests associated with family planning procedures (e.g., as a result of bleeding while taking oral contraceptives) for enrollees.³⁴ Pregnancy tests are also covered under Medi-Cal.³⁵

C. Abortion Services

The Hyde Amendment, which has been added to the annual appropriations measure for the federal Department of Health and Human Services (HHS) since 1976, prohibits the use of federal Medicaid funds to cover abortions except when necessary to save the life of a pregnant person or in pregnancies resulting from rape or incest.³⁶ Federal law mandates that state Medicaid programs cover the limited abortions for which federal funding is available. States may also use state-only funds to provide broader abortion coverage. Under the California

Constitution, Medi-Cal must provide comprehensive abortion coverage, and therefore Medi-Cal pays for such services using state-only dollars.³⁷

California prohibits health plans, including Medi-Cal MCPs, from requiring a medical justification for abortion services, and health plans can only require prior authorization for inpatient abortion procedures.³⁸ Health plans must ensure that enrollees have timely access to abortion services, and “implement and maintain procedures that ensure confidentiality and access to these sensitive services,” including for teenagers.^{39, 40} Unlike some states, there is no requirement that a Medi-Cal beneficiary wait a certain period of time before obtaining an abortion or that the recipient involve a parent or guardian.⁴¹ To ensure timely care, abortions are covered under the presumptive eligibility program, discussed in more detail below.

Abortion services are not subject to cost sharing, and Medi-Cal beneficiaries can obtain abortion services from any qualified Medi-Cal provider (e.g., an OB/GYN) willing to provide such services, including out-of-network providers in the case of Medi-Cal beneficiaries enrolled in managed care. This protection allows individuals to see any Medi-Cal provider without a referral from a primary care provider or approval from a health plan.⁴²

Medi-Cal covers other services and supplies incidental or preliminary to an abortion, including office visits, laboratory exams, ultrasounds, urine pregnancy tests, and patient education.⁴³ Following an abortion, Medi-Cal provides coverage of patient education and follow-up. In the case of a medication abortion, Medi-Cal covers a post-abortion ultrasound to confirm a complete abortion without complications.⁴⁴

Medi-Cal providers may refuse to perform abortions because of moral, ethical or religious objections, except in the case of an emergency.⁴⁵

D. Pregnancy Services

1. Pregnancy Services Overview

Medi-Cal provides full-scope coverage—including prenatal, perinatal, delivery and post-partum care—at no cost to pregnant people with incomes up to 213 percent of the federal poverty level (FPL).⁴⁶

Pregnant people may choose to receive their prenatal care, labor and delivery, and postpartum care in a hospital setting from an OB/GYN, or to access certified nurse midwife services, as well as freestanding birth centers.⁴⁷ These freestanding birthing centers, or specialty clinics, also provide comprehensive perinatal, obstetrical, and delivery services.⁴⁸ Advocates are also engaged in efforts to extend Medi-Cal coverage to doula care.⁴⁹

Adolescents can receive pregnancy testing, prenatal care, and labor and delivery services, among other services, without permission or notifying a parent or guardian.⁵⁰ Pregnant adolescents—individuals who are under the age of 18 years old— may face a different set of challenges when seeking health care services as compared to adults who become pregnant. Some adolescents and young people have difficulty finding a provider, encounter provider stigma, and/or are unaware of the confidentiality protections in Medi-Cal.

2. Prenatal Services

Medi-Cal offers prenatal services such as provider counseling, examinations, routine urinalyses, evaluations, and treatments.⁵¹ Other pregnancy-related services covered by Medi-Cal during pregnancy include home blood glucose monitors for patients with diabetes, injections to prevent preterm births, genetic counseling, tobacco cessation services, mental health services, and substance use disorder services.⁵²

3. Perinatal Services

In addition to traditional prenatal services, Medi-Cal also covers perinatal services under the Comprehensive Perinatal Services Program (CPSP) during pregnancy and through 60 days postpartum.⁵³ Services under CPSP include nutrition services, health education, and care coordination. To receive these services, the beneficiary must first undergo assessments conducted by their provider.⁵⁴ Following the nutrition assessment, a pregnant person may receive nutrition services such as prenatal vitamins or interventions that emphasize the importance of maintaining good nutrition during pregnancy and lactation. Health education interventions are provided to assist the pregnant person in making appropriate, well-informed decisions about pregnancy, delivery, and parenting. Psychosocial interventions are directed toward helping the pregnant person understand and deal effectively with the biological, emotional, and social stresses of pregnancy. Beneficiaries who receive CPSP services may receive referrals for additional services when appropriate.⁵⁵

4. Labor and Delivery Services

Medi-Cal covers both vaginal and caesarian deliveries. Delivery includes hospital admission, patient history, physical examination, management of labor, hospital discharge, and all applicable postoperative care. After a baby is born, the parent, guardian or a provider that has obtained written consent may establish Medi-Cal eligibility for the child by completing the Newborn Referral Form and sending it to the county of residence.⁵⁶

As mentioned, Medi-Cal also covers certified nurse midwife services and freestanding birth centers without cost sharing.⁵⁷

5. Post-Partum Services

Post-partum services, or services provided after childbirth, child delivery, or a miscarriage, include hospital and scheduled office visits, assessment of uterine involution, and, as appropriate, contraceptive counseling.⁵⁸

Unlike some other states' Medicaid programs, Medi-Cal covers the purchase or rental of lactation aids, including manual or electronic breast pumps. For babies up to one year of age with impaired sucking abilities due to conditions such as cleft lip, Medi-Cal covers Haberman Feeders, or specialty bottles that assist with feeding.⁵⁹

E. Reproductive and Sexual Health Care in Early and Periodic Screening, Diagnostic, and Treatment Services

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive health care services for children and youth under 21 years old who are enrolled in Medi-Cal.⁶⁰ EPSDT entitles those eligible to receive medical, vision, hearing, and dental screening at pre-set periodic intervals and when needed to determine whether a health issue or condition exists.⁶¹

The EPSDT medical screening is especially important for young people. Medi-Cal covers services as recommended by the “Bright Futures”/American Academy of Pediatrics periodicity schedule.⁶² Bright Futures calls for providers to deliver reproductive and sexual health services including STI screenings, HPV vaccines, pregnancy testing, HIV testing, family planning, and sexuality education and counseling.⁶³ Bright Futures also recommends that physicians provide “confidential, culturally sensitive and nonjudgmental” sexuality education and counseling to children, adolescents, and their caretakers, and that the entire clinical environment create an atmosphere where the discussion of sexual health is comfortable, regardless of social status, gender, disability, religious beliefs, sexual orientation, ethnic background, or country of origin.⁶⁴ The comprehensive health and developmental history assessment should also include a discussion of sexuality, healthy relationships, and sexual health.⁶⁵

F. Infertility

The Medicaid Act explicitly allows states to exclude fertility drugs from plan coverage.⁶⁶ Accordingly, conception and fertility services intended to promote childbearing are generally not included as Medicaid family planning services.

Medi-Cal covers a very limited range of infertility services. Diagnosis and treatment for infertility are generally not covered.

G. Additional Coverage Categories for Reproductive and Sexual Health Services

A Medi-Cal beneficiary can access the reproductive and sexual health services described above if the beneficiary has full-scope Medi-Cal. There are several programs that provide access to reproductive and sexual health services for individuals who are not qualified for full-scope Medi-Cal.

1. Family Planning, Access, Care, and Treatment (Family PACT)

The Family PACT Program covers family planning services and family planning-related services for individuals who have a gross family income at or below 200 percent of the FPL, have no other source of health care coverage for family planning services, and reside in California.⁶⁷ Family PACT covers contraception, emergency contraception, sterilization, health education and counseling, physical exams, pregnancy testing, sexually transmitted infection testing and treatment, cancer screening, and HIV screening.⁶⁸ Family PACT does not cover prenatal services, labor and delivery, or abortion.⁶⁹ Family PACT is a limited scope Medicaid program, but a component of Family PACT is funded solely by state funds, and therefore individuals can qualify for Family PACT services regardless of their immigration status.⁷⁰

2. Minor Consent Medi-Cal

The Medi-Cal Minor Consent program is a source of reproductive and sexual health coverage for minors. The program covers certain services for which a minor can legally provide consent. The minimum age requirement for consent varies depending on the service. Minors of any age including children under 12 may consent to contraception, pregnancy and pregnancy-related care, abortions.⁷¹ Minors age 12 and older can also consent for STI screenings and treatment, services to treat substance use disorders, outpatient mental health services, and sexual assault services.⁷²

The program provides temporary coverage and must be renewed monthly for services except pregnancy. A person must be under age 21 and living with a parent or guardian in order to enroll in Minor Consent Medi-Cal (a minor who is temporarily living at school or college is considered to be living at home).⁷³ Eligibility is determined on the basis of the minor's income and resources, not the income and resources of the minor's parent(s) or guardian(s).⁷⁴ Minors do not have to provide any identification when they apply, and eligibility workers are prohibited from requiring documents related to immigration status when assessing eligibility for the program. However, if the minor is employed, then they must provide pay stubs to verify income.⁷⁵ Services provided under the program are confidential, therefore providers are not allowed to contact parents or guardians about the minor's receipt of these services.⁷⁶

3. Pregnancy-Related Medi-Cal

Pregnant individuals who do not qualify for full-scope Medi-Cal may be eligible for pregnancy-related Medi-Cal coverage. This is a limited scope program for pregnant individuals with incomes between 138 percent and up to 213 percent of the FPL.⁷⁷ Pregnancy-related services are services required to assure the health of the pregnant person and fetus. These include, but are not limited to, prenatal care, services for other conditions that might complicate the pregnancy, labor, delivery, postpartum care, and family planning services.⁷⁸ Pregnancy-related services may be provided prenatally from the day that pregnancy is medically established and postpartum until the two full calendar months after the month in which the end of the pregnancy occurs.⁷⁹ Drug coverage, prescribed for pregnancy-related services and dispensed within this eligibility time period, includes the full scope of Medi-Cal pharmaceutical benefits.⁸⁰ There is no Medi-Cal service that is excluded from pregnancy-related coverage as long as the service is medically necessary.⁸¹

4. Medi-Cal Access Program

The Medi-Cal Access Program (MCAP) – formerly known as the Access for Infants and Mothers Program – provides comprehensive Medi-Cal services for individuals during their pregnancy and their postpartum period, including labor and delivery. Individuals who qualify for the program are entitled to Medi-Cal services such as maternity care, family planning physician services, hospital services, prescription drugs, medical transportation, durable medical equipment, mental health care, substance use disorder treatment, among other categories of benefits.⁸² Enrollees receive all services without cost sharing, but they are required to pay a fee for coverage equal to 1.5 percent of their annual income; such fee can be paid all at once or via monthly payments.⁸³ Although called a Medi-Cal program, MCAP is funded with dollars from the Children’s Health Insurance Program (CHIP).⁸⁴

In order to qualify for MCAP, a person must be pregnant or in their post-partum period, a California resident, not covered by other health insurance, and have income between 213 and 322 percent of the federal poverty level.⁸⁵ Individuals can qualify for MCAP regardless of their immigration status. MCAP coverage terminates two full calendar months after the month in which the end of pregnancy occurs (e.g., if a person gives birth on July 10, MCAP coverage ends on September 30).⁸⁶

5. Presumptive Eligibility for Pregnant Women

The presumptive eligibility program is a means by which pregnant individuals can obtain temporary Medi-Cal coverage prior to submitting an application for Medi-Cal coverage. Under the program, individuals who are pregnant or believe they are pregnant can visit a provider that participates in the program and provide information on their income; if the provider determines their income is low enough to qualify for Medi-Cal then coverage begins immediately and

services can be provided on the same day.⁸⁷ Only outpatient prenatal services – including abortions – and prescription drugs are covered.⁸⁸ Labor and delivery and family planning services are not covered. Moreover, coverage is temporary, expiring by the last day of the month following the month in which the individual obtained coverage of the presumptive eligibility program (i.e., coverage can be for two months at most).⁸⁹ Thus, individuals who are found eligible for the program should submit a full Medi-Cal application to ensure they continue to receive coverage after the temporary coverage period expires.

H. Breast and Cervical Cancer Screening and Treatment Programs

Cervical and breast cancer screenings are covered as a family planning-related benefit for Medi-Cal beneficiaries. Uninsured and underinsured individuals regardless of gender with incomes below 200 percent of the federal poverty level may also be eligible for free screenings and diagnostic services through the Every Woman Counts program.⁹⁰ Family PACT also provides free and confidential breast and cervical cancer screenings.

Full-scope Medi-Cal provides treatment to beneficiaries diagnosed with breast and/or cervical cancer, among other forms of cancer. A California resident who has breast or cervical cancer may be eligible for Medi-Cal coverage even if the person would not otherwise qualify for Medi-Cal. There are two separate Breast and Cervical Cancer Treatment Programs (BCCTPs), a federal program and a state program.

Under the federal BCCTP, an individual is entitled to full-scope of Medi-Cal services, including breast and cervical cancer treatment if the individual (1) is uninsured; (2) resides in California; (3) has an income at or below 200 percent of the federal poverty level; (4) has a need for breast or cervical cancer treatment; (5) is a U.S. citizen or an immigrant with satisfactory immigration status; and (6) is under the age of 65. Both women and men can receive coverage under the program if they have breast cancer. An individual enrolled in the federal BCCTP program is entitled to Medi-Cal coverage so long as that individual continues to receive cancer treatment and meets the other eligibility criteria for coverage.⁹¹

Individuals who do not otherwise qualify for federal BCCTP can still receive Medi-Cal coverage under the state-only BCCTP. Many of the eligibility requirements that apply to the federal BCCTP also apply to state-only BCCTP, but the programs differ in that individuals over 65 years of age, undocumented immigrants, and those with health insurance can qualify for the state-only BCCTP. Unlike the federal program, the state-only BCCTP covers only breast and cervical cancer treatment, services related to such treatment, and reimbursement of insurance premiums under certain circumstances. Moreover, the state-only BCCTP is time limited. It covers breast cancer treatment services for up to 18 months, and cervical cancer treatment services for up to 24 months, although the coverage period can be extended if cancer reoccurs.⁹²

I. Reproductive and Sexual Health Services for Dual Eligibles

Dual-eligible individuals of reproductive age – those who qualify for coverage under both the Medicare and Medicaid programs due to disability or chronic illness – often face barriers to receiving the sexual and reproductive health care they need.

Medicare does not include comprehensive coverage of contraception or abortion. For example, Medicare covers abortions, but only in the case of rape, incest, or life-threatening circumstances to the pregnant person.⁹³ Medi-Cal (Medicaid) is the payer of last resort, and therefore claims for dual-eligible beneficiaries must first be submitted to Medicare for a denial before billing Medi-Cal, unless the health care services are not covered by Medicare.⁹⁴ Obtaining a coverage denial may be difficult as many reproductive health providers are not Medicare providers. In addition, some providers may be unwilling to go through the burden of submitting multiple claims. A dual eligible individual seeking coverage of an abortion must find a provider enrolled in both Medicare and Medi-Cal who will first submit a claim to Medicare and then follow with a claim to Medi-Cal once the Medicare denial has been received.

Moreover, while Medi-Cal enrollees have access to extensive family planning services and supplies, Medicare generally only covers contraception for non-contraceptive purposes. However, the Centers for Medicare and Medicaid Services (CMS) recently clarified that since Medicare does not pay for LARCS, a provider seeing dually-eligible patients does not need to obtain a Medicare denial. Instead, the provider can directly submit a claim to Medicaid.⁹⁵

Endnotes

¹ Kaiser Fam. Found., Status of State Action on the Medicaid Expansion Decisions, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Nov. 30, 2019).

² CMS, Dear State Health Official Letter (June 14, 2016) (SHO # 16-008), at 3 [hereinafter SHO # 16-008], <https://www.medicare.gov/federal-policy-guidance/downloads/sho16008.pdf>.

³ See CMS, Dear State Medicaid Director Letter (April 16, 2014) (SMD # 14-003), <https://www.medicare.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf> (clarifying the scope of family planning and family planning related services).

- ⁴ 42 U.S.C. § 1396o(a)(2)(D).
- ⁵ 42 U.S.C § 1396a(a)(23).
- ⁶ 42 U.S.C § 1396a(a)(23)(B); 42 C.F.R. § 431.51(b)(2).
- ⁷ CAL. WELF. & INST. CODE § 14132.07; see also Amy Chen & Priscilla Huang, Nat'l Health Law Prog., *California's Medi-Cal "Protection of Choice for Family Planning Act"* (2018), <https://9kqpw4dcaw91s37kozm5jx17-wpengine.netdna-ssl.com/wp-content/uploads/2018/09/Californias-Medi-Cal-Protection-of-Choice-for-Family-Planning.pdf>.
- ⁸ 42 C.F.R. § 438.206(b)(2).
- ⁹ 2013 Cal. Stat. ch. 444 (S.B. 138).
- ¹⁰ CAL. FAM. CODE §§ 6924, 6925, 6926, 6927, 6928, and 6929; CAL. HEALTH & SAFETY CODE §§ 121020, 124260.
- ¹¹ CAL. CIV. CODE § 56.107(5).
- ¹² Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Family Planning 6-7* [hereinafter Medi-Cal Family Planning Manual], http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/famplanning_m00o03.doc.
- ¹³ *Id.* at 9-14.
- ¹⁴ Cal. Dep't Health Care Servs., All Plan Letter 18-019, at 2 (Nov. 21, 2018) [hereinafter APL 18-019, <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-019.pdf>].
- ¹⁵ CAL. HEALTH & SAFETY CODE § 1367.25(d)(4).
- ¹⁶ CAL. HEALTH & SAFETY CODE § 1367.25(d); CAL. WELF. & INST. CODE § 14000.01; see also APL 18-019, *supra* note 14, at 2.
- ¹⁷ Kaiser Fam. Found., *Medicaid Coverage of Over-the-Counter Contraceptives* (as of July 1, 2015), <https://www.kff.org/womens-health-policy/state-indicator/medicaid-coverage-of-over-the-counter-contraceptives/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Nov. 30, 2019).
- ¹⁸ Medi-Cal Family Planning Manual, *supra* note 12, at 10.
- ¹⁹ *Id.* at 17-20.
- ²⁰ SHO # 16-008, *supra* note 2.
- ²¹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Sterilization* (2015) [hereinafter Medi-Cal Sterilization Manual], http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ster_m00i00o03.doc.
- ²² Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Hysterectomy* (2008), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/hyst_m00i00o03.doc.
- ²³ 42 C.F.R. §§ 441.250-259; see generally CAL. CODE REGS. tit. 22, §§ 51305.1-51305.4.

- ²⁴ 42 C.F.R. § 441.253.
- ²⁵ CAL. CODE REGS. tit. 22, § 51305.1(a)(4), (b)(2).
- ²⁶ *Id.* § 51305.3(b).
- ²⁷ 42 C.F.R. § 441.257(a); CAL. CODE REGS. tit. 22, § 51305.3.
- ²⁸ Medi-Cal Sterilization Manual, *supra* note 21, at 5.
- ²⁹ CAL. WELF. & INST. CODE § 14193.
- ³⁰ 42 C.F.R. § 441.258.
- ³¹ Medi-Cal Sterilization Manual, *supra* note 21, at 3.
- ³² CAL. CODE REGS. tit. 22, § 51305.1(a)(6)(A).
- ³³ *Id.* § 51305.1(a)(6)(B).
- ³⁴ Medi-Cal Family Planning Manual, *supra* note 12, at 2-3.
- ³⁵ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy Determination 1* (2017), http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregdeterm_m00o03.doc.
- ³⁶ Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, Div. C, §§ 506, 507 (Dec. 16, 2014).
- ³⁷ *Comm. to Defend Reprod. Rights v. Myers*, 625 P.2d 779, 886 (Cal. 1981) (striking down abortion funding restrictions as an unconstitutional invasion of a woman's freedom of reproductive choice).
- ³⁸ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Abortions 1* (2015) [hereinafter *Medi-Cal Abortion Manual*], http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/abort_m00o03.doc
- ³⁹ Cal. Dep't of Health Care Servs., All Plan Letter No. 15-020, at 1 (Sept. 30, 2015) [hereinafter *APL 15-020*], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-020.pdf>.
- ⁴⁰ *American Academy of Pediatrics v. Lungren*, 16 Cal. 4th 307 (Cal. 1997).
- ⁴¹ Guttmacher Inst., *State Facts About Abortion: California, 2019*, <https://www.guttmacher.org/fact-sheet/state-facts-about-abortion-california> (last visited Nov. 30, 2019).
- ⁴² *APL 15-020*, *supra* note 39, at 1.
- ⁴³ *Medi-Cal Abortion Manual*, *supra* note 38, at 2.
- ⁴⁴ *Id.* at 7.
- ⁴⁵ CAL. HEALTH & SAFETY CODE § 123420. If you were denied care, please contact the National Health Law Program to learn about your options.
- ⁴⁶ Covered California, *Pregnancy Coverage Quick Guide Certified Enrollers* (2017), https://hbex.coveredca.com/toolkit/webinars-briefings/downloads/Pregnancy_Quick_Sheet_FINAL.pdf.

- ⁴⁷ 42 U.S.C. § 1396d (l)(3)(C).
- ⁴⁸ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Alternative Birthing Centers* (2009), http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/altern_m00o03.doc.
- ⁴⁹ See Nat'l Health Law Program, *Supporting Mothers and Saving Lives: Creating a Medi-Cal Coverage Program for Doula Care in California* (2019), <https://drive.google.com/file/d/1-vfiFwTTRZFo1qm3ISVPR8vBvH56Wx3l/view>.
- ⁵⁰ CAL. FAM. CODE § 6925.
- ⁵¹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Postpartum and Newborn Referral Services* (2018) [hereinafter *Medi-Cal Postpartum and Newborn Referral Manual*], http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregpost_i00m00o03o07.doc.
- ⁵² Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Early Care and Diagnostic Services* (2017), http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregearly_m00o03.doc.
- ⁵³ CAL. CODE REGS. tit. 22, §§ 51179, 51348(a).
- ⁵⁴ *Id.* § 51348; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Comprehensive Perinatal Services Program (CPSP) 5* (2018) [hereinafter *Medi-Cal Comprehensive Perinatal Services Manual*], http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregcom_m00o03.doc.
- ⁵⁵ CAL. CODE REGS. tit. 22, § 51348(a); *Medi-Cal Comprehensive Perinatal Services Manual*, *supra* note 54, at 12.
- ⁵⁶ *Medi-Cal Postpartum and Newborn Referral Manual*, *supra* note 51, at 7.
- ⁵⁷ 42 U.S.C. § 1396d (l)(3)(C).
- ⁵⁸ *Medi-Cal Postpartum and Newborn Referral Manual*, *supra* note 51.
- ⁵⁹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Durable Medical Equipment (DME): Bill for DME 27* (2019), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durabildme_a04p00.doc.
- ⁶⁰ 42 U.S.C. § 1396d(r).
- ⁶¹ *Id.* For a comprehensive overview of EPSDT, see CMS, *EPSDT—A Guide for States: Coverage in the Medical Benefit for Children and Adolescents* (2014), https://www.medicare.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
- ⁶² Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, EPSDT 3* (2019), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/epsdt_m00o03a02a06a07p00l00v00.doc.
- ⁶³ Joseph F. Hagan, Jr. et al., Am. Acad. of Pediatrics, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* 174 (4th ed. 2017). A free pocket guide version of the Bright Futures guidelines is available at https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_POCKETGUIDE.pdf.

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ 42 U.S.C. §1396r-8(d)(2)(B).

⁶⁷ Cal. Dep't Health Care Servs., *Family PACT Policies, Procedures and Billing Instructions Manual, Client Eligibility*¹ (2018), http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/clientelig_f00.doc.

⁶⁸ CAL. WELF. & INST. CODE § 14132(aa)(8); see also Cal. Dep't Health Care Servs., *Family PACT Policies, Procedures and Billing Instructions Manual, Family PACT Program Overview* (2013), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/fam_f00.doc.

⁶⁹ CAL. WELF. & INST. CODE §§ 14132(aa)(8) (Medicaid-funded component), 24001(a)(1) (state-funded component).

⁷⁰ The state-funded program is called the State-Only Family Planning Program. Sometimes this program is described as part of Family PACT, and in other cases it is described as a separate program. See CAL. WELF. & INST. CODE §§ 24000–24027.

⁷¹ CAL. FAM. CODE § 6925. A law requiring parental consent for abortion was found unconstitutional as violating the right of privacy in the California Constitution. *Am. Acad. of Pediatrics v. Lungren*, 16 Cal. 4th 307 (1997).

⁷² Cal. Dep't of Health Servs., Medi-Cal Eligibility Procedures Manual Letter No. 183, at 4V-1 (Aug. 12, 1997) [hereinafter Eligibility Procedures Manual Letter No. 183], <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c183.pdf>. CAL. FAM. CODE § 6920 and subsequent provisions describe the health care services for which a minor may provide consent without the knowledge of such minor's parents or guardians. CAL. FAM. CODE §§ 6927, 6928 describes minor consent of medical treatment for sexual assault.

⁷³ Eligibility Procedures Manual Letter No. 183, *supra* note 72, at 4V-2.

⁷⁴ *Id.* at 4V-1, 4V-2.

⁷⁵ *Id.* at 4V-2, 4V-3; see also CAL. CODE REGS. tit. 22, §§ 50147.1, 50167(a)(6)(D)(4).

⁷⁶ Cal. Dep't of Health Servs., *Medi-Cal Provider Manual, Minor Consent Program 2* (1999), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/minor_m00i00o03v00.doc

⁷⁷ Cal. Dep't of Health Servs., Full Scope Medi-Cal Coverage and Affordability and Benefit Program for Low-Income Pregnant Women and Newly Qualified Immigrants [hereinafter Medi-Cal Pregnancy Coverage Prog.], <https://www.dhcs.ca.gov/services/medi-cal/Pages/Affordability-and-Benefit-Program.aspx> (last visited January 19, 2020).

⁷⁸ Medi-Cal Pregnancy Coverage Prog., *supra* note 77.

- ⁷⁹ On October 12, 2019, the Governor enacted a bill that would extend the duration of Medi-Cal postpartum coverage for individuals with a diagnosed maternal mental health condition. These individuals may receive extended coverage for up to 12 months from the end of pregnancy or the date of diagnosis, whichever occurs later. See AB 577 (2019), amending CAL. HEALTH & SAFETY CODE § 1373.96
- ⁸⁰ Medi-Cal Pregnancy Coverage Prog., *supra* note 77.
- ⁸¹ *Id.*
- ⁸² CAL. WELF. & INST. CODE § 15822; Cal. Dep't of Health Servs., *Medi-Cal Access Program Handbook* 4–7 (2014), http://mcap.dhcs.ca.gov/Publications/MCAP_Handbook_en.pdf.
- ⁸³ Cal. Dep't of Health Servs., *Medi-Cal Access Program Handbook*, *supra* note 82, at 15.
- ⁸⁴ CAL. WELF. & INST. CODE § 15841(b).
- ⁸⁵ *Id.* § 15832(a)(1); CAL. CODE REGS. tit. 10, § 2699.200(b)(1). California's statute indicates income should be between 208 and 317 percent of the poverty level. However, as a CHIP program, MCAP follows Medicaid rules for determining modified adjusted gross income, and those rules require states to disregard the first five percentage points of income when determining eligibility. 42 U.S.C. §§ 1396a(e)(14)(I), 1397bb(b)(1)(B)(v). Therefore, once this disregard is taken into account, the MCAP eligibility range is 213 to 322 percent of the poverty level.
- ⁸⁶ CAL. CODE REGS. tit. 10, § 2699.209(b); Cal. Dep't of Health Servs., *Medi-Cal Access Program Frequently Asked Questions*, http://mcap.dhcs.ca.gov/MCAP_Program/FAQs.aspx?lang=en (last visited Nov. 30, 2019).
- ⁸⁷ Cal. Dep't of Health Servs., *Information on the Presumptive Eligibility for Pregnant Women*, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE_Info_women.aspx (last visited Nov. 30, 2019). A list of qualified hospital presumptive eligibility providers in California is available on the DHCS website at <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/HospitalPE.aspx> or by calling 800-824-0088.
- ⁸⁸ 42 U.S.C. § 1396r-1(a); Cal. Dep't of Health Servs., *Information on the Presumptive Eligibility for Pregnant Women*, *supra* note 87. See also Cal. Dep't of Health Servs., *Presumptive Eligibility for Pregnant Women Program Patient Fact Sheet* (2011), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/presumfpatfact_m00o03p00.doc.
- ⁸⁹ 42 U.S.C. § 1396r-1(b)(1); CAL. WELF. & INST. CODE § 14148.7.
- ⁹⁰ Cal. Dep't of Health Servs., *Medi-Cal Provider Manual, Every Woman Counts* (2017), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ewoman_m00o03.doc.

- ⁹¹ Cal. Dep't of Health Servs., Breast and Cervical Cancer Treatment Program (BCCTP), <https://www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx> (last visited Nov. 30, 2019). See also 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa).
- ⁹² Cal. Dep't of Health Servs., Breast and Cervical Cancer Treatment Program (BCCTP), *supra* note 91.
- ⁹³ CMS, National Coverage Determination (NCD) for Abortion (140.1), <https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=127&ncdver=2&bc=AAAAGAAAAAAA&> (last visited Nov. 30, 2019).
- ⁹⁴ Cal. Dep't of Health Servs., *Medi-Cal Provider Manual, Medicare/Medi-Cal Crossover Claims Overview* (2018), http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/medicare_z01.doc.
- ⁹⁵ CMS, *Frequently Asked Questions (FAQs) Medicaid Family Planning Services and Supplies* (2017), <https://www.medicaid.gov/federal-policy-guidance/downloads/faq11117.pdf>.



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter VII:
Dental Services**

Chapter VII: Dental Services

Dental Services Covered in this Chapter*

- Dental Services
 - Adult dental coverage
 - Full-scope dental benefits
 - Limited-scope dental benefits
 - Dental benefits for pregnant women
 - Cap on adult dental services
 - Children Dental Coverage
 - Prior Authorization
 - Tele-dentistry
 - General Anesthesia Services
 - Delivery System: Fee-For-Service vs. Managed Care

*This is a non-exhaustive list of services. It may not include all available services.

While comprehensive dental coverage is mandatory for children enrolled in Medicaid, dental services are not a required benefit for adults over age 21.¹ Therefore, the state has flexibility in determining the scope of dental services it covers. The Medi-Cal Dental Program (Denti-Cal) covers comprehensive dental services for both children **and** adults, but the range of dental benefits covered for adults has varied significantly in recent years. In July 2009, due to budget constraints, California eliminated its comprehensive adult dental coverage. In May 2014, there was a partial restoration of Medi-Cal adult dental benefits, and on January 1, 2018, adult dental benefits were fully restored.²

A. Adult Dental Coverage

1. Full-Scope Dental Benefits

Adults with full-scope Medi-Cal are eligible for comprehensive dental services.³

Adult dental services include:

- Exams and X-rays
- Cleanings (Prophylaxis)
- Fluoride Treatments
- Fillings
- Root Canals in Front Teeth
- Prefabricated Crowns (stainless steel or tooth colored)
- Full Dentures
- Denture Relines
- Other Medically Necessary Dental Services
- NEW*: Laboratory Processed Crowns
- NEW*: Root Canals in Back Teeth
- NEW*: Partial Dentures
- NEW*: Partial Denture Adjustments, Repairs, and Relines
- NEW*: Periodontics (Scaling and Root Planing)

*“NEW” refers to the restored benefits in 2018.

2. Limited Scope Dental Benefits

Adults with limited-scope Medi-Cal have restricted coverage with only extractions and emergency services covered.

Emergency services for purposes of those with limited scope coverage means:

- A condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:⁴
 - Placing the patient’s health in serious jeopardy.
 - Serious impairment to bodily functions.
 - Serious dysfunction of any bodily organ or part.

3. Dental Benefits for Pregnant Women

Pregnant Medi-Cal beneficiaries, regardless of the scope of benefits available to other adults, are eligible to receive all dental procedures listed in the Denti-Cal Manual of Criteria (MOC) that are covered by the Medi-Cal program (as long as procedure requirements and criteria are met).⁵ These beneficiaries are also eligible to receive these services for 60 days postpartum, including any remaining days in the month in which the 60th day falls.⁶

4. Cap on Adult Dental Services

Dental services for individuals 21 years or older are limited to \$1,800 per beneficiary for each calendar year.⁷ The cap is considered a “soft” cap because once Denti-Cal has paid \$1,800 in claims; all subsequent claims require a treatment authorization request (TAR). Therefore, services can still be covered beyond \$1,800, however, documentation of medical necessity is required for approval.⁸ The \$1,800 cap resets each calendar year.

Certain services are exempt from the cap, including:⁹

- Emergency dental services,
- Services that are federally mandated, including pregnancy related services,
- Dentures;
- Maxillofacial and complex oral surgery;
- Maxillofacial services, including dental implants and implant-retained prostheses; and
- Services provided in long-term facilities.

Providers may not bill beneficiaries if Medi-Cal paid **any amount** on a specific procedure.¹⁰ So even if there was a partial payment, the provider must consider it payment in full.¹¹ Providers may only bill Medi-Cal beneficiaries if the beneficiary has met the \$1,800 cap, the service is not exempt from the cap, and nothing was paid on a procedure.¹²

B. Children Dental Coverage

Children ages 0 to 20 with full-scope Medi-Cal benefits and are eligible for the following services:

- Oral evaluation (under age 3)
- Initial Exam (ages 3-20)
- Periodic Exam (ages 3-20)
- Prophylaxis
- Fluoride
- Restorative Services—Amalgams, Composites, and Pre-fabricated Crowns
- Laboratory Processed Crowns
- Scaling and Root planing
- Anterior Root Canals
- Posterior Root Canals
- Partial Dentures
- Full Dentures
- Extractions
- Emergency Services

Under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, children under age 21 must receive benefits and services necessary to “correct or ameliorate defects and physical and mental illnesses and conditions.”¹³ EPSDT is designed to ensure children get the health care they need when they need it, so that health problems are treated as early as possible. In addition to periodic and interperiodic assessment of the child’s teeth, EPSDT coverage must, at a minimum, include “relief of pain and infections, restoration of teeth, and maintenance of dental health.”¹⁴ (For more information about EPSDT, see Chapter VIII on Children’s Health Services.)

C. Prior authorization

Prior approval of certain dental services must be sought through a Treatment Authorization Request (TAR).¹⁵ Services subject to prior authorization include restorative services, endodontics, periodontics, prosthodontics, implant services, oral and maxillofacial surgery and orthodontics services.¹⁶ Services provided to patients in hospitals, skilled nursing facilities and other intermediate care facilities require prior authorization unless exempted as emergency services.¹⁷ For detailed information regarding procedures requiring prior authorization, refer to “Section 5: Manual of Criteria and Schedule of Maximum Allowances” of the Medi-Cal Dental Program Provider Handbook.¹⁸

Prior authorization is not transferable from one provider to another. If for some reason the provider who received authorization is unable to complete the service or the beneficiary wishes to go to another provider, another provider cannot perform the service until a new treatment plan is authorized under the new provider’s name.

D. Tele-dentistry

DHCS permits the use of tele-dentistry as an alternative way to provide dental services. Therefore, enrolled Denti-Cal providers may render certain services via tele-dentistry, which may be provided via “asynchronous store and forward” or “synchronous or live transmission.” Asynchronous store and forward is “the transmission of medical information to be reviewed at a later time by licensed dental provider at a distant site,” such as may occur if medical staff take images of a patient’s teeth for a dentist to review a day later.²⁰ Synchronous or live transmission “is a real-time interaction between a beneficiary and a provider located at a distant

ADVOCACY TIP:

- ✓ The Medi-Cal Dental Program Provider Handbook contains detailed information regarding Denti-Cal policies, procedures, and instructions for completing necessary forms and other related documents. The Handbook, put together by the Department of Health Care Services (DHCS), is over 400 pages long and is updated quarterly with information from Denti-Cal Provider Bulletins. The Handbook is designed for Denti-Cal accepting providers and their staff as their primary reference for information about the Denti-Cal Program, and can also be a helpful tool for advocates.¹⁹

ADVOCACY TIP:

- ✓ It is critical to ensure that Medi-Cal accepting dental providers bill Medi-Cal for covered dental services. This includes pursuing Medi-Cal authorization of dental treatment, including dental services for children under the EPSDT benefit.

site.”²¹ Eligible tele-dentistry services include oral evaluation for new or established patients, periodic oral evaluation for established patients, and examination of radiographic images.

E. General Anesthesia Services

Prior Authorization is required for general anesthesia and intravenous sedation. Only an enrolled Denti-Cal provider may request a TAR for this service. Anesthesiologists may submit a TAR if they are enrolled as a billing provider. If an anesthesiologist is not a billing provider, the billing provider rendering the dental services may submit the TAR on behalf of the anesthesiologist rendering the anesthesia. Additionally, if an anesthesiologist is part of a group practice, the group practice may submit a TAR on behalf of anesthesiologist.²² Prior authorization may be waived when the service is medically necessary to treat an emergency medical condition or for beneficiaries who reside in a state certified skilled nursing facility or any category of intermediate care facility for developmentally disabled individuals.²³

F. Delivery System: FFS vs. Managed Care

Denti-Cal is administered through two delivery systems: Dental Fee-For-Service (FFS) and Dental Managed Care (DMC). Dental FFS is the delivery system in all counties except Sacramento and Los Angeles counties. DMC enrollment is mandatory in Sacramento County (with a few exceptions), and beneficiaries in Los Angeles County, have the option to enroll in a DMC.

To operationalize FFS dental services, DHCS has contracted with DXC Technology to serve as the fiscal intermediary and Delta Dental as administrative services organization. DXC processes claims and TARs submitted by dental health providers, while Delta Dental provides dental administrative services including network management.²⁴

In the fee-for-service system, beneficiaries can access any dental provider who participates in Medi-Cal. In managed care, beneficiaries are restricted to those providers participating in the dental plan in which the beneficiary is enrolled.²⁵

Resources:

- Denti-Cal Provider Handbook: https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf
- Denti-Cal Beneficiary Handbook: https://www.denti-cal.ca.gov/Beneficiaries/Denti-Cal/Beneficiary_Handbook/
- Dental Credit Card Debt: California Advocates Toolkit: <https://healthlaw.org/resource/dental-credit-card-debt-california-advocates-toolkit/>

Endnotes

¹ 42 U.S.C. § 1396d(a)(10).

² See CAL. WELF. & INST. CODE § 14131.10(b)(2)(C) for the May 2014 restoration, and CAL. WELF. & INST. CODE § 14131.10(b)(1)(A)(i) for the 2018 restoration. See also Cal. Dep't Health Care Servs., All Plan Letter 17-009 (Nov. 27, 2017) (informing Medi-Cal Dental Managed Care Plans of the full restoration of adult dental benefits), https://www.dhcs.ca.gov/services/Documents/MDSD/2017%20DAPLs/APL_17-009_Fully_Restore_Adult_Dental_Benefits.pdf, and Cal. Dep't Health Care Servs., *Full Restoration of Adult Dental Benefits – Frequently asked questions* (Jan. 1, 2018), https://www.dhcs.ca.gov/services/Documents/MDSD/Adult_Resto_FAQ-Fact_Sheet_12-2017.pdf.

³ *Id.*

⁴ CAL. WELF. & INST. CODE § 14007.5(d).

⁵ Cal. Dep't Health Care Servs., *Medi-Cal Dental Program Provider Handbook* 4-12 (Dec. 2019) [hereinafter Denti-Cal Provider Handbook], https://www.denti-cal.ca.gov/DC_documents/providers/provider_handbook/handbook.pdf.

⁶ CAL. WELF. & INST. CODE § 14005.18(a).

⁷ CAL. WELF. & INST. CODE § 14080(a).

⁸ Denti-Cal Provider Handbook, *supra* note 5, at 4-11 and 4-12.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ 42 U.S.C. § 1396d(r)(5). See also Cal. Health & Safety Code § 124025 et seq., CAL. WELF. & INST. CODE § 14132(v), CAL. CODE REGS. tit. 22 §§ 51184, 51242, 51340, 51340.1, 51532.

¹⁴ 42 C.F.R. § 441.56(c)(2); CAL. CODE REGS. tit. 17, § 6843(a)(1).

¹⁵ Denti-Cal Provider Handbook, *supra* note 5, at 2-11.

¹⁶ *Id.*

¹⁷ *Id.* see also CAL. CODE REGS. tit. 22, § 51056 (a), (b).

¹⁸ Denti-Cal Provider Handbook, *supra* note 5, at 5-1 to 5-126.

¹⁹ See Michelle Lillienfeld, Nat'l Health Law Prog., *Dental Credit Card Debt: California Advocates Toolkit* (Dec. 2018) (Appendix 2 of Dental Credit Card Toolkit provides a reference sheet to help advocates get acquainted with the services section of the Denti-Cal Provider Handbook), <https://healthlaw.org/resource/dental-credit-card-debt-california-advocates-toolkit/>.

- ²⁰ Cal. Dep't Health Care Servs., *Denti-Cal Bulletin* Vol. 32, 4 (Mar. 2016), https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/archive/Volume_32_Number_04.pdf.
- ²¹ Each transmission is "limited to 90 minutes per beneficiary per provider, per day." *Id.*
- ²² For helpful flow charts to help determine whether or not a beneficiary is eligible for such services, see Cal. Dep't Health Care Servs., Dental All Plan Letter 17-004 (Jun. 28, 2017), http://www.dhcs.ca.gov/services/Documents/MDSO/2017%20DAPLs/APL17_004.pdf.
- ²³ Cal. Dep't Health Care Servs., Dental All Plan Letter 15-005, at 2 (Apr. 1, 2015), <https://www.dhcs.ca.gov/services/Documents/MDSO/2015%20DAPLs/APL%2015-005.pdf>.
- ²⁴ Cal. Dep't Health Care Servs., *Denti-Cal Bulletin* Vol. 33, 11 (Sept. 2017), https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/Volume_33_Number_11.pdf.
- ²⁵ CAL. WELF. & INST. CODE § 14087.46; Cal. Dep't Health Care Servs., All County Welfare Directors' Letter 94-88 (Nov. 21, 1994), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c94-88.pdf>.



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter VIII:
Children's Health Services**

Chapter VIII: Children's Health Services

Children's Health Services (in addition to general Medi-Cal services) Covered in this Chapter*

- Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)
 - Generally, all medically necessary services
 - Specific Categories of Services:
 - Frequent check-ups/screenings
 - Dental
 - Vision
 - Hearing
 - Mental health
 - Substance use disorders
 - Developmental and specialty services
 - Diagnostic services
 - Assistance with scheduling appointments
 - Transportation for Medi-Cal covered appointments
 - Pediatric day health care services
 - Skilled nursing
 - Occupational therapy
 - Other therapeutic services
 - Case management
 - Mental health medication and treatment, psychiatric hospital services, and mental health services provided at home or in the community
- California Children's Services (CCS)
 - Diagnostic and treatment services, medical case management, and physical and occupational therapy services
 - Whole Child Model
- Child Health and Disability Prevention Program (CHDP)
 - Health assessments and immunizations
- Minor Consent Medi-Cal

*This is a non-exhaustive list of services. It may not include all available services.

Federal law requires state Medicaid programs to provide coverage for all children in families with incomes up to 138% of the federal poverty level (FPL).¹ California elects to cover all children up to 19 years old in families with incomes up to 266% FPL.² Additionally, in 2016, California extended full-scope Medi-Cal benefits to all eligible children under age 19 regardless of immigration status.³ Currently, Medi-Cal covers health services for more than 5.2 million children.⁴

Medi-Cal coverage of services for children is more robust than the services available to adults to assure that children receive early detection and care. Children under age 21 can obtain all Medicaid covered services, whether or not the service is covered under California's Medicaid State Plan or available for adults.⁵ This chapter addresses the Medi-Cal services that are available to children, some of which are offered through different programs.

This chapter focuses broadly on services provided exclusively to children. See Chapter VI of this guide for more information on reproductive and sexual health services for children and youth through EPSDT services and other programs.

A. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)

1. In General

Federal and state laws require Medi-Cal to offer Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to enrolled children and youth under age 21.⁶ These services are designed to foster strong childhood development. Children experience rapid developmental and behavioral changes that require identification and treatment of health-related conditions at the earliest possible time. As part of the EPSDT benefit, Medi-Cal offers no-cost health care screening, diagnostic and treatment services to prevent, identify, and address health and behavioral health problems.⁷

The scope of services covered under EPSDT is broad. EPSDT covers all medically necessary services and treatments that can *potentially* be covered by Medicaid under federal law, even if those services are not included in the scope of Medi-Cal coverage for adults.⁸ For example, while Medi-Cal covers limited chiropractic services for adults (see Chapter XI on Ancillary Services of this guide), under EPSDT chiropractic services must be covered when it is medically necessary for an individual child. EPSDT services must be covered when they are necessary to correct or *ameliorate* the individual child's physical and mental illnesses and conditions.⁹ This means that Medi-Cal must cover services to maintain or improve a child's health or condition, not just correct the problem.

EPSDT requires early and routine screening for health problems through frequent check-ups. The purpose of EPSDT's broad mandate is to assess and

identify problems early, by checking children's health at periodic, age-appropriate intervals.¹⁰ The Department of Health Care Services (DHCS) uses the American Academy of Pediatrics Bright Futures Guidelines and periodicity schedule to establish appropriate intervals, and when "inter-periodic" checkups are necessary, they are covered as well.¹¹ Medi-Cal screens for a variety of conditions through these checkups, including dental, vision, hearing, mental health, and substance use disorder issues, as well as developmental and specialty services.¹² When a screening indicates the need for further evaluation and follow-up, EPSDT covers diagnostic services.¹³ Medically necessary referrals should be made without delay to ensure a child receives a complete diagnostic evaluation whenever a potential risk is identified.

Beyond screenings and preventive measures, EPSDT ensures that children have access to adequate services and treatments. EPSDT includes services like pediatric day health care services, which are skilled nursing, occupational therapy, and other therapeutic services provided in a day program.¹⁴ EPSDT also covers mental health medication and treatment, including psychiatric hospital services, and mental health services provided at home or in the community.¹⁵ See the chapters on Mental Health and Services for People with Substance Use Disorders for more details on coverage of these services under EPSDT.

EPSDT also covers case management services to support a child's access to medical, social, educational, and other services.¹⁶ Case management services are available through DHCS' Targeted Case Management (TCM) program, Regional Centers, child protection agencies, and other entities or individual providers that contract with the Department of Health Care Services (DHCS) to provide EPSDT case management services.¹⁷ TCM is also a specialty mental health service, and may be provided to beneficiaries through a contract with the Mental Health Plan (MHP).¹⁸ TCM services are carved out of Medi-Cal managed care plans (MCPs), but the plan is responsible for determining whether an enrollee requires TCM services and referring the enrollee to the appropriate type of case management service.¹⁹ EPSDT also covers assistance with scheduling appointments and arranging transportation for Medi-Cal-covered appointments.²⁰

2. EPSDT and Medi-Cal Managed Care

Medi-Cal MCPs are required to cover all of the same screening, diagnostic, and treatment services for enrollees under age 21 that children and youth in fee-for-service (FFS) Medi-Cal are entitled to.²¹ Although some EPSDT services are carved out of the MCP contract, MCPs have the primary responsibility to provide all medically necessary EPSDT services.²² In other words, MCPs are responsible for coordination of care for all medically necessary EPSDT services delivered within and outside the MCP's provider network, regardless of whether the MCP is responsible for paying for the service.²³ MCPs are also required to provide appointment scheduling assistance and necessary transportation, including

non-emergency medical and non-medical transportation (NMT) services to and from medical appointments for medically necessary EPSDT services.²⁴ MCPs must provide NMT for all EPSDT services, including those services carved out of the MCP.²⁵

MCPs must ensure that members under the age of 21, and their families or primary caregivers, know what EPSDT services are available and where and how to obtain these services.²⁶ MCPs have a responsibility to provide health education to enrollees under age 21, and to their parents or guardians, in order to effectively use those resources, including screenings and treatment.²⁷ This information must be provided in the member's primary language at a sixth grade reading level.²⁸

B. Other Medi-Cal Programs for Children

1. California Children's Services (CCS)

The California Children's Services (CCS) program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children up to age 21 with CCS-eligible medical conditions.²⁹ Approximately 90% of children enrolled in CCS are Medi-Cal eligible.³⁰ As a result, Medi-Cal pays for the cost of CCS care for these children and the services provided to the remaining ten percent of CCS beneficiaries are funded equally by county and state funds.³¹

Medi-Cal MCPs are required to refer all children with certain medical conditions to CCS.³² Until the child's CCS eligibility is confirmed, the MCP remains responsible for providing all medically necessary EPSDT services.³³ It is also the MCP's obligation to communicate with the county CCS program to ensure the enrollee's needs are met, and to provide EPSDT services when the county CCS program is not providing those services.

a. Whole Child Model

In 2018, the Whole Child Model (WCM) program was implemented, which authorizes MCPs to administer the CCS program in 21 County Organized Healthy System (COHS) counties.³⁴ In WCM counties, the MCP integrates Medi-Cal managed care and CCS program administrative functions to provide comprehensive care coordination and integrated services to children on CCS for both their CCS eligible and non-CCS eligible medical conditions.³⁵ As a result, the MCP assumes full financial responsibility for authorization and payment of CCS eligible medical services, including service authorizations, claim processing and payment, case management, and quality oversight.³⁶ Typically, the child will receive care through the MCP's network of CCS

paneled providers but if a child needs to see a specialist that is not in the plan's network, the plan must coordinate and approve those services as well.³⁷

In non-WCM counties, Medi-Cal beneficiaries with CCS continue to access services as they did before the implementation of the WCM program, and county size determines who administers the program. In non-WCM counties with populations *greater than* 200,000 people, the county is responsible for administering the CCS program independently.³⁸ In non-WCM counties with populations *less than* 200,000, the Children's Medical Services (CMS), a subset of DHCS, can provide medical case management, eligibility, and benefit determinations.³⁹ Even if a child in a non-WCM county is enrolled in a Medi-Cal MCP, CCS services are "carved out" of the MCP – so the child must obtain CCS services, and authorization for services, from the CCS program, not their Medi-Cal MCPs.⁴⁰

Ultimately, how a child accesses services if enrolled in both Medi-Cal and CCS depends on the county in which the child lives. However, advocates are reminded that if CCS determines that the medically necessary service is not tied to the CCS-eligible condition, the MCP is responsible for providing the medically necessary service as determined by the MCP provider.⁴¹ DHCS, and MCPs as agents of the state, are ultimately responsible for ensuring that children and youth under age 21 have access to EPSDT services. For more information about the CCS Program, see NHeLP's Issue Brief, *Helping Families Obtain Durable Medical Equipment and Supplies Through The California Children's Services (CCS) Program*.⁴²

2. The Child Health and Disability Prevention Program

Before Medi-Cal was administered by MCPs, the Child Health and Disability Prevention (CHDP) program was created to oversee the screening and follow-up care of EPSDT for Medi-Cal eligible children and youth.⁴³ Today, Medi-Cal beneficiaries may access EPSDT services through CHDP prior to completing an application for Medi-Cal. CHDP services are available to all children and youth up to age 21 who are eligible for Medi-Cal.⁴⁴ Proof of residence and income is not required.⁴⁵ The CHDP program is operated at the county level by local health departments.⁴⁶ Once a child is enrolled in CHDP, the CHDP Gateway provides presumptive eligibility (PE) or temporary Medi-Cal to the child or youth pending the submission of a full Medi-Cal application, streamlining access to Medi-Cal services.⁴⁷ Once a child is enrolled in Medi-Cal, children access CHDP services through FFS Medi-Cal or their Medi-Cal MCP.

3. Minor Consent Medi-Cal

Minor Consent Medi-Cal is a program that provides limited services to youth under age 21, regardless of their immigration status, without parental consent or notification.⁴⁸ In this program, minors can provide legal consent for sensitive services.⁴⁹ Children under age 12 can receive family planning, pregnancy and pregnancy-related care, and sexual assault services. Youth age 12 and older can receive coverage for these same services as well as coverage for sexually transmitted disease treatment, substance use disorder treatment and outpatient mental health treatment.⁵⁰ However, a child or youth cannot receive methadone treatment, psychotropic drugs, convulsive therapy, psychosurgery or sterilization without parental consent.⁵¹ Under a California Supreme Court decision, a minor also has a right to consent to an abortion without parental or court authorization, and therefore abortions may be covered under Minor Consent Medi-Cal.⁵²

A child or youth must apply each month for Minor Consent Medi-Cal services. The child or youth must be under age 21 and living at home with a parent or guardian in order to enroll in Minor Consent Medi-Cal (if a minor is temporarily living at school or college, the minor is considered to be living at home).⁵³ Eligibility is based on the minor's income and resources, not the income and resources of the minor's parent(s) or guardian(s).⁵⁴ Minors do not have to provide any identification when they apply, and eligibility workers are prohibited from requiring documents related to immigration status when assessing eligibility for the program; however, if the minor is employed, they must provide pay stubs to verify income.⁵⁵ Services provided under the program are confidential, so providers are not allowed to contact parents or guardians about the minor's receipt of these services.⁵⁶ If a child or youth is enrolled in a MCP, the MCP must abide by these Minor Consent services program rules, and DHCS also prohibits plans from applying prior authorization requirements to these services.⁵⁷

Endnotes

¹ 42 U.S.C. §1396a(a)(1)(2)(C) (the statute sets the upper limit at 133% FPL but income is determined according to MAGI methodology, which provides a 5% income disregard, so the upper income limit is 138% FPL).

- ² CAL. WELF. & INST. CODE § 14005.26(d)(1)(B) (California implemented the federal optional Targeted Low-Income Children’s Program (TLICP) pursuant to 42 U.S.C. §1396a(a)(10)(A)(ii)(XIV) and a state plan amendment to move the TLICP into Medi-Cal permits the state to impose premiums on children in families with income of 161% FPL to 266% FPL); *id.* § 14005.26(b) (the state statute sets the upper limit at 261% FPL but income is determined according to MAGI methodology, which provides a 5% income disregard, so the upper income limit for children in the TLICP is 266% FPL).
- ³ CAL. WELF. & INST. CODE § 14007.8; see Cal. Dep’t. Health Care Servs., *Senate Bill 75 Full Scope Medi-Cal for All Children: Eligibility and Enrollment Plan* (2016), https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/SB75/SB75_EE_Plan_032116_Final.PDF.
- ⁴ Cal. Dep’t. Health Care Servs., *Medi-Cal Children’s Health Dashboard 1* (2019), <https://www.dhcs.ca.gov/services/Documents/December-2019-Pediatric-Dashboard.pdf>
- ⁵ 42 U.S.C. § 1396d(r)(5).
- ⁶ 42 U.S.C. §§ 1396a(a)(10)A, 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); CAL. WELF. & INST. CODE § 14132(v); see CAL. CODE REGS., tit. 22, §§ 51184, 51340, 51340.1.
- ⁷ CAL. WELF. & INST. CODE § 14132(v); CAL. CODE REGS., tit. 22, §§ 51184, 51340, 51340.1; Cal. Dep’t Health Care Servs., All Plan Letter 19-010 (Aug. 14, 2019) [hereinafter APL 19-010], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf>; see also Ctrs. Medicare & Medicaid Servs., *EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (2014), https://www.medicare.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
- ⁸ 42 U.S.C. § 1396d(r)(5).
- ⁹ 42 U.S.C. § 1396d(r)(5); see also CAL. WELF. & INST. CODE § 14059.5(b)(1); CAL. CODE REGS., tit 22, § 51184; cf. *id.* § 51303(a) (defining services that are medically necessary for the purpose of being covered under Medi-Cal, generally).
- ¹⁰ 42 U.S.C. § 1396d(r)(1); CAL. CODE REGS., tit. 22, § 51184; see also Cal. Dep’t Health Care Servs., *Medi-Cal Coverage for EPSDT* (2019), <https://www.dhcs.ca.gov/services/medi-cal/Documents/Medi-Cal-Coverage-for-EPSDT.pdf>.
- ¹¹ Cal. Dep’t Health Care Servs., *supra* note 10; see also APL 19-010, *supra* note 7, at 4.
- ¹² 42 U.S.C. § 1396d(r)(1); see also Cal. Dep’t Health Care Servs., *supra* note 10.
- ¹³ 42 U.S.C. § 1396d(r)(5); CAL. CODE REGS., tit 22, § 51184.

- ¹⁴ CAL. CODE REGS., tit. 22, § 51340.1(e). “Pediatric day health care EPSDT services” are defined as services that “(a) promote the physical, developmental and psychosocial well-being of individuals eligible for EPSDT services who are medically fragile...and who live with their parent, foster parent, or legal guardian; (b) provide medically necessary skilled nursing care and therapeutic interventions which include occupational therapy, physical therapy, speech therapy and medical nutrition therapy provided by licensed or registered therapists and furnished in response to the attending physician’s orders and in accordance with the individual’s plan of treatment (not including respite care); and (c) are provided in a day program of less than 24 hours that is individualized and family-centered, with developmentally appropriate activities of play, learning and social interaction designed to optimize the individual’s medical status and developmental functioning so that he or she can remain within the family. “*Id.* § 51184(k).
- ¹⁵ CAL. CODE REGS., tit. 9, § 1810.215.
- ¹⁶ CAL. CODE REGS., tit. 22, § 51184(g).
- ¹⁷ *Id.*, tit. 22, §§ 51184(h), 51340(f)(1).
- ¹⁸ CAL. CODE REGS., tit. 9, § 1810.249.
- ¹⁹ CAL. CODE REGS., tit. 22, § 51340(k); *see also* APL 19-010, *supra* note 7, at 8.
- ²⁰ 42 C.F.R. §§ 441.62; *see also* Cal. Dep’t Health Care Servs., *supra* note 10.
- ²¹ *See generally* APL 19-010, *supra* note 7; *see also, e.g.*, Cal. Dep’t Health Care Servs., *Two-Plan Boilerplate Contract*, Ex. A, Attach. 10 (2014) [hereinafter Cal. Dep’t Health Care Servs., *Two-Plan Boilerplate Contract*], <https://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf>.
- ²² APL 19-010, *supra* note 7, at 9.
- ²³ *Id.* at 7.; Cal. Dep’t Health Care Servs., *Two-Plan Boilerplate Contract*, *supra* note 20, at Ex. A, Attach. 11.
- ²⁴ APL 19-010, *supra* note 7, at 7.
- ²⁵ *Id.*; Cal. Dep’t Health Care Servs., All Plan Letter 17-010 (Jul. 17, 2017) [hereinafter APL 17-010], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf>.
- ²⁶ APL 19-010, *supra* note 7, at 8.
- ²⁷ 42 U.S.C. § 1396d(r)(1)(B)(v); *see also* APL 17-010, *supra* note 25.
- ²⁸ APL 19-010, *supra* note 7.
- ²⁹ CAL. HEALTH & SAFETY CODE § 123800-123995 (enabling legislation); CAL. WELF. & INST. CODE § 14094 – 14094.3; CAL. CODE REGS., tit. 22, § 51013.
- ³⁰ Cal. Dep’t Health Care Servs., *Medi-Cal Provider Manual: California Children’s Services Program 2* (2016), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchild_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc.

- ³¹ CAL. HEALTH & SAFETY CODE § 123905; Cal. Dep't Health Care Servs., *supra* note 29, at 2.
- ³² APL 19-010, *supra* note 7, at 8.
- ³³ *Id.*
- ³⁴ CAL. WELF. & INST. CODE § 14094.5 (as amended by SB 586-Hernandez in 2016); *see also* Cal. Dep't Health Care Servs., *California Children's Services (CCS) Program Whole Child Model Frequently Asked Questions 2* (2019) [hereinafter CCS Whole Child FAQ], <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-WCM-FAQ-2019.pdf>.
- ³⁵ CAL. WELF. & INST. CODE § 14094.6.
- ³⁶ Cal. Dep't Health Care Servs., CCS Letter 04-0618 at 2 (June 7, 2018), https://www.dhcs.ca.gov/services/ccs/Documents/04-0618_WCM.pdf.
- ³⁷ *See CCS Whole Child FAQ, supra* note 34, at 3.
- ³⁸ CAL. HEALTH & SAFETY CODE § 123850(a).
- ³⁹ *Id.*
- ⁴⁰ APL 19-010, *supra* note 7, at 8.
- ⁴¹ *Id.* at 7.
- ⁴² Alicia Emanuel & Michelle Lilienfeld, Nat'l Health Law Prog., *Helping Families Obtain Durable Medical Equipment and Supplies Through The California Children's Services (CCS) Program* (2019), <https://healthlaw.org/resource/helping-families-obtain-durable-medical-equipment-and-supplies-through-the-california-childrens-services-ccs-program>.
- ⁴³ CAL. HEALTH & SAFETY CODE §§ 124025–124110; *see also* Cal. Dep't Health Care Servs., *Child Health and Disability Prevention Information Brochure* (2015), <https://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/CHDPInfoEnglish.pdf>.
- ⁴⁴ CAL. HEALTH & SAFETY CODE § 104395(a); CAL. CODE REGS., tit. 17, § 6802(a). CHDP is also available to all children and youth under age 19 with family income up to 200% FPL. *See id.*
- ⁴⁵ Cal. Dep't Health Care Servs., *supra* note 43, at 2.
- ⁴⁶ *See, e.g.*, CAL. HEALTH & SAFETY CODE § 124040.
- ⁴⁷ CAL. WELF. & INST. CODE § 14011.7(b), (e); *see also* Cal. Dep't Health Care Servs., All County Welfare Director's Letter 03-33 (June 18, 2003), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-33.pdf>.
- ⁴⁸ *See* Cal. Dep't. Health Care Servs., *Medi-Cal Eligibility Procedures Manual § 4V* (2006), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Article4-ApplicationProcess.pdf>.
- ⁴⁹ CAL. FAMILY CODE § 6920 and subsequent provisions describe the health care services for which a minor may provide consent without the knowledge of the minor's parents or guardians.

- ⁵⁰ Cal. Dep't. Health Care Servs., *supra* note 48, at § 4V; *see also* CAL. FAMILY CODE § 6920.
- ⁵¹ Cal. Dep't Health Care Servs., *supra* note 48, at § 4V.
- ⁵² *Am. Acad. of Pediatrics v. Lundgren*, 16 Cal. 4th 307 (1997) (holding that the right to privacy found in the California Constitution invalidates a statute requiring that pregnant minors obtain judicial or parental consent prior to abortion).
- ⁵³ Cal. Dep't Health Care Servs., *supra* note 48, at § 4V; CAL. CODE REGS., tit 22, § 50147.1(e).
- ⁵⁴ Cal. Dep't Health Care Servs., *supra* note 48, at § 4V.
- ⁵⁵ *Id.*; *see also* CAL. CODE REGS., tit. 22, § 50167(a)(6)(D)(4).
- ⁵⁶ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: Minor Consents Program* (1999), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/minor_m00i00o03v00.doc.
- ⁵⁷ *See, e.g., Two-Plan Boilerplate Contract*, *supra* note 20, at Ex. A, Att. 9, § 9(D) (affirming all services named in minor consent regulation as minor consent services); *id.* at Ex. A, Att. 5, § 2(G).



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter IX:
Long-Term Services and Supports**

Chapter IX: Long-Term Services and Supports

Long-Term Services and Supports Covered in this Chapter*

- Facility-Based Long-Term Care
 - Skilled Nursing Facilities (SNFs)
 - Skilled Nursing Facility Special Treatment Programs (SNF/STPs)
 - Subacute-Care Facilities
 - Intermediate-Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)
- Home and Community-Based Services (HCBS)
 - HCBS Waiver Programs
 - In-Home Services and Supports (IHSS)

*This is a non-exhaustive list of services. It may not include all available services.

Medi-Cal is the primary payer of long-term services and supports (LTSS) in California, and long-term care (LTC) accounts for about one-third of Medi-Cal fee-for-service (FFS) spending annually.¹ LTSS provided by Medicaid is generally provided in two types of settings: institutional facilities, such as nursing homes and intermediate-care facilities; and home and community settings, such as individuals' homes, community centers, or assisted living facilities. When LTSS is provided in home and community settings, it is known as Home and Community-Based Services (HCBS).

Approximately two-thirds of California's nursing home residents – more than 60,000 people – rely on Medi-Cal to cover all or part of their LTC costs.² In addition, more than 500,000 individuals receive Medi-Cal HCBS annually.³ The majority of beneficiaries receiving LTSS through Medi-Cal are dual Medi-Cal and Medicare beneficiaries. Since Medicare's coverage of LTSS is very limited, most low-income Californians rely on Medi-Cal for these services.

A. Facility-Based Long-term Care

LTC may encompass stays in a number of different types of facilities. Medi-Cal pays for nursing facility services for individuals who need skilled nursing care or rehabilitation services or who require health-related services on a regular basis

due to a mental or physical disability.⁴ Medi-Cal does not pay for room and board expenses in assisted living facilities, which differ from skilled nursing facilities because residents in such facilities do not routinely receive skilled nursing care (although certain services provided to residents of assisted living facilities may be covered under a HCBS waiver program, as discussed in Section B of this chapter).

In order to qualify for facility-based LTC, a beneficiary or the beneficiary's representative must provide information showing that the beneficiary is financially eligible for LTC (see Section C below) and that the beneficiary meets the clinical qualifications for such care. Whether a beneficiary meets the clinical qualifications for facility-based LTC depends on the type of facility to which the beneficiary is seeking admission. A beneficiary always needs to obtain prior authorization from Medi-Cal before obtaining admission to a LTC facility.⁵ The Long Term Care Treatment Authorization Request (LTC TAR, form 20-1) is used to request authorization for all Medi-Cal recipients seeking LTC facility coverage. The form is initiated by the nursing facility.⁶

Below is a summary of the types of facilities Medi-Cal covers under the LTC benefit.

1. Skilled Nursing Facilities (SNFs)

Also called “skilled nursing homes,” “convalescent hospitals,” “nursing homes,” or “nursing facilities,” these facilities provide comprehensive nursing care for chronically ill or short-term residents of all ages, along with rehabilitation and other services (e.g., dietary assistance, pharmaceutical services, and an activity program).⁷ Skilled nursing facility services covered by Medi-Cal include nursing and related care services, room and board, and commonly used items of equipment, supplies, and services used for the medical and nursing benefit of patients.⁸

Skilled Nursing Facilities (SNFs) offer the level of care needed by patients who do not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care, but who require the continuous availability of skilled nursing care. Medi-Cal considers various clinical criteria in determining the need for services, such as the need for observation and medications that cannot be self-administered and require skilled nursing services. Among other requirements, an individual must need physician visits at least every 60 days and constantly available skilled nursing services.⁹

2. Skilled Nursing Facility Special Treatment Programs (SNF/STPs)

SNF/STPs are skilled nursing facilities that serve patients who have a chronic psychiatric impairment and whose skills for handling common demands of everyday life are impaired. STP services include therapeutic services, such as self-help skills, behavioral adjustment, pre-vocational preparation and pre-

release planning. Other program services include group and individual counseling, instruction on personal care and medication management, use of community, and personal resources.¹⁰ SNF/STPs typically are considered Institutions for Mental Disease (IMDs) under federal law and therefore are subject to the IMD exclusion, which prohibits Medi-Cal coverage of their services if the beneficiary is older than 21 and younger than 65.¹¹

SNFs/STP are designed to serve individuals who have a chronic psychiatric impairment and whose adaptive functioning is moderately impaired. To be eligible for STP services, the individual's condition should be responsive to STP services and not appropriate for placement in a skilled nursing facility.¹²

3. Subacute-care facilities

These are specialized units often in a distinct part of a nursing facility that focus on intensive rehabilitation, complex wound care, and post-surgical recovery for patients who do not require hospital acute care but require more intensive care than is generally provided in a skilled nursing facility.¹³ Subacute-care facilities provide care for individuals that are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, and complex wound management care. Patients must meet a "subacute level of care criteria," which is determined by the treating physician and approved by Medi-cal.¹⁴

4. Intermediate-Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

ICFs/IID are health facilities that provide, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, care coordination, and integration of health or rehabilitative services to help each resident function at his or her greatest ability. ICFs are designed to provide services to individuals requiring protective and supportive care because of a mental or physical condition or both. Individuals requiring assistance with multiple personal care tasks may benefit from ICFs. These individuals are stable but may require daily, if not 24-hour, nursing supervision. Many factors are considered in determining appropriate placement in ICFs, such as the need for skilled nursing care or observation on an ongoing or intermittent basis and 24-hour supervision to meet the individual's health needs.

There are four types of ICFs, all of which provide services to beneficiaries with developmental disabilities:

Figure 1

ICF/DD (Developmentally Disabled)	Provides 24-hour personal care, habilitation, developmental, and supportive health services to individuals with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services. ¹⁵
ICF/DD-H (Habilitative)	Provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer individuals with developmental disabilities who have intermittent recurring needs for nursing services but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care. ¹⁶
ICF/DD-N (Nursing)	Provides 24-hour personal care, developmental services, and nursing supervision for individuals with developmental disabilities who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. ¹⁷
DD-CNC (Continuous Nursing Care)	Facilities that are licensed as an ICF/DD-N, but the license is suspended while the facility operates under a Home and Community Based Waiver program. DD/CNC differs from the other three types of ICFs in that the individual must have a continuous, not intermittent, need for skilled nursing services.

B. Home and Community-Based Services (HCBS)

HCBS programs are intended to support individuals who need assistance to remain living at home and in the community. California has a number of HCBS programs, including several HCBS waiver programs and the Medi-Cal In-Home Supportive Services (IHSS) program. The availability of such services helps promote independence and provides supports that enable people to live outside of institutions and participate in their communities.

The scope of HCBS varies based on the specific program in which an individual is enrolled. HCBS may include the following services:¹⁸

- Adult Day Health Services
- Behavioral Intervention Services
- Case Management
- Chore Services

- Communication Aides
- Community-Based Adult Services
- Community-Based Training Services
- Dental Services
- Enhanced Habilitation-Supported Employment Individual and Group Prevocational Services
- Environmental Accessibility Adaptations
- Financial Management Service
- Habilitation-Community Living Arrangement Services, Day Services
- Home Health Aide Services
- Homemaker Services
- Non-Medical Transportation
- Nutritional Consultation
- Optometric/Optician Services
- Personal Care Services
- Personal Emergency Response Systems
- Prescription Lenses and Frames
- Psychology Services
- Respite Care
- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Specialized Therapeutic Services
- Speech, Hearing and Language Services
- Transition/Set-Up Expenses
- Vehicle Modification and Adaptation

1. HCBS Waiver Programs

Medi-Cal’s HCBS waiver programs, operating under Section 1915(c) of the Social Security Act, vary in terms of the populations served and the services provided. Some waiver programs are generally available to older adults or individuals with disabilities, while others target a subset of these populations, such as individuals with HIV/AIDS. HCBS waiver programs operate under federal statutes that allow for the waiver of certain Medicaid rules, such as a waiver of the “comparability” requirement that typically mandates that states provide comparable services to all Medicaid beneficiaries.

A Medi-Cal beneficiary may be enrolled in only one HCBS waiver program at a time. Because the waiver programs typically limit enrollment to a certain number of beneficiaries, the State may maintain a wait list for the HCBS waiver programs. HCBS waiver services and qualifications are summarized in the table below.¹⁹ This table is intended to provide only an overview of the waiver programs, and other limitations may be applicable.

Figure 2

Waiver	Services Covered	Target Population/ Eligibility
<i>General/ Physical Disability Waivers</i>		
Assisted Living Waiver	Homemaker, home health aide, personal care, care coordination, residential habilitation, augmented plan of care development and follow-up, nursing facility transition care coordination, and other HCBS for residents of assisted living facilities (residential care facilities for the elderly) or independent publicly subsidized housing private residences.	<ul style="list-style-type: none"> • Individuals 65 or older • Adults with disabilities ages 21 or older • Nursing facility level of care
Multipurpose Senior Services Program Waiver ²⁰	Care management, respite care, supplemental personal care, adult day care, communication, housing assistance, nutritional services, protective services, purchased care management, supplemental chore, supplemental health care, supplemental protective supervision, and transportation.	<ul style="list-style-type: none"> • Individuals ages 65 or older • Nursing facility level of care
Community-Based Adult Services (CBAS) ²¹	Professional nursing, physical, occupational and speech therapies, mental health services, social services, personal care, meals, nutritional counseling, and transportation to and from the individual's residence to the CBAS Center (CBAS replaced the Adult Day Health Care (ADHC) benefit. CBAS services are provided in community settings.)	<ul style="list-style-type: none"> • Individuals 65 or older • Adults with disabilities 18 or older
<i>Medically Fragile/ Technology Dependent Waivers</i> ²²		
Home and Community-Based Alternatives Waiver (previously titled "Nursing Facility/ Acute Hospital Waiver")	<p>Case management, habilitation services, home respite, personal care services, community transition services, developmentally disabled/continuous nursing care non-ventilator dependent services and other HCBS.</p> <p>Case management/coordination, habilitation services, home respite, personal care, community transition, environmental accessibility adaptations and other HCBS.</p> <p>Note: This waiver is scheduled to sunset at the end of 2019, and beneficiaries will be given the option to enroll in the HCB Alternatives Waiver instead.²³</p>	<ul style="list-style-type: none"> • Individuals who are medically fragile or technology dependent of any age • Hospital, nursing facility, or intermediate care facility level of care • Individuals who are medically fragile or technology dependent of any age • Nursing facility level of care

Figure 2 (continued)

Waiver	Services Covered	Target Population/ Eligibility
<i>Developmentally/ Intellectually Disabled Waivers</i>		
HCBS Waiver for Californians with Developmental Disabilities ²⁴	Behavioral intervention services, community living arrangement services, day service, homemaker, communication aides, community-based training service, environmental accessibility adaptations, family support services, and other HCBS.	<ul style="list-style-type: none"> • Individuals with autism, a developmental disability, or an intellectual disability of any age • Intermediate care facility level of care
Self-Determination Program for Individuals with Developmental Disabilities	<p>Community living supports, employment supports, homemaker, live-in caregiver, prevocational supports, respite services, acupuncture services, chiropractic service, dental services, home health aide, lenses and frames, occupational therapy, optometric/optician services, physical therapy, psychology services, speech, hearing and language services, financial management service, independent facilitator, behavioral intervention services, communication support, community integration supports, and other HCBS.</p> <p>The waiver allows beneficiaries the opportunity to accept greater control and responsibility regarding the delivery of needed services, including managing their service mix within an individual budget amount.</p>	<ul style="list-style-type: none"> • Individuals with autism, a developmental disability, or an intellectual disability of any age • Intermediate care facility level of care
<i>HIV/AIDS Waivers</i>		
California HIV/AIDS Waiver	Enhanced case management, homemaker, skilled nursing, attendant care, home-delivered meals / nutritional supplements, minor physical adaptations to the home, non-emergency medical transportation, nutritional counseling, psychotherapy, and specialized medical equipment.	<ul style="list-style-type: none"> • Individuals with HIV or AIDS of any age • Hospital or nursing facility level of care

In addition to these HCBS waivers, California operates an HCBS program under its state plan that provides services to individuals with developmental disabilities. This program, which operates under Section 1915(i) of the Social Security Act, is administered by the Department of Developmental Services and utilizes the same provider types as the HCBS Waiver for Persons with Developmental Disabilities. Unlike the waiver, however, an individual does not need to have an institutional level of care in order to qualify for services under the state plan.²⁵

2. In-Home Supportive Services (IHSS)

Certain aged, blind, and disabled individuals may qualify for IHSS—a program that provides in-home assistance as an alternative to out-of-home care and enables recipients to remain safely in their own homes. IHSS currently serves over 580,000 recipients.²⁶ The types of services that can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, and grooming), paramedical services, accompaniment to medical appointments, and protective supervision for the mentally impaired.²⁷ To be eligible for IHSS, individuals must be 65 years or older, disabled, or blind. Children with disabilities are potentially eligible for IHSS.²⁸ Receipt of IHSS does not impact a child's eligibility for services under Medi-Cal, including services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

IHSS is actually four different programs in one. The services available under the programs are largely the same, but their eligibility requirements differ. Three of the programs are for Medi-Cal beneficiaries, with the fourth providing services to individuals who do not qualify for federally-funded full-scope Medi-Cal. The three IHSS Medi-Cal programs are:

- The Personal Care Services Program (PCSP) is for individuals who do not need an institutional level of care. Approximately half of IHSS recipients are enrolled in PCSP.²⁹
- The Community First Choice Option (CFCO) is for individuals who need an institutional level of care.³⁰ Approximately 43 percent of IHSS beneficiaries are enrolled in the program.³¹
- The IHSS Plus Option (IPO) is for individuals who cannot qualify for PCSP or CFCO because of restrictions in those programs but do not need to be at an institutional level of care. In particular, IPO is for an individual who has a personal care attendant who is the individual's parent or spouse, or for an individual who receives Advance Pay (AP) or a Restaurant Meal Allowance (RMA).³²

In addition, individuals who do not qualify for federally-funded Medi-Cal, including those who do not qualify due to immigration status, can receive HCBS through the Residual IHSS Program (IHSS-R), which provides a maximum of 283 hours of services per month for people with severe disabilities and a maximum of 195 hours for people with disabilities that are not severe. A small percentage of California's IHSS population is enrolled in IHSS-R.³³

IHSS services are provided under the Medicaid State Plan, not under waivers, and therefore different legal requirements apply to IHSS than waiver programs.³⁴ For example, IHSS programs are not subject to wait lists, meaning that IHSS is available to all persons who meet the income and benefit eligibility criteria.³⁵ Additionally, Medi-Cal beneficiaries can qualify for state plan HCBS

covered under IHSS even if their conditions are not severe enough to require institutionalization.³⁶

The scope of services provided under IHSS is narrower than that provided under HCBS waivers in that the IHSS program generally covers non-medical attendant services. This means that medical services available under some HCBS waivers, such as nursing care, are not covered under IHSS. However, coverage of IHSS services do extend to paramedical services, which are skilled tasks necessary to maintain the recipient's health and which but for their disability, the recipients would perform themselves.³⁷ Examples are administration of medication, inserting medical devices, and puncturing the skin. Finally, in terms of eligibility, IHSS is available only to individuals while receiving care in their "own home."³⁸ IHSS does not cover services for those residing in institutional settings, such as assisted living facilities and skilled nursing facilities, in contrast to some HCBS waivers that do cover services to individuals while they are in those settings (neither IHSS nor HCBS waivers cover services provided in institutions such as hospitals or nursing homes).

For more information about the IHSS program, please consult Justice in Aging's and Disability Rights California's IHSS advocates manual.³⁹

Endnotes

- ¹ Kaiser Fam. Found., Distribution of Medicaid Spending by Service, <https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?dataView=0¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Nov. 5, 2019).
- ² Kaiser Fam. Found., Medicaid's Role in Nursing Home Care, <https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/> (last visited Sept. 5, 2019).
- ³ Kaiser Fam. Found., *Medicaid Home and Community-Based Services: Results from a 50-State Survey of Enrollment, Spending, and Program Policies 22* (2018), <http://files.kff.org/attachment/Report-Medicaid-Home-and-Community-Based-Services>.
- ⁴ 42 U.S.C. § 1396r(a)(1).
- ⁵ See CAL. CODE REGS. tit. 22, §§ 51334 (ICFs), 51335 (SNFs).
- ⁶ For more information on treatment authorization, see Cal. Dep't Health Care Servs., *Med-Cal Provider Manual, Long Term Care, TAR Completion for Long Term Care* (2019), http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/tarcompltc_100.doc. Note that managed care changes these processes.

- ⁷ CAL. CODE REGS. tit. 22, § 51121.
- ⁸ For additional information on the criteria considered appropriate placement, see CAL. CODE REGS. tit. 22, § 51335.
- ⁹ CAL. CODE REGS. tit. 22, § 51335(j).
- ¹⁰ See also Cal. Dep't Health Care Servs., Mental Health Treatment Programs, <https://www.dhcs.ca.gov/services/MH/Pages/MentalHealthTreatmentProgramscertifiedbyDHCSare.aspx> (last visited Sept. 5, 2019).
- ¹¹ 42 C.F.R. § 435.1009(a)(2). An IMD is defined as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.” 42 C.F.R. § 435.1010. As part of California’s Section 1115 waiver, the Centers for Medicare and Medicaid Services (CMS) waived the IMD exclusion for individuals receiving substance use disorder (SUD) treatment in these facilities. For all other services, the exclusion continues to apply. Chapter 4 of NHeLP’s Medi-Cal Services Guide on SUD Services provides more information on the current waiver.
- ¹² CAL. CODE REGS. tit. 22, § 72443(b).
- ¹³ CAL. CODE REGS. tit. 22, § 51124.5.
- ¹⁴ CAL. CODE REGS. tit. 22, § 51124.5.
- ¹⁵ CAL. CODE REGS. tit. 22, § 51343.
- ¹⁶ CAL. CODE REGS. tit. 22, § 51343.1.
- ¹⁷ CAL. CODE REGS. tit. 22, § 51343.2.
- ¹⁸ For more information, see Cal. Dep't Health Care Servs., Home & Community-Based Alternatives Waiver, [https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-\(HCB\)-Alternatives-Waiver.aspx](https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx) (last visited December 22, 2019).
- ¹⁹ For a list and description of all approved waivers in California see, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/CA-Waiver-Factsheet.html>. The text of the approved waiver applications, which provide detailed information on eligibility requirements and services available under each waiver, may be obtained from <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html> and selecting “California.”
- ²⁰ See Cal. Dep't Health Care Servs., Multipurpose Senior Services Program, <https://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx> (last visited December 22, 2019).

- ²¹ CBAS is not provided under a 1915(c) waiver, but is instead included under the Section 1115(a) demonstration waiver. See CMS, Special Terms and Conditions for California Medi-Cal 2020 Demonstration (Nov. 22, 2016), <https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs11-22-16.pdf>. See also Cal. Dep't Health Care Servs., Community-Based Adult Services, [https://www.dhcs.ca.gov/services/Pages/Community-BasedAdultServices\(CBAS\)AdultDayHealthCare\(ADHC\)Transition.aspx](https://www.dhcs.ca.gov/services/Pages/Community-BasedAdultServices(CBAS)AdultDayHealthCare(ADHC)Transition.aspx) (last visited Sept. 5, 2019).
- ²² In addition to these waivers, up until 2018 Medi-Cal offered a Pediatric Palliative Care waiver to medically fragile or technology dependent children who had a life-threatening condition. At the beginning of 2019, DHCS transitioned the services offered under such waiver to managed care plans and the fee-for-service delivery system. See Cal. Dep't Health Care Servs., Partners for Children, a Pediatric Palliative Care Waiver Program, <https://www.dhcs.ca.gov/services/ppc/Pages/default.aspx> (last visited Sept. 5, 2019).
- ²³ Cal. Dep't Health Care Servs., *Statewide Transition Plan for Compliance with Home and Community Based Settings Rules 12* (2018), <https://www.dhcs.ca.gov/services/ltc/Documents/CASTP-11Jan2018ADA.pdf>.
- ²⁴ See also Cal. Dep't Soc. Servs. All County Letter 00-83 (Dec. 7, 2000), <https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl00/pdf/00-83.PDF>.
- ²⁵ Cal. Dep't Health Care Servs., *Statewide Transition Plan for Compliance with Home and Community Based Settings Rules*, *supra* note 23, at 7.
- ²⁶ CAL. WELF. & INST. CODE § 12300; Cal. Dep't Soc. Servs., *Manual of Policies and Procedures* § 30-700, <http://www.cdss.ca.gov/ord/entres/getinfo/pdf/ssman2.pdf>. See also Cal. Dep't Soc. Servs., In Home Supportive Services (IHSS) Program, <http://www.cdss.ca.gov/inforesources/IHSS> (last visited Sept. 5, 2019).
- ²⁷ CAL. WELF. & INST. CODE § 12300; Cal. Dep't Soc. Servs., *Manual of Policies and Procedures*, *supra* note 26, § 30-756.
- ²⁸ CAL. WELF. & INST. CODE §§ 12305.5-12305.6.
- ²⁹ CAL. WELF. & INST. CODE § 14132.95; Cal. Dep't Soc. Servs., *Manual of Policies and Procedures*, *supra* note 26, § 30-780.
- ³⁰ 42 U.S.C § 1396n(k)(1); 42 C.F.R. § 441.510(c). From a beneficiary's perspective, PCSP and CFCO are largely the same, but states receive an enhanced federal match for services provided under CFCO. Cal. Dep't Soc. Servs., All County Letter 14-60 (August 29, 2014), <https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.
- ³¹ Cal. Dep't Soc. Servs., In Home Supportive Services (IHSS) Program, *supra* note 26.
- ³² CAL. WELF. & INST. CODE § 14132.952; Cal. Dep't Soc. Servs., *Manual of Policies and Procedures*, *supra* note 26, § 30-700.
- ³³ Cal. Dep't Soc. Servs., In Home Supportive Services (IHSS) Program, <http://www.cdss.ca.gov/inforesources/IHSS> (last visited December 20, 2019).

- ³⁴ CFCO operates under Social Security Act Section 1915(k), a new option for HCBS that was established under the Affordable Care Act. IPO operates under Section 1915(j) of the Social Security Act. CAL. WELF. & INST. CODE §14132.952. See also Cal. Dep't Soc. Servs., All-County Information Notice I-33-10 (April 21, 2010), https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2010/I-33_10.pdf.
- ³⁵ HHS, *Analysis of the California In-Home Supportive Service (IHSS) Plus Waiver Demonstration Program 1* (2008), <https://aspe.hhs.gov/system/files/pdf/75596/IHSSPlus.pdf>.
- ³⁶ See 42 U.S.C. § 1396n(i)(1).
- ³⁷ CAL. WELF. & INST. CODE § 12300.1
- ³⁸ Cal. Dep't Soc. Servs., *Manual of Policies and Procedures*, supra note 26, § 30-755.11.
- ³⁹ Disability Rights California and Justice in Aging, *In-Home Supportive Services (IHSS): A Guide for Advocates* (2019), https://www.justiceinaging.org/wp-content/uploads/2019/06/Final_IHSS-Adocate-Manual.pdf.



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter X: Durable Medical Equipment, Orthotics and Prosthetics,
and Other Non-Pharmaceutical Items**

Chapter X: Durable Medical Equipment, Orthotics and Prosthetics, and Other Non-Pharmaceutical Items

Durable Medical Equipment, Orthotics & Prosthetics, and Other Non-Pharmaceutical Items Covered in this Chapter*

- Durable Medical Equipment (DME)
 - Prescribed by a licensed practitioner
 - Medi-Cal covers the lowest cost item that meets the beneficiary's needs
 - Covered DME, and items excluded from coverage
 - Prior authorization
 - Replacement and repair of DME
- Orthotics and Prosthetics
 - Covered Orthotics and Prosthetics
 - Prior Authorization
 - Other coverage issues
- Medical Supplies
 - Covered medical supplies
 - Prescription required
 - Prior authorization generally not needed if below a certain quantity
- Enteral Nutrition
 - Prescription required
 - Prior Authorization

*This is a non-exhaustive list of services. It may not include all available services.

In addition to covered services and pharmaceuticals, Medi-Cal covers a wide variety of items used for medical purposes, which fall into the following categories:

- Durable medical equipment (DME),
- Orthoses and prostheses,
- Medical supplies, and
- Enteral nutrition products.

The types of items that may be covered include bathroom seats, hospital beds, scooters, oxygen tanks, orthopedic shoes, artificial arms and legs, diabetic testing strips, and diapers. In order to obtain coverage of such items, a prescription is required and beneficiaries must often obtain prior authorization from Medi-Cal.

A. Durable Medical Equipment

In Medi-Cal, DME equipment is covered when it withstands repeated uses; serves a medical purpose; is not useful to the beneficiary in the absence of an illness, injury, functional impairment, or congenital anomaly; and is appropriate for use in or out of the beneficiary's home.¹ The definition of DME excludes prosthetics and orthotics, which are discussed in Section B of this Chapter.²

Medi-Cal will only cover “the lowest cost item that meets a patient’s medical needs.”⁴ For example, individuals that need a wheelchair and have their medical needs met by a manual wheelchair may not have a power wheelchair approved. In contrast, if the beneficiary lacks the arm strength to self-propel a manual wheelchair, a power wheelchair may be covered.⁵ Note that consistent with the Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) benefit, a beneficiary under age 21 is entitled to services, including DME, when necessary to correct or ameliorate the child or adolescent’s illness or condition. In addition, children eligible for the California Children Services (CCS) program may have their DME covered through that program.⁶ (See Chapter VIII of this Guide on Children’s Health Services for more information.)

ADVOCACY TIP:

- ✓ Unlike Medicare, Medi-Cal **does not** require that DME have an expected life of at least three years and that the device be appropriate for use in the home.³ Therefore, a Medi-Cal beneficiary can obtain coverage of DME even if the equipment has an expected life of less than three years and is intended for use outside the home. For example, a beneficiary who needs a wheelchair to travel to doctor’s appointments, but does not need a wheelchair for moving about the house, may be entitled to Medi-Cal coverage of that wheelchair.

1. Types of Covered DME

Medi-Cal covers many different types of items as DME, including, but not limited to:⁷

- Ambulation devices such as walkers and gait trainers
- Bathroom equipment such as rails, seats, stools, benches, and shower hoses
- Blood glucose monitors
- Blood pressure equipment
- Hospital beds and accessories, such as mattresses and bedside rails
- Infusion pumps
- Negative Pressure Wound Therapy (NPWT) devices used to treat skin wounds
- Oxygen and respiratory equipment, including Continuous Positive Airway Pressure (CPAP) equipment, nebulizers, oxygen, oxygen racks, and ventilators
- Patient lifts and standing systems, which may include stairway chairlifts and standing frames to allow wheelchair dependent patients to achieve a passive standing position
- Pneumatic compressors
- Portable ramps (non-portable ramps that are fixed are not covered)
- Pulsed Irrigation Enhanced Evacuation (PIEE)
- Spinal Electrical Devices
- Wheelchairs and scooters, including manual wheelchairs, power wheelchairs, lightweight and ultra-lightweight wheelchairs, and stair climbing wheelchairs

Medi-Cal also covers DME to assist parents, stepparents, foster parents, or legal guardians with disabilities care for a child.⁸

Medi-Cal excludes several items from coverage as DME:⁹

- Air conditioners, air filters, or heaters
- Bicycles, tricycles, or exercise equipment (subject to certain exceptions)
- Books or other items of a primarily educational nature
- Food blenders
- Household items
- Modification of automobiles/or other highway motor vehicles
- Orthopedic mattresses, recliners, rockers, seat lift chairs, or other furniture items
- Reading lamps, or other lighting devices
- Television sets
- Waterbeds

2. Prior Authorization of DME

Medi-Cal has detailed rules regarding DME approval. DME items may be covered as medically necessary “only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability.”¹⁰ DME is only covered if a beneficiary has a prescription for the DME, and often prior authorization is also required.¹¹ For example, all DME above certain price thresholds is subject to prior authorization. If the beneficiary is seeking to obtain purchased DME, then Medi-Cal prior approval is required if the cost exceeds \$100 (this cost may include multiple DME items if purchased in the same month). If the DME is being rented, authorization is required if the cost of renting will exceed \$50 in a 15-month period. Repair and/or maintenance of DME are subject to prior approval if the cost exceeds \$250. Oxygen tanks are subject to prior approval if more than two “H” tanks are provided in a month, and “unlisted” DME – that is, DME that does not appear on Medi-Cal’s list of covered items – is always subject to prior approval.¹² Since most items of DME exceed these cost thresholds, a beneficiary typically will need to obtain Medi-Cal’s prior approval before receiving DME.

DME is also subject to a “face-to-face” encounter requirement, meaning the DME can be prescribed to a beneficiary only after a practitioner (e.g., a physician, nurse practitioner, clinical nurse specialist or physician assistant) has physically examined the beneficiary, (examinations via telehealth are permitted). The face-to-face encounter must “relate[] to the primary reason the recipient requires the DME item.”¹³ For example, if a beneficiary is seeking a wheelchair, then the face-to-face encounter should address the beneficiary’s mobility issues. The practitioner prescribing the DME need not be the same practitioner who examined the beneficiary, but if they are different individuals then the clinical findings from the examining practitioner must be communicated to the prescribing practitioner. Moreover, the encounter must have occurred within six months of the date of the prescription.

ADVOCACY TIPS:

- ✓ Even if an item is not on Medi-Cal’s list of covered DME, a beneficiary may still be able to obtain coverage of the item if it is medically necessary.
- ✓ The Medi-Cal Provider Manual includes helpful information on covered DME services, which is split into the following groups (each with its own manual section): Infusion Equipment; Oxygen Contents, Oxygen Equipment and Respiratory Equipment; Speech Generating Devices; Therapeutic Anti-Decubitus Mattresses and Bed Products, Wheelchairs and Wheelchair Accessories, and Other DME.

3. Replacement and Repair of DME

Medi-Cal covers the replacement of DME. The frequency of replacement depends on the nature of the item. For example, Medi-Cal will provide up to three aerosol masks in a given month, but crutches and wheelchair accessories are subject to replacement only once every five years.¹⁴ However, exceptions can be made to these limits. Under state law, Medi-Cal must “allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary’s control.”¹⁵ Thus, if an item of DME is stolen, then a beneficiary may be able to obtain coverage of a replacement item even if Medi-Cal policies indicate that the beneficiary is not yet entitled to a replacement. In addition, state law requires the DME vendor to replace a substandard or “unsuitable item” at no additional cost to Medi-Cal or the beneficiary.¹⁶

Beneficiaries are responsible for the appropriate use and care of DME purchased for their care.¹⁷ If an item of DME is destroyed or damaged due to the beneficiary’s fault, then Medi-Cal may not be required to replace the item.

Medi-Cal also covers repairs of DME under certain circumstances. Under Medi-Cal, a warranty period must extend for at least six months from the date of purchase.¹⁸ If the item needs repair during this warranty period, then the DME supplier is responsible for having the item repaired for free, and Medi-Cal will not pay for the repairs.¹⁹ A separate warranty period applies for at least three months after the date of repair: if an item needs a second repair during the warranty period, then the vendor who initially repaired the item must conduct another repair without billing Medi-Cal a second time.²⁰ If the warranty has expired, then Medi-Cal will pay a separate claim for repairs. Both the labor costs of repair and the costs of parts may be covered.

A beneficiary can only obtain coverage of a replacement or repair of DME if the beneficiary has a prescription. In some cases, the existing prescription may cover the replacement or repair, but if a year has passed since the date on the prescription, then the beneficiary is required to obtain a new prescription.²¹

B. Orthotics and Prosthetics

Under Medi-Cal, “orthosis” is “an externally applied appliance used to modify the structural and functional characteristics of the neuromuscular and skeletal systems.”²² A “prosthesis” is “an externally applied appliance used to replace wholly, or in part, an absent or deficient body part.”²³ A common example of an orthosis is a neck brace and a common example of a prosthesis is an artificial arm or leg. In addition to the actual prosthetic or orthotic appliance, prosthetic or orthotic services are covered. Such services include medical examinations related to the provision of appliances, laboratory work necessary for the

construction of the appliance, adjustment of appliances, application of dressings, and fitting of appliances.²⁴

1. Types of Covered Orthotics and Prosthetics

Covered orthotic appliances include:²⁵

- Compression burn garments
- Gradient compression stockings
- Lower limb orthotic devices, such as knee, ankle-foot, or hip orthoses
- Orthopedic shoes
- Shoe supplies for diabetics
- Spinal orthoses, such as cranial orthoses (helmets) and cervical orthoses (collars)
- Upper limb orthotic devices, such as shoulder or elbow orthoses

Covered prosthetic appliances include:²⁶

- Breast prostheses
- Lower limb prostheses, such as an artificial foot
- Terminal devices such as hooks
- Upper limb prostheses, such as an artificial hand or arm.

Medi-Cal does not cover appliances whose sole purpose is cosmetic restoration, nor does it cover backup appliances except when the primary appliance must be worn by the beneficiary 24 hours per day or when the appliance must be cleaned on a regular basis and cannot be dried overnight.²⁷

2. Prior Authorization

The prosthetics and orthotic appliance coverage rules mirror the DME rules in many respects. As with DME, prosthetics and orthotic appliances are covered only if a patient has a prescription.²⁸ Prior authorization for orthotics is required if the cumulative costs of purchase, replacement and repair exceed \$250 in a 90-day period; the threshold is \$500 in a 90-day period for prosthetic appliance. If the orthotic or prosthetic appliance does not appear on Medi-Cal's list of covered appliances, then it can be obtained only via prior authorization.²⁹ In addition, prior authorization is always required if the item is furnished by a podiatrist.³⁰ As is the case with DME, only the lowest cost appliance that meets the beneficiary's needs is covered, but the EPSDT benefit applies for children.³¹

Prosthetic and orthotic appliances are covered only if the appliance is "medically necessary for the restoration of bodily functions, to support a weakened or deformed body member or for the replacement of a body part and is reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain."³² In addition, the appliance must be "essential to performing activities of daily living or instrumental activities of daily

living.”³³ In other words, Medi-Cal does not cover appliances prescribed for the sole purpose of restoring functions beyond activities of daily living or instrumental activities of daily living, nor does it cover appliances intended to improve the beneficiary’s abilities beyond those that existed prior to the onset of the disability or injury.³⁴

3. Other Coverage Issues

As is the case with DME, Medi-Cal covers replacement of orthotic and prosthetic appliances according to a set schedule.³⁵ Medi-Cal also covers the replacement of an orthosis or a prosthesis if the device is lost or destroyed due to circumstances beyond the beneficiary’s control.³⁶

Generally, an orthosis or prosthesis must be furnished by an orthotist, a prosthetist, a physician, a podiatrist, a mastectomy fitter, or a California Children Services provider.³⁷ However, for certain categories of prosthetic and orthotic appliances, a Medi-Cal beneficiary can obtain such devices from a pharmacy.³⁸

C. Medical Supplies

Common medical supplies covered by Medi-Cal include:³⁹

- Diabetic testing strips and lancets
- Incontinence medical supplies, such as diapers, undergarments, liners and pants, adult pant systems, barrier creams for the skin, and incontinence washes
- Needles
- Tracheostomy supplies
- Urinary catheters
- Wound care dressings.

Common household items such as rubbing alcohol, cotton balls and swabs, Q-tips, hydrogen peroxide, non-prescription shampoos, and dry skin oils are not covered as medical supplies.⁴⁰ Medi-Cal typically is more generous in its coverage of supplies than Medicare, which generally only covers supplies as part of a home health visit.

Medical supplies are only covered if a physician has issued a prescription for such supplies. If a beneficiary seeks to obtain supplies more than one year after the prescription has been issued, the beneficiary must obtain a new prescription.⁴¹

Because medical supplies are typically less expensive than DME and orthotic and prosthetic appliances, they often can be obtained without prior authorization if the prescription is below a certain quantity limit. For example, up to 100 insulin syringes (U-500) can be provided in a 27-day period without

prior authorization. Other supplies, such as a tracheostomy speaking valve, are always subject to prior authorization.

Incontinence medical supplies are covered only for use in chronic pathologic conditions causing the beneficiary's incontinence. Generally, children under the age of five cannot receive coverage of incontinence medical supplies, given that the need for diapers for young children is not considered a medical condition. However, such supplies may be covered for children under five under EPSDT, where the incontinence is due to a chronic physical or mental condition.⁴³

ADVOCACY TIP:

- ✓ DHCS has posted online a spreadsheet with medical supplies billing codes, units, quantity limits, and prior authorization information.⁴²

D. Enteral Nutrition

Enteral nutrition is a means of delivering nutrition directly to an individual's digestive tract, sometimes referred to as tube feeding. Medi-Cal beneficiaries may require enteral nutrition if they have a form of cancer that makes it difficult to swallow food or some other disease or trauma that interferes with the ability to eat.

Enteral nutrition products are only covered for Medi-Cal beneficiaries who have medical conditions that preclude the use of regular food.⁴⁴ Regular food, including pureed foods, infant formula, shakes, bars, gels, and products for weight loss assistance are not covered by Medi-Cal.⁴⁵ Because enteral nutrition products are only covered for those who cannot eat regular food, they are not covered for individuals who use such products as a convenient alternative to eating regular food.⁴⁶

A beneficiary can only obtain an enteral nutrition product if the beneficiary has obtained a physician's prescription for such product. In addition, such products are always subject to prior authorization.⁴⁷

Beneficiaries can obtain coverage of products on the Medi-Cal list of covered enteral nutrition products. If a beneficiary is taking a product that is deleted from the list, the beneficiary may continue to receive that product if a claim for that product continues to be submitted on behalf of the beneficiary at least every 100 days. Medi-Cal is required to notify beneficiaries at least 60 days prior to the deletion of a product from the list of covered enteral nutrition products.⁴⁸

Endnotes

- ¹ CAL. CODE REGS. tit. 22, § 51160.
- ² Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines*, at 21, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durawheelguide_a04p00.doc.
- ³ 42 C.F.R. § 414.202.
- ⁴ CAL. CODE REGS. tit. 22, § 51321(g); see also Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Durable Medical Equipment (DME): An Overview*¹ (2019) [hereinafter DME Overview], https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/dura_a04p00.doc.
- ⁵ Cal. Dep't Health Care Servs., All Plan Letter 15-018 at 6 (July 9, 2015), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-018.pdf>.
- ⁶ See also Alicia Emanuel & Michelle Lilienfeld, Nat'l Health Law Prog. *Helping Families Obtain Durable Medical Equipment and Supplies Through The California Children's Services (CCS) Program* (Oct. 2019), <https://healthlaw.org/resource/helping-families-obtain-durable-medical-equipment-and-supplies-through-the-california-childrens-services-ccs-program/>.
- ⁷ Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Durable Medical Equipment (DME): Bill for DME 1-2*, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durabil_a04p00.doc.
- ⁸ CAL. WELF. & INST. CODE § 14132(m).
- ⁹ CAL. CODE REGS. tit. 22, § 51321(e).
- ¹⁰ DME Overview, *supra* note 4, at 1.
- ¹¹ CAL. CODE REGS. tit. 22, § 51160.
- ¹² *Id.* § 51321(b).
- ¹³ DME Overview, *supra* note 4, at 5.
- ¹⁴ Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Durable Medical Equipment (DME) Billing Codes: Frequency Limits*, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duracdfre_a04a06a08p00.doc.
- ¹⁵ CAL. WELF. & INST. CODE § 14132(m).

- ¹⁶ CAL. CODE REGS. tit. 22, § 51224.5(a)(6)(F).
- ¹⁷ *Id.* § 51321(i).
- ¹⁸ *Id.*
- ¹⁹ DME Overview, *supra* note 4, at 12.
- ²⁰ CAL. CODE REGS. tit. 22, § 51521(i).
- ²¹ DME Overview, *supra* note 4, at 5.
- ²² CAL. CODE REGS. tit. 22, § 51161(ppp).
- ²³ *Id.* § 51161(yyy).
- ²⁴ *Id.* § 51161(gggg).
- ²⁵ *Id.* § 51315.1.
- ²⁶ *Id.* § 51315.2.
- ²⁷ *Id.* § 51315(d); Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Orthotics and Prosthetics, Orthotic and Prosthetic Appliances and Services 1-2* [hereinafter Orthotics and Prosthetics Manual], https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ortho_a06p00.doc.
- ²⁸ CAL. CODE REGS. tit. 22, § 51315(a).
- ²⁹ *Id.* § 51315(b); *see also* CAL. WELF. & INST. CODE § 14132.765.
- ³⁰ Orthotics and Prosthetics Manual, *supra* note 27, at 5.
- ³¹ CAL. CODE REGS. tit. 22, § 51315(c)(5).
- ³² *Id.* § 51315(c)(1).
- ³³ *Id.* § 51315(c)(2).
- ³⁴ *Id.* § 51315(c)(3), (d)(3).
- ³⁵ *See Cal. Dep't Health Care Servs., Allied Health Provider Manual – Part 2: Orthotics and Prosthetics, Frequency Limits for Orthotics*, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/orthocdfre1_a04a06a08p00.doc.
- ³⁶ CAL. WELF. & INST. CODE § 14132(k).
- ³⁷ Orthotics and Prosthetics Manual, *supra* note 27, at 3.
- ³⁸ CAL. WELF. & INST. CODE § 14105.21(b).
- ³⁹ Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Medical Supplies 1* [hereinafter Medical Supplies Manual], https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mcsup_a04p00.doc.
- ⁴⁰ Medical Supplies Manual, *supra* note 39, at 3; *see also* CAL. CODE REGS. tit. 22, § 51320(b).
- ⁴¹ Medical Supplies Manual, *supra* note 39, at 1.

- ⁴² Cal. Dep't Health Care Servs., *Medical Supplies Billing Codes, Units, and Quantity Limits*, <http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mcsupbilling.xls>.
- ⁴³ Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Incontinence Medical Supplies 1*, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/incont_a04l00m01o03p00.doc.
- ⁴⁴ CAL. CODE REGS. tit. 22, § 51313.3(e)(2).
- ⁴⁵ Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Enteral Nutrition Products 3*, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc.
- ⁴⁶ *Id.*
- ⁴⁷ CAL. WELF. & INST. CODE § 14105.8(i); Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Supplies, Enteral Nutrition Products 4*, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral_a04p00.doc.
- ⁴⁸ CAL. WELF. & INST. CODE § 14105.8(h).



An Advocate's Guide to Medi-Cal Services

January 2020

**Chapter XI:
Ancillary Services**

Chapter XI: Ancillary Services

Ancillary Services Covered in this Chapter*

- Physical Therapy
- Occupational Therapy
- Respiratory Therapy
 - Administration of medical gases and pharmacologic agents
 - Ventilator support
 - Bronchopulmonary hygiene
 - Cardiopulmonary resuscitation
 - Maintenance of natural airways
 - Insertion without cutting tissues and maintenance of artificial airways
 - Diagnostic and testing techniques for respiratory care protocols
 - Collections of specimens from the airway tract
- Audiology
 - Measurement, appraisal, identification, and counseling related to hearing
 - Modification of communicative disorders resulting from hearing loss affecting speech, language, and auditory behavior
 - Recommendation and evaluation of hearing aids from physicians
 - Hearing aids
 - Cochlear Implants
- Speech Therapy
 - Evaluation and development of plan for speech and language therapy
 - Instruction of health team personnel and family members in methods of assisting participant to improve and correct speech disorders
- Chiropractic Services
 - Treatment of the spine by means of manual manipulation

Ancillary Services Covered in this Chapter* (continued)

- Vision Services
 - Routine eye exam
 - Vision tests
 - Fitting and prescription for eyeglasses and contact lenses
 - Diagnosis, treatment, and management of eye diseases
 - Eyeglasses (or contact lenses if eyeglasses not an option)
 - Optical aids
 - Prosthetic eyes
- Acupuncture
- Transportation
 - Emergency medical transportation
 - Non-emergency medical transportation
 - Non-medical transportation
 - Air transportation (under certain circumstances)
- Diagnostic Tests
 - Laboratory services
 - Imaging services
- Case Management and targeted case management
- Dialysis
- Transplants

*This is a non-exhaustive list of services. It may not include all available services.

Medi-Cal covers many different services that fall outside the traditional categories of hospital, medical, and nursing services. These services referred to as “ancillary” services often fall under optional coverage categories under federal Medicaid law. In 2009, due to budgetary concerns, California eliminated coverage of several categories of ancillary services for adults, including chiropractic services, audiology services, speech therapy, and acupuncture. As the economy recovered, the State restored coverage of many of these services. In addition, litigation has impacted Medi-Cal’s coverage of certain ancillary services, including non-medical transportation, which was added as a covered benefit for adults in 2017 following years of legal challenges.

A. Therapies and Other Professional Services

1. Physical Therapy, Occupational Therapy, and Respiratory Therapy

Medi-Cal covers physical therapy, occupational therapy, and respiratory therapy for children and adults. Physical therapy and occupational therapy involve the provision of rehabilitative and habilitative care, but the services differ in their respective treatment goal. Medi-Cal coverage of physical therapy is “limited to treatment immediately necessary to prevent or to reduce anticipated hospitalization or to continue a necessary plan of treatment after discharge from the hospital.”¹ In contrast, the purpose of occupational therapy is “to restore or improve a person’s ability to undertake activities of daily living when those skills are impaired by developmental or psycho-social disabilities, physical illness or advanced age.”² Thus, while physical therapy aims to prevent or treat injuries, occupational therapy aims to improve an individual’s ability to engage in daily activities such as eating, bathing, and getting dressed.

Respiratory therapy is available for Medi-Cal beneficiaries to treat deficiencies in the pulmonary (respiratory) system. These services include administration of medical gases and pharmacologic agents to treat the respiratory system; ventilator support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of natural airways; insertion without cutting tissues and maintenance of artificial airways; diagnostic and testing techniques required for implementation of respiratory care protocols; and collections of specimens from the airway tract.³

In order to access physical, occupational, or respiratory therapy through Medi-Cal, beneficiaries must have a prescription. For physical therapy and occupational therapy, the prescription can be from either a physician, dentist, or podiatrist.⁴ For respiratory care services, the prescription must be from a physician or surgeon.⁵ All prescriptions must specifically describe the services and include the duration and therapeutic goal of the therapy prescribed.⁶

Medi-Cal coverage of physical, occupational, and respiratory therapy services may be subject to prior authorization. For physical therapy, prior authorization is always required for children and adult beneficiaries alike.⁷ Prior authorization requests for physical therapy are approved when the service requested is necessary to prevent or substantially reduce an anticipated hospital stay, continues a plan of treatment initiated in the hospital, or is recognized as a logical component of post hospital care. Beneficiaries under 21, however, continue to be subject to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical necessity criteria. Therefore, physical therapy services are available for beneficiaries under 21 when the services are needed to correct or ameliorate an identified condition. For occupational therapy, initial and six-month evaluations do not require prior authorization, but all other

coverage requests do.⁸ Finally, initial respiratory therapy evaluations are not subject to prior authorization. Because Medi-Cal covers respiratory therapy services as physician services, subsequent respiratory therapies do not require prior authorization if performed by a physician or by a respiratory therapist or a nurse (trained in respiratory treatment administration) or staff under physician supervision, as long as the physician is present during the procedure.⁹

2. Audiology, Speech Therapy, Podiatry, and Chiropractic Services

Medi-Cal covers audiology, speech therapy, podiatry, and chiropractic services as outpatient services.¹⁰ Specifically, the program covers these services as physician services when rendered by physicians, and as rehabilitation center outpatient services when rendered by persons other than physicians at rehabilitation centers.¹¹ Rehabilitation centers are facilities that “provide an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.”¹²

Audiology services include “the measurement, appraisal, identification and counseling related to hearing and disorders of hearing; the modification of communicative disorders resulting from hearing loss affecting speech, language and auditory behavior; and the recommendation and evaluation of hearing aids.”¹³ Medi-Cal covers audiology services only if the beneficiary has obtained a written referral from a physician or dentist and if the services are provided by an audiologist licensed by the Speech Pathology and Audiology Examining Committee of the State Board of Medical Quality Assurance or similarly licensed by a comparable agency in the state in which he practices.¹⁴

Medi-Cal covers speech therapy services only if the beneficiary has obtained a written referral from a physician or dentist and if the services are provided by a speech pathologist licensed by the Speech Pathology and Audiology Examining Committee of the State Board of Medical Quality Assurance or similarly licensed by a comparable agency in the state in which he practices.¹⁵ For adults, coverage of speech therapy extends to the following components:¹⁶

- Evaluation of participants and development of necessary plans for appropriate speech and language therapy.
- Instruction of other health team personnel and family members in methods of assisting the participant to improve and correct speech disorders.

Medi-Cal covers podiatry services when provided by podiatrists licensed to practice podiatry by the California Board of Medical Quality Assurance or similarly licensed by a comparable agency of the state in which he practices.¹⁷ These services are covered as part of an evaluative office visit, if the services are necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, or if treating a disease that significantly impairs the ability to walk.¹⁸ Medi-Cal coverage, however, does not extend to routine nail trimming.¹⁹ Prior

authorization of podiatry services is required if the service involves anything other than an evaluative office visit.²⁰

Chiropractic services are services provided by chiropractors, acting within the scope of their practice as authorized by California law. Coverage for these services is limited to the following situations:

- Services provided as emergency procedures.²¹
- The beneficiary is pregnant and the services relate to the pregnancy.²²
- The beneficiary resides in a skilled nursing facility or an intermediate care facility.²³
- The services are provided by a physician, home health agency, or a hospital outpatient department or hospital outpatient clinic. For example, if a physician provides services that could be performed by a chiropractor, those services may be covered even though they would not be covered if performed by a chiropractor.²⁴

In addition, Medi-Cal coverage of chiropractic services extends only to treatment of the spine by means of manual manipulation.²⁵ Manual devices—that is, devices that are handheld with the thrust of the force of the device being controlled manually—may be used for provision of the service, but Medi-Cal coverage does not extend to the cost of the device itself.²⁶

Coverage for all these services is subject to certain restrictions, though for beneficiaries under 21, all services must be made available without restrictions as long as they are needed to correct or ameliorate an identified condition under the EPSDT benefit. Under state regulations, coverage of chiropractic, audiology, speech therapy, and podiatry services for adults is limited to two services in a calendar month.²⁷ This restriction applies to any combination of such services. For example, if an adult beneficiary receives both a speech therapy and audiology service in a given month, the beneficiary may not obtain coverage of a chiropractic service until the following month.

3. Hearing Aids and Cochlear Implants

In addition to the services of audiologists (see previous section), Medi-Cal also covers hearing aids. In order to obtain coverage for a hearing aid, a beneficiary must:²⁸

- Undergo a complete ear, nose, and throat examination from an otolaryngologist (or another type of physician if an otolaryngologist is not available);
- Obtain a prescription from an otolaryngologist (or other type of physician); and
- Undergo a hearing aid assessment performed by the dispensing practitioner, who may either be a physician, an audiologist, or a hearing aid dispenser.

In addition, Medi-Cal imposes an annual \$1,510 hearing aid cap per beneficiary.²⁹ This cap, however, does not apply to pregnant women who are seeking the hearing aid for a condition related to the pregnancy, children under 21 pursuant to the EPSDT mandate, and residents of skilled nursing facilities or intermediate care facilities.³⁰ Beneficiaries can obtain two hearing aids—one for each ear—so long as the total cost falls below \$1,510. If the cost of the hearing aid(s) exceeds \$1,510, the hearing aid vendor is prohibited from billing the beneficiary for the difference. Instead, the vendor must either provide a hearing aid(s) that costs less than \$1,510 or provide the more expensive hearing aid(s) and accept any financial loss.³¹ By law, the vendor cannot bill a beneficiary if they accept Medi-Cal payment for the service.³²

Medi-Cal also covers cochlear implants. These implants differ from hearing aids in that they do not only amplify sound but also deliver sound signals to the auditory nerve and bypass damaged portions of the ear, and therefore have to be surgically implanted. For this reason, Medi-Cal typically provides coverage for such implants to individuals with severe hearing loss who do not hear properly even after receiving a hearing aid. Since cochlear implants are more expensive than hearing aids, Medi-Cal has strict criteria regarding who may receive such implants. Among other requirements, Medi-Cal will only authorize coverage of a cochlear implant if the candidate or caregiver is willing to undergo a program of training and long-term rehabilitation, since it takes significant training and effort to learn to use such an implant.³³

In certain circumstances, replacement and repairs for hearing aids are also covered. Under state law, hearing aid suppliers must guarantee the hearing aid for at least one year, meaning they have to repair or replace the hearing aid if it or some of its parts become defective within a year after the beneficiary receives the aid (the guarantee does not apply to the ear piece, cord, or batteries).³⁴ If the guarantee period has expired, then repair of the hearing aid or replacement of the hearing aid (or just parts of the hearing aid) may be covered by Medi-Cal. However, replacement batteries are not covered for adults; beneficiaries needing new batteries must purchase the batteries on their own. Moreover, the cost of repair and replacement is subject to the \$1,510 cap unless the beneficiary can show that the hearing aids were lost, stolen, or irreparably damaged based on events beyond the beneficiary's control. If the hearing aid was stolen, for example, the beneficiary may need to provide a copy of the police report to document the theft.³⁵

Medi-Cal also covers repairs and replacement of cochlear implants, although prior authorization is required for many replacement supplies, such as headset/headpiece, replacement microphone, transmitting coil, replacement transmitter cable for use with cochlear implant, auditory osseointegrated device, and external speech processor and controller.³⁶ Unlike with hearing aids, Medi-Cal pays for replacement batteries for cochlear implants subject to prior authorization.

Finally, to conform with EPSDT requirements, federal law requires states to provide hearing screenings to children at “intervals which meet reasonable standards of medical practice” and at other intervals that are medically necessary to determine the existence of a suspected illness or condition.³⁷ California has adopted the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule, which requires hearing screens at birth, at two months, and regularly thereafter.³⁸ Medi-Cal must also cover all treatments necessary to address conditions discovered during hearing screenings, including hearing aids and cochlear implants.³⁹ As noted above, the \$1,510 cap on coverage of hearing aids and the prohibition on coverage of audiology services **does not** apply to children. In addition, children can obtain coverage of replacement hearing aid batteries on a quarterly basis without prior authorization.⁴⁰

4. Vision Services

Medi-Cal covers some vision services related to the health of the eye under the mandatory category of physician services. All adult beneficiaries may receive routine eye exams to check the health of their eyes once every 24 months. A second eye exam is covered within the 24-month period only when a sign or symptom indicates a need for another exam.⁴¹ In addition, services provided by ophthalmologists acting within the scope of their practice also fall within the mandatory physician services category.

California has also elected to cover vision services, an optional benefit under federal law, for adult beneficiaries in most circumstances.⁴² Along with ophthalmologist services, Medi-Cal also covers services provided by optometrists acting within the scope of their practice. These services include vision exams, the fitting and prescription for eyeglasses and contact lenses, and diagnosis, treatment, and management of certain eye diseases and disorders of the eye as well as related systemic conditions.⁴³ As with eye exams, vision tests with refraction to determine glasses and/or contact lenses prescription are limited to one per 24 months, except when a sign or symptom indicates a need for additional services.⁴⁴

Starting in 2020, Medi-Cal provides coverage for eyeglasses and contact lenses when prescribed by an ophthalmologist or an optometrist. Prescription lenses are covered when the prescription is for one of the following:

- Single vision lenses;
- Multifocal lenses;
- Replacement single or multifocal lenses;
- Absorptive lenses which reduce the amount of light energy reaching the eye;
- Trifocal lenses for beneficiaries who are currently wearing trifocals; and
- Single balance lens (other balance lenses are covered only when medically justified).

Coverage for prescription eyeglass frames is limited to one pair every two years, but beneficiaries can receive a replacement of frames lost, stolen or destroyed in circumstances beyond the beneficiary's control within that two-year period.⁴⁵ Replacement for frames for other reasons may be covered if the provider submits a statement explaining why the prior frame should be replaced.⁴⁶ Replacement of frames within two years is always limited to the same frame model whenever feasible.⁴⁷

In general, Medi-Cal covers contact lenses with a prescription only if the use of eyeglasses is not an option.⁴⁸ The following chart summarizes Medi-Cal coverage of contact lenses and whether prior authorization is required for each circumstance:

Prior Authorization Required	No Prior Authorization Required
Extended wear contact lenses and disposable contact lenses designed for short-term wear and frequent replacement if other lenses cannot be used	Contact lenses for a diagnosis of aphakia or keratoconus when contact lenses other than extended wear lenses are fitted
Contact lenses when chronic pathology or deformity of the nose, skin or ears precludes the use of glasses	Contact lenses when eyeglasses are contraindicated due to chronic corneal or conjunctival pathology or deformity other than corneal astigmatism when contact lenses other than extended wear lenses are fitted
Contact lenses for a diagnosis of aniseikonia when supported by clinical data	Therapeutic bandage lenses prescribed by a physician for a diagnosis approved by the federal Food and Drug Administration for those lenses, when fitted by a physician or by a dispensing optician or optometrist under the supervision of a physician

Medi-Cal also provides coverage for optical aids and prosthetic eyes. Beneficiaries can get low vision optical aids if the aids help to markedly enhance visual function and if all of the following conditions are met: the condition causing subnormal vision is chronic and cannot be treated by medical or surgical intervention; the physical and mental condition of the beneficiary is such that there is reasonable expectation that the aid will be used to enhance everyday functioning; and the aid prescribed is the least costly type that will meet the beneficiary's needs.⁴⁹ In addition, when the amount claimed for payment of a low vision optical aid is \$100 or more, prior authorization is

required.⁵⁰ Finally, prosthetic or artificial eyes are covered for beneficiaries who have lost an eye or eyes due to disease or injury if the beneficiary has obtained a written prescription from a physician or an optometrist.⁵¹ Replacement of artificial eyes is covered to prevent a significant disability, when the prior eye was lost or destroyed due to circumstances beyond the beneficiary's control, when the prior eye can no longer be rehabilitated, or to accommodate changes in orbital development in children under 18.⁵²

As with hearing services, coverage of vision services for children is more robust than it is for adults due to the EPSDT benefit. Medi-Cal uses the same American Academy of Pediatrics periodicity schedule for vision as it does for hearing services. Under the periodicity schedule for vision, beneficiaries under 21 must be screened for visual problems at each health assessment visit.⁵³ Moreover, federal law requires vision screenings that meet reasonable standards of medical practice at intervals that are medically necessary to determine the existence of a suspected illness or condition.⁵⁴ As a result, if a beneficiary under 21 needs additional vision exams within two years, Medi-Cal would cover these exams under the EPSDT benefit. Federal law also mandates coverage of eyeglasses for Medicaid beneficiaries under 21 who need them, so any state-imposed limitation on coverage of eyeglasses have no impact on the ability of children to receive this service.⁵⁵

5. Acupuncture

Largely in response to the opioid overdose epidemic, in 2016, California restored Medi-Cal coverage of acupuncture services, which had been eliminated as part of the 2009 budget cuts.⁵⁶ Acupuncture presents a treatment alternative to the overuse of prescription medication to treat chronic pain, one of the key factors driving the epidemic.

Under Medi-Cal, acupuncture is the “stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent, modify or alleviate” the perception of pain.⁵⁷ Acupuncture can be provided by an acupuncturist or a physician, dentist, or podiatrist.⁵⁸ Medi-Cal covers acupuncture either with or without electrical stimulations of the needles.⁵⁹ However, acupuncture is only covered if the perceived pain is severe, persistent, chronic and results from a generally recognized medical condition. Moreover, acupuncture is covered only when used to treat a condition for which treatment by other modalities is also covered.⁶⁰

A beneficiary does not need a prescription for acupuncture, nor does a beneficiary typically need to obtain prior authorization.⁶¹ Coverage of acupuncture services for adults is limited to two visits per month or any combination of two services per month from the following services: acupuncture, audiology, chiropractic, occupational therapy, podiatry and speech therapy.⁶² However, for managed care beneficiaries, additional services

can be provided based upon medical necessity subject to the Managed Care Plan (MCP) prior authorization process.⁶³ Importantly, pursuant to federal law, there is no frequency limitation for beneficiaries under 21 receiving services through EPSDT.

B. Transportation

Federal Medicaid law requires state Medicaid programs to ensure that beneficiaries have sufficient transportation to access medical care.⁶⁴ Transportation plays an important role in facilitating access to care. In California, to ensure Medi-Cal beneficiaries can access covered Medi-Cal services, the State covers three different types of transportation: emergency transportation, non-emergency medical transportation (NEMT), and non-medical transportation (NMT). On a limited basis, Medi-Cal covers transportation via air, which can be provided on an emergency or non-emergency basis.

1. Emergency Medical Transportation

Medi-Cal covers emergency medical transportation in medical emergencies. Coverage for emergency medical transportation extends to transportation to the nearest hospital or acute care facility that meets the beneficiary's medical needs.⁶⁵ Typically, emergency transportation is made via ambulance, but it can occur via other means of transportation, such as via air (see discussion in Section 4 below).

Prior authorization is not required to access emergency medical transportation. However, there are certain Medi-Cal billing requirements. Transportation providers must produce an emergency statement for each emergency medical transportation Medi-Cal claim they submit for reimbursement.⁶⁶ Medi-Cal will also only cover the lowest cost type of medical transportation that meets the individual's medical needs.⁶⁷

2. Non-Emergency Medical Transportation

NEMT is transportation of Medi-Cal beneficiaries by ambulance, wheelchair van, or litter van to get to and from covered Medi-Cal services. Medi-Cal covers NEMT only when the beneficiary's medical and physical condition is such that ordinary means of private transportation, such as bus, passenger car, or taxicab is contraindicated.⁶⁸ For example, NEMT is often approved for beneficiaries who cannot walk or stand without assistance from a wheelchair, walker, or crutches. Medi-Cal will cover only the lowest cost transportation that meets the beneficiary's needs.⁶⁹

Physician decisions regarding NEMT must be unhindered by fiscal and administrative management.⁷⁰ MCPs must ensure that providers make decisions about NEMT based solely on medical necessity and with no regard to

fiscal or administrative constraints. MCPs must make sure there are no limits to covering NEMT, as long as the NEMT has prior authorization and the beneficiary's services are medically necessary.⁷¹ The transportation provider must ensure door-to-door assistance from the point of departure to the destination.⁷² If the beneficiary is a minor, then the provider must also cover transportation of the minor's parent or guardian. A minor traveling to a "minor consent" service, i.e., a service to which the minor can provide consent without the knowledge of the parent or guardian, does not need written consent to travel alone.⁷³

a. Authorization Requirements

Unlike emergency medical transportation, NEMT services require prior written authorization by a licensed physician, dentist, podiatrist, or mental health or substance use disorder provider. The provider must submit a treatment authorization request (TAR) for the NEMT services. Prior authorization is not required, however, when an individual is being discharged from a hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or intermediate care facility.⁷⁴

b. Managed Care Plan vs. Fee-for-service

The authorization requirements for NEMT are the same for beneficiaries enrolled in fee-for-service (FFS) and in Medi-Cal MCPs. Medi-Cal MCP enrollees have providers submit NEMT requests directly to their plans, while FFS providers submit TARs to the Department of Health Care Services (DHCS) directly. A Medi-Cal MCP must also make its best effort to refer for and coordinate NMT for all Medi-Cal services not covered by the MCP contract, such as specialty mental health, substance use disorder, dental, and any other services through the FFS delivery system.⁷⁵

3. Non-Medical Transportation

NMT is round trip transportation to access covered Medi-Cal services. NMT is provided by public conveyance—such as taxis, buses, trains and ride share apps such as Uber and Lyft—and transportation via private conveyance, such as a friend driving a beneficiary in the friend's car.⁷⁶ NMT also covers mileage reimbursement.⁷⁷ NMT does not include transportation of the sick, injured, or infirm, or those who otherwise need to be transported by ambulance, litter van, or wheelchair van. NMT is available to travel to medically necessary appointments, to pick up prescriptions that cannot be mailed directly to the beneficiary, to pick up durable medical equipment and other medical supplies, and to visit a sick child in the hospital.⁷⁸

NMT has long been a benefit when provided as an EPSDT service.⁷⁹ However, in 2016 the governor signed AB 2394, which clarified that NMT is a Medi-Cal benefit as of July 1, 2017 for both adults and children.⁸⁰ Further, effective

October 1, 2017, Medi-Cal MCPs must also provide NMT for Medi-Cal services that are carved out of the plan, like specialty mental health, substance use disorder, dental, and any other services through the FFS delivery system.⁸¹

NMT is subject to many of the same rules as NEMT:

- NMT is only covered if the beneficiary is traveling to or from a Medi-Cal covered service.⁸² For beneficiaries in managed care, NMT is covered if the beneficiary is traveling to a service that is covered either by the managed care plan or by FFS Medi-Cal (i.e., the service is carved out of managed care coverage).⁸³
- In the case of minors, NMT can include transportation of the minor's parent or guardian.⁸⁴
- There are no mileage restrictions on the use of NMT.

a. Authorization Requirements: Managed Care Plan vs. Fee-for-service

Unlike NEMT, a Medi-Cal beneficiary does not need a prescription to obtain NMT.⁸⁵ However, beneficiaries using NMT must attest that other available transportation resources have been reasonably exhausted.⁸⁶ While MCP enrollees attest to their plans, FFS beneficiaries must attest to DHCS.

Medi-Cal MCPs have some discretion to set their own prior authorization rules for their enrollees, so MCP enrollees should contact their MCP to access this benefit.⁸⁷ MCPs may use prior authorization to reauthorize NMT every 12 months when necessary to avoid duplicative paperwork and ensure consumers have expedient access to ongoing care.⁸⁸ Beneficiaries in FFS Medi-Cal must request NMT directly from DHCS.⁸⁹ Additional guidance on how individuals can access FFS NMT is still expected.

4. Air Transportation

Medi-Cal may cover air transportation either in an emergency or non-emergency situation, but this is a limited benefit given the high cost of such transportation. For emergencies, Medi-Cal covers air transportation if the medical condition of the beneficiary precludes the use of other transportation or if the beneficiary, or the hospital that is the beneficiary's destination, is inaccessible to ground transportation.⁹⁰ Emergency air transportation is provided without authorization inside California and to specific border communities in Arizona, Nevada, and Oregon, but authorization is required for transportation to other states.⁹¹

In non-emergencies, Medi-Cal covers air transport only when the medical condition of the beneficiary requires such transport or if practical considerations render ground transportation infeasible. Coverage for non-emergency air transport is only available if a physician, podiatrist, or dentist has ordered such transportation.⁹²

C. Diagnostic Tests

Laboratory and imaging services are mandatory Medicaid services and therefore covered under Medi-Cal.⁹³

Covered laboratory tests include, but are not limited to:⁹⁴

- Blood counts
- Cholesterol tests
- Cytopathology
- Drug tests
- Glucose tests
- Hemoglobin tests
- Hepatitis screenings
- HIV screenings
- Human Papillomavirus (HPV) screenings
- Infectious agent detection by nucleic acid (DNA or RNA)
- Oncology screenings
- Pregnancy tests
- Uric acid tests.

Covered imaging includes:⁹⁵

- Computed Tomography (CT) scans
- Dual Energy X-Ray Absorptiometry (DXA)
- Endoscopic Retrograde Cholangiopancreatography (ERCP)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Cholangiopancreatography (MRCP)
- Magnetic Resonance Imaging (MRI)
- Mammography
- Positron Emission Tomography (PET) scans
- Ultrasound
- X-rays

Many of these types of imaging require prior authorization.⁹⁶

Medi-Cal covers portable imaging services under certain circumstances. Under portable imaging, the imaging equipment is brought to a location, such as a beneficiary's home or a nursing home. However, Medi-Cal prohibits coverage of certain procedures and examinations via portable imaging. For example, fluoroscopy and procedures requiring the administration of a substance to the beneficiary are not covered if provided through portable imaging.⁹⁷ In addition, in order to prevent unfair competition, Medi-Cal does not cover portable imaging services if the provider ordering the imaging services has a financial interest in the portable imaging services provider.⁹⁸

D. Case Management

Case management services—sometimes called care management or care coordination—are “services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services, but not the direct delivery of such services.”⁹⁹ They are exempt from the general federal Medicaid rules about statewideness and comparability.¹⁰⁰ This means that the State may limit case management to specific geographic areas and may target particular groups without making the service available to other Medi-Cal beneficiaries who have a comparable need for such services.¹⁰¹ Limiting the availability of case management to specific groups is known as “targeted care management.”

Under Medi-Cal, groups that are eligible to receive targeted case management include:¹⁰²

- Children who are at risk for medical compromise due to various circumstances, including non-compliance with a prescribed medical regime, substance abuse, or abuse;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes;
- Individuals with a communicable disease, including HIV or tuberculosis.

Targeted case management may be provided by counties or through community-based organizations under contract with counties.¹⁰³ Targeted case management services include an assessment of the beneficiary’s needs, the development of a comprehensive service plan, referral to providers for services, arranging appointments and transportation, crisis assistance, and review and modification of the service plan.¹⁰⁴

In addition to Medi-Cal’s targeted case management program, beneficiaries can receive case management services pursuant to other programs. For example, Medi-Cal covers most case management services provided to Medi-Cal beneficiaries with developmental disabilities through regional centers and through other programs administered by the California State Department of Developmental Services (DDS).¹⁰⁵ Case management is also a part of the services provided through California Children’s Services-approved special care centers, and beneficiaries enrolled in home and community-based service programs often receive case management through such programs.¹⁰⁶ Finally, targeted case management is also available for beneficiaries receiving specialty mental health services (SMHS) through county Mental Health Plans (MHP) and for beneficiaries with substance use disorders (SUD) residing in counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver program.¹⁰⁷

Medi-Cal MCPs employ a different case management system. Plans must ensure that their primary care providers provide at least basic case management services to each of their members. Such services include health assessments and behavioral health assessments, identification of appropriate providers, member education on issues such as health lifestyles, and referral to appropriate community resources. Plans must also provide complex case management to enrollees “who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.”¹⁰⁸ Such services include support from a multidisciplinary case management team and development of care plans.

Under federal law, beneficiaries do not have to agree to receive case management services and Medi-Cal cannot condition receipt of other Medi-Cal covered services on a beneficiary’s agreement to participate in case management.¹⁰⁹ If a member is in need of targeted case management, the plan must refer the member to the appropriate county or regional center.

E. Other Specialized Services

1. Dialysis

Medi-Cal covers dialysis, which is the removal by artificial means of waste products normally excreted by the kidneys.¹¹⁰ Dialysis is used to treat people with kidney failure or end-stage renal disease (ESRD).

Dialysis may be provided in renal dialysis centers, community hemodialysis units, or in a beneficiary’s home. Coverage for this service is subject to prior authorization, which may be granted for up to 12 months at a time.¹¹¹ If a beneficiary seeks to receive home dialysis, the beneficiary’s providers must submit evidence of the following:¹¹²

- The beneficiary, the beneficiary’s spouse, or other co-learner is suitable for training in home dialysis.
- The home facilities are suitable for dialysis;
- The overall installation costs in the home are reasonable and in no event exceed \$750.00;
- The water supply in the home is suitable for renal dialysis;
- Availability of a qualified local physician to be responsible for the ongoing medical supervision of the beneficiary;
- Plan for continuing case management.
- Budget for all expenses related to home dialysis, including supplies prorated on a monthly cost basis, and that the costs to install dialysis equipment in the home will be less than \$750.

2. Transplants

Medi-Cal covers organ and bone marrow transplants and coverage extends to both the surgery to remove the organ from a donor and the transplant surgery.¹¹³ Covered transplants include:¹¹⁴

- Bone marrow (stem cell)
- Heart
- Heart-lung
- Kidney
- Liver
- Small bowel
- Combined liver/small bowel
- Lung
- Simultaneous kidney-pancreas
- Pancreas

Transplants are always subject to prior authorization. Beneficiaries with HIV are eligible for transplants if their providers can demonstrate that their HIV infection is well controlled with medical therapy.¹¹⁵ Finally, Medi-Cal only covers transplants if the surgeries are performed at hospitals that are recognized by Medi-Cal as centers of excellence for the specific organ transplant involved.¹¹⁶

Individuals often need to continue taking anti-rejection medication after a transplant. If the individual loses Medi-Cal eligibility during the time period in which the individual is taking such medications, the loss of such eligibility may harm access to the anti-rejection medication and threaten the person's health. To address this situation, Medi-Cal provides continuing coverage for those on anti-rejection drugs for up to two years following a transplant if the person loses coverage during that time, unless the person becomes eligible for other health insurance that would cover the medication.¹¹⁷

ADVOCACY TIP:

- ✓ Some services have a quantitative limit on coverage per month. Services that are limited to two visits per month, or a combination of two service per month are:
 - Chiropractor Services
 - Acupuncture Services
 - Psychology
 - Physical Therapy
 - Occupational Therapy
 - Speech Pathology
 - Audiological Services
 - Podiatry Services
 - Prayer or Spiritual Healing
 - Hospital Outpatient Department Services and Organized Outpatient Clinic Services
- ✓ While quantitative limits can be placed on services for adults, remember that children and youth under 21 are entitled to all EPSDT covered treatment or services needed to correct or ameliorate their illness or condition.

Importantly, since the enactment of the Affordable Care Act (ACA), individuals who previously qualified for Medi-Cal coverage based on a disability may now be eligible for coverage under the Medicaid expansion.

Endnotes

¹ CAL. CODE REGS. tit. 22, § 51309(b).

² CAL. CODE REGS. tit. 22, § 51085.

³ CAL. CODE REGS. tit. 22, § 51082.1.

⁴ CAL. CODE REGS. tit. 22, §§ 51081, 51085, 51309(a).

⁵ CAL. CODE REGS. tit. 22, § 51316(a).

⁶ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Physical Therapy 2* (2001), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/phys_a08o01o11.doc; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Occupational Therapy 2* (2019), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/occu_a08o01o11.doc; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care 6, 9* (2001), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/respir_a04a08m01o03o11.doc.

⁷ CAL. CODE REGS. tit. 22, § 51309(d); Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Physical Therapy*, *supra* note 6, at 3.

⁸ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Occupational Therapy*, *supra* note 6, at 3.

⁹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care*, *supra* note 6, at 3.

- ¹⁰ CAL. WELF. & INST. CODE § 14132(a). As part of the 2009 budget cuts, California declined to cover audiology, speech therapy, and podiatry services for adult beneficiaries. CAL. WELF. & INST. CODE § 14131.10(b)(1). See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Optional Benefits Exclusion 1* (2016), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/optbenexc_a02a03a04a05a07a08i00o01o03o11m00l00p00v00.doc. Beneficiaries under 21, pregnant women who needed these services in connection with their pregnancy, and residents of skilled nursing facilities and intermediate care facilities were exempted from this policy. CAL. WELF. & INST. CODE § 14131.10(b)(3), (c). In 2019, however, as part of the Budget approval process, the State restored Medi-Cal coverage for audiology, speech therapy, and podiatry services for all adult beneficiaries beginning on January 1, 2020. CAL. WELF. & INST. CODE § 14131.10(h)(1). Pursuant to the approved budget and relevant statutory provisions, the increased funding will be suspended on December 31, 2021, unless the State determines through the 2021 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years. CAL. WELF. & INST. CODE § 14131.10(h)(2)-(4); See also Cal. State Budget 2019-2020 Summary, at 57, <http://www.ebudget.ca.gov/2019-20/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf>.
- ¹¹ CAL. CODE REGS. tit. 22, § 51314(a); CAL. CODE REGS. tit. 22, § 51305(f).
- ¹² CAL. CODE REGS. tit. 22 § 51117.
- ¹³ CAL. CODE REGS. tit. 22, § 51098.
- ¹⁴ CAL. CODE REGS. tit. 22, § 51309(a); CAL. CODE REGS. tit. 22, § 51219. See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Audiological Services* (2019), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/audio_a02a08o01o11.doc.
- ¹⁵ CAL. CODE REGS. tit. 22, § 51309(a); CAL. CODE REGS. tit. 22, § 51202. See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Speech Therapy 1* (2019), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/speech_a02a08o01o11.doc.
- ¹⁶ CAL. CODE REGS. tit. 22, § 54317(a).
- ¹⁷ CAL. CODE REGS. tit. 22, § 51310(a). See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Podiatry Services 1* (2017), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/podi_m01o03.doc.
- ¹⁸ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Podiatry Services*, *supra* note 17.
- ¹⁹ *Id.* at 2.
- ²⁰ CAL. CODE REGS. tit. 22, § 51310(a).
- ²¹ CAL. WELF. & INST. CODE § 14131.10(b)(2)(B)
- ²² CAL. WELF. & INST. CODE § 14131.10(b)(3).
- ²³ CAL. WELF. & INST. CODE § 14131.10(c)(2).

- ²⁴ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Optional Benefits Exclusion*, *supra* note 10, at 4, 6.
- ²⁵ CAL. CODE REGS. tit. 22, § 51308. See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Chiropractic Services* 1 (2017), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/chiro_a03.doc.
- ²⁶ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Chiropractic Services*, *supra* note 25.
- ²⁷ CAL. CODE REGS. tit. 22, § 51304(a).
- ²⁸ CAL. WELF. & INST. CODE § 14133.16.
- ²⁹ CAL. WELF. & INST. CODE § 14131.05(c).
- ³⁰ CAL. WELF. & INST. CODE § 14131.05(d), (e).
- ³¹ Cal. Dep't Health Care Servs., *Hearing Aid Benefit Cap & Benefits - Frequently Asked Questions for Beneficiaries*, <https://www.dhcs.ca.gov/services/pages/hearingaidcapfaq.aspx> (last visited Nov. 20, 2019).
- ³² 42 C.F.R. § 447.15; CAL. WELF. & INST. CODE §§ 14019.3(d), 14019.4(a).
- ³³ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Audiological Services*, *supra* note 14, at 6–8.
- ³⁴ CAL. CODE REGS. tit. 22, § 51517(b)(1).
- ³⁵ Cal. Dep't Health Care Servs., *Hearing Aid Benefit Cap & Benefits - Frequently Asked Questions for Beneficiaries*, *supra* note 31.
- ³⁶ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Audiological Services*, *supra* note 14, at 9.
- ³⁷ 42 U.S.C. § 1396d(r)(4).
- ³⁸ CAL. CODE REGS. tit. 22, § 51184(a)(1); Cal. Dep't Health Care Servs., *Periodicity Schedules*, <https://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx> (last visited Nov. 20, 2019).
- ³⁹ CMS, *EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* 15 (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf.
- ⁴⁰ CAL. CODE REGS. tit. 22, § 51340.1(c)(2).
- ⁴¹ CAL. CODE REGS. tit. 22, § 51305(j).

⁴² As part of the 2009 budget cuts, California declined to cover “optometric and optician services, including services provided by a fabricating optical laboratory” (glasses and contact lenses) for adult beneficiaries. CAL. WELF. & INST. CODE § 14131.10(b)(1)(D). See also Cal. Dep’t Health Care Servs., *Medi-Cal Provider Manual, Optional Benefits Exclusion*, *supra* note 10; Cal. Dep’t Health Care Servs., Medi-Cal Vision Benefits, <https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/VisionBenefits.aspx> (last visited Nov. 20, 2019). As with chiropractic, audiology, speech therapy, and podiatry services, beneficiaries under 21, pregnant women who needed vision care in connection with their pregnancy, and residents of skilled nursing facilities and intermediate care facilities were exempted from this policy and could obtain optician and optometry services, including glasses and contact lenses when use of glasses was not possible due to an eye disease or condition. CAL. WELF. & INST. CODE § 14131.10(b)(3), (c). In 2017, however, the State restored Medi-Cal coverage for vision services for all adult beneficiaries beginning on January 1, 2020 or January 1 of the year after the Legislature allocates funding for this purpose, whichever is later. CAL. WELF. & INST. CODE § 14131.10(g)(1)–(2). On June 13, 2019, the California Legislature approved the Governor’s Budget for 2019–2020, which allocates funding for vision services for Medi-Cal beneficiaries, allowing beneficiaries to access the services beginning on January 1, 2020. Pursuant to the approved budget and relevant statutory provisions, the increased funding will be suspended on December 31, 2021, unless the State determines through the 2021 Budget Act process that there is sufficient General Fund revenue to support all suspended programs in the subsequent two fiscal years. CAL. WELF. & INST. CODE § 14131.10(g)(3)–(5). See also Cal. State Budget 2019–2020 Summary, *supra* note 10.

⁴³ CAL. CODE REGS. tit. 22, § 51306(a). See also Cal. Dep’t Health Care Servs., Medi-Cal Vision Benefits, *supra* note 42.

⁴⁴ CAL. CODE REGS. tit. 22, § 51306(c).

⁴⁵ CAL. CODE REGS. tit. 22, § 51317(d).

⁴⁶ CAL. CODE REGS. tit. 22, § 51317(d)(1).

⁴⁷ CAL. CODE REGS. tit. 22, § 51317(d)(2).

⁴⁸ CAL. CODE REGS. tit. 22, § 51317(e).

⁴⁹ CAL. CODE REGS. tit. 22, § 51317(f).

⁵⁰ CAL. CODE REGS. tit. 22, § 51317(f)(5).

⁵¹ CAL. CODE REGS. tit. 22, § 51317(g). Cal. Dep’t Health Care Servs., Medi-Cal Vision Benefits, *supra* note 42.

⁵² CAL. CODE REGS. tit. 22, § 51317(g)(2).

⁵³ CAL. CODE REGS. tit. 22, § 51184(a); Cal. Dep’t Health Care Servs., Periodicity Schedules, *supra* note 38. See also Cal. Dep’t Health Care Servs., *Health Assessment Guidelines - Chapter 27: Vision* (2017), <https://www.dhcs.ca.gov/services/chdp/Documents/HAG/Chapter27.pdf>.

- ⁵⁴ 42 U.S.C. § 1396d(r)(2).
- ⁵⁵ 42 U.S.C. § 1396d(r)(2)(B).
- ⁵⁶ See 2016 Cal. Stat. ch. 30 (S.B. 833), §§ 28, 36.
- ⁵⁷ CAL. CODE REGS. tit. 22, § 51074.5.
- ⁵⁸ CAL. CODE REGS. tit. 22, § 51308.5(a).
- ⁵⁹ CAL. CODE REGS. tit. 22, § 51308.5(c).
- ⁶⁰ CAL. CODE REGS. tit. 22, § 51308.5(b), (d). See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Acupuncture Services 1* (2019), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/acu_a01o11.doc.
- ⁶¹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Acupuncture Services*, *supra* note 60.
- ⁶² CAL. CODE REGS. tit. 22, §§ 51304(a), 51308.5(a). See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Acupuncture Services*, *supra* note 60. See Appendix 1 for a list of services subject to the monthly limitation.
- ⁶³ See Cal. Dep't Health Care Servs., All Plan Letter 16-015 (Dec. 1, 2016), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-015.pdf>.
- ⁶⁴ 42 C.F.R. § 431.53.
- ⁶⁵ CAL. CODE REGS. tit. 22, § 51323(b)(1).
- ⁶⁶ *Id.*
- ⁶⁷ CAL. CODE REGS. tit. 22, § 51323(b).
- ⁶⁸ CAL. CODE REGS. tit. 22, § 51323(a); Cal. Dep't Health Care Servs., *Medi-Cal Provider Training 2018: Medical Transportation Services 5* (2018), https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/mc-trans_2018.pdf
- ⁶⁹ CAL. CODE REGS. tit. 22 § 51323(b).
- ⁷⁰ Cal. Dep't Health Care Servs., All-Plan Letter 17-010, at 2 (July 17, 2017) [hereinafter All-Plan Letter 17-010], <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-010.pdf>.
- ⁷¹ *Id.*
- ⁷² *Id.*
- ⁷³ *Id.* at 3.
- ⁷⁴ CAL. WELF. & INST. CODE § 14136.3; CAL. CODE REGS tit. 22, § 51323(b)(2)(C).
- ⁷⁵ All-Plan Letter 17-010, *supra* note 70, at 2.
- ⁷⁶ CAL. WELF. & INST. CODE § 14132(ad)(2)(A)(i).
- ⁷⁷ All-Plan Letter 17-010, *supra* note 70, at 5.
- ⁷⁸ *Id.* at 6.
- ⁷⁹ *Id.* at 5.

- ⁸⁰ CAL. WELF. & INST. CODE § 14132(ad)(9).
- ⁸¹ All-Plan Letter 17-010, *supra* note 70, at 5.
- ⁸² Cal. Dep't Health Care Servs., *Frequently Asked Questions for Medi-Cal Transportation Services*, at 2 (2019), https://www.dhcs.ca.gov/services/medi-cal/Documents/NMT_Frequently_Asked_Questions.pdf.
- ⁸³ All-Plan Letter 17-010, *supra* note 70, at 5.
- ⁸⁴ *Id.* at 6.
- ⁸⁵ Cal. Dep't Health Care Servs., *Frequently Asked Questions for Medi-Cal Transportation Services*, *supra* note 82, at 5.
- ⁸⁶ CAL. WELF. & INST. CODE § 14132(ad)(2)(B).
- ⁸⁷ Cal. Dep't Health Care Servs., *Frequently Asked Questions for Medi-Cal Transportation Services*, *supra* note 82, at 6.
- ⁸⁸ All-Plan Letter 17-010, *supra* note 70, at 6.
- ⁸⁹ Cal. Dep't Health Care Servs., DHCS Transportation Services, <https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx> (last visited Nov. 20, 2019). FFS beneficiaries can access NMT by emailing DHCS-Benefits@dhcs.ca.gov or going to the DHCS Transportation webpage to find the list of available NMT providers.
- ⁹⁰ CAL. CODE REGS. tit. 22 §, 51323(c)(1).
- ⁹¹ Cal. Dep't Health Care Servs., *Medi-Cal Provider Training 2018: Medical Transportation Services*, *supra* note 68, at 18.
- ⁹² CAL. CODE REGS. tit. 22, § 51323(c)(2).
- ⁹³ CAL. CODE REGS. tit. 22, § 51311(a).
- ⁹⁴ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pathology: Billing and Modifiers* (2017), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pathbil_m00o03o04.doc.
- ⁹⁵ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Radiology: Diagnostic* (2017), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/radidia_m00o03.doc.
- ⁹⁶ For more information on prior authorization requests, see Cal. Dep't Health Care Servs., Treatment Authorization Request, <https://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx> (last visited Nov. 20, 2019).
- ⁹⁷ CAL. CODE REGS. tit. 22, § 51311(c).
- ⁹⁸ CAL. CODE REGS. tit. 22, § 51311(d)(1).
- ⁹⁹ 42 U.S.C. §§ 1396d(a)(19), 1396n(g)(2)(A)(i), 1396n(g)(2)(iii). Contacts with individuals who are not eligible for Medicaid (or in the case of targeted case management, which is a Medicaid-eligible individual who is not in the target population) do not count as case management unless the purpose of the contact is directly related to managing the eligible individual's care. 42 U.S.C. § 1396n(g)(3); 42 C.F.R. § 440.169(e).

- ¹⁰⁰ 42 U.S.C. § 1396n(g)(1).
- ¹⁰¹ 42 U.S.C. § 1396n(g)(2)(B).
- ¹⁰² Cal. Dep't Health Care Servs., *Targeted Case Management: Program Overview*, https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM_FactSheet_01212016.pdf.
- ¹⁰³ CAL. CODE REGS. tit. 22, § 51351.1.
- ¹⁰⁴ CAL. WELF. & INST. CODE § 14132.44(k); CAL. CODE REGS. tit. 22, § 51351(a); 42 U.S.C. § 1396n(g)(2)(A)(ii).
- ¹⁰⁵ CAL. WELF. & INST. CODE § 14132.48(a)–(b).
- ¹⁰⁶ Cal. Dep't Health Care Servs., *California Children's Services: Program Overview*, <https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx> (last visited Nov. 20, 2019); Cal. Dep't Health Care Servs., *Home & Community-Based Alternatives*, [https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-\(HCB\)-Alternatives-Waiver.aspx](https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx) (last visited Nov. 20, 2019).
- ¹⁰⁷ CAL. WELF. & INST. CODE §§ 14132.48(c), 14021.3. *See also* CAL. CODE REGS. tit. 9, § 1810.247(c).
- ¹⁰⁸ Cal. Dep't Health Care Servs., *COHS Boilerplate Contract*, Exhibit A, Attachment 11, §§ 1–2, <https://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>.
- ¹⁰⁹ 42 C.F.R. § 441.18(a)(3).
- ¹¹⁰ CAL. CODE REGS. tit. 22, § 51157(a).
- ¹¹¹ CAL. CODE REGS. tit. 22, § 51330(b).
- ¹¹² CAL. CODE REGS. tit. 22, § 51330(c).
- ¹¹³ CAL. WELF. & INST. CODE § 14132.69(a).
- ¹¹⁴ Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transplants*, at 5–6 (2016), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplant_m01i00o03.doc.
- ¹¹⁵ *Id.* at 1.
- ¹¹⁶ *Id.* at 7. *See also* CAL. WELF. & INST. CODE § 14132.71(a) (requiring DHCS to establish standards for facilities that provide transplants).
- ¹¹⁷ CAL. WELF. & INST. CODE § 14132.70.

Appendix A: Commonly Referenced Laws and Commonly Used Terms

AAP	American Academy of Pediatrics
ABP	Alternative Benefit Plan
ACA	Patient Protection and Affordable Care Act
ACWDL	All-County Welfare Director Letter
ADA	Americans with Disabilities Act
ADHC	Adult Day Health Care Services
AFDC	Aid to Families with Dependent Children
AMSC	Alcohol Misuse Screening and Counseling Services
APA	Administrative Procedure Act
APL	All-Plan Letter
APP	Aid Paid Pending an Appeal
APTC	Advance Premium Tax Credit
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
BCCTP	Breast and Cervical Cancer Treatment Program
BHP	Basic Health Program
CalAIM	California Advancing and Innovating Medicaid
CAP	Consumer Assistance Program
CBAS	Community-Based Adult Services
CCIIO	Center for Consumer Information and Insurance Oversight
CCS	California Children's Services Program
CDL	Contract Drug List
CFCO	Community First Choice Option
CHDP	Child Health and Disability Prevention Program
CHIP	Children's Health Insurance Program
CIWA	Clinical Institute Withdrawal Assessment Scale for Alcohol

CMS	Centers for Medicare and Medicaid Services
COHS	County Organized Health System Model
CPSP	Comprehensive Perinatal Services Program
CSR	Cost-Sharing Reductions
DDS	California State Department of Developmental Services
DHCS	California Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMHC	California Department of Managed Health Care
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
EHB	Essential Health Benefits
EMTALA	Emergency Medical Treatment and Labor Act
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ESRD	End-Stage Renal Disease
Family PACT	Family Planning, Access, Care, and Treatment Program
FDA	Food and Drug Administration
FFS	Fee-for-Service
FFP	Federal Financial Participation
FFM	Federally Facilitated Marketplace
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
GHPP	Genetically-Handicapped Persons Program
GMC	Geographic Managed Care Model
GNA	Health Education and Cultural and Linguistic Group Needs Assessment
HCBS	Home and Community Based Services
HCP	Hearing Conservation Program
HCPCFC	Health Care Program for Children in Foster Care
HHS	United States Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus

HRIF	High-Risk Infant Follow-Up Program
ICF/IID	Intermediate-Care Facility for Individuals with Intellectual Disabilities
IDEA	Individuals with Disabilities Education Act
IHSS	In-Home Supportive Services
IHSS-R	Residual In-Home Supportive Services Program
IMD	Institution for Mental Diseases
IOT	Intensive Outpatient Treatment
IPO	In-Home Supportive Services Plus Option
IUT	Intrauterine Contraception
LARC	Long-Acting Reversible Contraceptives
LEP	Limited-English Proficiency
LIHP	Low-Income Health Program
LIS	Low-Income Subsidy for Medicare
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCAP	Medi-Cal Access Program
MCO / MCP	Managed Care Organization / Managed Care Plan
MEBIL / MEDIL	Medi-Cal Eligibility Branch Information Letter / Medi-Cal Eligibility Division Information Letter
MHSUDS IN	Mental Health and Substance Use Disorder Services Information Notice
MHP	County Mental Health Plan
MHPAEA	Mental Health Parity and Addiction Equity Act
MMCO	Medicare-Medicaid Coordination Office
MMT	Methadone Maintenance Treatment
MOC	Manual of Criteria
MOU	Memorandum of Understanding
MSP	Medicare Savings Program
MTP	Medical Therapy Program
NEMT	Non-Emergency Medical Transportation
NHSP	Newborn Hearing Screening Program

NICU	Neonatal Intensive Care Unit
NMT	Non-Medical Transportation
NTP	Narcotic Treatment Program
OHC	Other Health Coverage
OMEA	Office of Marketplace Eligibility Appeals
ODU	Opioid Use Disorder
PCP	Primary Care Physician
PCSP	Personal Care Services Program
PE	Presumptive Eligibility
PHSA	Public Health Services Act
PIHP	Prepaid Inpatient Health Plan
QHP	Qualified Health Plan
QMB	Qualified Medicare Beneficiary
SBE	State Based Exchange
SBIRT	Screening, Brief Intervention, and Referral to Treatment
Section 504	Rehabilitation Act anti-discrimination provision
Section 1115	Provision of the Social Security Act allowing states to request permission to ignore (or "waive") certain Medicaid requirements to conduct an experimental pilot program.
SMHS	Specialty Mental Health Services
SNF	Skilled Nursing Facility
SNF/STP	Skilled Nursing Facility Special Treatment Programs
SNP	Medicare Special Needs Plan
SPA	State Plan Amendment
SSA	Social Security Act
SSI	Supplemental Security Income
STI	Sexually-Transmitted Infection
SUD	Substance Use Disorder
TANF	Temporary Assistance to Needy Families
TAR / SAR	Treatment Authorization Request / Service Authorization Request
TCM	Targeted Case Management

Title V	Provision of the Social Security Act authorizing and funding maternal and child health programs
USPSTF	United States Preventive Services Task Force
UTI	Urinary Tract Infection
VID	Voluntary Inpatient Detoxification
WCM	Whole Child Model
WIC	Women, Infants, and Children supplemental food program

Appendix B:

Medi-Cal Resource List

Federal Resources:

42 U.S.C. § 1396 et seq.
42 C.F.R. § 430 et seq.

CMS: State Medicaid Manual
www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927.html

CMS: Dear State Medicaid Director Letters
www.medicaid.gov/federal-policy-Guidance/index.html
(Includes State Medicaid Director Letters, State Health Officer Letters, Informational Bulletins, FAQs, and federal regulations; can search by document type or subject matter)

California State Resources:

California Code of Regulations, Title 22, § 50,000 et seq. and Title 9, § 18,000 et seq. oal.ca.gov/publications/ccr/

California Welfare and Institutions Code § 14000 et seq.
<http://leginfo.legislature.ca.gov/faces/codesTOCSelected.xhtml?tocCode=wic>

Official California Legislative Information
leginfo.legislature.ca.gov/
(Text and history of current and recent bills in the state legislature)

Medi-Cal Eligibility Procedures Manual
www.dhcs.ca.gov/services/medi-cal/eligibility/pages/medeligprocmanual.aspx

All County Welfare Directors Letters (ACWDLs) and Medi-Cal Eligibility Division Information Letters (MEDILs)
www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLbyyear.aspx
(ACWDLs from 1978 to present. Includes a link to the ACWDLs Master Index. MEDILs from 1995 to present.)

Medi-Cal Managed Care All Plan, Policy, and Duals Plan Letters
<https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx>
(All Plan Letters from 1998 to present. Listing of Duals Plan Letters and Policy Letters include description and issue date of letter. Policy Letters were not issued in 2004, 2005, or 2006.)

Mental Health & Substance Use Disorder Services and Behavioral Health (MHSUDS) Information Notices
https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx
(Includes MH Letters (1995-2011), ADP Bulletins (1999-2013), and Informational Notices from 1995 to present.)

Medi-Cal Fair Hearing information
<https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx>

Other Helpful Resources

Advocates Guide to MAGI (Updated Guide for 2018), National Health Law Program
<https://healthlaw.org/resource/advocates-guide-to-magi-updated-guide-for-2018/>

Getting and Keeping Health Coverage for Low-Income Californians: A Guide for Advocates (March 2016), Western Center on Law & Poverty
https://wclp.org/wp-content/uploads/2016/04/Western_Center_2016_Health_Care_Eligibility_Guide_Full.pdf

Health Consumer Alliance
www.healthconsumer.org

Addendum:

Accessing Medi-Cal Services During COVID-19 Pandemic

An addendum, *Accessing Medi-Cal Services During COVID-19 Pandemic*, has been added to this guide (6/26/2020).