



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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## Foreword

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The National Health Law Program (NHeLP) is pleased to present *An Advocate's Guide to Medi-Cal Services*. This 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 Guide is intended to be a resource for health care and low-income advocates, legal aid attorneys, and other health care stakeholders in California. The 2022 update focuses on some of the most important benefits in Medi-Cal, including those services and initiatives that are part of the California Advancing and Improving Medi-Cal (CalAIM) reforms, and provides important information concerning services that have been expanded or modified as a result of the COVID-19 pandemic, as well as useful information about the availability of telehealth services.

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

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Founded in 1969, 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.

At NHeLP, we believe that health equity is achieved when a person's characteristics and circumstances — including race and ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, health, immigration status, nationality, religious beliefs, language proficiency, or geographic location — do not predict their health outcomes. We also believe that these characteristics and circumstances should not limit people's experience in the world or in our organization. Our equity vision is one of collective liberation, where individuals of all identities and backgrounds are valued and where we can all achieve our full potential as individuals and as a society, as well as live with dignity. NHeLP works towards a society where everyone can achieve an optimal state of well-being and where everyone has a fundamental right to their highest attainable standard of health. You can read more about NHeLP's Equity Stance at <https://healthlaw.org/equity-stance/>.

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

# Chapter I:

## Overview of Medicaid and Medi-Cal

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

### A. Framework

#### 1. Legal Framework for Medicaid and Medi-Cal

The Medicaid Act is part of the larger Social Security Act (SSA). Medicaid provisions can be found in section 1902 of the SSA, codified in 42 United States Code (U.S.C) Section 1396 et seq. Appendix A 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.<sup>1</sup> 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 or Behavioral Health Information Notices (BHINs) 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).<sup>2</sup> Currently, California receives FMAP at the rate of 50 percent for most services covered under Medi-Cal.<sup>3</sup> 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.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

### ***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.<sup>7</sup> 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.<sup>8</sup> In California, the Medicaid single state agency is DHCS.

### ***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.<sup>9</sup>



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.<sup>10</sup> 1915(b) waivers are often referred to as freedom-of-choice waivers because the program designs restrict beneficiaries' 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.<sup>11</sup>

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.<sup>12</sup> 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.<sup>13</sup> 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:<sup>14</sup>

- 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.

### **3. Service Delivery Models**

#### ***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.<sup>15</sup> In fee-for-service Medicaid, a beneficiary may obtain services from any health care provider who participates in the Medicaid program.<sup>16</sup> 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.

### ***Managed Care***

Today, the majority of Medicaid beneficiaries (over 85%) receive services through some type of managed care arrangement.<sup>17</sup> 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 regulations provide an important array of consumer protections for enrollees.<sup>18</sup>

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.<sup>19</sup> In 2023, most people dually eligible for Medicare and Medi-Cal will also be enrolled in a Medi-Cal managed care plan to receive their Medi-Cal benefits.<sup>20</sup>

In Medi-Cal, managed care is delivered using six different models in various counties.<sup>21</sup> 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 and the COHS-like Single Plan 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. In 2024, some counties will change to a different managed care model.<sup>22</sup>

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 those 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.<sup>23</sup> Because COHS Medi-Cal plans are exempt from DMHC licensure, currently only one COHS, Health Plan of San Mateo, is Knox-Keene licensed.<sup>24</sup> Medi-Cal Managed Care Plans licensed under the Knox-Keene Act are also regulated by DMHC.

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.<sup>25</sup> 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.<sup>26</sup>

Both federal and state laws require Medi-Cal managed care plans to have adequate provider networks to serve their enrollees. 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.<sup>27</sup> Federal Medicaid regulations require states to develop and publish quantitative network adequacy standards, for certain types of providers.<sup>28</sup> 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.<sup>29</sup> 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.<sup>30</sup> California Medi-Cal law provides sets both geographic and timely access standards for all Medi-Cal MCOs, including County Mental Health Plans and Drug Medi-Cal Organized Delivery Systems.<sup>31</sup> 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*.<sup>32</sup>

## 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.<sup>33</sup> 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.<sup>34</sup> The service package offered through Medicaid was developed to help address these health care needs.

#### ***Mandatory Services for Categorically Needy Beneficiaries***

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.<sup>35</sup> Individuals covered by their state Medicaid expansion program under the ACA (including California), are also included in this category.<sup>36</sup> The Medicaid Act requires states to cover a broad array of services for all categorically needy beneficiaries, including, but not limited to:

- Inpatient hospital services (other than services in an institution for people with mental health diagnoses);<sup>37</sup>
- Outpatient hospital services;<sup>38</sup>
- Physician services;<sup>39</sup>
- Rural health clinic services, including ambulatory services offered by a rural health clinic and otherwise included in the state's Medicaid plan;<sup>40</sup>
- Federally-qualified health center services;<sup>41</sup>
- Laboratory and X-ray services;<sup>42</sup>
- Nursing facility services (other than in an institution for people with mental health diagnoses) for individuals 21 or older;<sup>43</sup>
- EPSDT services for recipients under age 21;<sup>44</sup>
- Pregnancy-related services and services for conditions that might complicate pregnancy;<sup>45</sup>
- Family planning services and supplies;<sup>46</sup>

## ***Optional Services for Categorically Needy Beneficiaries***

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 beneficiaries who do not reside in a permanent dwelling or have a fixed mailing address;<sup>47</sup>
- Physical therapy and related services;<sup>48</sup>
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses;<sup>49</sup>
- Other diagnostic, screening, preventive, and rehabilitative services;<sup>50</sup>
- Dental services;<sup>51</sup> and
- Intermediate care facility services for the developmentally disabled (other than institutions for people with mental health diagnoses).<sup>52</sup>

## ***Services for Medically Needy Beneficiaries (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.<sup>53</sup> 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.<sup>54</sup> The state must also cover ambulatory services for children under age 18 and for individuals entitled to institutional services.<sup>55</sup> Individuals entitled to nursing facility services must also have access to home health services.<sup>56</sup>

## **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.<sup>57</sup> These services are described in detail in subsequent chapters of this Guide.

### ***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.<sup>58</sup> 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:<sup>59</sup>

- State Breast and Cervical Cancer Treatment Program (BCCTP)
- Family Planning, Access, Care, and Treatment (FPACT)
- 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.<sup>60</sup> 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.<sup>61</sup>

### **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.<sup>62</sup> 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.<sup>63</sup> These standards must be consistent with the objectives of the Medicaid Act.<sup>64</sup> While enforcing these rights may only happen through a legal challenge in the courts, these consumer protections are key features to the Medicaid program.

#### ***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.”<sup>65</sup> 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.”<sup>66</sup> 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.

### ***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.<sup>67</sup> 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.<sup>68</sup> Some exceptions exist, for example, children are entitled to receive additional services.<sup>69</sup> 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.<sup>70</sup> 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.<sup>71</sup>

### ***Reasonable Promptness***

The Medicaid Act requires that state “medical assistance . . . be furnished with reasonable promptness to all eligible individuals.”<sup>72</sup> 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.”<sup>73</sup> 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.<sup>74</sup> 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.

### **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.”<sup>75</sup> The state Medicaid plan must be continuously in operation throughout the state.<sup>76</sup> 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.<sup>77</sup> 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.<sup>78</sup>

### **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.<sup>79</sup> 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).<sup>80</sup> 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.<sup>81</sup> 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.<sup>82</sup> 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.<sup>83</sup> 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.<sup>84</sup> 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.

### ***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.<sup>85</sup> Through Executive Order 13166, Title VI applies to federal agencies themselves.<sup>86</sup>

**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.<sup>87</sup> The regulations implementing Section 1557 outline requirements for notifying clients/ patients of language services, providing oral interpreting and including taglines on significant written documents.<sup>88</sup> 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.<sup>89</sup> 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.<sup>90</sup>

**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.<sup>91</sup>

**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.<sup>92</sup>

**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.”<sup>93</sup> 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.<sup>94</sup> 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.<sup>95</sup>

In addition to the federal requirements, Medi-Cal participating providers and Medi-Cal managed plans must also comply with state requirements.<sup>96</sup> For those who receive their health care through managed care plans, there are added requirements to ensure access to language assistance services.<sup>97</sup> 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.<sup>98</sup>

### ***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.<sup>99</sup>

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*.<sup>100</sup> 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.<sup>101</sup>

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.<sup>102</sup> 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.<sup>103</sup> 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.<sup>104</sup> 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.<sup>105</sup> The regulations provide specifics as to the requirements for notice of an adverse benefit determination.<sup>106</sup> They also specify procedures for the opportunity for a hearing if a state agency or plan makes an adverse benefit determination.<sup>107</sup> California has specific state laws, regulations and guidance that govern managed care plans obligations concerning notice and appeal rights involving benefit determinations.<sup>108</sup>

#### **4. Utilization Controls, Prior Authorization, Limits to Services**

The Medicaid Act allows states to impose utilization controls on the delivery of services.<sup>109</sup> 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.<sup>110</sup> 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.<sup>111</sup> Medicaid managed care plans may adopt their own utilization controls, subject to certain limitations.<sup>112</sup> 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.<sup>113</sup> DHCS does place some limits of Medi-Cal plans authorization of services.<sup>114</sup>

### **C. California Advancing and Innovating Medi-Cal (CalAIM) Initiative**

CalAIM is a long-term initiative through which DHCS seeks to transform the Medi-Cal program in order to improve services and health outcomes for Medi-Cal beneficiaries.<sup>115</sup> The initiative consists of several reforms to standardize Medi-

Cal services and strengthen integration and coordination with social needs services. These reforms include: building the capacity and infrastructure of community-based organizations, public hospitals, county agencies, tribes, and other participants in the delivery system; implementing a person-centered strategy that emphasizes prevention and provides care management and care transitions across delivery systems; integrating existing and new child and family health initiatives and strengthening DHCS' accountability and oversight of children's services; expanding and improving behavioral health and dental benefits; partnering with entities offering community supports for housing and other social needs; expanding and standardizing the use of managed care; addressing health disparities among justice-involved adults and youth; among others.<sup>116</sup>

DHCS began implementation of CalAIM in January 2022, with various programs being phased in through 2027. A significant part of the initiative is contingent on federal approval of various waiver requests. While several proposals are still pending, CMS approved most of these requests in December 2021 pursuant to Section 1115 and Section 1915(b) authority.<sup>117</sup>

CalAIM impacts many of the services discussed in this Guide. As such, several chapters include summaries about the transformation and new services achieved through the initiative.

### **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

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- <sup>1</sup> See generally CMS, *State Medicaid Manual*, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927> (last visited Nov. 30, 2022) [hereinafter *State Medicaid Manual*].
- <sup>2</sup> See 42 U.S.C. § 1301(a)(8).
- <sup>3</sup> 89 Fed. Reg. 61,157, 61,159 (Nov. 28, 2018). Some Medi-Cal services are eligible for an enhanced FMAP.
- <sup>4</sup> 42 C.F.R. § 430.10; see also generally 42 U.S.C. § 1396a.
- <sup>5</sup> 42 C.F.R. § 430.12(c).
- <sup>6</sup> See 42 U.S.C. § 1396c; 42 C.F.R. §§ 430.15, 430.35.
- <sup>7</sup> 42 U.S.C. §1396a(a)(5) 42 C.F.R. § 431.10.
- <sup>8</sup> For more information on consumer protections in Medicaid, see Kim Lewis & Wayne Turner, Nat'l Health Law Prog. *What Makes Medicaid, Medicaid? – Consumer Protections and Due Process* (2017), <https://healthlaw.org/resource/what-makes-medicaid-medicaid-consumer-protections-and-due-process/>.
- <sup>9</sup> Cal. Dep't Health Care Servs, *Medi-Cal Waivers*, <https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx> (last visited Nov. 30, 2022).
- <sup>10</sup> See 42 U.S.C. § 1396n(b).
- <sup>11</sup> See 42 U.S.C. §§ 1396n(c), 1396a(a)(10)(A)(ii)(VI), 1396n(b)-(e).
- <sup>12</sup> *Id.* § 1315(a).
- <sup>13</sup> See *id.* § 1396.
- <sup>14</sup> *Id.* § 1315(a).
- <sup>15</sup> *Id.* § 1396a(a)(25)(C); 42 C.F.R. §§ 447.15, 447.20.
- <sup>16</sup> 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51.
- <sup>17</sup> Cal. Dep't Health Care Servs., *Medi-Cal Managed Care Performance Dashboard 2* (2022), [https://www.dhcs.ca.gov/dataandstats/reports/Documents/MC\\_Performance\\_Dashboard/MC-Performance-Monitoring-Dashboard.pdf](https://www.dhcs.ca.gov/dataandstats/reports/Documents/MC_Performance_Dashboard/MC-Performance-Monitoring-Dashboard.pdf) [hereinafter *Medi-Cal Dashboard*] (over 12 Million beneficiaries receive care from a managed care plan as of March 2022). For more information, see also Abbi Coursolle, Nat'l Health Law 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/>.
- <sup>18</sup> Lewis & Turner, *supra* note 8.
- <sup>19</sup> *Medi-Cal Dashboard*, *supra* note 17, at 3 (managed care enrollment at 85% as of March 2022).



- <sup>20</sup> See Cal. Dep't Health Care Servs., All Plan Letter 21-015 at 2 (Oct. 18, 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015.pdf>.
- <sup>21</sup> 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* (2020), <https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf>.
- <sup>22</sup> See Cal. Dep't Health Care Servs., Managed Care Plan County Model Change Information, <https://www.dhcs.ca.gov/services/Pages/County-Model-Change-Information.aspx> (last visited Nov. 30, 2022).
- <sup>23</sup> See generally CAL. HEALTH & SAFETY CODE §§ 1340–1399.818.
- <sup>24</sup> CAL. WELF. & INST. CODE § 14087.95; see also, e.g., Gil Rojas, Cal. Dep't Managed Health Care, *Financial Summary of Local Initiative Health Plans and County Organized Health Systems* 19 (2015), <https://www.dmhc.ca.gov/Portals/0/AbouttheDMHC/FSSB/p6120915.pdf>.
- <sup>25</sup> 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/PDF-MediCalFactsAndFigures2013.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\\_FI.pdf](https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2017-18_EQR_Technical_Report_FI.pdf).
- <sup>26</sup> See 42 C.F.R. § 438.2 (defining “comprehensive risk contract” and “capitation payment” for Medi-Cal plans).
- <sup>27</sup> 42 U.S.C. § 1396u-2(b)(5).
- <sup>28</sup> 42 C.F.R. § 438.68.
- <sup>29</sup> *Id.* § 438.207(a).
- <sup>30</sup> *Id.* § 438.207(d).
- <sup>31</sup> CAL. WELF. & INST. CODE § 14197.
- <sup>32</sup> See generally Coursolle, *supra* note 17.
- <sup>33</sup> See generally Nat'l Health Law Prog., *An Advocate's Guide to the Medicaid Program* (2013) (providing additional information about mandatory and optional Medicaid covered services, including citations to the Act and the Code of Federal Regulations).
- <sup>34</sup> 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>.

- <sup>35</sup> For a comprehensive list of groups covered under the mandatory categorically needy, see Nat'l Health Law Program, *supra* note 33.
- <sup>36</sup> 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.
- <sup>37</sup> 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).
- <sup>38</sup> 42 U.S.C. § 1396d(a)(2)(A); 42 C.F.R. §§ 440.2(a) (defining outpatient), 440.20(a) (defining outpatient hospital service); *State Medicaid Manual*, *supra* note 1, at § 4221 (discussing outpatient psychiatric services as outpatient hospital or clinic service).
- <sup>39</sup> 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.
- <sup>40</sup> 42 U.S.C. §§ 1396d(a)(2)(B), 1396d(l)(1); 42 C.F.R. § 440.20(b), (c).
- <sup>41</sup> 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 State Medicaid Manual*, *supra* note 1, at §§ 4231, 6303.
- <sup>42</sup> 42 U.S.C. § 1396d(a)(3); 42 C.F.R. § 440.30.
- <sup>43</sup> 42 U.S.C. §§ 1396d(a)(4)(A), 1396d(f) (defining nursing facility), 1396r (defining nursing facility and establishing certification, quality of care, and resident rights requirements); 42 C.F.R. §§ 440.40(a), 440.155, pt. 442 (standards for payment).
- <sup>44</sup> 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).
- <sup>45</sup> 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); *State Medicaid Manual*, *supra* note 1, at §§ 3311.2, 3571.2, 4421.



- <sup>46</sup> 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20; see *State Medicaid Manual, supra* note 1, at § 4270; CMS, Dear State Health Official Letter (July 2, 2010) (SHO # 16-008) (discussing family planning and family planning related services in context of new eligibility option under ACA § 2303), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf> [hereinafter SHO # 16-008].
- <sup>47</sup> 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); *State Medicaid Manual, supra* note 1, at § 4221 (discussing outpatient psychiatric services as clinic or outpatient hospital service); *Id.* § 4320.
- <sup>48</sup> 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).
- <sup>49</sup> 42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.120.
- <sup>50</sup> 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130; *State Medicaid Manual, supra* note 1, at § 4385 (preventive services).
- <sup>51</sup> 42 U.S.C. § 1396d(a)(10); 42 C.F.R. § 440.100.
- <sup>52</sup> 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”); *State Medicaid Manual, supra* note 1, at §§ 4395–4397, 4398 (discussing persons with related conditions and regulatory history of including individuals with developmental disabilities).
- <sup>53</sup> 42 U.S.C. §§ 1396a(a)(10)(C)(iii); 42 C.F.R. § 440.220(a)(1).
- <sup>54</sup> 42 C.F.R. § 440.220(a)(5).
- <sup>55</sup> 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).
- <sup>56</sup> 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 440.220(a)(3) (designating home health services as a required service).
- <sup>57</sup> See CAL. WELF. & INST. CODE § 14132.
- <sup>58</sup> 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 Law & 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](https://wclp.org/wp-content/uploads/2016/06/Western_Center_2016_Health_Care_Eligibility_Guide_Full_rev.1.pdf).
- <sup>59</sup> For more details on the scope of these programs, and detailed eligibility requirements, see Flory et al., *supra* note 58, at § 3.111–19, Ch. 7.
- <sup>60</sup> CAL. WELF. & INST. CODE § 14007.8.

- <sup>61</sup> 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 visited Nov. 30, 2022).
- <sup>62</sup> See 42 U.S.C. § 1396a(a)(10)(including text following subsection (G) of a(a)(10)).
- <sup>63</sup> 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.”).
- <sup>64</sup> 42 U.S.C. § 1396a(a)(17).
- <sup>65</sup> 42 C.F.R. § 440.230(b); see 42 U.S.C. § 1396a(a)(10)(B).
- <sup>66</sup> 42 C.F.R. § 440.230(c); see 42 U.S.C. § 1396a(a)(10)(B).
- <sup>67</sup> 42 U.S.C. § 1396a(a)(10)(B)(ii).
- <sup>68</sup> *Id.* § 1396a(a)(10)(B)(i).
- <sup>69</sup> 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).
- <sup>70</sup> See 42 U.S.C. §§ 1396n(c), 1396a(a)(10)(A)(ii)(VI), 1396n(b)-(e).
- <sup>71</sup> 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).
- <sup>72</sup> 42 U.S.C. § 1396a(a)(8).
- <sup>73</sup> 42 C.F.R. § 435.930(a).
- <sup>74</sup> See *id.* §§ 435.912, 435.930.
- <sup>75</sup> 42 U.S.C. § 1396a(a)(1); see also 42 CFR § 431.50.
- <sup>76</sup> 42 CFR § 431.50(b)(3).
- <sup>77</sup> See *id.* § 431.50(c).
- <sup>78</sup> 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>.
- <sup>79</sup> 42 U.S.C. § 1396a(23); 42 CFR § 431.51.
- <sup>80</sup> 42 U.S.C. § 1396u-2(a)(1).
- <sup>81</sup> *Id.* § 1396a(23); 42 C.F.R. § 431.51(a)(3).

<sup>82</sup> CMS, Dear State Medicaid Director Letter 2 (April 19, 2016) (SMD # 16-005), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf>.

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*

<sup>85</sup> 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). 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>.

<sup>86</sup> 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>.

<sup>87</sup> 42 U.S.C. § 18116.

<sup>88</sup> See 45 C.F.R. §§ 92.8(f)(1), 92.201.

<sup>89</sup> 42 U.S.C. § 291c(e); see also 42 C.F.R. § 124.603(a)(1).

<sup>90</sup> See HHS, *Know Your Rights Under the Community Service Assurance Provisions of the Hill-Burton Act* 1 (1990), <https://www.hhs.gov/sites/default/files/knowyourrightshillburtonfactsheet.pdf>.

<sup>91</sup> See 42 U.S.C. § 1395dd; see also 42 C.F.R. § 489.24.

<sup>92</sup> See 28 C.F.R. § 35.160

<sup>93</sup> 42 C.F.R. § 435.905(b).

<sup>94</sup> 42 U.S.C. § 1396u-2(a)(5)(A).

<sup>95</sup> See 42 C.F.R. § 483.10(g) (residents of long-term care facilities); 42 U.S.C. § 1396a(a)(43)(A) (ESPDT).

<sup>96</sup> 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/>.

<sup>97</sup> See generally Cal. Dep't Health Care Servs., All Plan Letter 21-004 (May 3, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-004.pdf>.

<sup>98</sup> See generally Cal. Dep't Health Care Servs., All Plan Letter 19-011 (Sept. 30, 2019), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-011.pdf>.

- <sup>99</sup> See U.S. CONST., AMEND. XIV, § 1.
- <sup>100</sup> *Goldberg v. Kelly*, 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).
- <sup>101</sup> 42 C.F.R. §§ 431.206, 431.210.
- <sup>102</sup> 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).
- <sup>103</sup> *Goldberg*, 397 U.S. at 267; see also 42 C.F.R. § 431.230.
- <sup>104</sup> 42 C.F.R. § 438.400(c).
- <sup>105</sup> *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 21-011 at 2 (Aug. 31, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf> [hereinafter All Plan Letter 21-011]. Cal. Dep’t Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 18-010E at 5 (March 27, 2018), [https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS\\_IN\\_18-010\\_Federal\\_Grievance\\_Appeal\\_System\\_Requirements.pdf](https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf). [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 18-010E].
- <sup>106</sup> 42 C.F.R. § 438.404.
- <sup>107</sup> 42 C.F.R. §§ 438.402(c), 431.220, 431.244.
- <sup>108</sup> CAL. WELF. & INST. CODE § 14197.3; All Plan Letter 21-011, *supra* note 105; Mental Health and Substance Use Disorder Services Information Notice No. 18-010E, *supra* note 105.
- <sup>109</sup> 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 440.230(d); *id.* §§ 456.1–456.6.
- <sup>110</sup> 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 beneficiary had exceeded the annual cap on dental services).
- <sup>111</sup> See 42 U.S.C. § 1396u-2(b)(2)(A)(i) (emergency services); 42 C.F.R. § 441.59(a) (EPSDT screens).
- <sup>112</sup> 42 C.F.R. § 438.210(a)(4).
- <sup>113</sup> 42 C.F.R. § 438.210(a)(4)(ii)(C); see also SHO # 16-008, *supra* note 46. 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>.

- <sup>114</sup> See, e.g., Cal. Dep't Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 19-026 (May 31, 2019), [https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS\\_IN\\_19-026\\_Authorization\\_of\\_SMHS.pdf](https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_IN_19-026_Authorization_of_SMHS.pdf).
- <sup>115</sup> For more resources and information about CalAIM, see Cal. Dep't Health Care Servs., CalAIM: Our Journey to a Healthier California for All, <https://www.dhcs.ca.gov/calaim#initiatives> (last visited Nov. 30, 2022). See also Cal. Health Care Found., *CalAIM Explained: A Five-Year Plan to Transform Medi-Cal* (July 26, 2021), <https://www.chcf.org/publication/calaim-explained-five-year-plan-transform-medi-cal/#who-will-calaim-help>.
- <sup>116</sup> These initiatives have been authorized in California law and are outlined at CAL. WELF. & INST. CODE §§ 14184.100–.800.
- <sup>117</sup> CMS, Approval Letter for California Advancing & Innovating Medi-Cal Section 1915(b) Waiver (Dec. 29, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-appvl-ltr.pdf>; CMS, Special Terms and Conditions for California Advancing & Innovating Medi-Cal Section 1915(b) Waiver (2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-stc.pdf>; CMS, Approval Letter for California Advancing & Innovating Medi-Cal Section 1115 Demonstration Extension (Dec. 29, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ext-appvl-12292021.pdf>. For more information and resources on the Sections 1115 and 1915(b) CalAIM waivers, see Cal. Dep't Health Care Servs., CalAIM 1115 Demonstration & 1915(b) Waiver, <https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-1115-and-1915b-Waiver-Renewals.aspx> (last visited Nov. 30, 2022).



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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## **Chapter II: Prescription Drugs**

# Chapter II: Prescription Drugs

## Outline of Medi-Cal Prescription Drug Services\*

- Prescription Drugs Covered by Medi-Cal
  - Coverage of every Food and Drug Administration approved drug
  - Excluded drugs
- Other Items Covered by Medi-Cal Rx
  - Over-the-counter medications
  - Vaccines
  - Certain medical supplies
  - Certain enteral nutrition products
- 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 prior authorization request
    - Medi-Cal Rx must respond within 24 hours of request, and
    - Dispense a 72-hour supply of covered outpatient drug in an emergency situation pending prior authorization response
- Other Utilization Controls
  - No more than 100 calendar day supply
  - Generic drugs
- 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.<sup>1</sup> Subject to certain narrow limitations, Medi-Cal must cover nearly every prescription 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” or “CDL.”

Starting in 2022, most prescription drugs for almost all Medi-Cal beneficiaries are delivered through the Medi-Cal Rx program, which is currently administered by Magellan Medicaid Administration, Inc.<sup>2</sup> The implementation of Medi-Cal Rx came about after Governor Newsom in 2019 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.<sup>3</sup> Through Medi-Cal Rx, DHCS has “carved out” the prescription drug benefit for Medi-Cal so that prescription drugs for Medi-Cal beneficiaries are paid on a fee-for-service basis, even for people who are enrolled in a managed care plan for their other Medi-Cal benefits.<sup>4</sup> Beneficiaries will still obtain their prescription from their managed care provider as long as those providers are also enrolled in Medi-Cal Rx, but those prescriptions will be reviewed by Medi-Cal Rx and not their plan, and if approved, will be filled at a Medi-Cal participating pharmacy.<sup>5</sup>

Medi-Cal Rx uses a uniform approval process as well as uniform authorization and scope-of-coverage rules for Medi-Cal prescription drugs.<sup>6</sup> For beneficiaries who had prescriptions in place before the transition to Medi-Cal Rx, the state has implemented continuity of care protections to ensure that beneficiaries do not experience gaps in their prescription drug coverage and access.<sup>7</sup>

## **A. Prescription Drugs Covered by Medi-Cal<sup>8</sup>**

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.<sup>9</sup> 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 extended-release over-the-counter cough and cold products.<sup>10</sup>

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.<sup>11</sup> Medi-Cal, however, covers both prescription and over-the-counter tobacco cessation products for all beneficiaries.<sup>12</sup>

## **B. Other Items Covered by Medi-Cal Rx**

In addition to covering most prescription medications, the Medi-Cal Rx program is responsible for providing beneficiaries with other related Medi-Cal benefits, for example, select over-the-counter medications.<sup>13</sup> Consistent with federal Medicaid law, Medi-Cal only covers over-the-counter medications dispensed when they are prescribed by an authorized prescriber.<sup>14</sup> Medi-Cal covers a limited selection of over-the-counter medications, including certain cold and cough medications, pain killers, allergy medications, contraceptives, smoking cessation preparations, and topical dermatological treatments.<sup>15</sup> Medi-Cal Rx also covers vaccines when they are billed on a pharmacy claim, including vaccines against COVID-19.<sup>16</sup>

Medi-Cal Rx also covers certain medical supplies, including insulin syringes, pen needles, lancets, and diabetic test strips.<sup>17</sup> Other medical supplies, including condoms, diaphragms / cervical caps, heparin / saline flush, continuous glucose monitoring systems, blood pressure monitoring devices and cuffs, and Covid antigen tests, are covered by Medi-Cal Rx when they are billed on a pharmacy claim, but covered by Medi-Cal managed care when they are billed on a medical claim.<sup>18</sup> Still other medical supplies, such as incontinence supplies, thermometers, alcohol wipes, and waterproof sheets, are always covered by Medi-Cal managed care plans, not Medi-Cal Rx.<sup>19</sup>

Medi-Cal Rx also covers enteral nutrition products when they are billed on a pharmacy claim, but these products are covered by Medi-Cal managed care when they are billed on a medical claim.<sup>20</sup> In addition, related supplies, including intubation tubing and pumps, are always covered by Medi-Cal managed care plans, not Medi-Cal Rx.<sup>21</sup>

## **C. Medi-Cal Contract Drug List**

DHCS maintains the Medi-Cal Contract Drugs List (CDL), which operates as preferred drug list.<sup>22</sup> That is, the CDL generally includes drugs that do not require prior authorization for coverage, 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.<sup>23</sup> In some cases, however, drugs listed on the Medi-Cal CDL may still require prior authorization for coverage (for example, a drug may require prior authorization when prescribed to treat certain conditions), although the prior authorization requirements will be noted in the CDL.<sup>24</sup> Medi-Cal covered drugs that do not appear on the CDL require prior authorization from Medi-Cal.<sup>25</sup>

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.<sup>26</sup> 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.<sup>27</sup>

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.<sup>28</sup> 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.<sup>29</sup> In addition, beneficiaries who were prescribed a particular medication that is not on the CDL prior to January 1, 2022 are entitled to continue that prescription for a period of time, depending on the drug, consistent with Medi-Cal Rx's Transition of Care Policy.<sup>30</sup>

## D. 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.<sup>31</sup> 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.<sup>32</sup>

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."<sup>33</sup> 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.<sup>34</sup> 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 request to Medi-Cal Rx in order to obtain such prior authorization.<sup>35</sup> Medi-Cal Rx must: 1) provide a response by telephone or other telecommunication device within 24 hours of the request or receipt of the prior authorization request; 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 request for prior authorization.<sup>36</sup> If DHCS or a Medi-Cal MCP denies the prior authorization request, both the beneficiary and the beneficiary's provider should receive a notice explaining why authorization was denied, and the beneficiary may request a fair hearing.<sup>37</sup>

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.<sup>38</sup> A pharmacist may not induce the Medi-Cal beneficiary to 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 prior authorization request were submitted.<sup>39</sup>

#### **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.<sup>40</sup>

## **E. 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.<sup>41</sup>
- California has adopted policies to promote the use of generic drugs.<sup>42</sup> Although the Medi-Cal program does not require generic substitution, the program is required to purchase the most cost-effective drug.<sup>43</sup>

Medi-Cal no longer charges any copayments for prescription drugs.<sup>44</sup> In addition, co-payments are not permitted for contraceptive drugs and devices.<sup>45</sup>

## **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.<sup>46</sup> These beneficiaries are entitled to and should be automatically enrolled in the Low-Income Subsidy (LIS) program.<sup>47</sup> Dual eligibles may receive Medi-Cal coverage for medications that are categorically excluded under Medicare Part D but are covered by Medi-Cal.<sup>48</sup> 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.<sup>49</sup>

# Endnotes

- <sup>1</sup> 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).
- <sup>2</sup> Cal. Dep't Health Care Servs., *Medi-Cal Rx: Transitioning Medi-Cal Pharmacy Services from Managed Care to Fee-for-Service Frequently Asked Questions* 14 (V. 13.0, 2022), [https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/faq/Medi-Cal\\_Rx\\_Transitioning\\_Medi-Cal\\_Pharmacy\\_Services\\_from\\_Managed\\_Care\\_to\\_FFS\\_FAQs.pdf](https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/faq/Medi-Cal_Rx_Transitioning_Medi-Cal_Pharmacy_Services_from_Managed_Care_to_FFS_FAQs.pdf) [hereinafter *Medi-Cal Rx FAQs*]. Note that a few drugs are still covered by Medi-Cal plans, including certain contraceptives and physician administered drugs when they are billed by a facility or institution as part of a medical claim. See Cal. Dep't Health Care Servs., All Plan Letter 20-020 at 4, 6–8 (Nov. 4, 2020), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf> [hereinafter All Plan Letter 20-020]. In addition, pharmacist services are the responsibility of Medi-Cal plans. *Id.* at 9.
- <sup>3</sup> Cal. Exec. 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>.
- <sup>4</sup> Cal. Dep't Health Care Servs., *Medi-Cal Rx Scope* (V. 5.0, 2021), <https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MediCalRxScopeV5-11222021.pdf>.
- <sup>5</sup> Cal. Dep't Health Care Servs., *Medi-Cal Rx Provider Manual* § 2.1 (2022), [https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal\\_Rx\\_Provider\\_Manual.pdf](https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf) [hereinafter *Medi-Cal Rx Provider Manual*]; see *Medi-Cal Rx FAQs*, *supra* note 2, at 14.
- <sup>6</sup> See *Medi-Cal Rx FAQs*, *supra* note 2, at 4.
- <sup>7</sup> See *id.* at 22–23; see also Cal. Dep't Health Care Servs., *Medi-Cal Rx Pharmacy Transition Policy* (V. 8.3, 2021), <https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Pharmacy-Transition-Policy-Ver8.3-4-30-2021.pdf>.
- <sup>8</sup> 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>.
- <sup>9</sup> 42 U.S.C. § 1396r-8(d)(1)(B), (4).
- <sup>10</sup> Compare *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 4.6.11 with 42 U.S.C. § 1396r-8(d)(2)(D).

- <sup>11</sup> 42 U.S.C § 1396r-8(d)(2). CMS, Dear State Medicaid Director Letter (June 24, 2011) (SMD # 11-007) (New Medicaid Tobacco Cessation Services), <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD11-007.pdf>.
- <sup>12</sup> CAL. WELF. & INST. CODE § 14134.25(b)(2).
- <sup>13</sup> All Plan Letter 20-020, *supra* note 2, at 7.
- <sup>14</sup> *Id.* § 1396r-8(k)(4); CMS, *Defining a “Prescribed Drug” and a “Covered Outpatient Drug”* 4 (Oct. 5, 2016) (No. 178), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Prescription-Drugs/Downloads/Rx-Releases/State-Releases/state-rel-178.pdf>; see also Abbi Coursolle & Liz McCaman Taylor, Nat’l Health Law Prog., *Coverage of Over-the-Counter Drugs in Medicaid* (Rev. Ed. 2022), <https://healthlaw.org/resource/coverage-of-over-the-counter-drugs-in-medicaid>.
- <sup>15</sup> For the full list of covered over-the-counter medications, see Cal. Dep’t Health Care Servs., *Medi-Cal Rx Contract Drugs List – Over-the-Counter Drugs* (2022), [https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal\\_Rx\\_Contract\\_Drugs\\_List\\_OTC\\_FINAL.pdf](https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_OTC_FINAL.pdf).
- <sup>16</sup> See Cal. Dep’t Health Care Servs., *Medi-Cal Rx Contract Drugs List – Therapeutic Classifications* 33 (2022), [https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal\\_Rx\\_CD\\_L\\_Therapeutic\\_Classifications\\_FINAL.pdf](https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_CD_L_Therapeutic_Classifications_FINAL.pdf); Cal. Dep’t Health Care Servs., *Covered Products List*, <https://medi-calrx.dhcs.ca.gov/provider/forms> (last visited Aug. 8, 2022); All Plan Letter 20-020, *supra* note 2, at 7. Vaccines provided in a facility or institution billed on a medical claim must be covered by the beneficiary’s Medi-Cal plan. *Id.* Medi-Cal will cover the Monkeypox vaccine, and providers should administer the vaccine to people when it is administered consistent with FDA and CDC but as of this writing, DHCS has not determined how providers should bill those claims. Cal. Dep’t Health Care Servs., *Coming Soon: Monkeypox Vaccines as Medi-Cal Benefits* (Aug. 5, 2022), [https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom\\_31823\\_01.aspx](https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_31823_01.aspx).
- <sup>17</sup> All Plan Letter 20-020, *supra* note 2, at 7–8; Cal. Dep’t Health Care Servs., *Covered Products List*, *supra* note 16.
- <sup>18</sup> All Plan Letter 20-020, *supra* note 2, at 7–8; Cal. Dep’t Health Care Servs., *Covered Products List*, *supra* note 16.
- <sup>19</sup> All Plan Letter 20-020, *supra* note 2, at 7–9; Cal. Dep’t Health Care Servs., *Covered Products List*, *supra* note 16.
- <sup>20</sup> All Plan Letter 20-020, *supra* note 2, at 9; Cal. Dep’t Health Care Servs., All Plan Letter 22-012 at 3 (July 11, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-012.pdf> [hereinafter All Plan Letter 22-012]; Cal. Dep’t Health Care Servs., *Covered Products List*, *supra* note 16.



- <sup>21</sup> All Plan Letter 20-020, *supra* note 2, at 9; All Plan Letter 22-012, *supra* note 20, at 30; Cal. Dep’t Health Care Servs., *Covered Products List*, *supra* note 16.
- <sup>22</sup> The Contract Drugs List may be found at <https://medi-calrx.dhcs.ca.gov/home/cdl>. Medications are listed by their generic name.
- <sup>23</sup> Cal. Dep’t Health Care Servs., *Medi-Cal Rx: Medi-Cal Contract Drugs List* (2022), <https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/MRX-CDL.pdf> [hereinafter *Medi-Cal Contract Drugs List*].
- <sup>24</sup> CAL. CODE REGS. tit. 22, § 51313.3(b); *see generally* *Medi-Cal Contract Drugs List*, *supra* note 23; *see also* *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 11.
- <sup>25</sup> CAL. CODE REGS. tit. 22, § 51313(c); *see also* *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 14.
- <sup>26</sup> *See* *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 11.0.
- <sup>27</sup> CAL. WELF. & INST. CODE § 14105.39(c)(1); CAL. CODE REGS. tit. 22, § 51313.6(a).
- <sup>28</sup> CAL. WELF. & INST. CODE § 14105.33(i).
- <sup>29</sup> CAL. WELF. & INST. CODE § 14105.33(r), (s).
- <sup>30</sup> *See* Cal. Dep’t Health Care Servs., *Medi-Cal Rx Pharmacy Transition Policy* (2021), <https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Pharmacy-Transition-Policy-Ver8.3-4-30-2021.pdf>.
- <sup>31</sup> *See* *Medi-Cal Rx Provider Manual*, *supra* note 5, at §§ 11, 14.
- <sup>32</sup> CAL. CODE REGS. tit. 22, § 51313(c)(1).
- <sup>33</sup> 42 U.S.C. § 1396r-8(d)(1)(B)(i), (5).
- <sup>34</sup> 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). *Cf.* Abbi Coursolle, Nat’l Health Law Prog., *More Transparency Needed to Ensure Medicaid Beneficiaries Have Access to Necessary Off Label Prescription Drugs* (2022), <https://healthlaw.org/wp-content/uploads/2022/04/2022-04-07-Off-Label-Paper-Final.pdf>.
- <sup>35</sup> *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 14.1.
- <sup>36</sup> CAL. WELF. & INST. CODE § 14133.37(a) & (b), 42 U.S.C. § 1396r-8(d)(5)(A) & (B); *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 14.1.
- <sup>37</sup> CAL. WELF. & INST. CODE § 14133.37(a); *see also* *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 14.1 (provider notice); *Medi-Cal Rx FAQs*, *supra* note 2, at 39 (beneficiary notice and hearing rights); Cal. Dep’t Health Care Servs., *Medi-Cal Fair Hearing*, <https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx> (last visited Aug. 3, 2022).
- <sup>38</sup> *See* *Medi-Cal Rx Provider Manual*, *supra* note 5, at § 2.1.3.4.

- <sup>39</sup> Medi-Cal fraud by providers or beneficiaries may be reported by calling the statewide Medi-Cal Fraud Hotline at 1-800-822-6222.
- <sup>40</sup> S.B. 1053, Contraceptive Coverage Equity Act (2014).
- <sup>41</sup> CAL. CODE REGS. tit. 22, § 51313(b).
- <sup>42</sup> CAL. BUS. & PROF. CODE § 4073; CAL. HEALTH & SAFETY CODE § 1367.22(a).
- <sup>43</sup> 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](http://files.medi-cal.ca.gov/pubsdoco/dur/Articles/packet20170516_25904.pdf).
- <sup>44</sup> CAL. WELF. & INST. CODE § 14134(a)(3).
- <sup>45</sup> 42 U.S.C. §§ 1396o(a)(2), (b)(2); 42 C.F.R. § 447.56(a)(2)(ii).
- <sup>46</sup> CAL. WELF. & INST. CODE § 14133.23(a).
- <sup>47</sup> 42 C.F.R. §§ 423.772, 423.773(c)(1)(i), 423.780, 423.782.
- <sup>48</sup> CAL. WELF. & INST. CODE § 14133.23(b) & (c).
- <sup>49</sup> *See* Randolph T. Boyle, Nat'l Health Law Prog., *Medicare Part D and Dual Eligibles: A Guide for California Advocates* (2008), [https://healthlaw.org/wp-content/uploads/2018/09/medicare\\_ptD\\_dualsadvocates\\_guide.pdf](https://healthlaw.org/wp-content/uploads/2018/09/medicare_ptD_dualsadvocates_guide.pdf).





# **An Advocate's Guide to Medi-Cal Services**

December 2022

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**Chapter III:  
Mental Health Services**

# Chapter III: Mental Health Services

## Outline of Medi-Cal Mental Health Services\*

- Specialty Mental Health Services
  - Rehabilitative mental health services
    - Medication support
    - Day treatment intensive care and rehabilitation
    - Crisis intervention (including community-based mobile crisis)
    - Crisis stabilization
    - Crisis 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
  - Peer Support Services
  - EPSDT Specialty Mental Health Services (including intensive care coordination, intensive home-based services, therapeutic behavioral services, and therapeutic foster care)
- Non-specialty Mental Health Services
  - Mental health evaluation and treatment (including individual, group, and family psychotherapy)
  - Psychological and neurological 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
  - Dyadic services for families
- Eating Disorder Services
- 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.<sup>1</sup> 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.<sup>2</sup> In California, Medi-Cal covers mental health services through different delivery systems: 1) specialty mental health services (SMHS) 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 ACA also requires MCPs to provide mental health services in compliance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).<sup>3</sup> 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.<sup>4</sup>

Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, effective July 1, 2022, California implemented a No Wrong Door Policy to ensure that all Medi-Cal beneficiaries receive timely mental health services without delay regardless of the delivery system where they seek care and that beneficiaries are able to maintain treatment relationships with trusted providers without interruption.<sup>5</sup> Under the No Wrong Door policy,

beneficiaries may concurrently receive NSMHS via a FFS or MCP provider and SMHS via a MHP provider, when the services are clinically appropriate, coordinated, and not duplicative.<sup>6</sup> Also, MCPs and MHPs are required to coordinate care for Medi-Cal beneficiaries receiving SMHS through a MHP and NSMHS or/ and physical health services through a MCP.<sup>7</sup> Moreover, if beneficiaries choose to transition from one service type to another (such as from receiving SMHS to NSMHS and vice versa), MHPs and MCPs must facilitate care transitions and guide referrals for beneficiaries.<sup>8</sup> DHCS is currently developing a set of statewide Screening and Transition of Care tools that will take effect in 2023 to facilitate screenings and transitions care for the SMHS, Medi-Cal Managed Care, and FFS.<sup>9</sup>

### **ADVOCACY TIP:**

- ✓ For Medi-Cal beneficiaries who are not enrolled in a Medi-Cal MCP, non-specialty mental health services are delivered through FFS Medi-Cal. Further, 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.

## A. Specialty Mental Health Services in Medi-Cal

Since 1995, California has covered Medi-Cal SMHS through a prepaid inpatient health plan (PIHP) administered by each county.<sup>10</sup> These PIHPs are known as MHPs in California.

Currently, SMHS covered by MHPs include:<sup>11</sup>

- 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;<sup>12</sup>
- targeted case management;
- psychiatrist services;
- psychologist services;
- psychiatric nursing facility services;
- EPSDT services (including intensive care coordination, intensive home-based services, therapeutic behavioral services, and therapeutic foster care); and
- peer support services.

Effective January 1, 2023, in addition to the existing “crisis intervention services,” Medi-Cal will also cover “community-based mobile crisis intervention service” for all ages.<sup>13</sup> Crisis intervention services are “unplanned, expedited services, to or on behalf of a beneficiary to address a condition that requires more timely response than a regularly scheduled visit.”<sup>14</sup> They may be provided “anywhere in the community” but are not required to be mobile or 24/7.<sup>15</sup> MHPs are required to cover crisis intervention services as part of the requirements pursuant to their contract with DHCS.<sup>16</sup> MHPs are also required to cover crisis intervention services under EPSDT to those under age 21. Currently, DHCS has requested federal approval to for its new “community-based mobile crisis intervention” Medi-Cal benefit pursuant to Section 9813 of the American Rescue Plan Act of 2021 (ARPA).<sup>17</sup> To receive federal matching funding under the ARPA, the community-based mobile crisis service must meet all of the qualifying requirements, such as 24/7, multi-disciplinary, mobile, and not taking place in a hospital or other facility settings.<sup>18</sup>

MHPs must operate a utilization management program that ensures beneficiaries have appropriate access to SMHS and must follow all clinical documentation requirements for SMHS.<sup>19</sup> MHPs also must make SMHS available 24 hours a day, seven days a week, as needed to treat a beneficiary’s urgent condition.<sup>20</sup> An urgent psychiatric condition exists when, without timely intervention, the beneficiary’s condition is “highly likely to result in an immediate emergency psychiatric condition.”<sup>21</sup> 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 SMHS to beneficiaries and providers, and to facilitate authorization of urgent mental health services.<sup>22</sup>

While prior authorization or MHP referral is required for some SMHS, including intensive home-based services (IHBS), day treatment intensive, day rehabilitation, therapeutic behavioral services, and therapeutic foster care, prior authorization may NOT be required for mental health assessment services (including initial assessment), crisis intervention, crisis stabilization, targeted case management, intensive care coordination, peer support services, and medication support services.<sup>23</sup> Additionally, each MHP is financially responsible for payment of emergency psychiatric services provided to its enrollees.<sup>24</sup> MHPs may not require prior authorization for emergency services.<sup>25</sup> Emergency psychiatric services are covered by the MHP when the recipient has been admitted to a hospital or a psychiatric health facility due to either being a current danger to self or others, or unable to provide for, or utilize, food, shelter or clothing, due to a mental disorder.<sup>26</sup>

MHPs have additional obligations to certain Medi-Cal beneficiaries. For example, MHPs are obligated to reimburse Indian Health Care Providers (IHCPs) for the provision of SMHS to all American Indian/Alaska Native (AI/AN) Medi-Cal beneficiaries, even when the IHCP is not contracted with the MHP.<sup>27</sup> Also, each MHP must make a good faith effort to contract with all IHCPs located in the MHP's county and document those efforts.<sup>28</sup>

## **1. Specialty Mental Health Services for Beneficiaries over the age of 21**

For individuals 21 years of age or older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.<sup>29</sup> These beneficiaries are eligible for SMHS when meeting both of the following criteria:<sup>30</sup>

- The beneficiary has one or both of the following:
  - Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.
  - A reasonable probability of significant deterioration in an important area of life functioning.
- The beneficiary's condition is due to either of the following:
  - A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.
  - A suspected mental disorder that has not yet been diagnosed.

Pursuant to changes adopted through CalAIM, a mental health diagnosis is not a prerequisite to access covered SMHS.<sup>31</sup>

MHPs are required to establish and implement written policies and procedures for the authorization of SMHS (whether voluntary or involuntary) and to include the procedures for obtaining benefits (including any requirements for service authorizations or/and referrals for SMHS) in the beneficiary handbook.<sup>32</sup> MHPs also must disclose to beneficiaries, upon request, the utilization management or utilization review policies and procedures that the MHP (or any entity that the MHP contracts with) uses to authorize, modify, or deny SMHS.<sup>33</sup>

All MHP decisions to modify or deny a treatment request shall be made by a physician or psychologist who has appropriate expertise in addressing the beneficiary's behavioral health needs.<sup>34</sup> If a MHP modifies or denies an authorization request, the MHP shall notify the beneficiary in writing of the adverse benefit determination before the hospital discontinues inpatient psychiatric hospital services.<sup>35</sup> Also, if a MHP denies a hospital's authorization request, it must work with the treating provider to develop a plan of care that is appropriate for the needs of the beneficiary before any service and payment for services may be discontinued.<sup>36</sup> MHPs may conduct retrospective authorization of inpatient SMHS under limited circumstances.<sup>37</sup>

## 2. 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 provide a broader array of services to beneficiaries under age 21. Specifically, consistent with federal and state law, MHPs must provide services when they are necessary to correct or ameliorate a child or adolescent's illness or condition, which extends to mental health conditions.<sup>38</sup> Furthermore, pursuant to state guidance implementing federal EPSDT and state law requirements, MHPs are required to provide all medically necessary SMHS to any beneficiary under age 21 who meet either of the following criteria:

**Criteria 1:** has a condition placing the youth at high risk for a mental health disorder due to experiencing trauma evidenced by scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.<sup>39</sup>

**Criteria 2:** (a) has "a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing developmentally as appropriate, **or** a need for SMHS regardless of the presence of an impairment, that are not included as NSMS required to be provided by the MCP, **and** (b) has a diagnosed mental disorder, a suspected mental disorder not yet diagnosed, or a significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.<sup>40</sup> A mental health diagnosis is not required, and a suspected mental health disorder that has not



yet been diagnosed, or significant trauma placing the beneficiary at risk of a future mental health condition, also can be a qualifying factor.

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.”<sup>41</sup> Some SMHS 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.<sup>42</sup>

MHPs are obligated to provide any medically necessary intensive care coordination, intensive home-based services, and therapeutic behavioral services to all children and youth under the age of 21 eligible for full-scope Medi-Cal.<sup>43</sup> Each MHP must make these services available in all geographic service areas served by the MHP and may not restrict eligibility to children who have open child welfare services cases.<sup>44</sup>

Beneficiaries under 21 under may be able to access services through the Short Term Residential Therapeutic Program (STRTP). STRTP was established through the Continuum of Care Reform to provide SMHS to children with mental health needs within a short-term residential therapeutic setting that relies on integrated trauma-informed community care to assist in resiliency and permanency outcomes for the child.<sup>45</sup> Starting October 1, 2021, a Qualified Individual Assessment must be completed any time a child or youth is placed in a STRTP to determine if the child or youth’s needs may instead be met with family members, in a family home, or in one of the other approved settings.<sup>46</sup> MHPs are responsible for certifying the person completing the Qualified Individual Assessment, which should be a SMHS provider who may recommend appropriate SMHS services for the child or youth.<sup>47</sup> Family-based aftercare services must also be provided to families as a medically necessary SMHS, if all necessary federal approvals are obtained, state and federal Medi-Cal requirements are met, and federal financial participation is not jeopardized.<sup>48</sup>

## **ADVOCACY TIP:**

- ✓ 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 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 a service delivery dispute to DHCS if they are unable to resolve them on their own.<sup>49</sup>
- ✓ If there is a dispute between a hospital, provider or beneficiary, and the MCP about the need for transportation, the beneficiary may file a grievance or appeal with the MCP and also contact the Ombudsman's Office.
- ✓ The County of Responsibility listed in MEDs, MEDSLITE, and Automated Eligibility Verification System (AEVS) file determines which county's MHP is responsible for providing or arranging SMHS, approving care, and paying claims for medically necessary services for beneficiaries. If there is any dispute, the county identified in the system shall provide, arrange, and pay for all eligible services, no matter where the beneficiary is located or residing, until the dispute is resolved and another MHP is determined responsible.<sup>50</sup>

### ***Non-Medical Transportation and Non-Emergency Medical Transportation***

Medi-Cal beneficiaries in behavioral health inpatient and residential facilities may receive transportation services, both during the stay and after discharge, and after discharge from an emergency department visit:<sup>51</sup>

- If the beneficiary is enrolled in a Medi-Cal MCP, the MCP must arrange for and provide Non-Medical transportation (NMT) or Non-emergency medical transportation (NEMT) in the following situations: (i) Transportation to medical, dental, or behavioral health appointments for all Medi-Cal services, including those not covered by the MCP contract; (ii) Transportation for transfer from general acute care hospitals or emergency departments to psychiatric facilities, including psychiatric hospitals, skilled nursing facilities, and mental health rehabilitation centers; or (iii) Transportation after discharge from an admission (inpatient or residential care, whether or not the facility is an Institution for Mental Diseases, emergency visit, or an out of county facility).
- If the beneficiary is not enrolled in a MCP (or is in FFS Medi-Cal) and needs NEMT, the providers should have access to NEMT providers 24/7 in their area

(or if none is available, access to DHCS's helpline). If the beneficiary is in FFS Medi-Cal and needs NMT, the beneficiary can either call a previously used NMT provider, access a provider from the approved NMT providers list, call NMT in nearby counties, or send a request to DHCS.<sup>52</sup>

### **Peer Support Services**

Effective July 1, 2022, Peer Support Services are an optional behavioral health Medi-Cal benefit in California.<sup>53</sup> Peer Support Services are a distinct service type under the SMHS System for counties that opt in to cover the service.<sup>54</sup> The benefit also adds Peer Support Specialists as a distinct Medi-Cal provider type. Peer support services are “culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.”<sup>55</sup> Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.<sup>56</sup>

Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals (family members or other people supporting the beneficiary) if the purpose of their participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. They include the following components:<sup>57</sup>

- Educational Skill Building Groups: a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills;
- Engagement: encouraging and supporting beneficiaries to participate in behavioral health treatment, including supporting beneficiaries in their transitions between levels of care;
- Therapeutic Activity: a structured non-clinical activity provided to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills.

Peer Support Specialists are individuals who have been successful in the recovery process and wish to use their lived experience to help others in similar situations. Peer Support Specialists providing Medi-Cal benefits must receive Peer Support Specialist Certification consistent with DHCS guidance and deliver the new Peer Support Services Medi-Cal benefit.<sup>58</sup> A county or an agency representing the county is responsible for developing, overseeing, and enforcing a peer support specialist certification program.<sup>59</sup> Peer Support Specialists are

not required to complete any areas of specialization training, although certification programs are required to make areas of specialization training available to Peer Support Specialists.<sup>60</sup> Certified Peer Support Specialists must be over the age of 18.<sup>61</sup>

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

Since 2014, MCPs have been required to deliver non-specialty mental health services (NSMHS) to their enrollees. As part of the Affordable Care Act (ACA), starting on January 1, 2014, California was required to provide behavioral health services, including mental health services, to the Medicaid Expansion population.<sup>62</sup> 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.<sup>63</sup>

To implement the alignment, California requires MCPs to cover the following mental health services:<sup>64</sup>

- Mental health evaluation and treatment (including individual, group, and family psychotherapy);
- Psychological and neurological 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;
- Psychiatric consultation; and
- Dyadic care services.

NSMHS are covered by the MCPs even when: 1) services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met; 2) services are not included in an individual treatment plan; 3) the member has a co-occurring substance use disorder (SUD); or 4) NSMHS and SMHS services are already provided concurrently, as long as those services are coordinated and not duplicated.<sup>65</sup> Further information on SUD can be found in Chapter IV of this Guide.

### **1. Non-Specialty Mental Health Services for ages 21 and over**

MCPs must provide NSMHS for members of any age with potential mental health disorders not yet diagnosed and members who are 21 years of age and older with “mild to moderate impairment of mental, emotional, or behavioral functioning.”<sup>66</sup> For this reason, the scope of services provided by the Medi-Cal plans to adult enrollees is sometimes referred to as “mild to moderate.” NSMHS services must be provided to beneficiaries age 21 and over when they are “reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.”<sup>67</sup>

Additional requirements may apply for certain conditions. For example, MCPs must cover up to 20 individual and/ or group counseling sessions for pregnant and postpartum individuals with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth.<sup>68</sup>

## 2. Non-Specialty Mental Health Services for Children and Youth Under Age 21

As described above, both specialty and non-specialty mental health services must be provided under federal EPSDT obligations to beneficiaries under age 21 when they are necessary to correct or ameliorate a child's or adolescent's illness or condition.<sup>69</sup> Therefore, children and youth are entitled to non-specialty and specialty mental health services regardless of the severity of their condition.<sup>70</sup>

MCPs have obligations to provide EPSDT screening services and NSMHS to all members under age 21.<sup>71</sup> MCPs must provide psychotherapy to members under the age of 21 with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder diagnosis.<sup>72</sup>

Effective January 2023, Medi-Cal also covers dyadic services for families, which are integrated physical and behavioral health screenings and services provided to the entire family based on a child's Medi-Cal eligibility, even if other family members are not eligible for Medi-Cal.<sup>73</sup> The dyadic services benefit will allow providers to offer family and caregiver focused services at the child's medical visits.<sup>74</sup> Specific services offered to family members and caregivers through the dyadic services benefit may include screening, assessment, evaluation, and case management services, in addition to integrated behavioral health services, tobacco cessation counseling, and alcohol and/or drug use Screening, Brief Interventions and Referral to Treatment (SBIRT).<sup>75</sup>

### ADVOCACY TIP:

- ✓ While plans are responsible for different services, they still have a responsibility to coordinate services between plans. These coordination obligations are spelled out in Memorandums of Understanding (MOUs) between plans.<sup>76</sup> 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.<sup>77</sup> The dispute resolution process between plans is required to ensure that beneficiaries have continued access to medically necessary services while the dispute is pending.<sup>78</sup>

MCPs cannot require prior authorization for an initial mental health assessment. Psychological services are covered services when ordered by a PCP, but if a PCP cannot perform the mental health assessment because it is outside of their scope of practice, they must refer the beneficiary to the appropriate mental health provider. If a recipient has fee-for-service Medi-Cal and is not enrolled in an MCP, the recipient can go to any Medi-Cal provider who accepts Medi-Cal and provides mental health services.<sup>79</sup>

### **C. Eating Disorders Services**

Eating Disorders are complex conditions that involve both physical and psychological symptoms and complications.<sup>80</sup> Thus, MCPs and MHPs share joint responsibility to provide medically necessary services to Medi-Cal beneficiaries with eating disorders. While MCPs are responsible for the physical health components of eating disorder treatment and NSMHS (including comprehensive medical case management services), MHPs are responsible for the SMHS components of eating disorder treatment (including both inpatient and outpatient).

### **D. Psychotherapeutic Medications**

Psychotherapeutic medications in Medi-Cal are provided through the Medi-Cal Rx program.<sup>81</sup> These medications may be prescribed by either an MCP or MHP provider, and fulfilled by a participating pharmacy.<sup>82</sup> In general, MCPs are responsible for coordinating the provision of these carved-out medications to their enrollees.<sup>83</sup> Prescribing and administration of psychotropic medications requires specific procedures and informed consent from the beneficiary or appropriate authorizing entity.<sup>84</sup>



# Endnotes

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- <sup>1</sup> Most mental health services are provided pursuant to the rehabilitative services option (42 U.S.C. § 1396d(a)(xvii)(13); 42 C.F.R. § 440.130(c)) or other licensed practitioner option (42 U.S.C. § 1396d(a)(xvii)(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)(xvii)(12), 1396r-8; 42 C.F.R. § 440.120), or targeted case management (42 U.S.C. § 1396n(g)).
- <sup>2</sup> 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., Mental Health and Substance Use Disorder Services Information Notice No. 16-061 (Dec. 9, 2016), [https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS\\_16-061.pdf](https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS%20Information%20Notices/MHSUDS_16-061.pdf) [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 16-061].
- <sup>3</sup> 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.
- <sup>4</sup> 42 U.S.C. § 300gg-26.
- <sup>5</sup> CAL. WELF. & INST. CODE § 14184.402(f)(1). Cal. Dep't Health Care Servs., CalAIM, <https://www.dhcs.ca.gov/calaim> (last visited Aug. 3, 2022); see also Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-011 (March 31, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf>; see also Cal. Dep't Health Care Servs., All Plan Letter 22-005 (March 30, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-005.pdf> [hereinafter All Plan Letter 22-005]; and Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-073 at 5 (Dec. 10, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-073-Criteria-for-Beneficiary-to-Specialty-MHS-Medical-Necessity-and-Other-Coverage-Req.pdf> [hereinafter Behavioral Health Information Notice No. 21-073].
- <sup>6</sup> All Plan Letter 22-005, *supra* note 5.
- <sup>7</sup> MCPs are required to provide medical case management and cover all medically necessary Medi-Cal covered physical health care services for beneficiaries receiving SMHS through MHPs. Cal. Dep't Health Care Servs., All Plan Letter 22-006 (April 8, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-006.pdf> [hereinafter All Plan Letter 22-006].
- <sup>8</sup> *Id.*
- <sup>9</sup> *Id.*

- <sup>10</sup> 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 1915(b) waiver for a five-year period starting on January 1, 2022. CMS, Approval Letter for California Advancing & Innovating Medi-Cal Section 1915(b) Waiver (Dec. 29, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-appvl-ltr.pdf> [hereinafter Approval Letter for CalAIM Section 1915(b) Waiver]; CMS, Special Terms and Conditions for California Advancing & Innovating Medi-Cal Section 1915(b) Waiver (2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-stc.pdf>.
- <sup>11</sup> CAL. CODE REGS. tit. 9, § 1810.247; see also Cal. Dep’t Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 18-054, Enclosure 1, at 3 (Nov. 2 2018), [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](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) [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 18-054]; Cal. Dep’t Health Care Servs., All Plan Letter 17-018 (Oct. 17, 2017), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-018.pdf> [hereinafter All Plan Letter 17-018]. See also Cal. Dep’t Health Care Servs., Peer Support Services, <https://www.dhcs.ca.gov/services/Pages/Peer-Support-Services.aspx> (last visited Aug. 8, 2022).
- <sup>12</sup> MHPs cover the following inpatient specialty mental health services: acute psychiatric inpatient hospital services, psychiatric health facility services, and psychiatric inpatient hospital professional services. CAL. CODE REGS. tit. 9, §§ 1810.201, .237, .237.1, .238, .239, .345, .350. See also Cal. Dep’t Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 18-008 (Feb. 7, 2018), [https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS\\_Information\\_Note\\_18-008-IMD-FINAL.pdf](https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_Information_Note_18-008-IMD-FINAL.pdf). In general, MHPs only provide inpatient care in hospitals that participate in FFS Medi-Cal. See CAL. CODE REGS. tit. 9, § 1820.100(a); see also All Plan Letter 17-018, *supra* note 11, at 10.
- <sup>13</sup> Cal. Dep’t Health Care Servs., Mobile Crisis Services, <https://www.dhcs.ca.gov/Pages/CalAIM-Mobile-Crisis-Services-Initiative.aspx> (last visited Dec. 17, 2022). See also Cal. Dep’t Health Care Servs., Draft Behavioral Health Information Notice No. 22-XXX (Nov. 9, 2022), <https://www.dhcs.ca.gov/Documents/Mobile-Crisis-BHIN-for-Stakeholder-Feedback-11-9-22.pdf> [hereinafter Draft Behavioral Health Information Notice No. 22-XXX].

- <sup>14</sup> Cal. Dep't Health Care Servs., State Plan Amendment Request # 22-0043 (Oct. 24, 2022), <https://www.dhcs.ca.gov/Documents/SPA-22-0043-Pending-Redacted.pdf>.
- <sup>15</sup> CAL. CODE REGS. tit. 9, § 1840.336.
- <sup>16</sup> Cal. Dep't Health Care Servs., *Mental Health Plan Boilerplate Contract*, Exhibit A, Attachment 2 (2022), <https://www.dhcs.ca.gov/Documents/2022-27-MHP-Contract-Exhibit-A-PSS-Boilerplate-and-Exhibit-B-E.pdf>.
- <sup>17</sup> 42 U.S.C. § 1396w-6.
- <sup>18</sup> Id. at § 1396w-6(b). See also Draft Behavioral Health Information Notice No. 22-XXX, *supra* note 13, at 4.
- <sup>19</sup> CAL. CODE REGS. tit. 9 § 1810.440(b); 42 C.F.R., § 438.210, subd. (b)(1), (b)(2); The clinical documentation requirements took effect on July 1, 2022 and applies to all SMHS, DMC, and DMC-ODS services. CAL. WELF. & INST. CODE § 14184.402; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-019 (April 22, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-019-Documentation-Requirements-for-all-SMHS-DMC-and-DMC-ODS-Services.pdf>.
- <sup>20</sup> CAL. CODE REGS. tit. 9, § 1810.405(c); Mental Health and Substance Use Disorder Services Information Notice No. 18-054, *supra* note 11, at 4.
- <sup>21</sup> CAL. CODE REGS. tit. 9, § 1810.253.
- <sup>22</sup> CAL. CODE REGS. tit. 9, § 1810.405(d).
- <sup>23</sup> Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-016 (April 15, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-016-Authorization-of-Outpatient-Specialty-Mental-Health-Services.pdf>.
- <sup>24</sup> 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>.
- <sup>25</sup> CAL. CODE REGS. tit. 9, § 1820.220(l)(2); Cal. Dep't Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 19-026 (May 31, 2019), [https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS\\_IN\\_19-026\\_Authorization\\_of\\_SMHS.pdf](https://www.dhcs.ca.gov/services/MH/Documents/FMORB/MHSUDS_IN_19-026_Authorization_of_SMHS.pdf) [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 19-026]
- <sup>26</sup> CAL. CODE REGS. tit. 9, §§ 1820.225(b), 1820.200(d); see also Mental Health and Substance Use Disorder Services Information Notice No. 19-026, *supra* note 25, at 8; Mental Health and Substance Use Disorder Services Information Notice No. 18-054, *supra* note 11, Enclosure 1, at 3.
- <sup>27</sup> 42 C.F.R. § 438.14(b); see also Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-020 (April 27, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-020-County-Mental-Health-Plan-Obligations-Related-to-Indian-Health-Care-Providers.pdf>.
- <sup>28</sup> Cal. Dep't Health Care Servs., *supra* note 27.

- <sup>29</sup> CAL. WELF. & INST. CODE § 14184.402(a).
- <sup>30</sup> CAL. WELF. & INST. CODE § 14184.402(c); Behavioral Health Information Notice No. 21-073, *supra* note 5, at 3.
- <sup>31</sup> CAL. WELF. & INST. CODE § 14184.402(f)(1)(A). *See also* Behavioral Health Information Notice No. 21-073, *supra* note 5, at 6.
- <sup>32</sup> Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 22-017 at 4–5 (April 15, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-017-Concurrent-Review-Standards-and-Updated-Criteria-for-Psychiatric-Inpatient-Hospital.pdf>.
- <sup>33</sup> *Id.* at 5.
- <sup>34</sup> *Id.* at 9.
- <sup>35</sup> *Id.*
- <sup>36</sup> *Id.* at 9–10.
- <sup>37</sup> *Id.* at 11.
- <sup>38</sup> 42 U.S.C. § 1396d(r)(5); CAL. WELF. & INST. CODE §§ 14059.5(a), 14184.402(a). *See also* Behavioral Health Information Notice No. 21-073, *supra* note 5, at 3.
- <sup>39</sup> Behavioral Health Information Notice No. 21-073, *supra* note 5, at 4.
- <sup>40</sup> *Id.*
- <sup>41</sup> CAL. CODE REGS. tit. 9, § 1810.215. For more information on covered SMHS for beneficiaries under 21, see Behavioral Health Information Notice No. 21-073, *supra* note 5.
- <sup>42</sup> *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](https://www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf); *see also* Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 21-058 (Sept. 17, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-058-Claiming-for-Intensive-Care-Coordination.pdf> [hereinafter Behavioral Health Information Notice No. 21-058] (describing requirements for intensive care coordination, intensive home-based services, and therapeutic foster care services); For more information about the EPSDT requirements, see Chapter VIII of this Guide on Children’s Health Services.
- <sup>43</sup> *See generally* Behavioral Health Information Notice No. 21-058, *supra* note 42.
- <sup>44</sup> *Id.* at 2.
- <sup>45</sup> Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 21-060 at 3 (Sept. 30, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-060-ACIN-21-113-FFPSA-QI-ACL.pdf>.
- <sup>46</sup> *Id.* at 5.

- <sup>47</sup> Behavioral Health Information Notice No. 21-058, *supra* note 42, at 6.
- <sup>48</sup> *Id.*; see also Cal. Dep't Health Care Servs. and Dep't Social Servs., *FFPSA Part IV Aftercare Requirements* (Sept. 30, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-061-CDSS-DHCS-FFPSA-Aftercare-Letter.pdf>.
- <sup>49</sup> Dispute Resolution Process Guidance to MHPs is provided in the Behavioral Health Information Notice, and guidance to MCPs is provided in the All Plan Letter. See Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-034 (Oct. 4, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-034-Dispute-Resolution-Process-Between-MHPs-and-MCPs.pdf> [hereinafter Behavioral Health Information Notice No. 21-034]; see Cal. Dep't Health Care Servs., All Plan Letter 21-013 (Oct. 4, 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-013.pdf> [hereinafter All Plan Letter 21-013].
- <sup>50</sup> Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-072 (Dec. 9, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-072-County-of-Responsibility-for-SMHS-Arbitration-Between-MHPs.pdf>.
- <sup>51</sup> Non-medical transportation (NMT) is for beneficiaries who do not need medical assistance during transit and non-emergency medical transportation (NEMT) is for when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated. See Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-031 (May 23, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-031-Transportation-for-Beneficiaries-Receiving-BH-Residential-Inpatient-or-Emergency-Department-Services.pdf>.
- <sup>52</sup> *Id.*; Approved Nonmedical Transportation Providers is listed by county. Cal. Dep't Health Care Servs., List of Approved Nonmedical Transportation Providers, <https://www.dhcs.ca.gov/services/medi-cal/Documents/List-of-Approved-Nonmedical-Transportation-Providers.pdf> (last visited Aug. 9, 2022).
- <sup>53</sup> CAL. WELF. & INST. CODE § 14045.14; See also Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-018 (April 21, 2022), [https://www.dhcs.ca.gov/Documents/CSD\\_YV/BHIN/BHIN-22-018.pdf](https://www.dhcs.ca.gov/Documents/CSD_YV/BHIN/BHIN-22-018.pdf); see also Cal. Dep't Health Care Servs., Medi-Cal Peer Support Specialist Certification Program Implementation (July 22, 2021), [https://www.dhcs.ca.gov/Documents/CSD\\_BL/BHIN-21-041.pdf](https://www.dhcs.ca.gov/Documents/CSD_BL/BHIN-21-041.pdf).
- <sup>54</sup> See Cal. Dep't Health Care Servs., Peer Support Services, <https://www.dhcs.ca.gov/services/Pages/Peer-Support-Services.aspx> (last visited Aug. 17, 2022). The service is also available for people with substance use disorders in Drug Medi-Cal (DMC) and Drug Medi-Cal Organized Delivery System (DMC-ODS) programs in participating counties. See Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-026 (May 6, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-026-Drug-Medi-Cal-Drug-Medi-Cal-Organized-Delivery-System-SMHS-Peer-Support-Services.pdf> [hereinafter Behavioral Health Information Notice No. 22-026].



- <sup>55</sup> Behavioral Health Information Notice No. 22-026, *supra* note 54, at 2.
- <sup>65</sup> *Id.*
- <sup>57</sup> *Id.* at 3.
- <sup>58</sup> Cal. Dep't Health Care Servs., *Peer Support Specialists- FAQs* (Aug. 16, 2021), [https://www.dhcs.ca.gov/Documents/CSD\\_BL/Peer-Support-Services/FAQ-Peer-Support-Specialists.pdf](https://www.dhcs.ca.gov/Documents/CSD_BL/Peer-Support-Services/FAQ-Peer-Support-Specialists.pdf).
- <sup>59</sup> *Id.*
- <sup>60</sup> Specializations may include: (1) Parent, Caregiver, Family Member, (2) Working with Persons who are unhoused, (3) Working with Persons who are Involved in the Criminal Justice System, and (4) Working with Person who are in Crisis. Cal. Dep't Health Care Servs., *Peer Support Specialists: Areas of Specialization* (June 14, 2022), [https://www.dhcs.ca.gov/Documents/CSD\\_BL/Peer-Support-Services/Peers-Areas-of-Specialization-webinar-06-14-22.pptx](https://www.dhcs.ca.gov/Documents/CSD_BL/Peer-Support-Services/Peers-Areas-of-Specialization-webinar-06-14-22.pptx).
- <sup>61</sup> *Id.*
- <sup>62</sup> 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), (last visited Aug. 2, 2022).
- <sup>63</sup> 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 62, at 2-3 (discussing benefit alignment).
- <sup>64</sup> All Plan Letter 17-018, *supra* note 11, at 4; Behavioral Health Information Notice No. 21-073, *supra* note 5, at 6. *See also* Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Services* (Dec. 2021), <https://filessysdev.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/nonspecmental.pdf>; 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.
- <sup>65</sup> All Plan Letter 22-006, *supra* note 7, at 4.
- <sup>66</sup> *Id.* at 4.
- <sup>67</sup> CAL. WELF. & INST. CODE § 14059.5(a).
- <sup>68</sup> Cal. Dep't Health Care Servs., All Plan Letter 22-006, *supra* note 7, at 4.
- <sup>69</sup> 42 U.S.C. § 1396d(r)(5); CAL. WELF. & INST. CODE §§ 14059.5(a), 14184.402(a). *See also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-073, *supra* note 5, at 3.
- <sup>70</sup> Behavioral Health Information Notice No. 21-073, *supra* note 5, at 7.



- <sup>71</sup> Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-003 (Feb. 3, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-003-Medi-Cal-Substance-Use-Disorder-Treatment-Services-for-Beneficiaries-under-age-21.pdf>.
- <sup>72</sup> All Plan Letter 22-006, *supra* note 7, at 4.
- <sup>73</sup> CAL. WELF. & INST. CODE § 14132.755; see also Cal. Dep't Health Care Servs., *Medi-Cal Strategy to Support Health and Opportunity for Children and Families* (March 2022), <https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf>.
- <sup>74</sup> CAL. WELF. & INST. CODE § 14132.755(b).
- <sup>75</sup> *Id.*
- <sup>76</sup> See CAL. CODE REGS. tit. 9, § 1810.370; 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>.
- <sup>77</sup> CAL. CODE REGS. tit. 9, §§ 1850.505–.535.
- <sup>78</sup> CAL. WELF. & INST. CODE § 14184.402(g); CAL. CODE REGS. tit. 9, § 1850.525. See also Behavioral Health Information Notice No. 21-034, *supra* note 49; All Plan Letter 21-013, *supra* note 51.
- <sup>79</sup> Kim Lewis & Rachel Velcoff Hults, Nat'l Health Law Prog. and Nat'l Center for Youth Law, *Medi-Cal Family Therapy Benefit* (2022), [https://healthlaw.org/wp-content/uploads/2022/04/Medi-Cal-Family-Therapy-Benefit\\_for-publication.pdf](https://healthlaw.org/wp-content/uploads/2022/04/Medi-Cal-Family-Therapy-Benefit_for-publication.pdf) (last visited Aug. 2, 2022).
- <sup>80</sup> Cal. Dep't Health Care Servs., All Plan Letter 22-003 (March 17, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL-22-003.pdf>; see also Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-009 (March 16, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-009-Eating-Disorders.pdf>.
- <sup>81</sup> See Chapter II of this Guide for more information about Medi-Cal Rx.
- <sup>82</sup> See Cal. Dep't Health Care Servs., *Medi-Cal Rx Provider Manual* § 2.1 (2022), [https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal\\_Rx\\_Provider\\_Manual.pdf](https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf).
- <sup>83</sup> See Cal. Dep't Health Care Servs., All Plan Letter 22-012 at 7, 13 (July 11, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-012.pdf>.
- <sup>84</sup> See *id.* at 22; see generally Cal. Dep't Health Care Servs., *Mental Health and Substance Use Disorder Services Information Notice No. 17-040* (Aug. 24, 2017), [https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN\\_17-040\\_MHSUDS\\_Chart\\_Documentation\\_Information\\_Notice.pdf](https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN_17-040_MHSUDS_Chart_Documentation_Information_Notice.pdf).



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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## **Chapter IV: Substance Use Disorder Services**

# Chapter IV: Substance Use Disorder Services

## Outline of Medi-Cal Substance Use Disorder Services\*

- SUD Preventative Services
  - Alcohol and Drug Use Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)
    - Screening of unhealthy alcohol and drug use
    - Brief Assessment
    - Brief Interventions and Referral to 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
  - Care Coordination
  - Clinician Consultation
  - Partial Hospitalization
  - Medication-Assisted Treatment Services at Alternative Sites
  - Contingency Management Services for Stimulant Use Disorders
  - Peer Support Services
  - Traditional Healers and Natural Helpers
  - Crisis Intervention Services (including mobile crisis services)
- Voluntary Inpatient Detoxification

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

California significantly expanded coverage of substance use disorder (SUD) services in the Medi-Cal state plan 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.<sup>1</sup>

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).<sup>2</sup> As a result, SUD services cannot be subject to limitations that are more onerous than those limitations typically imposed on physical and surgical benefits.<sup>3</sup>

Subsequent to this expansion, in 2015, California added new SUD services in Medi-Cal through a Section 1115 waiver as part of the Drug Medi-Cal Organized Delivery System (DMC-ODS). This program, first approved in 2015 and subsequently extended with some modifications in 2021, remains the main vehicle by which most Medi-Cal beneficiaries with SUD access these vital services. In 2022, California made additional changes to the DMC-ODS Program through a new initiative called California Advancing and Innovating Medi-Cal (CalAIM) through renewed Section 1115 and 1915b Medi-Cal waivers.

## A. SUD Preventive Services

### 1. Alcohol and Drug Use Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT)

Medi-Cal provides coverage for all preventive services identified as United States Preventive Services Task Force (USPSTF) grade "A" and "B" recommendations.<sup>4</sup> Pursuant to USPSTF recommendation, preventive alcohol and drug use services are available for beneficiaries 11 years of age and older through the SABIRT benefit.<sup>5</sup> Medi-Cal MCPs are responsible for the availability of SABIRT services for MCP enrollees, while Medi-Cal primary care providers (PCP) are responsible for SABIRT services to Fee-for-Service (FFS) Medi-Cal beneficiaries.<sup>6</sup> Providers are responsible for maintaining proper documentation about SABIRT services rendered and any referrals made to alcohol and SUD programs.<sup>7</sup>

#### ADVOCACY TIP:

✓ While coverage of SABIRT services is technically available to Medi-Cal beneficiaries 11 years of age and older, all beneficiaries under 21 continue to be eligible for screening and preventive alcohol and SUD services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.<sup>8</sup> When an EPSDT screening and assessment shows a risk of developing an alcohol use disorder (AUD) or an SUD, beneficiaries in all counties may receive early intervention services under the outpatient services modality of the DMC-ODS program (described in more detail below).

SABIRT services are provided by PCPs within their scope of practice. Such providers may include physicians, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, licensed clinical social workers, licensed professional clinical counselors, psychologists, and licensed marriage and family therapists.<sup>9</sup> The benefit is divided into the following three components:

- **Screening of unhealthy alcohol and drug use:** This type of screening is performed to determine the level of risk for unhealthy alcohol and drug use. Screening must be performed using one of the validated screening forms, which include, but are not limited to *Tobacco, Alcohol, Prescription Medication, and Other Substance Use (TAPS)*; *Alcohol Use Disorders Identification Test (AUDIT-C)*; *Drug Abuse Screening Test (DAST-10)*; *Parents, Partner, Past and Present (4Ps)* for pregnant women and adolescents.<sup>10</sup>
- **Brief Assessment:** PCPs typically (but not always) perform these brief assessments when a screening is positive to determine the presence of unhealthy alcohol and drug use. The tools used for these assessments include: *NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (NM-ASSIST)*; *Drug Abuse Screening Test (DAST-20)*; and *Alcohol Use Disorders Identification Test (AUDIT)*.<sup>11</sup>
- **Brief Interventions and Referral to Treatment:** PCPs must offer brief misuse counseling when an assessment reveals unhealthy patterns of alcohol or drugs use. As part of these brief interventions, providers should provide feedback to the beneficiary about the screening and assessment results, discuss negative consequences of unhealthy substance use, support behavioral changes, and ensure proper follow-up is performed.<sup>12</sup>

## 2. Services for Prevention of Tobacco Use

The USPSTF also recommends tobacco smoking cessation services.<sup>13</sup> As a result, Medi-Cal provides coverage for the following services:<sup>14</sup>

- **Assessment of tobacco use during initial medical visit and annually thereafter**
- **FDA-approved tobacco cessation medications:**<sup>15</sup>
  - Bupropion SR (Zyban<sup>®</sup>)
  - Varenicline (Chantix<sup>®</sup>)
  - 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.<sup>16</sup> 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.<sup>17</sup>

- **Services for pregnant tobacco users:** Beneficiaries who are pregnant are eligible for tailored, one-on-one counseling for tobacco cessation.<sup>18</sup> 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 coverage for prescription drugs for treatment of alcohol and opioid use disorders has historically been carved out of MCP contracts.<sup>19</sup> As a result, coverage for these medications is not impacted by the Medi-Cal Rx Pharmacy Benefit carve out transition (for more information on the Rx Carve Out, see Chapter II of this Guide on Prescription Drugs Services). Medi-Cal covers the following medications:<sup>20</sup>

- Methadone, buprenorphine (Subutex<sup>®</sup> or Suboxone<sup>®</sup>), and injectable naltrexone (Vivitrol<sup>®</sup>) for medication-assisted treatment (MAT) of OUD;
- Naloxone (Narcan<sup>®</sup> or Evzio<sup>®</sup>) as an opioid overdose reversal medication; and
- Disulfiram (Antabuse<sup>®</sup>), acamprosate (Campral<sup>®</sup>), and oral and injectable naltrexone (Vivitrol<sup>®</sup>) 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.<sup>21</sup> 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 Medi-Cal prescription drug coverage benefit.<sup>22</sup> Pharmacies must bill Medi-Cal directly (i.e. FFS) 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.<sup>23</sup> In addition, pharmacists across the state are allowed to dispense naloxone without a prescription.<sup>24</sup> 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.<sup>25</sup> These services have been carved out of MCP contracts. Instead, county alcohol and drug programs are responsible for contracting with Medi-Cal-certified providers to arrange, provide, or subcontract the provision of DMC services.

### 1. Access and Patient Placement Criteria

In order to receive DMC services, adult beneficiaries must 1) have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or 2) have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.<sup>26</sup> Pursuant to changes adopted through the CalAIM demonstration, DMC services provided while an initial assessment is ongoing are reimbursable regardless of whether an SUD diagnosis is made for up to 30 days after the first visit to the provider if the patient is 21 years of age or older, and for up to 60 days after the first visit if the patient is either under 21 or experiencing homelessness.<sup>27</sup>

Beneficiaries under 21 are eligible for DMC services if they are needed to correct or ameliorate a condition, including an SUD, and the services need not be curative or completely restorative to ameliorate a behavioral health condition.<sup>28</sup> 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.<sup>29</sup>

After a determination that the beneficiary meets the access and medical necessity criteria has been made, the beneficiary is subject to an American Society of Addiction Medicine (ASAM) Placement Criteria Assessment to determine the level of care needed to address the beneficiary's condition.<sup>30</sup> The purpose of the ASAM criteria is to ensure that "beneficiaries are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition."<sup>31</sup> The ASAM assessment must be completed within 30 days of the first visit for an initial assessment for beneficiaries 21 and over, and within 60 days of the first visit for beneficiaries under 21 and beneficiaries experiencing homelessness, although a full ASAM assessment is not required to begin receiving services.<sup>32</sup>

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.<sup>33</sup> 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:<sup>34</sup>

- 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).

## 2. DMC Services

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.<sup>35</sup> 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].”<sup>36</sup>
- Outpatient Drug Free Treatment: Outpatient services directed at stabilizing and rehabilitating persons with SUD diagnoses.<sup>37</sup>
- Intensive Outpatient Treatment (IOT): “Outpatient counseling and rehabilitation services provided at least three hours per day, three days per week...”<sup>38</sup>
- Perinatal Residential SUD Services: “Non-institutional, non-medical residential programs which provide rehabilitation services.”<sup>39</sup>
- 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.<sup>40</sup>
- Peer Support Services: These services were approved as part of CalAIM for DMC-ODS counties, but counties not participating in the DMC-ODS program may also provide these services.<sup>41</sup> Section D below provides more detailed information about the components of the peer support benefit.

The following two tables summarize the components of the DMC program services (see Figure 1), 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 <sup>42</sup>	✓	✓	✓	✓	✓
Body specimen screening	✓	✓	✓	✓	✓
Admissions physical exams and laboratory tests	✓	✓	✓	✓	✓
Treatment Planning	✓	✓	✓	✓	✓
Physician/Nursing Services	✓				✓
Medical Direction	✓	✓	✓	✓	✓
Medical Psychotherapy <sup>43</sup>	✓				
Individual/Group Counseling <sup>44</sup>	✓ <sup>45</sup>	✓ <sup>46</sup>	✓ <sup>47</sup>	✓ <sup>48</sup>	✓ <sup>49</sup>
Medication Services <sup>50</sup>	✓	✓	✓	✓	✓
Provision of MMT and/or LAAM	✓				
Crisis Intervention <sup>51</sup>		✓	✓	✓	✓
Collateral Services <sup>52</sup>		✓	✓	✓	✓
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. <sup>53</sup>
Outpatient Drug Free Treatment	None
IOT	None <sup>54</sup>

**Figure 2 (continued)**

Services	Restrictions on Eligibility and Coverage Exclusions
Perinatal Residential	<p>Pregnant and postpartum individuals only.</p> <p>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.”<sup>55</sup></p> <p>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.<sup>56</sup> 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.<sup>57</sup></p>
Naltrexone Treatment	<p>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.<sup>58</sup></p>

## 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 was part of California’s Section 1115 waiver (Medi-Cal 2020), and sought to increase integration and coordination of SUD services.<sup>59</sup> The demonstration also adopted the ASAM continuum of care, recognizing that different interventions are necessary for individuals with SUD who have different levels of need.<sup>60</sup> The program was renewed and extended in 2021 as part of the CalAIM Initiative. DMC-ODS services are now incorporated into California’s Medicaid state plan and provided pursuant to the terms and conditions of a renewed Section 1915(b) waiver, except for residential services in IMDs, which are authorized under a renewed Section 1115 waiver.<sup>61</sup> In order to provide the whole

### ADVOCACY TIP:

- ✓ While CalAIM introduced many changes to the DMC-ODS program, counties must still opt-in to provide DMC-ODS services to adult beneficiaries. 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.

continuum of care, the DMC-ODS program covers several substance use disorder services and levels of care in addition to the services covered under the DMC program. These additional benefits are only available for Medi-Cal beneficiaries residing in counties that opt into the demonstration.<sup>62</sup>

## 1. Access and Patient Placement Criteria

Eligibility for DMC-ODS program services is restricted to Medi-Cal beneficiaries who meet specific service access criteria, while level of care is determined using the ASAM patient placement criteria. In order to receive DMC-ODS program services, adult beneficiaries must 1) have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or 2) have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.<sup>63</sup> Pursuant to changes adopted through the CalAIM demonstration, however, DMC-ODS services provided while an initial assessment is ongoing are reimbursable regardless of whether an SUD diagnosis is made for up to 30 days after the first visit to the provider if the patient is 21 years of age or older, and for up to 60 days after the first visit if the patient is either under 21 or experiencing homelessness.<sup>64</sup>

Despite the inclusion of this access criteria for children and adolescents as part of DMC-ODS, nothing in the demonstration overrides EPSDT requirements.<sup>65</sup> 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 access criteria and regardless of whether the beneficiary's county of residence is participating in the DMC-ODS program.<sup>66</sup> In addition, changes made pursuant to CalAIM clarify that, under EPSDT, DMC-ODS services need not be curative or completely restorative to ameliorate a behavioral health condition.<sup>67</sup>

After a determination that the beneficiary meets the access and medical necessity criteria has been made, the beneficiary is subject to an ASAM Placement Criteria Assessment to determine the level of care needed to address the beneficiary's condition.<sup>68</sup> The purpose of the ASAM criteria is to ensure that "beneficiaries are able to receive care in the least intensive level of care that is clinically appropriate to treat their condition."<sup>69</sup> The ASAM assessment must be completed within 30 days of the first visit for an initial assessment for beneficiaries 21 and over, and within 60 days of the first visit for beneficiaries under 21 and beneficiaries experiencing homelessness, although a full ASAM assessment is not required to begin receiving services.<sup>70</sup>

## 2. DMC-ODS Services

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/Levels of Care (available to beneficiaries in all counties)	DMC-ODS Benefits/Levels of Care (only available to beneficiaries in pilot counties, except when covered pursuant to EPSDT)
Early Intervention through SABIRT	Early Intervention Services (limited to beneficiaries under 21)
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)
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
	Care Coordination
	Physician Consultation
	Partial Hospitalization (optional for counties)
	MAT Delivered at Alternative Sites (optional for counties)
	<i>Contingency Management for Stimulant Use Disorders (optional for counties)</i>
	<i>Peer Support Services (optional for counties)</i>
	<i>Traditional Healers and Natural Helpers</i>

### **Early Intervention Services**

Because early intervention services are limited to beneficiaries under 21, these services are required to be provided both in DMC and DMC-ODS counties under EPSDT. However, coverage of the SABIRT benefit provided via either FFS or managed care (discussed in section A above) satisfies that requirement in DMC counties, whereas coverage of early intervention (or ASAM level 0.5) in alcohol and drug programs satisfies the requirement in DMC-ODS counties. In addition



to screening services, early intervention under the DMC-ODS program includes individual counseling, group counseling, and education services.<sup>71</sup> An SUD diagnosis is not required for early intervention services. Nonetheless, providers may use an abbreviated ASAM tool for an SUD diagnosis and must perform a full ASAM assessment and refer the beneficiary to the appropriate level of care if the beneficiary meets the diagnostic criteria.<sup>72</sup>

### ***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.<sup>73</sup> Pursuant to CalAIM, NTPs are now required to offer all FDA-approved medications for OUD when they can be readily purchased by the NTP.<sup>74</sup> The DMC-ODS program also clarifies that activities covered as part of NTP include the ordering, prescribing, administering, and monitoring of the medication regime.<sup>75</sup> NTPs must also provide assessment services, care coordination, counseling (individual and group), family therapy, medical psychotherapy, medication services (non-MAT), patient education, recovery services, and SUD crisis intervention services.<sup>76</sup>

### ***Residential Services***

Pursuant to the DMC-ODS Medi-Cal waiver, residential services must be available to all beneficiaries who meet the ASAM medical necessity criteria for residential treatment.<sup>77</sup> This 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. 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. There are no limitations on lengths-of-stay; however, the waiver requires California to achieve a thirty day statewide average length of stay at IMDs.<sup>78</sup>

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 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 assessment services, care coordination, counseling (individual and group), family therapy, medication services (non-MAT), patient education, recovery services, and SUD crisis intervention services.<sup>79</sup> CalAIM now also requires all residential facilities to offer MAT onsite or refer beneficiaries to outside providers offering MAT and to carry naloxone at all times.<sup>80</sup>

## ***Withdrawal Management***

Withdrawal management services are more commonly known as detoxification (“detox”) services. These services are provided to beneficiaries “when medically necessary for maximum reduction of the SUD symptoms and restoration of the beneficiary to their best possible functional level.”<sup>81</sup> Counties participating in the DMC-ODS waiver must provide coverage for at least one ASAM level of withdrawal management.<sup>82</sup> Regardless of which ASAM level the county elects to cover, the benefit includes assessment services, care coordination, medication services (non-MAT), MAT for OUD, MAT for AUD and other non-opioid SUDs, observation, and recovery services.<sup>83</sup>

## ***Recovery Services***

Recovery services are required to be covered 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.<sup>84</sup> Beneficiaries do not need to have been diagnosed as being in remission to receive recovery services and may receive the services while receiving MAT services, including NTP services.<sup>85</sup> Beneficiaries being released from incarceration may be eligible for recovery services with a prior diagnosis of SUD in order to not penalize individuals who actively received services during incarceration and may have recovered while incarcerated.<sup>86</sup> Services may be provided face-to-face, by telephone, or by telehealth and include the following components:<sup>87</sup>

- Assessment
- Care Coordination
- Individual and Group Counseling
- Family Therapy
- Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary’s SUD.
- Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary’s SUD.

## ***Care Coordination***

Care coordination services (previously called case management services) consist of “activities to provide coordination of SUD care, mental health care, and primary care, and to support the beneficiary with linkages to services and supports designated to restore the beneficiary to their best possible functional level.”<sup>88</sup> Services may be provided in clinical and non-clinical settings by a licensed practitioner or by a certified counselor at DMC provider sites, county locations, regional centers or as otherwise outlined by the county.<sup>89</sup> Services may be provided face-to-face, by telephone, or by telehealth with the beneficiary.<sup>90</sup>

The specific components of the DMC-ODS program care coordination benefit are:<sup>91</sup>

- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions;
- Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers; and
- Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports.

### ***Clinician Consultation***

Clinician consultation services allow DMC physicians to consult with addiction medicine physicians, addiction psychiatrists, licensed clinicians or clinical pharmacists.<sup>92</sup> These services are designed to assist DMC physicians seeking 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.<sup>93</sup> Services can only be billed by and reimbursed to DMC-ODS providers.<sup>94</sup>

### ***Partial Hospitalization***

Partial hospitalization services are available as optional services for counties participating in the DMC-ODS waiver.<sup>95</sup> 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.<sup>96</sup> 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.<sup>97</sup> The service components of partial hospitalization are assessment services, care coordination, counseling (individual and group), family therapy, medication services (both MAT and non-MAT), patient education, recovery services, and SUD crisis intervention services.<sup>98</sup>

### ***MAT Delivered at Alternative Sites***

Previously known as “Additional MAT Services,” MAT Delivered at Alternative Sites is an optional benefit in DMC-ODS counties that covers the cost of ordering and purchasing FDA-approved medications for SUD.<sup>99</sup> This service is typically offered by providers who buy and administer methadone, buprenorphine, or naltrexone in alternative settings, which otherwise would not

be covered under the Medi-Cal pharmacy benefit discussed above, such as criminal justice settings or street-based outreach.<sup>100</sup> Medi-Cal also requires counties that cover this benefit to ensure that providers offer counseling or other behavioral health therapy.<sup>101</sup>

### ***Contingency Management for Stimulant Use Disorders: The Recovery Incentives Program***

In January 2022, California became the first state to receive approval to use federal Medicaid funding for a contingency management program to help treat certain SUDs.<sup>102</sup> This pilot program, called Recovery Incentives Program, will allow counties to offer contingency management to beneficiaries with a diagnosed stimulant use disorder beginning in early 2023.<sup>103</sup> Stimulants include illicit substances such as cocaine and methamphetamine, as well as prescription medications, like amphetamine.

California's contingency management program consists of providing incentives to participating beneficiaries who test negative for stimulants during the course of a 24-week course of treatment. The incentives are in the form of gift cards for retail stores, grocery stores, and gas stations, although no cannabis, tobacco, alcohol, or lottery tickets are allowed as purchases.<sup>104</sup> Participants can also receive additional support during their participation like counseling, MAT for OUD, patient education, peer support, withdrawal management, and recovery services.<sup>105</sup> Importantly, beneficiaries should be offered referral to these other DMC-ODS services when indicated, but acceptance of such services are not required to access contingency management services.<sup>106</sup>

During weeks 1 through 12 of the program participants will be asked to visit their contingency management provider or testing site to provide a urine sample that is tested for the presence of stimulants. If the test is negative for stimulants, the participant receives an incentive starting at \$10 for the first week and increasing by \$1.50 per week for each subsequent negative test. The maximum possible incentive for this period of the program is \$438. During weeks 13 to 24, participants visit their provider or testing site once a week. In weeks 13 to 18, participants receive \$15 for each negative urine test and in weeks 19 to 23 participants receive \$10 per negative urine test. In week 24, participants can receive a final incentive of \$21 for a negative urine test. A participant can receive a maximum total of \$599 if they do not miss any visits and consistently test negative for stimulants.<sup>107</sup>

A “reset” will occur when an individual submits a positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their incentive amount will return to the initial value (i.e., \$10). A “recovery” of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participant will recover their previously earned incentive level without having to restart the process.<sup>108</sup>

## ***Peer Support Services***

Beginning July 1, 2022, DMC-ODS counties have the option of providing peer support services for individuals with SUD. Peer support services are “culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals.”<sup>109</sup> Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.<sup>110</sup>

Peer support services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals (family members or other people supporting the beneficiary) if the purpose of their participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary’s treatment goals. They include the following components:<sup>111</sup>

- Educational Skill Building Groups: a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills;
- Engagement: encouraging and supporting beneficiaries to participate in behavioral health treatment, including supporting beneficiaries in their transitions between levels of care;
- Therapeutic Activity: a structured non-clinical activity provided to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills.

## ***Crisis Intervention Services***

Crisis intervention services consist of contacts with a beneficiary in crisis, defined as “an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse.”<sup>112</sup> These services focus on alleviating the crisis problem and stabilization of the beneficiary’s immediate situation in the least intensive level of care that is medically necessary to treat the beneficiary’s condition.

In addition to covering crisis intervention services, the State has sought federal approval to cover Medi-Cal qualifying community-based mobile crisis services statewide beginning in 2023. States are required to provide coverage for behavioral health mobile crisis services pursuant to Section 9813 of the American Rescue Plan Act of 2021 (ARPA).<sup>113</sup> Mobile crisis services are services

provided by health professionals on the scene where the beneficiary is experiencing a crisis related to a mental health or substance use condition, including the person's home, work, and all other locations, except a hospital or other facility settings.<sup>114</sup> The State intends to start partial implementation of the mobile crisis benefit in January 2023, with full implementation statewide required by December 2023.<sup>115</sup> As with other DMC-ODS services, mobile crisis services are required to be provided under EPSDT, which means that beneficiaries under 21 should be able to access these services when medically necessary, regardless of whether their county of residence has implemented this new mobile crisis service or is participating in the DMC-ODS program.

**Additional Requirements Regarding Medication-Assisted Treatment (MAT):** Pursuant to a new policy adopted through the CalAIM initiative, all DMC-ODS providers at all levels of care, including residential facilities, are now required to either offer MAT onsite or refer beneficiaries to any Medi-Cal provider offering MAT.<sup>116</sup> In addition, all DMC-certified providers are required to offer counseling or behavioral health therapy to beneficiaries in MAT. However, provision of MAT is not contingent on acceptance of behavioral health therapy.<sup>117</sup>

## **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.<sup>118</sup> Both MCP enrollees and FFS beneficiaries are entitled to the service, subject to approval of a Treatment Authorization Request (TAR).<sup>119</sup>

To receive VID, the beneficiary must meet at least one of the following criteria:<sup>120</sup>

- 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 its 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.<sup>121</sup>

## Endnotes

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

<sup>2</sup> 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.

<sup>3</sup> 42 U.S.C. § 300gg-26.

<sup>4</sup> 42 U.S.C. § 1396d(a)(13)(A).

<sup>5</sup> U.S. Preventive Servs. Task Force, Final Recommendation Statement: Unhealthy Drug Use: Screening (June 9, 2020), <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening> (last visited Nov. 30, 2022); Cal. Dep’t Health Care Servs., All Plan Letter 21-014 (Oct. 11, 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf> [hereinafter All-Plan Letter 21-014].

<sup>6</sup> Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 21-075 at 7 (Dec. 17, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-075-DMC-ODS-Requirements-for-the-Period-2022-2026.pdf> [hereinafter Behavioral Health Information Notice No. 21-075].

<sup>7</sup> *Id.* at 7–8.

- <sup>8</sup> Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-003 at 2-3 (Feb. 3, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-003-Medi-Cal-Substance-Use-Disorder-Treatment-Services-for-Beneficiaries-under-age-21.pdf> [hereinafter Behavioral Health Information Notice No. 22-003]. See also All Plan Letter 21-014, *supra* note 5, at 5-6 and Behavioral Health Information Notice No. 21-075, *supra* note 6, at 5, 7-8.
- <sup>9</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 3.
- <sup>10</sup> *Id.* at 4.
- <sup>11</sup> *Id.*
- <sup>12</sup> *Id.* at 4-5.
- <sup>13</sup> U.S. Preventive Servs. Task Force, Final Recommendation Statement: Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions (Jan. 19, 2021), <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions> (last visited Nov. 30, 2022).
- <sup>14</sup> CAL. WELF. & INST. CODE § 14134.25(a); Cal. Dep't Health Care Servs., All Plan Letter 16-014 at 1-2 (Nov. 30, 2016), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-014.pdf> [hereinafter All-Plan Letter 16-014].
- <sup>15</sup> CAL. WELF. & INST. CODE § 14134.25(b)(2); All Plan Letter 16-014, *supra* note 14, 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.
- <sup>16</sup> CAL. WELF. & INST. CODE § 14134.25(b)(1); All Plan Letter 16-014, *supra* note 14, at 4-5.
- <sup>17</sup> All Plan Letter 16-014, *supra* note 14, at 5.
- <sup>18</sup> All Plan Letter 16-014, *supra* note 14, at 5-6.
- <sup>19</sup> For information on the original 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>.
- <sup>20</sup> See Cal. Dep't Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 15-033 (Aug. 14, 2015), [https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS\\_Information\\_Notice\\_15-033\\_MAT.pdf](https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_15-033_MAT.pdf) [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 15-033].

- <sup>21</sup> 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>.
- <sup>22</sup> *Id.* See also Mental Health and Substance Use Disorder Services Information Notice No. 15-033, *supra* note 20.
- <sup>23</sup> 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>.
- <sup>24</sup> CAL. BUS. & PROF. CODE § 4052.01.
- <sup>25</sup> 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)).
- <sup>26</sup> Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-071 at 3 (Dec. 3, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-071-Medical-Necessity-Determination-Level-of-Care-Determination-Requirements.pdf>.
- <sup>27</sup> *Id.* at 2. CAL. WELF. & INST. CODE § 14184.402(f)(2).
- <sup>28</sup> *Id.* at 3; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 3–4. See also CAL. WELF. & INST. CODE § 14059.5(b) (incorporating the EPSDT medical necessity criteria into state law) and CAL. WELF. & INST. CODE § 14184.402(a), (e)(2) (extending the state law requirement to use the EPSDT medical necessity criteria to behavioral health services).
- <sup>29</sup> Behavioral Health Information Notice No. 22-003, *supra* note 8, at 4.
- <sup>30</sup> CAL. WEL. & INST. CODE § 14184.402(e)(1).
- <sup>31</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 6.
- <sup>32</sup> *Id.* CAL. WELF. & INST. CODE § 14184.402(e)(3).
- <sup>33</sup> CAL. CODE REGS. tit. 22, § 51341.1(c).
- <sup>34</sup> *Id.*
- <sup>35</sup> 42 C.F.R. § 8.12.
- <sup>36</sup> CAL. CODE REGS. tit. 22, § 51341.1(b)(17). See also CAL. CODE REGS. tit. 22, § 51341.1(d)(1).
- <sup>37</sup> CAL. CODE REGS. tit. 22, § 51341.1(b)(18). See also CAL. CODE REGS. tit. 22, § 51341.1(d)(2).
- <sup>38</sup> 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.

- <sup>39</sup> CAL. CODE REGS. tit. 22, § 51341.1(b)(20). *See also* CAL. CODE REGS. tit. 22, § 51341.1(d)(4).
- <sup>40</sup> CAL. CODE REGS. tit. 22, § 51341.1(b)(16). *See also* CAL. CODE REGS. tit. 22, § 51341.1(d)(5).
- <sup>41</sup> Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 22-026 (May 6, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-026-Drug-Medi-Cal-Drug-Medi-Cal-Organized-Delivery-System-SMHS-Peer-Support-Services.pdf> [hereinafter Behavioral Health Information Notice No. 22-026].
- <sup>42</sup> 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).
- <sup>43</sup> 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).
- <sup>44</sup> 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).
- <sup>45</sup> 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.
- <sup>46</sup> 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).
- <sup>47</sup> 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).

- <sup>48</sup> At least two counseling sessions per month. CAL. CODE REGS. tit. 22, § 51341.1(h)(4)(A).
- <sup>49</sup> At least two counseling sessions per month. CAL. CODE REGS. tit. 22, § 51341.1(h)(4)(A).
- <sup>50</sup> 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).
- <sup>51</sup> 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).
- <sup>52</sup> 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).
- <sup>53</sup> CAL. CODE REGS. tit. 9, § 10270; CAL. CODE REGS. tit. 22, § 51341.1(h)(1)(B). See *also* Cal. Dep’t Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 18-061 (Dec. 28, 2018), [https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS\\_Information\\_Notice\\_18-061\\_-\\_Treating\\_Youth\\_in\\_NTPs.pdf](https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Notice_18-061_-_Treating_Youth_in_NTPs.pdf).
- <sup>54</sup> 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. See CMS, Approval Letter for Cal. State Plan Amendment # 13-038 (Sept. 5, 2014), [https://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA\\_SPA\\_13-038\\_Approved\\_Package\\_Redacted.pdf](https://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA_SPA_13-038_Approved_Package_Redacted.pdf).
- <sup>55</sup> CAL. CODE REGS. tit. 22, § 51341.1(b)(20).
- <sup>56</sup> 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).
- <sup>57</sup> CAL. CODE REGS. tit. 22, § 51341.1(d)(4)(A).
- <sup>58</sup> CAL. CODE REGS. tit. 22, § 51341.1(d)(5).
- <sup>59</sup> CMS, Approval Letter for California’s Bridge to Reform Section 1115 Demonstration Amendment (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. 28, 2022).



- <sup>60</sup> For more information on the ASAM criteria, see Am. Soc. Addiction Med., What is the ASAM Criteria?, <https://www.asam.org/asam-criteria/about-the-asam-criteria> (last visited Nov. 28, 2022).
- <sup>61</sup> CMS, Approval Letter for California Advancing & Innovating Medi-Cal Section 1915(b) Waiver (Dec. 29, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-appvl-ltr.pdf> [hereinafter Approval Letter for CalAIM Section 1915(b) Waiver]; CMS, Special Terms and Conditions for California Advancing & Innovating Medi-Cal Section 1915(b) Waiver (2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca-17-stc.pdf>; CMS, Approval Letter for California Advancing & Innovating Medi-Cal Section 1115 Demonstration Extension (Dec. 29, 2021), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ext-appvl-12292021.pdf> [hereinafter Approval Letter for CalAIM Section 1115 Waiver]; CMS, Approval Letter for Cal. State Plan Amendment # 21-0058 (Dec. 20, 2021), <https://www.dhcs.ca.gov/Documents/CA-21-0058-Approval-Package.pdf> [hereinafter State Plan Amendment # 21-0058].
- <sup>62</sup> Under federal law, unless the Centers for Medicare and Medicaid Services (CMS) waive the requirement through approval of a federal 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 1915(b) and Section 1115 waivers waive these requirements and allow the State to provide different services depending on whether the county of residence opts to participate in the demonstration. Approval Letter for CalAIM Section 1915(b) Waiver, *supra* note 61, at 1; Approval Letter for CalAIM Section 1115(b) Waiver, *supra* note 61, at Waiver Authority 3.
- <sup>63</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 4; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-019 at 2-3 (May 14, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-019-DMC-ODS-Updated-Policy-on-Medical-Necessity-and-Level-of-Care.pdf> [hereinafter Behavioral Health Information Notice No. 21-019].
- <sup>64</sup> CAL. WELF. & INST. CODE § 14184.402(f)(2); Behavioral Health Information Notice No. 21-019, *supra* note 63, at 2.
- <sup>65</sup> CAL. WELF. & INST. CODE § 14184.402(a), (e)(2); Behavioral Health Information Notice No. 21-075, *supra* note 6, at 4-5; Behavioral Health Information Notice No. 21-019, *supra* note 63, at 2; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 2-4.
- <sup>66</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 4-5; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 3.



- <sup>67</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 3–4. See also CMS, EPSDT – A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents (2014), [https://www.medicaid.gov/sites/default/files/2019-12/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf).
- <sup>68</sup> Cal. Wel. & Inst. Code § 14184.402(e)(1).
- <sup>69</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 6.
- <sup>70</sup> *Id.* CAL. WELF. & INST. CODE § 14184.402(e)(3).
- <sup>71</sup> Behavioral Health Information Notice No. 21-019, *supra* note 63, at 2.
- <sup>72</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 7–8; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 3.
- <sup>73</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6q; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 13.
- <sup>74</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 13; Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 21-024 at 2–3 (May 21, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-024-DMC-ODS-Expanding-Access-to-Medications-for-Addiction-Treatment-MAT.pdf> [hereinafter Behavioral Health Information Notice No. 21-024].
- <sup>75</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6h, 6q; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 14, 34; Behavioral Health Information Notice No. 21-024, *supra* note 74, at 2.
- <sup>76</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6q; Behavioral Health Information Notice No. 21-075, *supra* note 61, at 14.
- <sup>77</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6p; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 10–12; Behavioral Health Information Notice No. 21-019, *supra* note 63, at 3.
- <sup>78</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 12; Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 21-021 (May 14, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-021-DMC-ODS-Updated-Policy-on-Residential-Treatment-Limitations.pdf>.
- <sup>79</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6p–6q; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 12.
- <sup>80</sup> Behavioral Health Information Notice No. 21-024, *supra* note 74, at 2; Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 22-025, <https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-22-025.pdf>.
- <sup>81</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6j.
- <sup>82</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 28.
- <sup>83</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6j–6k; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 15.

- <sup>84</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6i–6j; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 18. *See also* Cal. Dep’t Health Care Servs., Behavioral Health Information Notice No. 21-020 (May 14, 2021), <https://www.dhcs.ca.gov/Documents/BHIN-21-020-DMC-ODS-Clarification-on-Recovery-Services.pdf> [hereinafter Behavioral Health Information Notice No. 21-020].
- <sup>85</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6j; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 18; Behavioral Health Information Notice No. 21-020, *supra* note 84, at 2.
- <sup>86</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6j; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 18; Behavioral Health Information Notice No. 21-020, *supra* note 84, at 3.
- <sup>87</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6j; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 18–19; Behavioral Health Information Notice No. 21-020, *supra* note 84, at 2.
- <sup>88</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6g; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 19.
- <sup>89</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6g; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 19.
- <sup>90</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 19.
- <sup>91</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6g; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 19.
- <sup>92</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 20.
- <sup>93</sup> *Id.*
- <sup>94</sup> *Id.*
- <sup>95</sup> *Id.* at 10.
- <sup>96</sup> *Id.*
- <sup>97</sup> *Id.*
- <sup>98</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6p; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 10.
- <sup>99</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 20; Behavioral Health Information Notice No. 21-024, *supra* note 74, at 3.
- <sup>100</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 21; Behavioral Health Information Notice No. 21-024, *supra* note 74, at 3.
- <sup>101</sup> Behavioral Health Information Notice No. 21-024, *supra* note 74, at 3.
- <sup>102</sup> *See* Approval Letter for CalAIM Section 1115(b) Waiver, *supra* note 61, at Expenditure Authority 2.

- <sup>103</sup> See generally Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-056 (Oct. 14, 2022), <https://www.dhcs.ca.gov/Documents/BHIN-22-056-The-Recovery-Incentives-Program-Californias-Contingency-Management-Benefit.pdf> [hereinafter Behavioral Health Information Notice No. 22-056]. See also Cal. Dep't Health Care Servs., *The Recovery Incentives Program: California's Contingency Management Benefit, Frequently Asked Questions (FAQs)* 3, 15 (Sept. 2022), <https://www.dhcs.ca.gov/Documents/Recovery-Incentives-Program-Contingency-Management-FAQs.pdf> [hereinafter *Recovery Incentives Program FAQs*]; Cal. Dep't Health Care Servs., *Medi-Cal Contingency Management Pilot Program Policy Design* (Feb. 2022) 4, <https://www.dhcs.ca.gov/Documents/Contingency-Management-Policy-Paper.pdf> [hereinafter *Contingency Management Policy Paper*].
- <sup>104</sup> Behavioral Health Information Notice No. 22-056, *supra* note 103, at 2; Recovery Incentives Program FAQs, *supra* note 103, at 14; *Contingency Management Policy Paper*, *supra* note 103, at 25.
- <sup>105</sup> Behavioral Health Information Notice No. 22-056, *supra* note 103, at 7; *Contingency Management Policy Paper*, *supra* note 103, at 16.
- <sup>106</sup> Behavioral Health Information Notice No. 22-056, *supra* note 103, at 4–5; *Recovery Incentives Program FAQs*, *supra* note 103, at 14; *Contingency Management Policy Paper*, *supra* note 103, at 17.
- <sup>107</sup> Behavioral Health Information Notice No. 22-056, *supra* note 103, at 5–10; *Contingency Management Policy Paper*, *supra* note 103, at 21–23.
- <sup>108</sup> Behavioral Health Information Notice No. 22-056, *supra* note 103, at 8–10; *Contingency Management Policy Paper*, *supra* note 103, at 22.
- <sup>109</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6h; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 16; Behavioral Health Information Notice No. 22-026, *supra* note 41, at 2.
- <sup>110</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6h; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 16; Behavioral Health Information Notice No. 22-026, *supra* note 41, at 2.
- <sup>111</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6i; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 17; Behavioral Health Information Notice No. 22-026, *supra* note 41, at 2–3.
- <sup>112</sup> State Plan Amendment # 21-0058, *supra* note 61, at 6j; Behavioral Health Information Notice No. 21-075, *supra* note 6, at 36.
- <sup>113</sup> 42 U.S.C. § 1396w-6.
- <sup>114</sup> See CMS, Dear State Health Official Letter (Dec. 28, 2021) (SHO # 21-008) 2, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>.

- <sup>115</sup> Cal. Dep't Health Care Servs., State Plan Amendment Request # 22-0043 (Oct. 24, 2022), <https://www.dhcs.ca.gov/Documents/SPA-22-0043-Pending-Redacted.pdf>. See also Draft All Plan Letter 22- (Jan. XX, 2023), <https://www.dhcs.ca.gov/Documents/Mobile-Crisis-BHIN-for-Stakeholder-Feedback-11-9-22.pdf>.
- <sup>116</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 20–21; Behavioral Health Information Notice No. 21-024, *supra* note 74, at 2.
- <sup>117</sup> Behavioral Health Information Notice No. 21-075, *supra* note 6, at 22; Behavioral Health Information Notice No. 21-024, *supra* note 74, at 3.
- <sup>118</sup> See Cal. Dep't Health Care Servs., All Plan Letter 18-001 (Jan. 11, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-001.pdf>.
- <sup>119</sup> *Id.* at 3.
- <sup>120</sup> *Id.* at 1–2.
- <sup>121</sup> *Id.* at 2.



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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## **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 III)
  - Gender dysphoria assessments
  - Counseling regarding gender expression and transition options
- Hormone Therapy
  - Covered when medically necessary
- Surgical Care
  - Variety of medically necessary and/or reconstructive procedures that bring primary and secondary gender characteristics in conformity with the individual's identified 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, gender diverse, 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.<sup>1</sup> Some transgender, gender diverse, 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 this condition. The standards of care for treating gender dysphoria involve a range of options depending on the needs and desires of the person seeking treatment.<sup>2</sup> 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, gender diverse, 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 and the Medi-Cal medical necessity standard.<sup>3</sup>

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 culturally competent care to transgender and gender diverse individuals.”<sup>4</sup> 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.<sup>5</sup>

### **A. Mental health services for transgender, gender diverse, and non-binary beneficiaries**

Transgender, gender diverse, and non-binary people may seek mental health services for a wide variety of reasons. For many transgender, gender diverse, and non-binary individuals, mental health services may be a component of their gender-affirming care.<sup>7</sup> Medi-Cal coverage of many gender-affirming procedures requires a diagnosis of gender dysphoria.<sup>8</sup> Gender dysphoria is a mental health condition defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).<sup>9</sup> 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.<sup>10</sup>

Medi-Cal considers mental health services a “core component” of treatment for gender dysphoria.<sup>11</sup> For transgender, gender diverse, and non-binary beneficiaries seeking surgical interventions, “[t]he determination of whether a service requested by a transgender [or gender diverse or non-binary] beneficiary is medically necessary and/or constitutes reconstructive surgery must be made by a qualified licensed mental health professional and the treating surgeon, in collaboration with the beneficiary’s primary care provider.”<sup>12</sup> In pursuing gender-

#### **ADVOCACY TIP:**

- ✓ The standards of care for transgender, gender diverse, and non-binary individuals in health care settings generally reflect the standards of care recommended for non-transgender, gender consistent, and binary individuals, however transgender, gender diverse, and non-binary individuals face barriers in accessing care and discrimination.<sup>6</sup> Advocates should ensure that their local provider communities receive training about how they can be culturally sensitive and provide appropriate care to transgender, gender diverse, and non-binary people, and address specific problems of cultural competence when they arise.

affirming services, transgender, gender diverse, 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.<sup>13</sup>

## B. Hormone Therapy

Hormone therapy is a covered benefit under Medi-Cal when medically necessary to treat gender dysphoria, and is available through Medi-Cal Rx regardless of whether the beneficiary has Fee-for-Service (FFS) Medi-Cal 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:<sup>14</sup>

- 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:<sup>5</sup>

- 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);<sup>16</sup>
- 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.

Since the implementation of Medi-Cal Rx in 2022 (see Chapter II for more information), hormone therapy is covered for treatment of gender dysphoria through Medi-Cal Rx when medically necessary. Requests for hormone therapy should be made by "specialists experienced in providing culturally competent care to transgender and gender diverse individuals and should use nationally recognized guidelines."<sup>17</sup> Medical necessity should be "assessed and services

shall be recommended by treating licensed mental health professionals and physicians and surgeons experienced in treating patients with incongruence between their gender identity and gender assigned at birth.”<sup>18</sup> 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, gender diverse, or non-binary beneficiaries if not applied to all beneficiaries in need of hormone therapy).<sup>19</sup>

The most common categories of hormone medications used to treat gender dysphoria are testosterone, estrogen, and anti-androgens.<sup>20</sup> Medi-Cal Rx covers at least some preparations of each of these categories of hormone drugs.<sup>21</sup>

### C. Surgical Care

Some transgender, gender diverse, and non-binary Medi-Cal beneficiaries will seek surgical procedures to align their primary and/or secondary sex characteristics with their gender identity.<sup>22</sup> Surgery is often the last and most seriously considered of the treatment options for gender dysphoria in transgender, gender diverse, and non-binary individuals. Not every transgender, gender diverse, or non-binary person wants, requires, or qualifies for every available surgical procedure. The number, type, and sequence of surgical interventions often varies widely from one person to another, depending on their particular clinical needs.<sup>23</sup>

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:<sup>24</sup>

- 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.<sup>25</sup> 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.<sup>26</sup>

## 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. 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.’”<sup>27</sup>

State policy differentiates between “reconstructive surgery,” which is covered by Medi-Cal, and “cosmetic surgery,” which is not.<sup>28</sup> 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.”<sup>29</sup> Medi-Cal policy states: “In the case of transgender [or gender diverse or non-binary] beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.”<sup>30</sup> It does not explicitly delineate when a particular procedure will be considered reconstructive versus cosmetic for a transgender, gender diverse, 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.<sup>31</sup> Medi-Cal policy further explains that any “determination of whether a service requested by a transgender [or gender diverse 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.”<sup>32</sup>

Although Medi-Cal policy 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 people who were assigned male at birth, 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:<sup>33</sup>

- 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 people who were assigned female at birth, 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:<sup>34</sup>

- 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 erectile device and/or testicular prostheses; and
- Other surgeries to masculinize the body, such as: liposuction, lipofilling, pectoral implants, and body contouring procedures.

### **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.

## **D. Other interventions and considerations for transgender, gender diverse, and non-binary beneficiaries**

There are a number of barriers to accessing services that transgender, gender diverse, 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 beneficiaries from seeking needed care.

### **1. Accessing services when gender marker does not match presupposed anatomy**

Sometimes transgender, gender diverse, and non-binary individuals can experience difficulty accessing medically necessary care because their gender marker does not match their presupposed anatomy. 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.<sup>35</sup> The beneficiary’s medical record must support that the treatment is medically necessary.

## 2. 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 may deny coverage of certain treatments as considered “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.<sup>36</sup> The California Courts of Appeal held in 1978 that gender-affirming surgeries are not “cosmetic” when medically necessary to treat gender dysphoria.<sup>37</sup> There are not clear guidelines on this distinction of medically necessary and cosmetic treatment 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.<sup>38</sup> Thus, any denial of services as “cosmetic” should be appealed through the proper channels.

### ADVOCACY TIPS:

- ✓ Providers may refuse to provide covered services to transgender, gender diverse, and non-binary beneficiaries due to their religious or moral beliefs about gender identity. These refusals can cause delays and obstacles to people receiving the standard of care. They can also be traumatic experiences that exacerbate a transgender, gender diverse, or non-binary person’s gender dysphoria and/or other mental health concerns.



# Endnotes

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- <sup>1</sup> Am. Psychiatric Ass'n, What Is Gender Dysphoria?, <https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria> (last visited July 25, 2022).
- <sup>2</sup> World Prof'l Ass'n Transgender Health, *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* (V. 8, 2022), <https://www.wpath.org/publications/soc> [hereinafter *WPATH Standards of Care*]. The World Professional Association for Transgender Health adopted updated standards of care in October 2022, Version 8. Medi-Cal plans may not yet fully reflect the changes made between Version 8 and Version 7.
- <sup>3</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transgender and Gender Diverse Services 2* (2022), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/transgender.pdf> (citing 22 C.C.R. § 51303) [hereinafter *Medi-Cal Provider Manual, Transgender and Gender Diverse Services*].
- <sup>4</sup> *Id.* at 1.
- <sup>5</sup> *Id.* See also *WPATH Standards of Care*, *supra* note 2.
- <sup>6</sup> 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>.
- <sup>7</sup> *WPATH Standards of Care*, *supra* note 2, at 24.
- <sup>8</sup> See, e.g., *Medi-Cal Provider Manual, Transgender and Gender Diverse Services*, *supra* note 3, at 2; Cal. Dep't Health Care Servs., All Plan Letter 20-018 at 3 (Oct. 26, 2020), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-018.pdf> [hereinafter All Plan Letter 20-018].
- <sup>9</sup> See "Gender Dysphoria" in Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) (DSM-5).
- <sup>10</sup> *Id.*
- <sup>11</sup> *Medi-Cal Provider Manual, Transgender and Gender Diverse Services*, *supra* note 3, at 2.
- <sup>12</sup> See All Plan Letter 20-018, *supra* note 8, at 4 (clarifying that "core services in treating gender dysphoria [include] mental health services [and] psychotherapy.").
- <sup>13</sup> *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 this Guide on Mental Health Services.
- <sup>14</sup> *WPATH Standards of Care*, *supra* note 2, at 34.

- <sup>15</sup> WPATH *Standards of Care*, *supra* note 2, at 18–19.
- <sup>16</sup> The Tanner Scale defines physical measurements of development based on external primary and secondary sex characteristics such as the size of the breasts, genitalia, testicular volume and the development of pubic and axillary hair. For more details, see generally Lawrence S. Neinstein, *Adolescent Health Care: A Practical Guide* (5th ed. 2008).
- <sup>17</sup> *Medi-Cal Provider Manual, Transgender and Gender Diverse Services*, *supra* note 3, at 1.
- <sup>18</sup> *Id.* at 2.
- <sup>19</sup> *Id.*
- <sup>20</sup> Transline, *What are commonly used medications for transition?*, <https://transline.zendesk.com/hc/en-us/articles/229373208-What-are-commonly-used-medications-for-transition-> (last visited Nov. 22, 2022).
- <sup>21</sup> Cal. Dep’t Health Care Servs., *Medi-Cal Rx Contract Drugs List – Therapeutic Classifications* (July 2022) 27–28 (2022), [https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal\\_Rx\\_CD\\_L\\_Therapeutic\\_Classifications\\_FINAL.pdf](https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_CD_L_Therapeutic_Classifications_FINAL.pdf).
- <sup>22</sup> WPATH *Standards of Care*, *supra* note 2, at 9–10.
- <sup>23</sup> *Id.* at 58.
- <sup>24</sup> *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).
- <sup>25</sup> 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.
- <sup>26</sup> 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.
- <sup>27</sup> *Medi-Cal Provider Manual, Transgender and Gender Diverse Services*, *supra* note 3, at 2 (citing CAL. CODE REGS. tit. 22, § 51303); see also All Plan Letter 20-018, *supra* note 8, at 2.
- <sup>28</sup> All Plan Letter 20-018, *supra* note 8, at 3–4.
- <sup>29</sup> *Id.* (quoting CAL. HEALTH & SAFETY CODE § 1367.63(c)(1)(B)).
- <sup>30</sup> *Id.*
- <sup>31</sup> *Id.*
- <sup>32</sup> *Id.*
- <sup>33</sup> WPATH *Standards of Care*, *supra* note 2, at 57.

<sup>34</sup> *Id.*

<sup>35</sup> *Medi-Cal Provider Manual, Transgender and Gender Diverse Services, supra* note 3, at 1.

<sup>36</sup> Transgender L. Ctr. *Medi-Cal and Gender Reassignment Procedures* (2002), <https://transgenderlawcenter.org/wp-content/uploads/2012/07/Medical-Fact-Sheet.pdf>.

<sup>37</sup> *GB v. Lackner*, 80 Cal. App. 3d (1978); *JD v. Lackner*, 80 Cal. App. 3d 90 (1978).

<sup>38</sup> 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. 22, 2022); *WPATH Standards of Care, supra* note 2.



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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## **Chapter VI: Reproductive and Sexual Health Services**

# Chapter VI: Reproductive and Sexual Health Services

## Outline of Medi-Cal Reproductive and Sexual Health Services\*

- 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
- Pregnancy Services
  - Pregnancy Services Overview – Prenatal, Labor/Delivery, Postpartum Care
  - Doula Services During and After Pregnancy
  - Comprehensive Perinatal Services Program
- Reproductive and Sexual Health Care in Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)
- Assisted Reproductive Services
- Additional Coverage Categories for Reproductive and Sexual Health Services
  - Family Planning, Access, Care, and Treatment (Family PACT)
  - Minor Consent Medi-Cal
  - Medi-Cal Access Program
  - Presumptive Eligibility for Pregnant Women
- Breast and Cervical Cancer Screening and Treatment Programs
- Reproductive and Sexual Health for Dual Eligibles

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

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 populations, including pregnant people and parents. In the 39 states like California that have expanded Medicaid under the Affordable Care Act, most previously uninsured, low-income individuals now have access to full Medicaid benefits.<sup>1</sup> Medi-Cal therefore plays a major role in the financing of reproductive and sexual health care services for millions of low-income people 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 contraception and family planning, pregnancy care, and abortion.

## A. Family Planning and Family Planning-Related Services

While the Medicaid Act does not define “family planning services and supplies,” CMS provides guidance on the types of family planning services and supplies that are covered.<sup>2</sup> This 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.<sup>3</sup>

### 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).<sup>4</sup> To promote access to family planning services and supplies, beneficiaries are entitled to receive family planning services and supplies from any qualified Medicaid provider.<sup>5</sup> In the case of a Medicaid beneficiary receiving services from a Medi-Cal managed care plan (MCP), this means the beneficiary can obtain family planning services from a particular provider even if the provider is out-of-network.<sup>6</sup> 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 beneficiaries to seek services from any qualified Medi-Cal provider, even if the provider of choice is out of their Medi-Cal managed care network.<sup>7</sup>

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.<sup>8</sup>

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.<sup>9</sup> Medi-Cal sensitive services include services related to STIs, pregnancy, family planning, abortions, HIV, sexual assault and rape, and other minor

#### ADVOCACY TIP:

- ✓ Barriers to care and confusion about state and federal requirements continue to prevent some Medi-Cal beneficiaries from accessing the family planning services and supplies that they need. In the Medi-Cal managed care context, NHeLP has a [Medi-Cal Managed Care Toolkit for Accessing Family Planning Services and Abortion Care](#) with background information on federal and state law, as well as tools for advocates and clinics to use in their work.



consent services.<sup>10</sup> 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.<sup>11</sup>

## **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 services may include contraceptive counseling and instruction in pregnancy prevention. Through these visits, individuals can obtain contraceptives, prescriptions for contraceptives, and/or advice about contraception.<sup>12</sup>

## **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.<sup>13</sup>

Emergency contraception (EC) pills often referred to as "Plan B" 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 the same as the "abortion pill."

Physicians, physician assistants, certified nurse midwives, nurse practitioners, registered nurses, and pharmacists are all authorized to dispense contraceptives in California.<sup>14</sup> 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.<sup>15</sup> 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.<sup>16</sup>

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.<sup>17</sup> Medi-Cal also imposes quantity limits for OTC contraceptives. For example, beneficiaries are allowed up to one pack of emergency contraception per month.<sup>18</sup>

#### **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.<sup>19</sup> 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.<sup>20</sup>

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.<sup>21</sup> Medi-Cal will cover a hysterectomy as a treatment option for a medical issue, however it is not covered as a sterilization procedure.<sup>22</sup>

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.<sup>23</sup> 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.<sup>24</sup> 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).<sup>25</sup> 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.<sup>26</sup>

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).<sup>27</sup> The information must be effectively communicated in order to overcome any language or communication barrier.<sup>28</sup> 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.<sup>29</sup>

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.<sup>30</sup> 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.<sup>31</sup>

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.<sup>32</sup> 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.<sup>33</sup>

## **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 beneficiaries.<sup>34</sup> Pregnancy tests are also covered under Medi-Cal.<sup>35</sup>

## **B. 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.<sup>36</sup> 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.<sup>37</sup> Additionally, in November 2022, California voters passed Proposition 1, the Constitutional Right to Reproductive Freedom, which amends the California Constitution to explicitly grant individual reproductive freedom, including the fundamental right to choose to have an abortion, and the fundamental right to choose or refuse contraceptives.<sup>38</sup>

Medi-Cal covers abortion services regardless of the gestational age of the fetus. California prohibits health plans, including Medi-Cal MCPs, from requiring medical justification or prior authorization for abortion services. The only exception is that prior authorization is permitted for non-emergency inpatient abortions.<sup>39</sup> Health plans must ensure that beneficiaries have timely access to abortion services, and “implement and maintain procedures that ensure confidentiality and access to these sensitive services,” including for teenagers.<sup>40</sup> 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.<sup>41</sup> To ensure timely care, abortions are covered under the presumptive eligibility program, discussed in more detail below.

### **ADVOCACY TIP:**

- ✓ In the fall 2022, the State of California launched [abortion.ca.gov](https://abortion.ca.gov), a website to provide information about abortion to people both inside and outside of California. The website includes information about the legal right to abortion in California, tools to help find an abortion provider, and other support resources such as how to pay for an abortion and how to find health and wellness supports. The website is currently available in English, Spanish, Korean, Tagalog, Vietnamese, and Chinese (simplified and traditional characters).

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.<sup>42</sup>

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.<sup>43</sup> 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.<sup>44</sup>

Where a Medi-Cal provider objects to performing an abortion because of moral, ethical, or religious objections, that provider must file a written

statement beforehand, and the medical institution must provide another provider to that patient. The burden is not on the Medi-Cal MCP to find a replacement provider.

## C. Pregnancy Services

### 1. Pregnancy Services Overview – Prenatal, Labor/Delivery, Postpartum Care

Medi-Cal provides full-scope coverage at no cost to pregnant people with incomes up to 213% of the federal poverty level (FPL).<sup>45</sup> As of April 1, 2022, the Medi-Cal postpartum coverage period now lasts for 12 months following the end of the pregnancy. The Medi-Cal coverage continues during this 12-month period regardless of citizenship or immigration status, and regardless of changes in income during that time. The postpartum coverage begins on the last day of the pregnancy and ends on the last day of the month in which the 365th day following the pregnancy falls.<sup>46</sup>

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.<sup>47</sup> These freestanding birthing centers, or specialty clinics, also provide comprehensive perinatal, obstetrical, and delivery services.<sup>48</sup> Beginning on January 1, 2023, Medi-Cal beneficiaries will have access to full spectrum doula care during and after their pregnancies.<sup>49</sup>

Adolescents can receive pregnancy testing, prenatal care, and labor and delivery services, among other services, without permission or notifying a parent or guardian.<sup>50</sup> 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.

Medi-Cal offers prenatal services such as prescribed medication, laboratory services, radiology, and dental services.<sup>51</sup> Other pregnancy-related services covered by Medi-Cal during pregnancy include home blood glucose monitors for patients with diabetes, genetic counseling, tobacco cessation services, mental health services, and substance use disorder services.<sup>52</sup> 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.<sup>53</sup>

Postpartum services, or services provided after childbirth, child delivery, or a miscarriage, include hospital and scheduled office visits, assessment of uterine involution, and contraceptive counseling.<sup>54</sup> 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.<sup>55</sup>

## **2. Doula Services During and After Pregnancy**

Doula services was included as a Medi-Cal benefit in the state budget for the first time in 2021.<sup>56</sup> The Medi-Cal reimbursement rates for the doula services was also established in the state budget.<sup>57</sup>

Doulas provide non-medical support for pregnant people during the prenatal, labor and delivery, and postpartum period. Doula services include health education, advocacy, and a range of supports including physical and emotional support before, during, and after the end of pregnancy. These services can assist in preventing perinatal complications and improve health outcomes overall, as well as improving feelings of satisfaction with the birth experience. In addition to emotional and physical support, doulas can also offer health navigation, education, birth planning, lactation support, and connections with community-based resources.<sup>58</sup> Doula services are provided as preventive services in both Medi-Cal managed care and fee-for-service. Additionally, the doula benefit covers full-spectrum doula care, which includes care for all ways in which a pregnancy ends, including abortion or miscarriage.<sup>59</sup>

Under the new Medi-Cal benefit, pregnant and postpartum Medi-Cal beneficiaries can receive eleven visits during the perinatal period, excluding labor and delivery which are covered separately. Of the eleven visits, the initial visit is expected to be longer, and up to two of the postpartum visits can be extended visits of three hours. Visits can take place at a variety of locations including the beneficiary's home, at an office visit, in an alternative birthing center, or through telehealth. To access this benefit and to receive approval for additional visits, pregnant people will need a recommendation to doula care services from a physician or other licensed Medi-Cal provider.<sup>60</sup>

The CA Department of Health Care Services submitted a State Plan Amendment for approval to the Center for Medicare and Medicaid Services on November 7, 2022.<sup>61</sup> Additional details around implementation of the benefit were still being worked out at the time of this manual's publication. The benefit is scheduled to begin on January 1, 2023.



### 3. Comprehensive Perinatal Services Program

Medi-Cal also covers perinatal services under the Comprehensive Perinatal Services Program (CPSP) during pregnancy and through 60 days postpartum.<sup>62</sup> 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.<sup>63</sup> 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, such as resources to address food insecurity, economic security, housing needs, child care, and other issues.<sup>64</sup>

### D. 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.<sup>65</sup> 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.<sup>66</sup>

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.<sup>67</sup> Bright Futures recommends providers deliver reproductive and sexual health services including STI screenings, HPV vaccines, pregnancy testing, HIV testing, family planning, and sexuality education and counseling.<sup>68</sup> 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.<sup>69</sup> The comprehensive health and developmental history assessment should also include a discussion of sexuality, healthy relationships, and sexual health.<sup>70</sup>

## E. Assisted Reproductive Services

The Medicaid Act explicitly allows states to exclude fertility drugs from plan coverage.<sup>71</sup> Accordingly, assisted reproductive services intended to promote childbearing are generally not included as Medicaid family planning services.

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

## F. 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. However, there are several programs that provide access to reproductive and sexual health services for individuals who have 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% of the FPL, have no other source of health care coverage for family planning services, and reside in California.<sup>72</sup> 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.<sup>73</sup> As of July 1, 2022, Family PACT covers the HPV-9 vaccine as a clinic benefit.<sup>74</sup> Family PACT does not cover prenatal services, labor and delivery, or abortion.<sup>75</sup> Family PACT is a limited scope Medi-Cal program, but a component of Family PACT is funded solely by state funds, and therefore individuals qualify for Family PACT services regardless of their immigration status.<sup>76</sup>

### 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 for pregnancy and pregnancy-related care, family planning services including contraception and abortion, and sexual assault services.<sup>77</sup> Minors age 12 and older can also consent for STI screenings and treatment, services to treat substance use disorders, and outpatient mental health services.<sup>78</sup>

The program provides temporary coverage and must be renewed monthly for services except pregnancy. Beneficiaries are permitted to apply or renew by telephone or in-person, and counties must accept telephonically recorded, electronic signatures and/or handwritten signatures.<sup>79</sup>

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).<sup>80</sup> 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).<sup>81</sup> 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.<sup>82</sup> 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.<sup>83</sup>

### **3. 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.<sup>84</sup> They are also eligible for doula services when the benefit is covered by Medi-Cal. Beneficiaries receive all services without cost sharing, but they are required to pay a fee for coverage equal to 1.5% of their annual income; such fee can be paid all at once or via monthly payments.<sup>85</sup> Although called a Medi-Cal program, MCAP is funded with dollars from the Children's Health Insurance Program (CHIP).<sup>86</sup>

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% of the federal poverty level.<sup>87</sup> Individuals can qualify for MCAP regardless of their immigration status. Effective April 1, 2022, MCAP coverage will continue for 12 months following the end of the pregnancy, regardless of any changes in income during that time.<sup>88</sup>

### **4. 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, women 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.<sup>89</sup> Only outpatient prenatal services – including abortions – and prescription drugs are covered.<sup>90</sup> 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).<sup>91</sup> Thus, women 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.

## **G. 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% of the federal poverty level may also be eligible for free screenings and diagnostic services through the Every Woman Counts program.<sup>92</sup> 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).

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% of the federal poverty level; (4) has a need for breast or cervical cancer treatment; (5) is a U.S. citizen or an alien 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.<sup>93</sup>

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 individual 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.<sup>94</sup>

## H. Reproductive and Sexual Health 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 woman.<sup>95</sup> Medi-Cal (Medicaid) is the payer of last resort, and therefore claims for dual eligibles beneficiaries must first be submitted to Medicare to obtain a denial before billing Medi-Cal, unless the health care services are not covered by Medicare.<sup>96</sup> 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 Medicaid beneficiaries 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.<sup>97</sup>

# Endnotes

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- <sup>1</sup> Kaiser Fam. Found., Status of State Action on the Medicaid Expansion Decision, <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act> (last visited Nov. 22, 2022).
- <sup>2</sup> CMS, Dear State Health Official Letter 3 (June 14, 2016) (SHO # 16-008), <https://www.medicaid.gov/federal-policy-guidance/downloads/sho16008.pdf> [hereinafter SHO # 16-008].
- <sup>3</sup> See CMS, Dear State Medicaid Director Letter (April 16, 2014) (SMD # 14-003), <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-14-003.pdf> (clarifying the scope of family planning and family planning related services).
- <sup>4</sup> 42 U.S.C. § 1396o(a)(2)(D).
- <sup>5</sup> 42 U.S.C § 1396a(a)(23).
- <sup>6</sup> 42 U.S.C § 1396a(a)(23)(B); 42 C.F.R. § 431.51(b)(2).
- <sup>7</sup> 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://healthlaw.org/resource/fact-sheet-californias-medi-cal-protection-of-choice-for-family-planning-act/>.
- <sup>8</sup> 42 C.F.R. § 438.206(b)(2).
- <sup>9</sup> 2013 Cal. Stat. ch. 444 (S.B. 138).
- <sup>10</sup> CAL. FAM. CODE §§ 6924, 6925, 6926, 6927, 6928, and 6929; CAL. HEALTH & SAFETY CODE §§ 121020, 124260.
- <sup>11</sup> CAL. CIV. CODE § 56.107(5).
- <sup>12</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Family Planning 2*, 6 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/famplanning.pdf> [hereinafter *Medi-Cal Provider Manual, Family Planning*].
- <sup>13</sup> *Id.* at 9-12.
- <sup>14</sup> Cal. Dep't Health Care Servs., All Plan Letter 18-019 at 2 (Nov. 21, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-019.pdf> [hereinafter All Plan Letter 18-019].
- <sup>15</sup> CAL. HEALTH & SAFETY CODE § 1367.25(d)(4).
- <sup>16</sup> CAL. HEALTH & SAFETY CODE § 1367.25(d); CAL. WELF. & INST. CODE § 14000.01; see also All Plan Letter 18-019, *supra* note 14, at 2.
- <sup>17</sup> Kaiser Fam. Found., *Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey* (Feb. 17, 2022), <https://www.kff.org/report-section/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey->.
- <sup>18</sup> *Medi-Cal Provider Manual, Family Planning*, *supra* note 12, at 5.



- <sup>19</sup> *Id.* at 17-23.
- <sup>20</sup> SHO # 16-008, *supra* note 2.
- <sup>21</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Sterilization* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/Masters-MTP/Part2/ster.pdf> [hereinafter *Medi-Cal Provider Manual, Sterilization*].
- <sup>22</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Hysterectomy* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/hyst.pdf>.
- <sup>23</sup> 42 C.F.R. §§ 441.250-259; see generally CAL. CODE REGS. tit. 22, §§ 51305.1-51305.4.
- <sup>24</sup> 42 C.F.R. § 441.253.
- <sup>25</sup> CAL. CODE REGS. tit. 22, § 51305.1(a)(4), (b)(2).
- <sup>26</sup> CAL. CODE REGS. tit. 22, § 51305.3(b).
- <sup>27</sup> 42 C.F.R. § 441.257(a); CAL. CODE REGS. tit. 22, § 51305.3.
- <sup>28</sup> *Medi-Cal Provider Manual, Sterilization, supra* note 21, at 4.
- <sup>29</sup> CAL. WELF. & INST. CODE § 14193.
- <sup>30</sup> 42 C.F.R. § 441.258.
- <sup>31</sup> *Medi-Cal Provider Manual, Sterilization, supra* note 21, at 6.
- <sup>32</sup> CAL. CODE REGS. tit. 22, § 51305.1(a)(6)(A).
- <sup>33</sup> CAL. CODE REGS. tit. 22, § 51305.1(a)(6)(B).
- <sup>34</sup> *Medi-Cal Provider Manual, Family Planning, supra* note 12, at 2.
- <sup>35</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy Determination* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregdeterm.pdf>.
- <sup>36</sup> Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, Div. G, §§ 506, 507 (Dec. 16, 2014).
- <sup>37</sup> *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).
- <sup>38</sup> Constitutional Right to Reproductive Freedom, SCA 10, 2021-2022 Cal. State Legislature (2022), [https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=20212022OSCA10](https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=20212022OSCA10).
- <sup>39</sup> Cal. Dep't Health Care Servs., All Plan Letter 22-022 (Oct. 28, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-022.pdf> [hereinafter All Plan Letter 22-022].
- <sup>40</sup> *American Academy of Pediatrics v. Lungren*, 16 Cal. 4th 307 (Cal. 1997).
- <sup>41</sup> Guttmacher Inst., State Facts About Abortion: California, 2022, <https://www.guttmacher.org/state-facts>.

[gutmacher.org/fact-sheet/state-facts-about-abortion-california](https://gutmacher.org/fact-sheet/state-facts-about-abortion-california) (last visited Nov. 22, 2022).

<sup>42</sup> All Plan Letter 22-022, *supra* note 39.

<sup>43</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Abortions* 8 (2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/abort.pdf>.

<sup>44</sup> *Id.* at 6.

<sup>45</sup> Cal. Dep't Health Care Servs., State Plan Amendment Request # 21-0066 (2021), <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-21-0066-Approval.pdf>.

<sup>46</sup> Cal. Dep't Health Care Servs., All County Welfare Directors Letter No. 21-15 (Aug. 6, 2021), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/21-15.pdf> [hereinafter All County Welfare Directors Letter No. 21-15].

<sup>47</sup> 42 U.S.C. § 1396d (l)(3)(C).

<sup>48</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Alternative Birthing Centers* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/altern.pdf>.

<sup>49</sup> Cal. Dep't Health Care Servs, Doula Services as a Medi-Cal Benefit, <https://www.dhcs.ca.gov/provgovpart/Pages/Doula-Services.aspx> (last visited Nov. 22, 2022).

<sup>50</sup> CAL. FAM. CODE § 6925.

<sup>51</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Early Care and Diagnostic Services* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregearly.pdf>.

<sup>52</sup> *Id.*

<sup>53</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Postpartum and Newborn Referral Services* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregpost.pdf>.

<sup>54</sup> *Id.* at 5.

<sup>55</sup> Cal. Dep't Health Care Servs., *Durable Medical Equipment (DME): Other DME Equipment* (2020), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/duraother.pdf>.

<sup>56</sup> Cal. Health & Human Servs, Budget Summary (2021), <https://www.ebudget.ca.gov/2021-22/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>.

<sup>57</sup> Cal. Health & Human Servs, Budget Summary (2022), <https://www.ebudget.ca.gov/2022-23/pdf/Revised/BudgetSummary/HealthandHumanServices.pdf>.

<sup>58</sup> See, e.g., Amy Chen, Alexis Robles-Fradet, & Helen Arega, Nat'l Health Law

Prog., *Building A Successful Program for Medi-Cal Coverage for Doula Care: Findings from A Survey of Doulas in California* (2020), <https://healthlaw.org/resource/doulareport/>.

- <sup>59</sup> Cal. Dep't Health Care Servs, *Doula FAQ Sheet* (2022), <https://www.dhcs.ca.gov/provgovpart/Documents/Doula-FAQ-Sheet.pdf>.
- <sup>60</sup> Cal. Dep't Health Care Servs, *Draft Doula Provider Manual* (2022), <https://www.dhcs.ca.gov/services/medi-cal/Documents/Doula-Provider-Manual-DRAFT.pdf>. Additional guidance on doula coverage is forthcoming. See Draft All Plan Letter 22-XXX (which is expected to be finalized in early 2023).
- <sup>61</sup> Cal. Dep't Health Care Servs, State Plan Amendment Request # 22-0002 (Nov. 21, 2022), <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0002-Pending-Redacted.pdf>.
- <sup>62</sup> CAL. CODE REGS. tit. 22, §§ 51179, 51348(a).
- <sup>63</sup> CAL. CODE REGS. tit. 22, § 51348; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pregnancy: Comprehensive Perinatal Services Program (CPSP)* 5 (2018), [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregcom\\_m00o03.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pregcom_m00o03.doc) [hereinafter *Medi-Cal Provider Manual, Pregnancy: Comprehensive Perinatal Services Program (CPSP)*].
- <sup>64</sup> CAL. CODE REGS. tit. 22, § 51348(a); *Medi-Cal Provider Manual, Pregnancy: Comprehensive Perinatal Services Program (CPSP)*, *supra* note 63, at 12.
- <sup>65</sup> 42 U.S.C. § 1396d(r).
- <sup>66</sup> *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.medicaid.gov/medicaid/benefits/downloads/epsdt\\_coverage\\_guide.pdf](https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf).
- <sup>67</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Preventive Services* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/prev.pdf>.
- <sup>68</sup> 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://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/>.
- <sup>69</sup> *Id.*
- <sup>70</sup> *Id.*
- <sup>71</sup> 42 U.S.C. §1396r-8(d)(2)(B).
- <sup>72</sup> Cal. Dep't Health Care Servs., *Family PACT Policies, Procedures and Billing Instructions Manual, Client Eligibility* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/clientelig.pdf>.
- <sup>73</sup> 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* (Dec. 31, 2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/fpact/fam.pdf>.

- <sup>74</sup> Cal. Dep't Health Care Servs., Family PACT Update, Bulletin 178 (July 2022), <https://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/fpact202207.aspx>.
- <sup>75</sup> CAL. WELF. & INST. CODE §§ 14132(aa)(8) (Medicaid-funded component), 24001(a)(1) (state-funded component).
- <sup>76</sup> 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.
- <sup>77</sup> 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).
- <sup>78</sup> Cal. Dep't Health Servs., Medi-Cal Eligibility Procedures Manual Letter No. 183 at 4V-1 (Aug. 12, 1997), <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c183.pdf> [hereinafter Eligibility Procedures Manual Letter No. 183]. 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.
- <sup>79</sup> Cal. Dep't Health Servs., All County Welfare Directors Letter No: 19-17, Telephonic or Electronic Signature Capability (June 21, 2019), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c19-17.pdf>; see also Cal. Dep't Health Servs., Medi-Cal Eligibility Division Information Letter No.: 21-09, Continuing Telephonic Flexibilities for the Minor Consent Program Beyond the COVID-19 Public Health Emergency (June 24, 2021), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/l21-09.pdf>.
- <sup>80</sup> Eligibility Procedures Manual Letter No. 183, *supra* note 78, at 4V-2.
- <sup>81</sup> *Id.* at 4V-1, 4V-2.
- <sup>82</sup> *Id.* at 4V-2, 4V-3; see also CAL. CODE REGS. tit. 22, §§ 50147.1, 50167(a)(6)(D)(4).
- <sup>83</sup> Cal. Dep't Health Servs., *Medi-Cal Provider Manual, Minor Consent Program* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/minor.pdf>.
- <sup>84</sup> CAL. WELF. & INST. CODE § 15822; Cal. Dep't Health Servs., Medi-Cal Access Program (2022), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/Medi-CalAccessProgram.aspx> (last visited Nov. 22, 2022).
- <sup>85</sup> Cal. Dep't Health Servs., Who Qualifies for MCAP? (2022), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/Qualifying.aspx> (last visited Nov. 22, 2022).
- <sup>86</sup> CAL. WELF. & INST. CODE § 15841(b).

- <sup>87</sup> CAL. WELF. & INST. CODE § 15832(a)(1); CAL. CODE REGS. tit. 10, § 2699.200(b)(1). California's statute indicates income should be between 208% and 317% 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% of the poverty level.
- <sup>88</sup> All County Welfare Directors Letter No. 21-15, *supra* note 46.
- <sup>89</sup> Cal. Dep't Health Servs., Information on the Presumptive Eligibility for Pregnant Women, [https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE\\_Info\\_women.aspx](https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE_Info_women.aspx) (last visited Nov. 22, 2022) 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.
- <sup>90</sup> 42 U.S.C. § 1396r-1(a); Cal. Dep't Health Care Servs., *supra* note 89.
- <sup>91</sup> 42 U.S.C. § 1396r-1(b)(1); CAL. WELF. & INST. CODE § 14148.7.
- <sup>92</sup> Cal. Dep't Health Servs., *Medi-Cal Provider Manual, Every Woman Counts* (2020), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/ewoman.pdf>.
- <sup>93</sup> Cal. Dep't Health Servs., Breast and Cervical Cancer Treatment Program (BCCTP), <https://www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx> (last visited Nov. 22, 2022). See also 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa).
- <sup>94</sup> 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa).
- <sup>95</sup> 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. 22, 2022).
- <sup>96</sup> Cal. Dep't Health Servs., *Medi-Cal Provider Manual, Medicare/Medi-Cal Crossover Claims Overview* (2020), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part1/medicare.pdf>.
- <sup>97</sup> 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**

December 2022

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**Chapter VII:  
Dental Services**



# Chapter VII: Dental Services

## Outline of Medi-Cal 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.<sup>1</sup> Therefore, the state has flexibility in determining the scope of dental services it covers. The Medi-Cal Dental Program (Medi-Cal Dental) 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.<sup>2</sup>

## A. Adult Dental Coverage

### 1. Full-Scope Dental Benefits

Adults with full-scope Medi-Cal are eligible for comprehensive dental services.<sup>3</sup>

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
- Laboratory Processed Crowns
- Root Canals in Back Teeth
- Partial Dentures
- Partial Denture Adjustments, Repairs, and Relines
- Periodontics (Scaling and Root Planing)
- NEW\*: Posterior Lab-Processed Crowns

\*“NEW” refers to the added benefit(s) in 2022.

Effective July 1, 2022, Medi-Cal Dental benefits cover laboratory-processed crowns. The new addition modified the criteria so that individuals age 21 or older can receive laboratory-processed crowns on posterior teeth when medically necessary to restore a posterior tooth back to normal function.<sup>4</sup> Posterior teeth for such individuals also do not have to serve as abutments for removable partial dentures in order to qualify for laboratory-processed crowns. The new benefit aligns standards of dental care with evidence-based practices and guidelines consistent with the American Dental Association.

## 2. Limited Scope Dental Benefits

Adults with limited-scope Medi-Cal have restricted coverage with only extractions and emergency services covered. Effective May 1, 2022, California expanded full scope Medi-Cal coverage to adults age 50 years or older. This expansion also includes the full spectrum of dental benefits listed above.

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:<sup>5</sup>
  - 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 Medi-Cal Dental Manual of Criteria (MOC) that are covered by the Medi-Cal program (as long as procedure requirements and criteria are met).<sup>6</sup> These beneficiaries are also eligible to receive these services for 12 months postpartum regardless of citizenship or immigration status, and regardless of changes in income during that time. The postpartum coverage begins on the last day of the pregnancy and ends on the last day of the month in which the 365th day following the pregnancy falls.<sup>7</sup>

### 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.<sup>8</sup> The cap is considered a “soft” cap because once Medi-Cal Dental 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.<sup>9</sup> The \$1,800 cap resets each calendar year. Providers are not responsible for verifying a Medi-Cal member’s dental cap prior to rendering medically necessary services.<sup>10</sup>

Certain services are exempt from the cap, including:<sup>11</sup>

- 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.<sup>12</sup> So even if there was a partial payment, the provider must consider it to be payment in full.<sup>13</sup> 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.<sup>14</sup>

## 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
- NEW\*: Caries Risk Assessment bundle
- NEW\*: Silver Diamine Fluoride

\*“NEW” refers to the added benefit(s) in 2022.

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.”<sup>15</sup> 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.”<sup>16</sup>

As part of the California Advancing and Innovating Medi-Cal (CalAIM) Dental Initiative, California is working to improve oral health and preventive services for children.<sup>17</sup> The initiative includes new benefits such as the Caries Risk Assessment (CRA) bundle and Silver Diamine Fluoride (SDF).<sup>18</sup> CRA services bundles a CRA exam and nutritional counseling to assess and manage caries risk and to emphasize the provision of preventive services in lieu of more invasive and costly procedures for children ages 0 to 6.<sup>19</sup> This benefit is available statewide and allows providers, including allied dental professionals, to bill for the CRA bundle rate including the allowable increased frequencies for certain preventive services for those with moderate and high caries risk.<sup>20</sup>

The goal of SDF is to provide an option for caries arresting treatment when restorative caries treatment may not be optimal. This benefit is available statewide and allows providers, including allied dental professionals, to bill for the application of the caries-arresting medicament SDF.<sup>21</sup> This benefit is reimbursable for children (ages 0 to 6) and provides two visits per member per year (once every six months), for up to ten teeth per visit, with a lifetime

maximum of four treatments per tooth.<sup>22</sup> In addition, the SDF benefit is available to persons with underlying conditions for whom nonrestorative caries treatment may be optimal. This can include individuals in Skilled Nursing Facility/Intermediate Care Facility (SNF/ICF) or individuals receiving services from the Department of Developmental Services (DDS).<sup>23</sup> The SDF benefit is available except if the tooth is nonrestorable or near exfoliation.<sup>24</sup>

### C. Prior authorization

Prior approval of certain dental services must be sought through a Treatment Authorization Request (TAR).<sup>25</sup> Services subject to prior authorization include restorative services, endodontics, periodontics, prosthodontics, implant services, oral and maxillofacial surgery and orthodontics services.<sup>26</sup> Services provided to patients in hospitals, skilled nursing facilities and other intermediate care facilities require prior authorization unless exempted as emergency services.<sup>27</sup> 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.<sup>28</sup>

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.

#### ADVOCACY TIP:

- ✓ The Medi-Cal Dental Program Provider Handbook contains detailed information regarding Medi-Cal Dental 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 Medi-Cal Dental Provider Bulletins. The Handbook is designed for Medi-Cal Dental accepting providers and their staff as their primary reference for information about the Medi-Cal Dental Program, and can also be a helpful tool for advocates.<sup>29</sup>

#### 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.

## D. Tele-dentistry

DHCS permits the use of tele-dentistry as an alternative way to provide dental services. Therefore, enrolled Medi-Cal Dental 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.<sup>30</sup> Synchronous or live transmission “is a real-time interaction between a beneficiary and a provider located at a distant site.”<sup>31</sup> Eligible tele-dentistry services include oral evaluation for new or established patients, periodic oral evaluation for established patients, and examination of radiographic images. For more information on telehealth services, refer to the “Telehealth Addendum”.

## E. General Anesthesia Services

Prior Authorization is required for general anesthesia and intravenous sedation. Only an enrolled Medi-Cal Dental 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.<sup>32</sup> 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.<sup>33</sup>

## F. Delivery System: FFS vs. Managed Care

Medi-Cal Dental 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 plan.

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.<sup>34</sup> On July 1, 2022 DHCS awarded dental administrative responsibilities to a new vendor, Gainwell Technologies LLC, which replaced Delta Dental and assumed responsibility for dental business operations on October 1, 2023.<sup>35</sup>





- <sup>7</sup> Cal. Dep't of Health Care Servs., All County Welfare Directors Letter No. 21-15 (Aug. 6, 2021), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/21-15.pdf>; see also Chapter VI of this Guide on Reproductive and Sexual Health Services.
- <sup>8</sup> CAL. WELF. & INST. CODE § 14080(a).
- <sup>9</sup> *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 4-11 and 4-12.
- <sup>10</sup> Cal. Dep't Health Care Servs., *Medi-Cal Dental Provider Bulletin, Vol. 37, No. 01* (Jan. 2021), [https://www.dental.dhcs.ca.gov/MCD\\_documents/providers/provider\\_bulletins/Volume\\_37\\_Number\\_01.pdf](https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_bulletins/Volume_37_Number_01.pdf) [hereinafter *Medi-Cal Dental Provider Bulletin, Vol. 37, No. 01*].
- <sup>11</sup> *Id.*
- <sup>12</sup> *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 4-11.
- <sup>13</sup> *Id.*
- <sup>14</sup> *Id.*
- <sup>15</sup> 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.
- <sup>16</sup> 42 C.F.R. § 441.56(c)(2); CAL. CODE REGS. tit. 17, § 6843(a)(1). See also Chapter VIII of this Guide on Children's Health Services.
- <sup>17</sup> Cal. Dep't of Health Care Servs., CalAIM Dental Initiative, <https://www.dhcs.ca.gov/services/Pages/DHCS-CalAIM-Dental.aspx> (last visited Nov. 23, 2022).
- <sup>18</sup> CMS, Approval Letter for Cal. State Plan Amendment # 21-0019 (Dec. 15, 2021), <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-21-0019-Approved.pdf>; Cal. Dep't Health Care Servs., Dental All Plan Letter 21-005 (Nov. 23, 2021), <https://www.dhcs.ca.gov/provgovpart/denti-cal/Documents/APL-21-005-CalAIM-Requirements-and-Enclosure.pdf> [hereinafter Dental All Plan Letter 21-005]; See also Cal. Dep't Health Care Servs., *Medi-Cal Dental Provider Bulletin, Vol. 38, No. 01* (Jan. 2022), [https://www.dental.dhcs.ca.gov/MCD\\_documents/providers/provider\\_bulletins/Volume\\_38\\_Number\\_01.pdf](https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_bulletins/Volume_38_Number_01.pdf).
- <sup>19</sup> Cal. Dep't Health Care Servs., Caries Risk Assessment, <https://www.dhcs.ca.gov/services/Pages/caries-risk-assessment.aspx> (last visited Nov. 28, 2022). See also Dental All Plan Letter 21-005, *supra* note 18, at 2-3.
- <sup>20</sup> Dental All Plan Letter 21-005, *supra* note 18, at 2-3.
- <sup>21</sup> Cal. Dep't Health Care Servs., Silver Diamine Fluoride, <https://www.dhcs.ca.gov/services/Pages/silver-diamine-fluoride.aspx> (last visited Nov. 28, 2022). See also Dental All Plan Letter 21-005, *supra* note 18, at 3.
- <sup>22</sup> Dental All Plan Letter 21-005, *supra* note 18, at 3.
- <sup>23</sup> *Id.*
- <sup>24</sup> *Medi-Cal Dental Provider Bulletin, Vol. 37, No. 01*, *supra* note 10, at 5.

- <sup>25</sup> *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 2-11.
- <sup>26</sup> *Id.* at 2-12.
- <sup>27</sup> *Id.* at 2-12; *see also* CAL. CODE REGS. tit. 22, § 51056 (a), (b).
- <sup>28</sup> *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 5-1-5-126.
- <sup>29</sup> See Michelle Lilienfeld, Nat'l Health Law Prog., *Dental Credit Card Debt: California Advocates Toolkit* (Dec. 2018), <https://healthlaw.org/resource/dental-credit-card-debt-california-advocates-toolkit/> (Appendix 2 of the Dental Credit Card Toolkit provides a reference sheet to help advocates get acquainted with the services section of the Medi-Cal Dental Provider Handbook).
- <sup>30</sup> Cal. Dep't Health Care Servs., *Denti-Cal Bulletin Vol. 32* at 4 (March 2016).
- <sup>31</sup> Each transmission is "limited to 90 minutes per beneficiary per provider, per day." *Id.*
- <sup>32</sup> 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 (June 28, 2017), [http://www.dhcs.ca.gov/services/Documents/MDSO/2017%20DAPLs/APL17\\_004.pdf](http://www.dhcs.ca.gov/services/Documents/MDSO/2017%20DAPLs/APL17_004.pdf).
- <sup>33</sup> Cal. Dep't Health Care Servs., Dental All Plan Letter 15-005 at 2 (April 1, 2015), <https://www.dhcs.ca.gov/services/Documents/MDSO/2015%20DAPLs/APL%2015-005.pdf>.
- <sup>34</sup> Cal. Dep't Health Care Servs., *Denti-Cal Bulletin Vol. 33* at 11 (Sept. 2017), [https://www.denti-cal.ca.gov/DC\\_documents/providers/provider\\_bulletins/Volume\\_33\\_Number\\_11.pdf](https://www.denti-cal.ca.gov/DC_documents/providers/provider_bulletins/Volume_33_Number_11.pdf).
- <sup>35</sup> Cal. Dep't Health Care Servs., Notice of Intent to Award, RFP # 20-10354 (July 1, 2022), [https://www.dhcs.ca.gov/provgovpart/rfa\\_rfp/Documents/NOIA-FIDBO-2010354.pdf](https://www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/NOIA-FIDBO-2010354.pdf).
- <sup>36</sup> CAL. WELF. & INST. CODE § 14087.46; Cal. Dep't Health Care Servs., All County Welfare Directors Letter No. 94-88 (Nov. 21, 1994), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c94-88.pdf>.



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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

# Chapter VIII: Children's Health Services

## Outline of Medi-Cal Children's Health Services (in addition to general Medi-Cal services)\*

- 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
    - Behavioral Health Services
- California Children's Services
  - Diagnostic and treatment services, medical case management, and physical and occupational therapy services
    - Whole Child Model
    - Traditional Counties
- Child Health and Disability Prevention Program (CHDP)
  - Health assessments and immunizations
- Minor Consent Medi-Cal
- Enhanced Care Management and Community Supports

\*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).<sup>1</sup> California elects to cover all children up to 19 years old in families with incomes up to 266% FPL.<sup>2</sup> Additionally, in 2016, California extended full-scope Medi-Cal benefits to all eligible children under age 19 regardless of immigration status.<sup>3</sup> Currently, Medi-Cal covers health services for more than 5.5 million children.<sup>4</sup>

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.<sup>5</sup> This chapter will address 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. For more information on reproductive and sexual health services for children and youth through EPSDT services and other programs, see Chapter VI of this guide.

## 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.<sup>6</sup> 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.<sup>7</sup>

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.<sup>8</sup> For example, while Medi-Cal covers limited chiropractic services for adults (see Chapter XII of this Guide on Ancillary Services), EPSDT chiropractic services must be covered when it is medically necessary for an individual child. Medi-Cal EPSDT services must be covered when they are necessary to correct or *ameliorate* the individual child's physical and behavioral health conditions.<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup> 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.<sup>12</sup> When a screening indicates the need for further evaluation and follow-up, EPSDT covers diagnostic and treatment services.<sup>13</sup> 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.<sup>14</sup> EPSDT also covers all behavioral health services that are medically necessary.<sup>15</sup> See Chapter III (Mental Health Services) and Chapter IV (Substance Use Disorder Services) of this Guide for more details on coverage of these services under Medi-Cal EPSDT.

Medi-Cal EPSDT also covers case management services to support a child's access to medical, social, educational, and other services.<sup>16</sup> 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 to provide case management services.<sup>17</sup> TCM is also a specialty mental health service, and may be provided to beneficiaries through a contract with the Mental Health Plan (MHP).<sup>18</sup> 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.<sup>19</sup> EPSDT also covers assistance with scheduling appointments and arranging transportation for Medi-Cal-covered appointments.<sup>20</sup>

## **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 and receive.<sup>21</sup> Although some Medi-Cal EPSDT services are carved out of the MCP contract, MCPs have the primary responsibility to provide all medically necessary EPSDT services.<sup>22</sup> 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.<sup>23</sup> 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 services.<sup>24</sup> MCPs must provide NMT for all medically necessary services, including those services carved out of the MCP.<sup>25</sup>

MCPs must ensure that members under the age of 21, and their families or primary caregivers, know what Medi-Cal services are available and where and how to obtain these services.<sup>26</sup> 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.<sup>27</sup> This information must be provided in the member's primary language at a sixth-grade reading level.<sup>28</sup>

### **ADVOCACY TIP:**

- ✓ Look out for situations where the Medi-Cal managed care plan (MCP) fails to coordinate medically necessary services that are carved out of the MCP contract, and appeal as necessary. MCPs are ultimately responsible coordination of care for all medically necessary EPSDT services delivered within and outside the MCP's network.

## **B. Other 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.<sup>29</sup> Approximately 90% of children enrolled in CCS are Medi-Cal eligible.<sup>30</sup> 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.<sup>31</sup>

Medi-Cal MCPs are required to refer all children with certain medical conditions to CCS.<sup>32</sup> Until the child's CCS eligibility is confirmed, the MCP remains responsible for providing all medically necessary EPSDT services.<sup>33</sup> 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.<sup>34</sup>

#### ***Whole Child Model***

In 2018, the Whole Child Model (WCM) program was implemented to authorize MCPs to administer the CCS program in 21 County Organized Health System (COHS) counties.<sup>35</sup> 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.<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup>

### **Traditional Counties**

In traditional, or 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.<sup>39</sup> 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.<sup>40</sup> 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.<sup>41</sup>

Ultimately, how a child accesses services if enrolled in both Medi-Cal and CCS depends on the county in which the child lives. 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.<sup>42</sup> MCPs 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*.<sup>43</sup>

#### **ADVOCACY TIP:**

- ✓ If CCS determines that the medically necessary service is not tied to the CCS-eligible condition, advocates are encouraged to seek authorization through the child's Medi-Cal managed care plan, if applicable.

## **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.<sup>44</sup> 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.<sup>45</sup> Proof of residence and income is not required.<sup>46</sup> The CHDP program is operated at the county level by local health departments.<sup>47</sup> 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.<sup>48</sup> Once a child is enrolled in Medi-Cal, children access CHDP services through FFS Medi-Cal or their Medi-Cal MCP.

The 2022-2023 California state budget approved the sunset of the CHDP program, and the implementation of the Children's Presumptive Eligibility program, effective July 1, 2024.<sup>49</sup> The goal is to simplify and streamline the delivery of services to children and youth under the age of 21, in alignment with the goals of California Advancing and Innovating Medi-Cal (CalAIM) Initiative, which is a long-term commitment to strengthen and transform Medi-Cal and offer person-centered, equitable and coordinated health care for children and youth on Medi-Cal.

### **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.<sup>50</sup> In this program, minors can provide legal consent for sensitive services.<sup>51</sup> 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.<sup>52</sup> However, a child or youth cannot receive methadone treatment, psychotropic drugs, convulsive therapy, psychosurgery or sterilization without parental consent.<sup>53</sup> 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.<sup>54</sup>

A child or youth must apply each month for Minor Consent Medi-Cal services. The one exception is when a child or youth is seeking outpatient mental health services as recommended by a mental health professional.<sup>55</sup> Additionally, 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).<sup>56</sup> Eligibility is based on the minor's income and resources, not the income and resources of the minor's parent(s) or guardian(s).<sup>57</sup> 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.<sup>58</sup> 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.<sup>59</sup> 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.<sup>60</sup>

## C. Enhanced Care Management and Community Supports

As part of the CalAIM initiative, several new services will be available for children on Medi-Cal. Enhanced Care Management (ECM) and Community Supports are two new foundational components of CalAIM and offer new services for children and youth beginning in 2023.

### 1. Enhanced Care Management

As part of CalAIM, some children and youth on Medi-Cal are entitled to Enhanced Care Management (ECM) services, beginning July 1, 2023. ECM is a whole-person, interdisciplinary approach to comprehensive care management intended to address the clinical and non-clinical needs of high-cost, high-need individuals through systematic coordination of services that is community-based, interdisciplinary, high-touch and person-centered.<sup>61</sup> ECM is delivered through Medi-Cal managed care plans (MCPs) and was implemented for some Medi-Cal adult populations beginning January 1, 2022. Each MCP must provide seven core services: 1.) Outreach and Engagement; 2.) Comprehensive Assessment and Care Management Plan; 3.) Enhanced Coordination of Care; 4.) Health Promotion; 5.) Comprehensive Transitional Care; 6.) Member and Family Supports; and 7.) Coordination of and Referral to Community and Social Support Services.<sup>62</sup> ECM services will be available to children and youth in select populations of focus, as follows:<sup>63</sup>

- Children and youth up to age 21 who are experiencing homelessness;
- Children and youth who are high utilizers of high-cost services such as emergency department and inpatient services;
- Children and youth with serious emotional disturbance or identified to be at clinical high clinical risk for psychosis or experiencing a first episode of psychosis;
- Children enrolled in California Children's Services (CCS) with additional needs beyond the CCS eligible condition
- Children and youth involved in, or with a history of involvement in, child welfare (including Foster Care up to age 26), and
- Youth transitioning from incarceration

### 2. Community Supports

Through CalAIM, children on Medi-Cal may also be eligible for Community

#### ADVOCACY TIP:

- ✓ Minors can apply for Minor Consent Medi-Cal, and renew eligibility, either in-person or by telephone. This change was adopted at the onset of the COVID-19 public health emergency and this change has been adopted on a permanent basis.



Supports. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services that address social drivers of health.<sup>64</sup> All Medi-Cal MCPs are encouraged, but not required, to offer the 14 Community Supports effective January 1, 2022, and use of Community Supports is optional for members.<sup>65</sup> For more information on Community Supports, see Chapter XI of this Guide.

## Endnotes

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<sup>1</sup> 42 U.S.C. §1396a(l)(2)(C); 42 U.S.C. 1396a(e)(14)(l)(i) (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).

<sup>2</sup> 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)), 14005.26(b), 1396a(e)(14)(l)(i) (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).

<sup>3</sup> 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](https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/SB75/SB75_EE_Plan_032116_Final.PDF).

<sup>4</sup> Cal. Dep't Health Care Servs., *Medi-Cal Children's Health Dashboard 1* (2022), <https://www.dhcs.ca.gov/services/Documents/Childrens-Health-Dashboard-June-2022.pdf>.

<sup>5</sup> 42 U.S.C. § 1396d(r)(5).

<sup>6</sup> 42 U.S.C. §§ 1396a(a)(10)A, 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); CAL. WELF. & INST. CODE §§ 14059.5(b)(1), 14132(v); see CAL. CODE REGS. tit. 22, §§ 51184, 51340, 51340.1.

<sup>7</sup> CAL. WELF. & INST. CODE §§ 14059.5(b)(1), 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), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-010.pdf> [hereinafter All Plan Letter 19-010]; see also CMS, *EPSDT—A Guide for States: Coverage in the Medical Benefit for Children and Adolescents* (2014), [https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt\\_coverage\\_guide\\_82.pdf](https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/epsdt_coverage_guide_82.pdf).



- <sup>8</sup> 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)A, 1396a(a)(43), 1396d(a)(4)(B).
- <sup>9</sup> 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).
- <sup>10</sup> 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>.
- <sup>11</sup> Cal. Dep’t Health Care Servs., *supra* note 10; *see also* All Plan Letter 19-010, *supra* note 7, at 4.
- <sup>12</sup> 42 U.S.C. § 1396d(r)(1); *see also* Cal. Dep’t Health Care Servs., *supra* note 10.
- <sup>13</sup> 42 U.S.C. § 1396d(r)(5); CAL. CODE REGS. tit 22, § 51184.
- <sup>14</sup> 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).
- <sup>15</sup> CAL. WELF. & INST. CODE §§ 14184.402(d), 14184.402(e)(2).
- <sup>16</sup> CAL. CODE REGS. tit. 22, § 51184(g).
- <sup>17</sup> *Id.* §§ 51184(h), 51340(f)(1).
- <sup>18</sup> CAL. CODE REGS. tit. 9, § 1810.249.
- <sup>19</sup> CAL. CODE REGS. tit. 22, § 51340(k); *see also* All Plan Letter 19-010, *supra* note 7, at 8.
- <sup>20</sup> 42 C.F.R. §§ 441.62; *see also* Cal. Dep’t Health Care Servs., *supra* note 10.
- <sup>21</sup> *See generally* All Plan Letter 19-010, *supra* note 7; *see also, e.g.*, Cal. Dep’t Health Care Servs., *Two-Plan Boilerplate Contract*, Exhibit A, Attachment 10 (2014), <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx> [hereinafter *Two-Plan Boilerplate Contract*].
- <sup>22</sup> All Plan Letter 19-010, *supra* note 7, at 9.
- <sup>23</sup> *Id.* at 7; *Two-Plan Boilerplate Contract*, *supra* note 21, at Exhibit A, Attachment 11.
- <sup>24</sup> All Plan Letter 19-010, *supra* note 7, at 7.

- <sup>25</sup> *Id.*; Cal. Dep't Health Care Servs., All Plan Letter 22-008 (May 18, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf> [hereinafter All Plan Letter 22-008].
- <sup>26</sup> All Plan Letter 19-010, *supra* note 7, at 8.
- <sup>27</sup> 42 U.S.C. § 1396d(r)(1)(B)(v); *see also* All Plan Letter 22-008, *supra* note 25.
- <sup>28</sup> All Plan Letter 19-010, *supra* note 7.
- <sup>29</sup> CAL. HEALTH & SAFETY CODE § 123800-123995 (enabling legislation); CAL. WELF. & INST. CODE § 14094-14094.3; CAL. CODE REGS. tit. 22, § 51013.
- <sup>30</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: California Children's Services Program 2* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchild.pdf>.
- <sup>31</sup> *Id.*
- <sup>32</sup> CAL. CODE REGS. tit 22, § 51013; *see also* All Plan Letter 19-010, *supra* note 7, at 8; Cal. Dep't Health Care Servs., All Plan Letter 21-005 at 3 (Dec. 10, 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-005.pdf> [hereinafter All Plan Letter 21-005].
- <sup>33</sup> All Plan Letter 19-010, *supra* note 7, at 8-9.
- <sup>34</sup> *Id.*
- <sup>35</sup> 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), <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-WCM-FAQ-2019.pdf> [hereinafter *CCS Whole Child FAQ*].
- <sup>36</sup> CAL. WELF. & INST. CODE § 14094.6; *see also* All Plan Letter 21-005, *supra* note 32, at 1.
- <sup>37</sup> All Plan Letter 21-005, *supra* note 32, at 2; *see also* Cal. Dep't Health Care Servs., CCS Numbered Letter 03-0421 at 2 (Dec. 9, 2021), <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-03-0421-Whole-Child-Model.pdf>.
- <sup>38</sup> *See CCS Whole Child FAQ, supra* note 35, at 3.
- <sup>39</sup> CAL. HEALTH & SAFETY CODE § 123850(a).
- <sup>40</sup> *Id.*
- <sup>41</sup> All Plan Letter 19-010, *supra* note 7, at 8.
- <sup>42</sup> *Id.*, at 7.
- <sup>43</sup> 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* (2021), <https://healthlaw.org/resource/helping-families-obtain-durable-medical-equipment-and-supplies-through-the-california-childrens-services-ccs-program/>.

- <sup>44</sup> 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>.
- <sup>45</sup> 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.*
- <sup>46</sup> Cal. Dep’t Health Care Servs., *supra* note 44, at 2.
- <sup>47</sup> *See, e.g.*, CAL. HEALTH & SAFETY CODE § 124040.
- <sup>48</sup> CAL. WELF. & INST. CODE § 14011.7(b), (e); *see also* Cal. Dep’t Health Care Servs., All County Welfare Director’s Letter No. 03-33 (June 18, 2003), <https://www.cdss.ca.gov/lettersnotices/entres/getinfo/ac103/pdf/03-33.pdf>.
- <sup>49</sup> Cal. Health & Human Servs. Agency, *2022–23 Enacted CA State Budget Summary* 73, <https://www.ebudget.ca.gov/2022-23/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>; *see also* Cal. Dep’t Health Care Servs., *Proposal to Discontinue the Child Health and Disability Prevention Program*, <https://www.dhcs.ca.gov/Documents/DHCS-Proposal-to-Discontinue-the-CHDP-Program.pdf>.
- <sup>50</sup> *See* Cal. Dep’t Health Care Servs., *Medi-Cal Eligibility Procedures Manual* § 4V (2021), <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEPM/4V-MinorConsent-12-16-21.pdf>.
- <sup>51</sup> 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.
- <sup>52</sup> Cal. Dep’t Health Care Servs., *supra* note 50, at § 4V; *see also* CAL. FAMILY CODE § 6920.
- <sup>53</sup> Cal. Dep’t Health Care Servs., *supra* note 50, at § 4V.
- <sup>54</sup> *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).
- <sup>55</sup> Cal. Dep’t Health Care Servs., *supra* note 50, at 3.
- <sup>56</sup> *Id.*, at § 4V; CAL. CODE REGS. tit. 22, § 50147.1(e).
- <sup>57</sup> Cal. Dep’t Health Care Servs., *supra* note 50, at § 4V.
- <sup>58</sup> *Id.*; *see also* CAL. CODE REGS. tit. 22, § 50167(a)(6)(D)(4).
- <sup>59</sup> Cal. Dep’t Health Care Servs., *Medi-Cal Provider Manual: Minor Consents Program* (Aug. 2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/minor.pdf>.

- <sup>60</sup> See, e.g., *Two-Plan Boilerplate Contract*, *supra* note 21, at Exhibit A, Attachment 9, § 9(D) (affirming all services named in minor consent regulation as minor consent services); *id.* at Exhibit A, Attachment 5, § 2(G).
- <sup>61</sup> Cal. Dep't Health Care Servs., All Plan Letter 21-012 (Sept. 15, 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-012.pdf> [hereinafter All Plan Letter 21-012]; See also Cal. Dep't Health Care Servs., *CalAIM Enhanced Care Management and In Lieu of Services FAQs* (Dec. 2021), <https://www.dhcs.ca.gov/Documents/MCQMD/ECMILOS-FAQs-May-05282021.pdf> [hereinafter *CalAIM ECM FAQs*].
- <sup>62</sup> *CalAIM ECM FAQs*, *supra* note 61.
- <sup>63</sup> All Plan Letter 21-012, *supra* note 61, at Attachment 1
- <sup>64</sup> Cal. Dep't Health Care Servs., All Plan Letter 21-017 (March 1, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-017.pdf>.
- <sup>65</sup> *Id.*



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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

# Chapter IX: Long-Term Services and Supports

## Outline of Medi-Cal Long-Term Services and Supports\*

- 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.<sup>1</sup> 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).

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.<sup>2</sup> 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 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.<sup>3</sup> 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.<sup>4</sup>

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 (for example, dietary assistance, pharmaceutical services, and an activity program).<sup>5</sup> 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.<sup>6</sup>

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.<sup>7</sup>

## **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.<sup>8</sup>

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.<sup>10</sup>

### 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.<sup>11</sup> 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.<sup>12</sup>

#### **ADVOCACY TIP:**

- ✓ 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.<sup>9</sup>

### 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. <sup>13</sup>
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. <sup>14</sup>
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. <sup>15</sup>
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:<sup>16</sup>

- 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.<sup>17</sup> 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>		
<b>Assisted Living Waiver</b>	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"> <li>• Individuals 65 or older</li> <li>• Adults with disabilities ages 21 or older</li> <li>• Nursing facility level of care</li> </ul>
<b>Multipurpose Senior Services Program Waiver</b> <sup>18</sup>	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"> <li>• Individuals ages 65 or older</li> <li>• Nursing facility level of care</li> </ul>
<b>Community-Based Adult Services (CBAS)</b> <sup>19</sup>	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"> <li>• Individuals 65 or older</li> <li>• Adults with disabilities 18 or older</li> </ul>
<i>Medically Fragile/ Technology Dependent Waivers</i> <sup>20</sup>		
<b>Home and Community-Based Alternatives Waiver (previously titled "Nursing Facility/ Acute Hospital Waiver")</b>	<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.<sup>21</sup></p>	<ul style="list-style-type: none"> <li>• Individuals who are medically fragile or technology dependent of any age</li> <li>• Hospital, nursing facility, or intermediate care facility level of care</li> <li>• Individuals who are medically fragile or technology dependent of any age</li> <li>• Nursing facility level of care</li> </ul>

**Figure 2 (continued)**

Waiver	Services Covered	Target Population/ Eligibility
<i>Developmentally/ Intellectually Disabled Waivers</i>		
<b>HCBS Waiver for Californians with Developmental Disabilities<sup>24</sup></b>	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"> <li>• Individuals with autism, a developmental disability, or an intellectual disability of any age</li> <li>• Intermediate care facility level of care</li> </ul>
<b>Self-Determination Program for Individuals with Developmental Disabilities<sup>22</sup></b>	<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"> <li>• Individuals with autism, a developmental disability, or an intellectual disability of any age</li> <li>• Intermediate care facility level of care</li> </ul>
<i>HIV/AIDS Waivers</i>		
<b>California HIV/AIDS Waiver</b>	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"> <li>• Individuals with HIV or AIDS of any age</li> <li>• Hospital or nursing facility level of care</li> </ul>

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.<sup>23</sup>



## 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.<sup>24</sup> 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.<sup>25</sup> To be eligible for IHSS, individuals must be 65 years or older, disabled, or blind. Children with disabilities are potentially eligible for IHSS.<sup>26</sup> 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 is enrolled in PCSP.<sup>27</sup>
- The Community First Choice Option (CFCO) is for individuals who need an institutional level of care.<sup>28</sup> Approximately 43% of IHSS beneficiaries are enrolled in the program.<sup>29</sup>
- 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).<sup>30</sup>

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.<sup>31</sup>

IHSS services are provided under the Medicaid State Plan, not under waivers, and therefore different legal requirements apply to IHSS than waiver programs.<sup>32</sup> 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.<sup>33</sup> Additionally, Medi-Cal beneficiaries can qualify for state plan HCBS covered under IHSS even if their conditions are not severe enough to require institutionalization.<sup>34</sup>

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.<sup>35</sup> 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."<sup>36</sup> 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.<sup>37</sup>

## C. CalAIM Changes to Long-Term Care

The California Advancing and Innovating Medi-Cal (CalAIM) Initiative includes multi-phased changes to the delivery of LTSS services.<sup>38</sup> By 2027, all LTSS benefits will transition to statewide delivery, rather than the fragmented delivery models by county that are currently in place.

### 1. LTC Carve-In

Starting January 1, 2023, Medi-Cal managed care plans in all counties will cover LTC benefits for skilled nursing facilities (including a distinct part or unit of a hospital), intermediate care facilities, and subacute facilities.<sup>39</sup> Prior to CalAIM, Medi-Cal managed care only covered LTC for a limited time before individuals were disenrolled from Medi-Cal Managed Care plans (MCPs) and transferred to FFS Medi-Cal, except for certain counties. Now, accessing LTC services will be more standardized and streamlined across counties, preserving continuity of coverage for individuals who need LTSS services.

### 2. Mandatory MCP Enrollment and Statewide Transitions for Dual Eligible Beneficiaries

People who are dually eligible for both Medi-Cal and Medicare will also experience changes in the way they receive LTSS benefits, beginning January 1, 2023.

First, dual eligible beneficiaries who are not already enrolled in a Medi-Cal MCP will transition to managed care.<sup>40</sup> This statewide enrollment in managed care will enhance coordination of care, reduce the complexity of the Medi-Cal program, and make it easier for beneficiaries to transfer their benefits when they move to a different county.

Second, the type of health plan that dual eligible beneficiaries are enrolled in will change. Individuals will be enrolled in a “Medi-Cal Medicare Plan” (MMP), also called an “Exclusively Aligned Enrollment Dual Eligible Special Needs” plan (EAE D-SNP). MMPs or EAE D-SNPs are a type of Medicare Advantage plan that will be operated by the same parent insurer as the beneficiary’s Medi-Cal plan. For individuals residing in Los Angeles, Santa Clara, San Bernardino, Riverside, San Mateo, Orange County, or San Diego County (i.e., the Coordinated Care Initiative (CCI) counties), the transition to MMPs will occur in 2023.<sup>41</sup> For individuals in all other counties, the transition will occur by 2026. This change will align the beneficiaries’ Medi-Cal and Medicare benefits into the same managed care organization, making it simpler to access LTSS services. Under this model, dual eligible beneficiaries will receive a single health plan card.

### **ADVOCACY TIP:**

- ✓ Other CalAIM initiatives will impact Long-Term Populations. For example, CalAIM introduced Community Supports, which are community-based services or settings that MCPs may offer as alternatives to those covered under the California Medicaid State Plan. These services are designed to help managed care beneficiaries meet social needs, such as housing, food support, and community transition services. Community Supports that may benefit members in the Long-Term Care populations include: Nursing Facility Transition/Diversion to Assisted Living Facilities; Community Transition Services/Nursing Facility Transition to a Home; Environmental Accessibility Adaptations (Home Modifications); Respite Services; and Personal Care and Homemaker Services<sup>42</sup>

# Endnotes

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<sup>1</sup> Kaiser Fam. Found., Distribution of Medicaid Spending by Service, <https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Dec. 13, 2022).

<sup>2</sup> 42 U.S.C. § 1396r(a)(1).

<sup>3</sup> See CAL. CODE REGS. tit. 22, §§ 51334 (ICFs), 51335 (SNFs).

<sup>4</sup> For more information on treatment authorization, see Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Long Term Care, TAR Completion for Long-Term Care* (2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/tarcompltc.pdf>. Note that managed care changes these processes.

<sup>5</sup> CAL. CODE REGS. tit. 22, § 51122.

<sup>6</sup> For additional information on the criteria considered appropriate placement, see CAL. CODE REGS. tit. 22, § 51335.

<sup>7</sup> CAL. CODE REGS. tit. 22, § 51335(j).

<sup>8</sup> See also Cal. Dep't Health Care Servs., Continuum of Mental Health Care Section, <https://www.dhcs.ca.gov/services/MH/Pages/Continuum-of-Mental-Health-Care-Section.aspx> (last visited Dec. 13, 2022).

<sup>9</sup> 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 IV of this Guide on SUD Services provides more information on the current waiver.

<sup>10</sup> CAL. CODE REGS. tit. 22, § 72443(b).

<sup>11</sup> *Id.* at § 51124.5

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at § 51343.

<sup>14</sup> *Id.* at § 51343.1.

<sup>15</sup> *Id.* at § 51343.2.

- <sup>16</sup> For more information, see Cal. Dep't Health Care Servs., Home & Community-Based Alternative Waivers, [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 Dec. 13, 2022).
- <sup>17</sup> For a list and description of all approved waivers in California see CMS, California Waiver Factsheet, <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/CA> (last visited Dec. 13, 2022). 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."
- <sup>18</sup> 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 Dec. 13, 2022).
- <sup>19</sup> 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 Dec. 13, 2022).
- <sup>20</sup> 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> (last visited Dec. 13, 2022).
- <sup>21</sup> Cal. Dep't Health Care Servs., *Statewide Transition Plan for Compliance with Home and Community Based Settings Rules 12* (2021), <https://www.dhcs.ca.gov/services/ltc/Documents/CASTP-5.12.21.pdf>.
- <sup>22</sup> See also Cal. Dep't Soc. Servs. All County Letter No. 00-83 (Dec. 7, 2000), <https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl00/pdf/00-83.PDF>.
- <sup>23</sup> Cal. Dep't Health Care Servs., *supra* note 21, at 7.
- <sup>24</sup> CAL. WELF. & INST. CODE § 12300; Cal. Dep't Soc. Servs., *Manual of Policies and Procedures* § 30-700, <https://www.cdss.ca.gov/ord/entres/getinfo/pdf/ssman1.pdf> [hereinafter *Manual of Policies and Procedures*]. See also Cal. Dep't Soc. Servs., In Home Supportive Services (IHSS) Program, <https://www.cdss.ca.gov/inforesources/ihss> (last visited Dec. 13, 2022) [hereinafter IHSS Program Webpage].

- <sup>25</sup> CAL. WELF. & INST. CODE § 12300; *Manual of Policies and Procedures*, *supra* note 24, at § 30-756.
- <sup>26</sup> CAL. WELF. & INST. CODE §§ 12305.5–12305.6.
- <sup>27</sup> CAL. WELF. & INST. CODE § 14132.95; *Manual of Policies and Procedures*, *supra* note 24, at § 30-780.
- <sup>28</sup> 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 (Aug. 29, 2014), <https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf>.
- <sup>29</sup> IHSS Program Webpage, *supra* note 24.
- <sup>30</sup> CAL. WELF. & INST. CODE § 14132.952; *Manual of Policies and Procedures*, *supra* note 24, at § 30-700.
- <sup>31</sup> IHSS Program Webpage, *supra* note 24.
- <sup>32</sup> 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](https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2010/I-33_10.pdf).
- <sup>33</sup> HHS, *Analysis of the California In-Home Supportive Service (IHSS) Plus Waiver Demonstration Program 1* (2008), <https://aspe.hhs.gov/sites/default/files/private/pdf/75596/IHSSPlus.pdf>.
- <sup>34</sup> See 42 U.S.C. § 1396n(i)(1).
- <sup>35</sup> CAL. WELF. & INST. CODE § 12300.1.
- <sup>36</sup> *Manual of Policies and Procedures*, *supra* note 24, at § 30-755.11.
- <sup>37</sup> Disability Rts. Cal. & 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](https://www.justiceinaging.org/wp-content/uploads/2019/06/Final_IHSS-Adocate-Manual.pdf).
- <sup>38</sup> Cal. Health Care Servs., *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* (Jan. 2021), <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf>.
- <sup>39</sup> Cal. Dep’t Health Care Servs., All Plan Letter 22-018 (Oct. 25, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-018.pdf>; See also Cal. Dep’t Health Care Servs., CalAIM Long Term Care Carve-In Transition, <https://www.dhcs.ca.gov/provgovpart/Pages/Long-Term-Care-Carve-In-Transition.aspx> (last visited Dec. 13, 2022).



- <sup>40</sup> Cal. Dep't Health Care Servs., All Plan Letter 21-015 (Oct. 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015.pdf>.
- <sup>41</sup> For more information on the CCI program, see Cal. Dep't Health Care Servs., Coordinated Care Initiative and Cal MediConnect, <https://www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareInitiative.aspx> (last visited Dec. 14, 2022).
- <sup>42</sup> See Cal. Dep't Health Care Servs., CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program Programs Initiatives, <https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx> (last visited Dec. 14, 2022). See *also* Chapter XI of this Guide on Case Management and Related Community-Based Services.



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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**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

## Outline of Medi-Cal Durable Medical Equipment, Orthotics & Prosthetics, and Other Non-Pharmaceutical Items\*

- 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 wheelchairs, hospital beds, bathroom seats, 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.<sup>1</sup> The definition of DME excludes prosthetics and orthotics, which are discussed in Section B of this chapter.<sup>2</sup>

Medi-Cal will only cover “the lowest cost item that meets a patient’s medical needs.”<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup> (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 or that the device be appropriate for use in the home.<sup>3</sup> 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:<sup>7</sup>

- 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) and Bi-Level Positive Airway Pressure (BIPAP) 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)
- Speech Generating Devices (SGD) and services
- Spinal Electrical Devices
- Therapeutic Anti-Decubitus Mattresses and Bed Products, such as pressure sore products and replacement pads
- Wheelchairs and scooters, including manual wheelchairs, power wheelchairs and other power mobility devices (PMD), lightweight and heavy-duty wheelchairs, pediatric adjustable wheelchairs, and seating and positioning components

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

Medi-Cal excludes several items from coverage as DME:<sup>9</sup>

- 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

### **ADVOCACY TIP:**

- ✓ 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 and Respiratory Equipment; Speech Generating Devices; Therapeutic Anti-Decubitus Mattresses and Bed Products; Wheelchairs and Wheelchair Accessories; and Other DME Equipment.

- 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.”<sup>10</sup> DME is only covered if a beneficiary has a prescription for the DME, and often prior authorization is also required.<sup>11</sup> For example, all DME above certain price thresholds is subject to prior authorization. If the beneficiary is seeking to purchase 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).<sup>12</sup> If the DME is being rented, authorization is required if the cost of renting will exceed \$50 in a 15-month period.<sup>13</sup> Repair and/or maintenance of DME are subject to prior approval if the cost exceeds \$250.<sup>14</sup> 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.<sup>15</sup> 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.”<sup>16</sup> 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 occur within six months of the date of the prescription.

## 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 may be replaced only once every five years.<sup>17</sup> 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.”<sup>18</sup>



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 “substandard or unsuitable items” at no additional cost to Medi-Cal or the beneficiary.<sup>19</sup>

Beneficiaries are responsible for the appropriate use and care of DME.<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup> 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.<sup>23</sup> 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.<sup>24</sup>

## 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.” A “prosthesis” is “an externally applied appliance used to replace wholly, or in part, an absent or deficient body part.”<sup>26</sup> 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.<sup>27</sup>

### 1. Types of Covered Orthotics and Prosthetics

Covered orthotic appliances include:<sup>28</sup>

- Compression burn garments
- Gradient compression stockings
- Lower limb orthotic devices, such as knee, ankle-foot, or hip orthoses

- Orthopedic shoes
- Shoe supplies for people who have diabetes
- 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:<sup>29</sup>

- 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.<sup>30</sup>

## 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.<sup>31</sup> 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 appliances.<sup>32</sup> 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.<sup>33</sup> In addition, prior authorization is always required if the item is furnished by a podiatrist.<sup>34</sup> 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.<sup>35</sup>

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."<sup>36</sup> In addition, the appliance must be "essential to performing activities of daily living or instrumental activities of daily living."<sup>37</sup> 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.<sup>38</sup>

### 3. Other Coverage Issues

As is the case with DME, Medi-Cal covers replacement of orthotic and prosthetic appliances according to a set schedule.<sup>39</sup> 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.<sup>40</sup>

Generally, an orthosis or prosthesis must be furnished by an orthotist, a prosthetist, a physician, a podiatrist, a mastectomy fitter, or a California Children's Services (CCS) provider.<sup>41</sup> However, for certain categories of prosthetic and orthotic appliances, a Medi-Cal beneficiary can obtain such devices from a pharmacy.<sup>42</sup>

### C. Medical Supplies

Common medical supplies covered by Medi-Cal include:<sup>43</sup>

- 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.<sup>44</sup> 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.<sup>45</sup>

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.

#### **ADVOCACY TIP:**

- ✓ DHCS has posted online a spreadsheet with medical supply billing codes, units, quantity limits, and prior authorization information.<sup>46</sup>

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.<sup>47</sup>

## 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.<sup>48</sup> Regular food, including pureed foods, infant formula, shakes, bars, gels, and products for weight loss assistance are not covered by Medi-Cal.<sup>49</sup> 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.<sup>50</sup>

A beneficiary can only obtain an enteral nutrition product if the beneficiary has obtained a physician's prescription for such product.<sup>51</sup> In addition, such products are always subject to prior authorization.<sup>52</sup>

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.<sup>53</sup> 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.<sup>54</sup>

# Endnotes

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- <sup>1</sup> CAL. CODE REGS. tit. 22, § 51160.
- <sup>2</sup> Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* 21 (2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durawheelguide.pdf> [hereinafter *Wheelchair Guidelines*].
- <sup>3</sup> Compare CAL. CODE REGS. tit. 22, § 51160 (Medi-Cal definition of DME) with 42 C.F.R. § 414.202 (Medicare definition of DME).
- <sup>4</sup> 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 Medical Supplies, Durable Medical Equipment (DME): An Overview* 1 (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/dura.pdf> [hereinafter *DME Overview*].
- <sup>5</sup> 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>.
- <sup>6</sup> 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* (June 11, 2021), <https://healthlaw.org/resource/helping-families-obtain-durable-medical-equipment-and-supplies-through-the-california-childrens-services-ccs-program/>.
- <sup>7</sup> *DME Overview*, *supra* note 4, at 1–2 (listing general categories of covered DME, each of which is detailed in separate manual sections); *Wheelchair Guidelines*, *supra* note 2, at 2, 6–13; Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment (DME): Infusion Equipment* 1 (2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durainf.pdf>; Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment (DME): Oxygen and Respiratory Equipment* 2 (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duraoxy.pdf>; Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment (DME): Therapeutic Anti-Decubitus Mattresses and Bed Products* 2 (2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/durathp.pdf>; Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment (DME): Other DME Equipment* 2 (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duraother.pdf>.

- <sup>8</sup> CAL. WELF. & INST. CODE § 14132(m).
- <sup>9</sup> CAL. CODE REGS. tit. 22, § 51321(e); see also *DME Overview*, *supra* note 4, at 3.
- <sup>10</sup> *DME Overview*, *supra* note 4, at 2.
- <sup>11</sup> CAL. CODE REGS. tit. 22, §§ 51160, 51321(b).
- <sup>12</sup> *Id.* § 51321(b)(1).
- <sup>13</sup> *Id.* § 51321(b)(2).
- <sup>14</sup> *Id.*
- <sup>15</sup> *Id.* § 51321(b)(3).
- <sup>16</sup> *DME Overview*, *supra* note 4, at 6.
- <sup>17</sup> Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment (DME) Billing Codes: Frequency Limits* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duracdfre.pdf>.
- <sup>18</sup> CAL. WELF. & INST. CODE § 14132(m).
- <sup>19</sup> CAL. CODE REGS. tit. 22, § 51224.5(a)(6)(F).
- <sup>20</sup> *Id.* § 51321(i).
- <sup>21</sup> *Id.*
- <sup>22</sup> *Id.* § 51224.5(a)(6)(B).
- <sup>23</sup> *Id.* § 51521(i).
- <sup>24</sup> *DME Overview*, *supra* note 4, at 6.
- <sup>25</sup> CAL. CODE REGS. tit. 22, § 51161(ppp).
- <sup>26</sup> *Id.* § 51161(yyy).
- <sup>27</sup> *Id.* § 51161(gggg).
- <sup>28</sup> *Id.* § 51315.1.
- <sup>29</sup> *Id.* § 51315.2.
- <sup>30</sup> *Id.* § 51315(d); Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Orthotics and Prosthetics, Orthotic and Prosthetic Appliances and Services 2* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/ortho.pdf> [hereinafter *Orthotic and Prosthetic Appliances and Services*].
- <sup>31</sup> CAL. CODE REGS. tit. 22, § 51315(a).
- <sup>32</sup> *Id.* § 51315(b); see also CAL. WELF. & INST. CODE § 14132.765.
- <sup>33</sup> CAL. CODE REGS. tit. 22, § 51315(b).
- <sup>34</sup> *Orthotic and Prosthetic Appliances and Services*, *supra* note 30, at 5.
- <sup>35</sup> CAL. CODE REGS. tit. 22, § 51315(c)(5).
- <sup>36</sup> *Id.* § 51315(c)(1).



- <sup>37</sup> *Id.* § 51315(c)(2).
- <sup>38</sup> *Id.* § 51315(c)(3), (d)(3).
- <sup>39</sup> See Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Orthotics and Prosthetics, Frequency Limits for Orthotics* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/orthocdfre1.pdf>; Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Orthotics and Prosthetics, Frequency Limits for Prosthetics* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/orthocdfre2.pdf>.
- <sup>40</sup> CAL. WELF. & INST. CODE § 14132(k).
- <sup>41</sup> *Orthotic and Prosthetic Appliances and Services*, *supra* note 30, at 3.
- <sup>42</sup> CAL. WELF. & INST. CODE § 14105.21(b).
- <sup>43</sup> Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Medical Supplies 1* (2022) <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mcsup.pdf> [hereinafter *Medical Supplies*]; Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Incontinence Medical Supplies 1* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/incont.pdf> [hereinafter *Incontinence Medical Supplies*].
- <sup>44</sup> *Medical Supplies*, *supra* note 43, at 4; see also CAL. CODE REGS. tit. 22, § 51320(b).
- <sup>45</sup> *Medical Supplies*, *supra* note 43, at 2.
- <sup>46</sup> Cal. Dep't Health Care Servs., *Medical Supplies Billing Codes, Units, and Quantity Limits* (2022), <http://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mcsupbilling.xlsx/>.
- <sup>47</sup> *Incontinence Medical Supplies*, *supra* note 43, at 1.
- <sup>48</sup> CAL. CODE REGS. tit. 22, § 51313.3(e)(2).
- <sup>49</sup> Cal. Dep't of Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Enteral Nutrition Products 2* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/enteral.pdf>.
- <sup>50</sup> *Id.*
- <sup>51</sup> *Id.* at 3.
- <sup>52</sup> CAL. WELF. & INST. CODE § 14105.8(i).
- <sup>53</sup> *Id.* § 14105.8(g).
- <sup>54</sup> *Id.* § 14105.8(h).



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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**Chapter XI:  
Case Management and Related Community-Based Services**

# Chapter XI: Case Management and Related Community-Based Services

## Outline of Medi-Cal Case Management and Related Community-Based Services\*

- Case Management
  - Targeted Case Management and Similar Programs
  - Basic Case Management
  - Enhanced Care Management
- Community Supports
- Community Health Workers

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

This chapter describes Medi-Cal services that focus on coordination of services (including social services) and assistance to beneficiaries in accessing non-clinical services that help improve or maintain a beneficiary's health status. Many of these services are available in Fee-for-Service (FFS) Medi-Cal but managed care plans (MCPs) play a vital role in delivering coordinated services for their enrollees. As described throughout the chapter, case management and other community-based coordination services have been significantly expanded by the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

### A. 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.”<sup>1</sup> They are exempt from the general federal Medicaid rules about statewideness and comparability.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

Medi-Cal covers case management services through programs designed for beneficiaries enrolled in either Medi-Cal FFS or MCPs. For beneficiaries enrolled in Medi-Cal FFS, targeted case management services are available; for beneficiaries enrolled in MCPs, managed care plans must provide case management for all enrollees, and enhanced care management (ECM) for select populations and Community Support as a covered option.

## **1. Targeted Case Management and Similar Programs**

Targeted case management is a Medi-Cal FFS benefit covered for all Medi-Cal-enrolled beneficiaries who fall within a Medi-Cal-defined eligible group. Under Medi-Cal, groups that are eligible to receive targeted case management include:<sup>5</sup>

- Children who are at risk for medical compromise due to various circumstances, including noncompliance with a prescribed medical regime, substance abuse, or abuse;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psychosocial outcomes; and
- 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.<sup>6</sup> 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 of appointments and transportation, crisis assistance, and review and modification of the service plan.<sup>7</sup>

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).<sup>8</sup> 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.<sup>9</sup> Finally, targeted case management is also available for beneficiaries receiving SMHS through county mental health plans (MHPs) and for beneficiaries with SUDs residing in counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver program.<sup>10</sup>

## **2. MCP Case Management Responsibilities (Basic Case Management)**

MCPs must ensure that their in-network primary care providers furnish 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 healthy lifestyles, and referral to appropriate community resources. Comprehensive case management for medically necessary services, including both basic and complex case management, is described in MCP contracts.<sup>11</sup> Further, the MCP contracts set forth requirements for Services for Children with Special Health Care Needs under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate, which include case management and coordination of care.<sup>12</sup>

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.<sup>13</sup> Such services include support from a multidisciplinary case management team and the development of care plans. In the case of Seniors and Persons with Disabilities (SPD), MCPs are specifically required to: ensure provision of treatment approaches that are collaborative and responsive to the SPD beneficiary's continuing health care needs; identify each SPD beneficiary's preferences and choices regarding treatments and services, and abilities; allow or ensure the participation of the SPD beneficiary, and any family, friends, and professionals of their choosing, to participate fully in any discussion or decisions regarding treatments and services; and ensure that SPD beneficiaries receive all necessary information regarding treatment and services so that they may make an informed choice.<sup>14</sup>

### **3. Enhanced Care Management**

Medi-Cal recently started making improvements to case management services provided through MCPs. In 2022, DHCS launched the CalAIM program, which builds upon the plan-based Health Home Program and county-based whole-person care pilots that use whole-person care approaches to address underlying social determinants of health.<sup>15</sup> The purpose of CalAIM is to address the complex needs of Medi-Cal's most vulnerable beneficiaries. CalAIM is meant to enhance care coordination, integration, and information exchange among MCPs. To achieve this purpose, CalAIM includes Enhanced Care Management (ECM) meant to provide additional support to MCP enrollees.

ECM is a Medi-Cal-covered benefit that provides comprehensive care management and coordination of health and health-related services to managed care beneficiaries with complex health needs.<sup>16</sup> The ECM benefit will be phased in over time and available statewide through the managed care delivery system starting January 1, 2022.<sup>17</sup> MCPs must proactively identify and offer ECM to their high-need, high-cost Members who meet the designated "Population of Focus" Criteria.<sup>18</sup> Recipients of ECM will be assigned a Lead Care Manager, who will assume primary responsibility for care coordination, including collaboration with providers across various delivery systems and other

care managers who may operate in a more limited scope.

ECM Populations of Focus consist of the following:

- Individuals and families who are experiencing homelessness and have at least one health condition that they cannot self-manage;<sup>19</sup>
- Adults, youth, and children who are high utilizers of certain high-cost services, such as emergency departments and inpatient settings;<sup>20</sup>
- Adults with a serious mental illness (SMI) or SUD;<sup>21</sup>
- Children and youth with serious emotional disturbance or at a high clinical risk for psychosis;<sup>22</sup>
- Adults and youth transitioning from incarceration;<sup>23</sup>
- Adults living in the community who are at risk for institutionalization;<sup>24</sup>
- Adult nursing facility residents who are transitioning to the community;<sup>25</sup>
- Children and youth enrolled in California Children’s Services (CCS) who have additional needs beyond CCS;<sup>26</sup> and
- Children and youth involved in or previously involved in child welfare (including former foster youth up to age 26).<sup>27</sup>

### **ADVOCACY TIP:**

- ✓ ECM substitutes the Health Homes Program (HHP) and Whole Person Care (WPC) Pilots. Across California, 25 counties participated in these demonstrations approved through Section 1115 of the Medicaid Act in the case of WPC and through a State Plan Amendment in the case of HHP. Beneficiaries residing in counties that were participating in these previous programs were eligible for and automatically transitioned to ECM on January 1, 2022.

The ECM benefit offers seven core services for all Populations of Focus:

1. Outreach and Engagement<sup>28</sup>
2. Comprehensive Assessment and Care Management Plan<sup>29</sup>
3. Enhanced Coordination of Care<sup>30</sup>
4. Health Promotion<sup>31</sup>
5. Comprehensive Transitional Care<sup>32</sup>
6. Member and Family Supports<sup>33</sup>
7. Coordination of and Referral to Community and Social Support Services<sup>34</sup>

MCPs are responsible for coordinating ECM services. MCPs may contract with a wide range of providers, and they are encouraged to draw on beneficiaries’ pre-existing relationships when building an ECM care team. Whenever possible, ECM is provided through in-person interaction in places where beneficiaries and their families or support networks live, seek care, and prefer to access covered services.<sup>35</sup>



ECM providers may include, but are not limited to:<sup>36</sup>

- Counties;
- Behavioral health providers;
- Primary care providers (PCPs);
- Federally qualified health centers (FQHCs);
- Community health centers;
- Hospitals or hospital-based physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
- Rural health clinics;
- Local health departments;
- Indian Health Service programs;
- Behavioral health entities;
- Community mental health centers;
- SUD treatment providers;
- Organizations serving individuals experiencing homelessness;
- Community-based adult services (CBAS) providers;
- In-home supportive services (IHSS) providers;
- Organizations serving justice-involved individuals;
- California Children’s Services (CCS) providers; and
- Other community-based organizations

ECM providers must enroll as Medi-Cal providers if there is a state-level enrollment pathway for them to do so. However, many ECM and Community Supports providers (e.g., housing agencies, medically tailored meal providers) may not have a corresponding state-level enrollment pathway and, therefore, are not required to enroll in Medi-Cal.<sup>37</sup>

## **B. Community Supports**

Through CalAIM, California also added Community Supports, or in-lieu of services (ILOS).<sup>38</sup> Community Supports are community-based services or settings that MCPs may offer as alternatives to those covered under the California Medicaid State Plan.<sup>39</sup> Community Supports are designed to help managed care beneficiaries meet social needs, such as housing, food support, and community transition services.<sup>40</sup> Community Supports are optional for MCPs to offer and for beneficiaries to use. MCPs cannot require their members to use a Community Support instead of a State-plan covered service.<sup>41</sup>

DHCS strongly encourages MCPs to offer some or all of the following Community Supports:

- Housing Search and Transition Navigation Services;<sup>42</sup>
- Housing Deposits;<sup>43</sup>
- Housing Tenancy and Sustaining Services;<sup>44</sup>
- Short-Term Post-Hospitalization Housing;<sup>45</sup>
- Recuperative Care After Hospitalization (Medical Respite);<sup>46</sup>

- Respite Services for Caregivers;<sup>47</sup>
- Home and Community-Based Habilitation Programs;<sup>48</sup>
- Nursing Facility Transition / Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF);<sup>49</sup>
- Community Transition Services / Nursing Facility Transition to a Home;<sup>50</sup>
- Personal Care and Homemaker Services;<sup>51</sup>
- Home Modifications to Improve Accessibility;<sup>52</sup>
- Medically Tailored Meals / Medically-Supportive Food;<sup>53</sup>
- Sobering Centers;<sup>54</sup> and
- Home Modifications for Asthma Remediation.<sup>55</sup>

In order to offer a Community Support, MCPs must obtain State approval. To be approved, the MCP must show that the service is voluntary, medically-appropriate, and cost-effective, and has a clearly defined population and criteria, among other requirements.<sup>56</sup> Once DHCS approves the Community Support, it will be added to the MCP's contract and posted on the DHCS website at <https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx>. MCPs may add additional Community Supports every six months and remove previously-offered services annually.<sup>57</sup>

### C. Community Health Workers

Community health workers (CHWs) services are Medi-Cal covered preventive health services.<sup>58</sup> CHW services are coordinated preventive health services that address a variety of concerns, including the control and prevention of chronic conditions or infectious diseases, behavioral health conditions, and the need for preventive services.<sup>59</sup> They are generally provided by frontline public health workers who may come from the community they serve or have an intimate understanding and trusting relationship with the communities they serve.<sup>60</sup>

CHWs help link beneficiaries to health and social services with the goal of improving the overall quality of services delivered.<sup>61</sup> CHWs encompass individuals with the following titles: promotores, community health representatives, navigators, and other nonlicensed public health workers, including violence prevention professionals.<sup>62</sup> CHWs must have lived experience that aligns with and provides a connection between the CHW and the population they serve, such as experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared traits such as race, ethnicity, or sexual orientation and having lived/worked in the same geographic community.<sup>63</sup>

Medi-Cal covers CHW services for all eligible beneficiaries on the written recommendation of a physician or other licensed practitioner of the healing

arts acting within their scope of practice under state law.<sup>64</sup> CHW services can help beneficiaries obtain perinatal care, preventive care, sexual and reproductive care, and oral care; address environmental and climate-sensitive health issues; and access aging, injury, and domestic violence or other violence prevention services.<sup>65</sup>

A beneficiary can receive CHW services if medically necessary, as determined by a recommending provider.<sup>66</sup> Typically, an enrollee can meet the medical necessity if the enrollee has one or more chronic health conditions (including behavioral health) or exposure to violence and trauma who are at risk for a chronic health condition or environmental health exposure, who face barriers meeting their health or health-related social needs, and/or who would benefit from preventive services.<sup>67</sup> CHW services are also available to beneficiaries with mental health issues and/or SUDs.<sup>68</sup>

Beneficiaries receiving CHW services must have a “Plan of Care,” a written document that describes the supports and services the CHW, and potentially other licensed care providers, furnish to address the ongoing needs of a beneficiary.<sup>69</sup> The Plan of Care must be developed by one or more licensed providers and must:<sup>70</sup>

- Specify the condition that the service is being ordered for and be relevant to the condition;
- Include a list of other health care professionals providing treatment for the condition or barrier;
- Contain written objectives that specifically address the recipient’s condition or barrier affecting their health;
- List the specific services required for meeting the written objectives; and
- Include the frequency and duration of CHW services (not to exceed the provider’s order) to be provided to meet the care plan’s objectives.

CHWs can assist with the Plan of Care’s development, and the provider ordering the Plan of Care does not need to be the same provider that initially recommended or supervises the CHW.<sup>71</sup> A licensed provider must review the Plan of Care at least every six months from its effective date and determine whether progress is being made toward the planned objectives.<sup>72</sup> The licensed provider should determine whether services are still medically necessary, there is a significant change in the beneficiary’s condition, and it is necessary to amend the plan or discontinue services.<sup>73</sup> CHWs must also adhere to certain documentation requirements, such as recording the date and time of services, the nature of the services, and the duration of those services.<sup>74</sup>

Covered CHW services consist of: health education, health navigation, screening and assessment, and individual support or advocacy.<sup>75</sup> Health education consists of providing information or instruction on health topics that promote the enrollee’s health or address barriers to physical and mental health care.<sup>76</sup>

Health navigation consists of a CHW providing information, training, referrals or support to enrollees when assessing healthcare or connecting to community health resources.<sup>77</sup> A CHW providing screening and assessment services consists of connecting the enrollee to appropriate services that would improve their health.<sup>78</sup> A CHW may also provide individual support or advocacy to assist an enrollee in preventing a health condition or preventing injury or violence.<sup>79</sup>

A CHW may also provide violence prevention services and asthma preventive services. CHW violence preventive services consist of a CHW providing evidence-based, trauma-informed, and culturally responsive preventive services to help reduce the incidence of violent injury and trauma and promote trauma recovery to improve health outcomes.<sup>80</sup> A beneficiary can receive violence preventive services if the beneficiary has been injured as a result of community violence; a licensed health care provider has determined that the beneficiary is at significant risk of experiencing injury as a result of community violence; or the beneficiary has experienced chronic exposure to community violence.<sup>81</sup> CHWs may provide CHW services to individuals with asthma, but evidence-based asthma self-management education and asthma trigger assessments may only be provided by certified asthma preventive service providers.<sup>82</sup>

CHW services do not include the following:

- Any services that require a license to be provided, including clinical case management/care management that requires a license
- Childcare
- Chore services, including shopping and cooking meals
- Companion services
- Employment services
- Helping a beneficiary enroll in government or other assistance programs that are not related to improving their health as part of a Plan of Care
- Delivery of medications, medical equipment, or medical supplies
- Personal care services/homemaker services
- Respite care
- Services that duplicate another covered Medi-Cal service already being provided to a beneficiary
- Socialization
- Transportation

#### **ADVOCACY TIP:**

- ✓ CHW services may be provided to the legal guardian or parent of beneficiaries under the age of 21 for the direct benefit of the beneficiaries, as recommended by a licensed provider. Such services must be billed under the beneficiaries' Medi-Cal ID (i.e., not the parent or legal guardian's Medi-Cal ID).<sup>83</sup>

For CHW services to be covered, a CHW supervising provider must submit claims for services.<sup>84</sup> A supervising provider must also ensure that a CHW meets

the necessary qualifications and oversees a CHW and the services delivered to the enrollees.<sup>85</sup> The supervising provider can be a licensed provider, clinic, hospital, community-based organization, or local health jurisdiction.<sup>86</sup> MCPs who have network providers and subcontractors who provide CHW services must develop and submit policies and procedures to ensure such providers have the appropriate training, qualifications, and supervision.<sup>87</sup>

In 2022, California Governor Gavin Newsom signed AB 2697 into law that codified the requirement that CHW services be a covered Medi-Cal benefit.<sup>88</sup> This law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees.<sup>89</sup> In addition, the law requires the department, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the community health worker services benefit.<sup>90</sup>

CHW services are essential to achieving health equity and justice. Health disparities occur when people do not have access to health and social service providers who speak their language, relate to their lived experiences, or understand the daily obstacles they must navigate in achieving health and well-being. Incorporating CHW services into Medi-Cal would help address health disparities, since CHWs would fill in that link to provide culturally humble, linguistically appropriate, experientially informed essential services to assist communities in navigating these obstacles and receiving needed health resources.

## Endnotes

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<sup>1</sup> 42 U.S.C. §§ 1396d(a)(19), 1396n(g)(2)(A)(i)–(iii). Contacts with individuals who are not eligible for Medicaid (or in the case of targeted case management, 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).

<sup>2</sup> 42 U.S.C. § 1396n(g)(1).

<sup>3</sup> 42 U.S.C. § 1396n(g)(2)(B).

<sup>4</sup> 42 C.F.R. § 441.18(a)(3).

<sup>5</sup> Cal. Dep't Health Care Servs., *Targeted Case Management: Program Overview*, [https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM\\_FactSheet\\_01212016.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM_FactSheet_01212016.pdf).

- <sup>6</sup> CAL. CODE REGS. tit. 22, § 51351.1.
- <sup>7</sup> CAL. WELF. & INST. CODE § 14132.44(k); CAL. CODE REGS. tit. 22, § 51351(a); 42 U.S.C. § 1396n(g)(2)(A)(ii).
- <sup>8</sup> CAL. WELF. & INST. CODE § 14132.48(a)–(b).
- <sup>9</sup> Cal. Dep’t Health Care Servs., California Children’s Services: Program Overview, <https://www.dhcs.ca.gov/services/ccs/Pages/ProgramOverview.aspx> (last visited Dec. 7, 2022); 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 Dec. 7, 2022).
- <sup>10</sup> CAL. WELF. & INST. CODE §§ 14132.48(c), 14021.3. See also CAL. CODE REGS. tit. 9, § 1810.247(c).
- <sup>11</sup> Cal. Dep’t Health Care Servs., *MCP Boilerplate Contract*, Exhibit A, Attachment 11, <https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx> [hereinafter *MCP Boilerplate Contract*]. See also Cal. Dep’t Health Care Servs., All Plan Letter 20-012 at 2 (May 15, 2020), <https://www.dhcs.ca.gov/services/Documents/APL-20-012.pdf>.
- <sup>12</sup> *MCP Boilerplate Contract*, *supra* note 11, at Exhibit A, Attachment 11.
- <sup>13</sup> *Id.*
- <sup>14</sup> *Id.*
- <sup>15</sup> Jonah P.B. Frohlic, Kevin Casey McAvey & Jonathan DiBello, Manatt Health, *CalAIM and Health Data Sharing: A Roadmap for Effective Implementation*, (May 5, 2021), <https://www.manatt.com/insights/white-papers/2021/calaim-and-health-data-sharing-a-roadmap-for-effec>.
- <sup>16</sup> See Cal. Dep’t Health Care Servs., All Plan Letter 21-012 (Sept. 15, 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-012.pdf> [hereinafter All Plan Letter 21-012]; see also Cal. Dep’t Health Care Servs., CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program Initiatives, <https://www.dhcs.ca.gov/enhancedcaremanagementandinlieuofservices> (last visited Dec. 5, 2022) [hereinafter CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program Initiatives].
- <sup>17</sup> All Plan Letter 21-012, *supra* note 16, at 2.
- <sup>18</sup> *Id.* at 6, Attachment 1.
- <sup>19</sup> Cal. Dep’t Health Care Servs., *CalAIM Enhanced Care Management Policy Guide* 8 (May 2022), <https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Policy-Guide-Updated-May-2022-v2.pdf> [hereinafter *ECM Policy Guide*].
- <sup>20</sup> *Id.* at 10.
- <sup>21</sup> *Id.* at 11.



- <sup>22</sup> Cal. Dep't Health Care Servs., *California Advancing & Innovating Medi-Cal (CalAIM) Proposal* 45–46, 145–50 (Jan. 2021), <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-Updated-1-8-21.pdf> [hereinafter *CalAIM Proposal*]; Cal. Dep't Health Care Servs., *Factsheet: California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management 2*, <https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-ECM-a11y.pdf> (last visited Nov. 10, 2022) [hereinafter *CalAIM ECM Factsheet*]. Additional guidance on the children and youth ECM Populations of Focus is forthcoming. See *ECM Policy Guide*, *supra* note 19, at 23.
- <sup>23</sup> *ECM Policy Guide*, *supra* note 19, at 13.
- <sup>24</sup> *Id.* at 16.
- <sup>25</sup> *Id.* at 20.
- <sup>26</sup> *CalAIM Proposal*, *supra* note 22, at 45–46, 145–50; *CalAIM ECM Factsheet*, *supra* note 22, at 2.
- <sup>27</sup> *CalAIM Proposal*, *supra* note 22, at 45–46, 145–50; *CalAIM ECM Factsheet*, *supra* note 22, at 2.
- <sup>28</sup> *ECM Policy Guide*, *supra* note 19, at 24–25.
- <sup>29</sup> *Id.* at 25–26.
- <sup>30</sup> *Id.* at 26–27.
- <sup>31</sup> *Id.* at 27.
- <sup>32</sup> *Id.* at 27–28.
- <sup>33</sup> *Id.* at 28–29.
- <sup>34</sup> *Id.* at 29.
- <sup>35</sup> Cal. Dep't Health Care Servs., *CalAIM Data Guidance: Billing and Invoicing between ECM/ Community Supports Providers and MCPs* 1 (Jan. 2022), <https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Billing-and-Invoicing-Guidance.pdf>.
- <sup>36</sup> Cal. Dep't Health Care Servs., *CalAIM Enhanced Care Management and Community Supports FAQ* 4–5 (last updated Aug. 23, 2022), <https://www.dhcs.ca.gov/Documents/MCQMD/ECM-Community-Supports-FAQ.pdf>.
- <sup>37</sup> *ECM Policy Guide*, *supra* note 19, at 39–40.
- <sup>38</sup> For the provision of federal regulations authorizing Community Supports, see 42 C.F.R. § 438.3(e)(2). For the state statutory authority, see CAL. WELF. & INST. CODE § 14184.206.
- <sup>39</sup> Cal. Dep't Health Care Servs., *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* 3 (Aug. 2022), <https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf> [hereinafter *Community Supports Policy Guide*].

- <sup>40</sup> CalAIM Enhanced Care Management, Community Supports, and Incentive Payment Program Initiatives, *supra* note 16.
- <sup>41</sup> *Community Supports Policy Guide*, *supra* note 39, at 3.
- <sup>42</sup> *Id.* at 8–13.
- <sup>43</sup> *Id.* at 14–16.
- <sup>44</sup> *Id.* at 17–22.
- <sup>45</sup> *Id.* at 23–26.
- <sup>46</sup> *Id.* at 27–30.
- <sup>47</sup> *Id.* at 31–33.
- <sup>48</sup> *Id.* at 34–36.
- <sup>49</sup> *Id.* at 37–39.
- <sup>50</sup> *Id.* at 40–42.
- <sup>51</sup> *Id.* at 43–44.
- <sup>52</sup> *Id.* at 45–47.
- <sup>53</sup> *Id.* at 48–49.
- <sup>54</sup> *Id.* at 50–51.
- <sup>55</sup> *Id.* at 52–55.
- <sup>56</sup> *Id.* at 61; *see also* 42 C.F.R. § 438.3.
- <sup>57</sup> *Community Supports Policy Guide*, *supra* note 39, at 4.
- <sup>58</sup> 42 C.F.R. § 440.130(c)(1)–(3); CMS, Approval Letter for Cal. State Plan Amendment # 22-001 (July 26, 2022), <https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf>; Cal. Dep’t Health Care Servs., All Plan Letter 22-016 (Revised) 1 (Sept. 9, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-016.pdf> [hereinafter All Plan Letter 22-016].
- <sup>59</sup> All Plan Letter 22-016, *supra* note 58, at 1.
- <sup>60</sup> *See The Children’s P’ship, Community Health Workers Advancing Child Health Equity* (2021), <https://childrenspartnership.org/wp-content/uploads/2021/06/TCP-Community-Health-Workers-Final-Single-Pages.pdf>.
- <sup>61</sup> All Plan Letter 22-016, *supra* note 58, at 1.
- <sup>62</sup> *Id.*
- <sup>63</sup> *Id.*

<sup>64</sup> 42 C.F.R. § 440.130(c); Cal. Dep't Health Care Servs., *Community Health Worker Preventive Services 1* (updated July 2022), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/chwprev.pdf>. Other health care practitioners who can recommend CHW services in their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

<sup>65</sup> All Plan Letter 22-016, *supra* note 58, at 1.

<sup>66</sup> *Id.* at 5.

<sup>67</sup> *Id.* at 5.

<sup>68</sup> *Id.* at 9. Although CHWs may provide CHW services to Members with mental health and/or substance use disorders, CHW services do not include Peer Support Services. CHW and Peer Support Services are distinct services.

<sup>69</sup> Cal. Dep't Health Care Servs., *supra* note 64, at 1.

<sup>70</sup> *Id.* at 5.

<sup>71</sup> *Id.* at 2.

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> All Plan Letter 22-016, *supra* note 58 at 7-8.

<sup>75</sup> Cal. Dep't Health Care Servs., *supra* note 64, at 2.

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> *Id.* at 1.

<sup>81</sup> *Id.* at 7.

<sup>82</sup> *Id.* at 3.

<sup>83</sup> All Plan Letter 22-016, *supra* note 58, at 8.

<sup>84</sup> Cal. Dep't Health Care Servs., *supra* note 64, at 1.

<sup>85</sup> *Id.*

<sup>86</sup> *Id.* CHWs may be supervised by a CBO or LHJ that does not have a licensed provider on staff. Currently, community-based organizations cannot enroll as a fee for service provider and are only limited to providing services through contracts with managed care plans. As a result, fee for service billing is only available for services rendered to individuals enrolled in fee for service Medi-Cal by a licensed provider on staff.

<sup>87</sup> All Plan Letter 22-016, *supra* note 58, at 10-11.

<sup>88</sup> CAL. WELF. & INST. CODE § 14132.36.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*



# **An Advocate's Guide to Medi-Cal Services**

December 2022

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## **Chapter XII: Ancillary Services**

# Chapter XII: Ancillary Services

## Outline of Medi-Cal Ancillary Services Covered in this Chapter\*

- Therapies and Other Professional Services
  - Physical Therapy
  - Occupational Therapy
  - Respiratory Therapy
  - Audiology
  - Speech Therapy
  - Vision Services
  - Acupuncture
  - Chiropractic Services
- Transportation
  - Emergency medical transportation
  - Nonemergency medical transportation
  - Nonmedical transportation
  - Air transportation (under certain circumstances)
- Diagnostic Tests
  - Laboratory services
  - Imaging services
- Other Specialized Services
  - 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 often fall under optional coverage categories under federal Medicaid law. In 2009, due to budgetary concerns, California eliminated coverage of several categories of such services for adults, including 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 services, including nonmedical transportation (NMT), 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.”<sup>1</sup> 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.”<sup>2</sup> 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, pharmacologic agents related to respiratory care procedures, mechanical or physiological 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 collection and analysis of blood specimens and specimens from the airway tract.<sup>3</sup>

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 a physician, dentist, or podiatrist.<sup>4</sup> For respiratory care services, the prescription must be from a physician or surgeon.<sup>5</sup> All prescriptions must specifically describe the services and include the frequency, duration, and therapeutic goal of the therapy prescribed, among other requirements.<sup>6</sup>

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.<sup>7</sup> 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 required to be provided for beneficiaries under 21 when the services are necessary 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.<sup>8</sup> 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.<sup>9</sup> Finally, coverage of occupational therapy 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.<sup>10</sup>

## **2. Audiology, Speech Therapy, and Podiatry**

Medi-Cal covers audiology services, speech therapy services, and podiatry services as outpatient services.<sup>11</sup> 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.<sup>12</sup> Rehabilitation centers are facilities that “provide an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.”<sup>13</sup>

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.”<sup>14</sup> 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 they practice.<sup>15</sup>

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 they practice.<sup>16</sup> For adults, coverage of speech therapy extends to the following components:

- 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 they practice.<sup>17</sup> These services are covered as part of an evaluative office visit if they are necessary to either treat disorders of the feet, ankles, or tendons that insert into the foot, or to treat a disease that significantly impairs the ability to walk.<sup>18</sup> Medi-Cal coverage, however, does not extend to routine nail trimming.<sup>19</sup> Prior authorization of podiatry services is required if the service involves anything other than an evaluative office visit.<sup>20</sup>

Coverage for all these services is subject to certain restrictions, although 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. Coverage for audiology, speech therapy, and podiatry 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.<sup>21</sup> This restriction applies to any combination of such services. For example, if an adult beneficiary receives both a speech therapy and an audiology service in a given month, the beneficiary may not obtain coverage of a podiatric service until the following month.

### 3. Hearing Aids and Cochlear Implants

In addition to the services of audiologists, Medi-Cal also covers hearing aids. In order to obtain coverage for a hearing aid, a beneficiary must:<sup>22</sup>

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

In addition, Medi-Cal imposes an annual \$1,510 hearing aid cap per beneficiary.<sup>23</sup> 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.<sup>24</sup> 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.<sup>25</sup> By law, the vendor cannot bill a beneficiary if it accepts Medi-Cal payment for the service.<sup>26</sup>

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.<sup>27</sup>

In certain circumstances, replacement of 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 earpiece, cord, or batteries).<sup>28</sup> 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.<sup>29</sup>

Medi-Cal also covers repairs and replacement of cochlear implants, although prior authorization is required for many replacement supplies, such as headset/headpiece, microphone, transmitting coil, transmitter cable for use with cochlear implant, auditory osseointegrated device, and external speech processor and controller.<sup>30</sup> 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 must 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.<sup>31</sup> California has adopted the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule, which requires hearing screenings at birth, at two months, and regularly thereafter.<sup>32</sup> Medi-Cal must also cover all treatments necessary to address conditions discovered during hearing screenings, including hearing aids and cochlear implants.<sup>33</sup> 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.<sup>34</sup>

## 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.<sup>35</sup> 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.<sup>36</sup> 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 of 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.<sup>37</sup> As with eye exams, vision tests with refraction to determine the prescription strength for glasses and/or contact lenses are limited to once per 24 months, except when a sign or symptom indicates a need for additional services.<sup>38</sup>

Since 2020, Medi-Cal has provided coverage for eyeglasses and contact lenses when prescribed by an ophthalmologist or 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.<sup>39</sup> Replacement for frames for other reasons may be covered if the provider submits a statement explaining why the prior frame should be replaced.<sup>40</sup> Replacement of frames within two years is always limited to the same frame model whenever feasible.<sup>41</sup>

In general, Medi-Cal covers contact lenses with a prescription only if the use of eyeglasses is not an option.<sup>42</sup> 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 receive 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.<sup>43</sup> In addition, when the amount claimed for payment of a low vision optical aid is \$100 or more, prior authorization is required.<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup>

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 AAP 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.<sup>47</sup> 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.<sup>48</sup> 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 has no impact on the ability of children to receive this service.<sup>49</sup>

## 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.<sup>50</sup> Acupuncture represents a treatment alternative to the use of prescription opioids to treat chronic pain.

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.<sup>51</sup> Acupuncture can be provided by an acupuncturist or a physician, dentist, or podiatrist.<sup>52</sup> Medi-Cal covers acupuncture either with or without electrical stimulations of the needles.<sup>53</sup> However, acupuncture is only covered if the perceived pain is severe, persistent, or 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.<sup>54</sup>

A beneficiary does not need a prescription for acupuncture, nor does a beneficiary typically need to obtain prior authorization.<sup>55</sup> 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.<sup>56</sup> However, for managed care beneficiaries, additional services can be provided based upon medical necessity subject to the Managed Care Plan (MCP) prior authorization process.<sup>57</sup> Importantly, pursuant to federal law, there is no frequency limitation for beneficiaries under 21 receiving services pursuant to EPSDT.

## 6. Chiropractic Services

Chiropractic services are services provided by chiropractors acting within the scope of their practice as authorized by California law. Chiropractic services have been excluded from Medi-Cal coverage under California law.<sup>58</sup> However, this coverage exclusion does not apply in the following situations:

- Services are provided as emergency procedures.<sup>59</sup>

- The beneficiary is pregnant, and the services relate to the pregnancy.<sup>60</sup>
- The beneficiary is a minor under 21 and covered under the EPSDT benefit.<sup>61</sup>
- The beneficiary resides in a skilled nursing facility or an intermediate care facility.<sup>62</sup>
- The services are provided in a Medi-Cal acute inpatient hospital; in an out-of-state inpatient hospital and other facilities when the service is included in the all-inclusive rate; in a hospital outpatient department and hospital outpatient clinic; or in emergency rooms for acute inpatient hospitals, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs).<sup>63</sup>

In addition, Medi-Cal coverage of chiropractic services extends only to treatment of the spine by means of manual manipulation.<sup>64</sup> 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.<sup>65</sup> Finally, coverage of outpatient chiropractic 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.<sup>66</sup>

## B. Transportation

Federal Medicaid law requires state Medicaid programs to ensure that beneficiaries have sufficient transportation to access medical care.<sup>67</sup> 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, nonemergency medical transportation (NEMT), and NMT. On a limited basis, Medi-Cal covers transportation via air, which can be provided on an emergency or nonemergency basis.

### ADVOCACY TIP:

- ✓ Some services have a quantitative limit on coverage per month. Such services that are limited to two visits per month or a combination of two services per month are:
  - Acupuncture
  - Psychology
  - Physical therapy
  - Occupational therapy
  - Speech pathology
  - Audiological
  - Podiatry
  - Prayer or spiritual healing
  - Hospital outpatient department services and organized outpatient clinic
- ✓ 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 necessary to correct or ameliorate their illness or condition.

## 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.<sup>68</sup> Typically, emergency transportation is made via ambulance, but it can occur via other means of transportation, such as via air.

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.<sup>69</sup> Medi-Cal will also only cover the lowest-cost type of medical transportation that meets the individual's medical needs.<sup>70</sup>

## 2. Nonemergency Medical Transportation (NEMT)

NEMT is transportation of Medi-Cal beneficiaries by ambulance, wheelchair van, or litter van to get to and from providers furnishing 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.<sup>71</sup> 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.<sup>72</sup>

Physician decisions regarding NEMT must be unhindered by fiscal and administrative management.<sup>73</sup> 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.<sup>74</sup> The transportation provider must ensure door-to-door assistance from the point of departure to the destination.<sup>75</sup> 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.<sup>76</sup>

### ***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 (SUD) 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.<sup>77</sup>

The authorization requirements for NEMT are the same for beneficiaries enrolled in fee-for-service (FFS) and in Medi-Cal MCPs. Medi-Cal MCP providers must submit NEMT requests directly to their plans, while FFS providers must submit TARs to the Department of Health Care Services (DHCS) directly.<sup>78</sup> A Medi-Cal MCP must also make its best effort to refer for and coordinate NEMT for all Medi-Cal services not covered by the MCP contract, such as specialty mental health, SUD, dental, and any other services through the FFS delivery system.<sup>79</sup> MCPs may use prior authorization to reauthorize NEMT every 12 months when necessary to avoid duplicative paperwork and ensure consumers have expedient access to ongoing care.<sup>80</sup>

### **3. Nonmedical Transportation (NMT)**

NMT is round-trip transportation to access covered Medi-Cal services. NMT is provided by public conveyance—such as taxis, buses, trains, and rideshare apps such as Uber and Lyft—and transportation via private conveyance, such as a friend driving a beneficiary in the friend’s car.<sup>81</sup> NMT also covers mileage reimbursement.<sup>82</sup> 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.<sup>83</sup>

NMT has long been a benefit when provided as an EPSDT service.<sup>84</sup> 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.<sup>85</sup> Further, effective October 1, 2017, Medi-Cal MCPs must also provide NMT for Medi-Cal services that are carved out of the plan, such as specialty mental health services (SMHS), SUD services, dental services, and any other services furnished through the FFS delivery system.<sup>86</sup>

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.<sup>87</sup> For beneficiaries in managed care, NMT is covered if the beneficiary is traveling to a service that is covered either by the MCP or by FFS Medi-Cal (i.e., the service is carved out of managed care coverage).<sup>88</sup>
- In the case of minors, NMT can include transportation of the minor’s parent or guardian.<sup>89</sup>
- There are no mileage restrictions on the use of NMT.

## ***Authorization Requirements: Managed Care Plan Versus Fee-for-Service***

Unlike NEMT, a Medi-Cal beneficiary does not need a prescription to obtain NMT.<sup>90</sup> However, beneficiaries using NMT must attest that other available transportation resources have been reasonably exhausted.<sup>91</sup> While MCP enrollees submit attestations to their MCP, FFS beneficiaries must submit attestations 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.<sup>92</sup> 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.<sup>93</sup> As with NEMT, beneficiaries in FFS Medi-Cal must request NMT directly from DHCS.<sup>94</sup>

### **4. Air Transportation**

Medi-Cal may cover air transportation in either an emergency or nonemergency 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 via ground transportation.<sup>95</sup> 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.<sup>96</sup>

In nonemergencies, 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 nonemergency air transport is only available if a physician, podiatrist, or dentist has ordered such transportation.<sup>97</sup>

## **C. Diagnostic Tests**

Laboratory and imaging services are mandatory Medicaid services and, therefore, are covered services under Medi-Cal.<sup>98</sup>

Covered laboratory tests include, but are not limited to:<sup>99</sup>

- Blood counts
- Cholesterol tests
- Cytopathology
- Drug tests
- Glucose tests
- Hemoglobin tests
- Hepatitis screenings
- Human immunodeficiency virus (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, but is not limited to:<sup>100</sup>

- Computed tomography (CT)
- 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)
- Ultrasound
- X-rays

Many of these types of imaging require prior authorization.<sup>101</sup>

Medi-Cal also covers portable imaging services under certain circumstances. Under the portable imaging benefit, 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.<sup>102</sup> 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.<sup>103</sup>

## D. Other Specialized Services

### 1. Dialysis

Medi-Cal covers dialysis, which is the removal by artificial means of waste products normally excreted by the kidneys.<sup>104</sup> 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 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.<sup>105</sup> If a beneficiary seeks to receive home dialysis, the beneficiary's providers must submit evidence of the following:<sup>106</sup>

- The beneficiary, the beneficiary's spouse, or other co-learner is suitable for training on 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;
- The water supply in the home is suitable for renal dialysis;
- A qualified local physician is available for the ongoing medical supervision of the beneficiary;
- There is a plan for continuing case management; and
- There is a budget for all expenses related to home dialysis, including supplies prorated on a monthly cost basis, and the costs to install dialysis equipment in the home will be less than \$750.

## 2. Transplants

Medi-Cal coverage of organ and bone marrow transplants extends to the surgery to remove the organ from a donor, the transplant surgery, and antirejection medications following the transplant surgery.<sup>107</sup> Covered transplants include:<sup>108</sup>

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

Authorization is required for major solid organ, autologous islet cell, and bone marrow transplants.<sup>109</sup> 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.<sup>110</sup>

Individuals often need to continue taking antirejection medication after a transplant. If the individual loses Medi-Cal eligibility during the period in which the individual is taking such medications, the loss of such eligibility may harm access to the antirejection medication and threaten the person's health. To address this situation, Medi-Cal provides continuing coverage for those on antirejection 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.<sup>111</sup> 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 California's Medicaid expansion.

# Endnotes

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- <sup>1</sup> CAL. CODE REGS. tit. 22, § 51309(b).
- <sup>2</sup> CAL. CODE REGS. tit. 22, § 51085.
- <sup>3</sup> CAL. CODE REGS. tit. 22, § 51082.1.
- <sup>4</sup> CAL. CODE REGS. tit. 22, §§ 51081, 51085, 51309(a).
- <sup>5</sup> CAL. CODE REGS. tit. 22, § 51316(a).
- <sup>6</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Physical Therapy* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/phys.pdf> [hereinafter *Medi-Cal Provider Manual, Physical Therapy*]. Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Occupational Therapy* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/occu.pdf> [hereinafter *Medi-Cal Provider Manual, Occupational Therapy*]. Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/respir.pdf> [hereinafter *Medi-Cal Provider Manual, Respiratory Care*].
- <sup>7</sup> CAL. CODE REGS. tit. 22, § 51309(d); *Medi-Cal Provider Manual, Physical Therapy*, *supra* note 6, at 2.
- <sup>8</sup> *Medi-Cal Provider Manual, Occupational Therapy*, *supra* note 6, at 4, <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/occu.pdf>.
- <sup>9</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care*, *supra* note 6, at 2.
- <sup>10</sup> CAL. CODE REGS. tit. 22, § 51304(a).
- <sup>11</sup> 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)(C), (F). 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). Effective July 27, 2021, the Legislature made audiology, speech therapy services, podiatric services, and incontinence creams and washes covered benefits under the Medi-Cal program. CAL. WELF. & INST. CODE § 14131.10(h)(2).
- <sup>12</sup> CAL. CODE REGS. tit. 22, § 51305(f); CAL. CODE REGS. tit. 22, § 51314(a).
- <sup>13</sup> CAL. CODE REGS. tit. 22, § 51117.
- <sup>14</sup> CAL. CODE REGS. tit. 22, § 51098.

- <sup>15</sup> 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* (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/audio.pdf> [hereinafter *Medi-Cal Provider Manual, Audiological Services*].
- <sup>16</sup> 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 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/speech.pdf>.
- <sup>17</sup> CAL. CODE REGS. tit. 22, §§ 51310(a), 51229. See also Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Podiatry Services* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/podi.pdf> [hereinafter *Medi-Cal Provider Manual, Podiatry Services*].
- <sup>18</sup> CAL. CODE REGS. tit. 22, § 51310(a)(1). See also *Medi-Cal Provider Manual, Podiatry Services*, *supra* note 17, at 1.
- <sup>19</sup> CAL. CODE REGS. tit. 22, § 51310(b); *Medi-Cal Provider Manual, Podiatry Services*, *supra* note 17, at 1.
- <sup>20</sup> CAL. CODE REGS. tit. 22, § 51310(a).
- <sup>21</sup> CAL. CODE REGS. tit. 22, § 51304(a).
- <sup>22</sup> CAL. WELF. & INST. CODE § 14133.16.
- <sup>23</sup> CAL. WELF. & INST. CODE § 14131.05(c); see Cal. Dep't Health Care Servs., *Hearing Aid Benefit Cap & Benefit FAQs* (updated Jan. 28, 2022), <https://www.dhcs.ca.gov/services/Pages/HearingAidCapFAQ.aspx> [hereinafter *Hearing Aid Benefit Cap & Benefit FAQs*].
- <sup>24</sup> CAL. WELF. & INST. CODE § 14131.05(d), (e).
- <sup>25</sup> *Hearing Aid Benefit Cap & Benefit FAQs*, *supra* note 23.
- <sup>26</sup> 42 C.F.R. § 447.15; CAL. WELF. & INST. CODE §§ 14019.3(d), 14019.4(a).
- <sup>27</sup> *Medi-Cal Provider Manual, Audiological Services*, *supra* note 15, at 8.
- <sup>28</sup> CAL. CODE REGS. tit. 22, § 51517(b)(1).
- <sup>29</sup> *Hearing Aid Benefit Cap & Benefit FAQs*, *supra* note 23.
- <sup>30</sup> *Medi-Cal Provider Manual, Audiological Services*, *supra* note 15, at 8.
- <sup>31</sup> 42 U.S.C. § 1396d(r)(4).
- <sup>32</sup> CAL. CODE REGS. tit. 22, § 51184(a)(1); Cal. Dep't Health Care Servs., *Periodicity Schedules* (updated March 8, 2022), <https://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx>.
- <sup>33</sup> CMS, *EPSDT-A Guide for States: Coverage in the Medical Benefit for Children and Adolescents* 15 (2014), [https://www.medicare.gov/medicaid/benefits/downloads/epsdt\\_coverage\\_guide.pdf](https://www.medicare.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf)
- <sup>34</sup> CAL. CODE REGS. tit. 22, § 51340.1(c)(2).
- <sup>35</sup> CAL. CODE REGS. tit. 22, § 51305(j).

- <sup>36</sup> 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). 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, the State restored Medi-Cal coverage for vision services for all adult beneficiaries pending legislative allocation of funding. CAL. WELF. & INST. CODE § 14131.10(g)(1)–(2). The approved Governor’s Budget for 2019–2020 allocated funding for vision services, allowing beneficiaries to access the services beginning on January 1, 2020. Vision benefits remain covered for those beneficiaries with full-scope Medi-Cal benefits. See Cal. Dep’t Health Care Servs., Medi-Cal Vision Benefits, <https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/VisionBenefits.aspx> (last visited Dec. 5, 2022).
- <sup>37</sup> CAL. CODE REGS. tit. 22, § 51306(a). See also Cal. Dep’t Health Care Servs., *supra* note 36.
- <sup>38</sup> CAL. CODE REGS. tit. 22, § 51306(c).
- <sup>39</sup> CAL. CODE REGS. tit. 22, § 51317(d).
- <sup>40</sup> CAL. CODE REGS. tit. 22, § 51317(d)(1).
- <sup>41</sup> CAL. CODE REGS. tit. 22, § 51317(d)(2).
- <sup>42</sup> CAL. CODE REGS. tit. 22, § 51317(e).
- <sup>43</sup> CAL. CODE REGS. tit. 22, § 51317(f).
- <sup>44</sup> CAL. CODE REGS. tit. 22, § 51317(f)(5).
- <sup>45</sup> CAL. CODE REGS. tit. 22, § 51317(g); Cal. Dep’t Health Care Servs., *supra* note 36.
- <sup>46</sup> CAL. CODE REGS. tit. 22, § 51317(g)(2).
- <sup>47</sup> CAL. CODE REGS. tit. 22, § 51184(a); Cal. Dep’t Health Care Servs., *supra* note 32. 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>.
- <sup>48</sup> 42 U.S.C. § 1396d(r)(2).
- <sup>49</sup> 42 U.S.C. § 1396d(r)(2)(B).
- <sup>50</sup> See 2016 Cal. Stat. ch. 30 (S.B. 833), §§ 28, 36.
- <sup>51</sup> CAL. CODE REGS. tit. 22, § 51074.5.
- <sup>52</sup> CAL. CODE REGS. tit. 22, § 51308.5(a).
- <sup>53</sup> CAL. CODE REGS. tit. 22, § 51308.5(c).
- <sup>54</sup> CAL. CODE REGS. tit. 22, § 51308.5(b), (d). See also Cal. Dep’t Health Care Servs.,

*Medi-Cal Provider Manual, Acupuncture Services* 1 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/acu.pdf> [hereinafter *Medi-Cal Provider Manual, Acupuncture Services*].

<sup>55</sup> *Medi-Cal Provider Manual, Acupuncture Services*, *supra* note 54, at 2.

<sup>56</sup> CAL. CODE REGS. tit. 22, §§ 51304(a), 51308.5(a). *See also Medi-Cal Provider Manual, Acupuncture Services*, *supra* note 54.

<sup>57</sup> *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>.

<sup>58</sup> CAL. WELF. & INST. CODE § 14131.10(b)(1)(C)..

<sup>59</sup> CAL. WELF. & INST. CODE § 14131.10(b)(2)(B).

<sup>60</sup> CAL. WELF. & INST. CODE § 14131.10(b)(3).

<sup>61</sup> CAL. WELF. & INST. CODE § 14131.10(c)(1).

<sup>62</sup> CAL. WELF. & INST. CODE § 14131.10(c)(2).

<sup>63</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Chiropractic Services* 6 (2020), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/chiro.pdf> [hereinafter *Medi-Cal Provider Manual, Chiropractic Services*].

<sup>64</sup> CAL. CODE REGS. tit. 22, § 51308. *See also Medi-Cal Provider Manual, Chiropractic Services*, *supra* note 63, at 1.

<sup>65</sup> *Medi-Cal Provider Manual, Chiropractic Services*, *supra* note 63.

<sup>66</sup> CAL. CODE REGS. tit. 22, § 51304(a); *Medi-Cal Provider Manual, Chiropractic Services*, *supra* note 63, at 6.

<sup>67</sup> 42 C.F.R. § 431.53.

<sup>68</sup> CAL. CODE REGS. tit. 22, § 51323(b)(1).

<sup>69</sup> *Id.*

<sup>70</sup> CAL. CODE REGS. tit. 22, § 51323(b).

<sup>71</sup> CAL. CODE REGS. tit. 22, § 51323(a); Cal. Dep't Health Care Servs., *Medi-Cal Provider Training 2022: Medical Transportation Services* 6 (2022), [https://files.medi-cal.ca.gov/pubsdoco/outreach\\_education/workbooks/workbook\\_mc-trans.pdf](https://files.medi-cal.ca.gov/pubsdoco/outreach_education/workbooks/workbook_mc-trans.pdf).

<sup>72</sup> CAL. CODE REGS. tit. 22, § 51323(b).

<sup>73</sup> Cal. Dep't Health Care Servs., All Plan Letter 22-008 at 3 (May 18, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf> [hereinafter All Plan Letter 22-008].

<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* at 10.

<sup>77</sup> CAL. WELF. & INST. CODE § 14136.3; CAL. CODE REGS. tit. 22, § 51323(b)(2)(C).

- <sup>78</sup> Cal. Dep't Health Care Servs., DHCS Transportation Services, <https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx> (last visited Dec. 8, 2022). FFS beneficiaries can access NEMT by emailing [DHCSNMT@dhcs.ca.gov](mailto:DHCSNMT@dhcs.ca.gov) or going to the DHCS Transportation webpage to find the list of available NMT and NEMT providers.
- <sup>79</sup> All Plan Letter 22-008, *supra* note 73, at 3, 7.
- <sup>80</sup> *Id.* at 3. See also Cal. Dep't Health Care Servs., *Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses Frequently Asked questions (FAQs)* 4 (V.4 May 18, 2022), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008-NEMT-NMT-FAQ.pdf> [hereinafter *NEMT and NMT FAQs*].
- <sup>81</sup> CAL. WELF. & INST. CODE § 14132(ad)(2)(A)(i); All Plan Letter 22-008, *supra* note 73, at 8.
- <sup>82</sup> All Plan Letter 22-008, *supra* note 73, at 8.
- <sup>83</sup> *Id.*
- <sup>84</sup> *Id.* at 1.
- <sup>85</sup> CAL. WELF. & INST. CODE § 14132(ad)(9).
- <sup>86</sup> All Plan Letter 22-008, *supra* note 73, at 2.
- <sup>87</sup> *Id.* at 8.
- <sup>88</sup> *Id.* at 2.
- <sup>89</sup> *Id.* at 9.
- <sup>90</sup> *See generally Id.*
- <sup>91</sup> CAL. WELF. & INST. CODE § 14132(ad)(2)(B); All Plan Letter 22-008, *supra* note 73, at 9. *See also NEMT and NMT FAQs, supra* note 80, at 4.
- <sup>92</sup> All Plan Letter 22-008, *supra* note 73, at 3, 9–10.
- <sup>93</sup> *Id.* at 9. See also *NEMT and NMT FAQs, supra* note 80, at 6.
- <sup>94</sup> Cal. Dep't Health Care Servs., *supra* note 78. FFS beneficiaries can access NMT by emailing [DHCSNMT@dhcs.ca.gov](mailto:DHCSNMT@dhcs.ca.gov) or going to the DHCS Transportation webpage to find the list of available NMT and NEMT providers.
- <sup>95</sup> CAL. CODE REGS. tit. 22, §, 51323(c)(1).
- <sup>96</sup> Cal. Dep't Health Care Servs., *supra* note 71, at 21.
- <sup>97</sup> CAL. CODE REGS. tit. 22, § 51323(c)(2).
- <sup>98</sup> CAL. CODE REGS. tit. 22, § 51311(a).
- <sup>99</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pathology: Billing and Modifiers* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/pathbil.pdf>.
- <sup>100</sup> Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Radiology: Diagnostic* (2022), <https://files.medi-cal.ca.gov/pubsdoco/publications/>



[masters-mtp/part2/radidia.pdf](#).

<sup>101</sup> 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 March 23,2021).

<sup>102</sup> CAL. CODE REGS. tit. 22, § 51311(c).

<sup>103</sup> CAL. CODE REGS. tit. 22, § 51311(d)(1).

<sup>104</sup> CAL. CODE REGS. tit. 22, § 51157(a).

<sup>105</sup> CAL. CODE REGS. tit. 22, § 51330(b).

<sup>106</sup> CAL. CODE REGS. tit. 22, § 51330(c).

<sup>107</sup> CAL. WELF. & INST. CODE § 14132.69(a); Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transplants 1* (2021), <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/transplant.pdf> [hereinafter *Medi-Cal Provider Manual, Transplants*].

<sup>108</sup> *Medi-Cal Provider Manual, Transplants*, *supra* note 107, at 1.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.* See also CAL. WELF. & INST. CODE § 14132.71(a) (requiring DHCS to establish standards for facilities that provide transplants).

<sup>111</sup> CAL. WELF. & INST. CODE § 14132.70.

# Appendix A: Commonly Referenced Laws and Commonly Used Terms

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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
BHIN	Behavioral Health Information Notice (formerly known as Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice
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
CYBHI	Children and Youth Behavioral Health Initiative
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
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
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 (also known as Opioid Treatment Program)
OHC	Other Health Coverage
OMEA	Office of Marketplace Eligibility Appeals
ODD	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
SABIRT	Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (formerly known as Screening, Brief Intervention, and Referral to Treatment (SBIRT))
SBE	State Based Exchange
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
Section 1915(b)	Provision of the Social Security Act giving states the flexibility to modify their delivery systems by allowing CMS to waive statutory requirements for comparability, statewideness, and freedom of choice.
SHO	CMS State Health Official Letter
SMD	CMS State Medicaid Director Letter
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

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### Federal Resources:

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

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

CMS: Federal Policy Guidance and State Medicaid Director Letters  
<https://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)

HealthCare.gov Glossary  
<https://www.healthcare.gov/glossary/>  
(Commonly used terms and links to definitions)

### California State Resources:

California Code of Regulations, Title 22, § 50,000 et seq. and Title 9, § 18,000 et seq. <https://govt.westlaw.com/calregs>

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

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

Medi-Cal Eligibility Procedures Manual  
<http://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)  
<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLbyyear.aspx>  
(Includes ACWDLs from 1978 to present, a link to the ACWDLs Master Index, and 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 or BH) Information Notices  
[https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral\\_Health\\_Information\\_Notice.aspx](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>

Medi-Cal Rx Website  
<https://medi-calrx.dhcs.ca.gov/home/>  
(Website for all guidance, notices, and other information about the Medi-Cal Rx program)

California Advancing and Innovating Medi-Cal (CalAIM) Website  
<https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx>

Drug Medi-Cal Organized Delivery System (DMC-ODS) Website  
<https://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.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/>

An Advocate's Guide to Reproductive and Sexual Health in the Medicaid Program (September 2019), National Health Law Program  
<https://healthlaw.org/resource/an-advocates-guide-to-reproductive-and-sexual-health-in-the-medicaid-program/>

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](https://wclp.org/wp-content/uploads/2016/04/Western_Center_2016_Health_Care_Eligibility_Guide_Full.pdf)

Health Consumer Alliance  
<http://www.healthconsumer.org/>

Helping Families Obtain Durable Medical Equipment and Supplies Through the California Children's Services (CCS) Program (Updated June 2021), National Health Law Program

<https://healthlaw.org/resource/helping-families-obtain-durable-medical-equipment-and-supplies-through-the-california-childrens-services-ccs-program/>

(Provides the framework for accessing Durable Medical Equipment and medical supplies through the California Children's Services (CCS) program, including: a program overview, existing guidance on how to access services in Whole Child Model and traditional counties, considerations when children have Medi-Cal and/or other health coverage, and consumer rights)

# Addendum: Telehealth in Medi-Cal

December 2022

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This addendum is part of “[An Advocate’s Guide to Medi-Cal Services](#)” and gives an overview of the history of telehealth policy in California, describes current telehealth policies and regulations in Medi-Cal, and provides telehealth-related resources.

## A. What is Telehealth?

**Telehealth** is “the use of digital technologies to deliver health care, health information, and other health services by connecting two or more users—principally the patient and the provider in separate locations.”<sup>1</sup> The definition of telehealth varies by state. California law defines telehealth as “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care.”<sup>2</sup> Using telehealth, a patient who is located in one location (“**originating site**”) may receive health care services from a health care provider who is located in another location (“**distant site**”).<sup>3</sup>

Telehealth modalities include **synchronous** (i.e., video calls, audio only telephone calls, and text messages), **asynchronous store-and-forward, remote patient monitoring**, and **mHealth**.<sup>4</sup> Currently, not every state recognizes all types of telehealth modalities.<sup>5</sup> Whether a modality is reimbursable also varies by state.<sup>6</sup> Until 2019, California only recognized synchronous video interactions and asynchronous store and forward interactions.<sup>7</sup> Currently, it recognizes all types of telehealth modalities.<sup>8</sup>

Telehealth has provided many people, including those in disadvantaged communities an additional tool to access health care services.<sup>9</sup> However, the expansion of telehealth use—primarily during the COVID-19 Public Health Emergency (PHE) also exposed new equity issues and highlighted the effects of the digital divide. Studies conducted prior to the COVID-19 PHE showed that underserved populations such as low-income, rural, and Medicaid populations did not use telehealth as widely as other demographic groups.<sup>10</sup> More recent research continues to suggest that telehealth access is not equitable across different population subgroups.<sup>11</sup>

For example, low-income households, older adults, and communities of color are more likely to lack the technical set up, device, or private space to effectively access health care services via telehealth.<sup>12</sup> Many individuals and families in rural or low-income urban communities also often lack the necessary broadband connectivity to access synchronous video telehealth modality.<sup>13</sup> Moreover, many telehealth service platforms are not yet available to people with disabilities or people with limited English proficiency.<sup>14</sup> For many older adults and people with limited English proficiency—who are often already experiencing low health literacy, low digital literacy is another barrier they have to face while navigating a complex health care system.<sup>15</sup>

With equity in mind, NHeLP developed a set of Medicaid Principles on Telehealth for policymakers' considerations.<sup>16</sup> The federal government has also issued guidance to explain how federal laws require making telehealth accessible to people with disabilities and limited English proficient persons.<sup>17</sup>

## **B. Federal Medicaid Telehealth Policies**

The Centers for Medicare & Medicaid Services (CMS) does not recognize telehealth as a distinct service. It recognizes telehealth interchangeably as “telemedicine” and “a cost-effective alternative to the more traditional face-to-face way of providing medical care that states can choose to cover under Medicaid”—a definition that is consistent with federal Medicare statute.<sup>18</sup> To assist states in expanding their telehealth policies, CMS issued a Telehealth Toolkit: COVID-19 Version in 2020, and then a Supplement in 2021. Additionally, the U.S. Federal Communications Commission (FCC) officially launched the Affordable Connectivity Program to help provide financial assistance toward internet services and purchase of equipment for eligible households.<sup>19</sup>

In 2020, the U.S. Department of Health and Human Services (HHS) established a website, [Telehealth.HHS.gov](https://www.hhs.gov/telehealth), to provide information for health care providers and patients and support and promote telehealth. In 2022, it also issued, through its Office of Civil Rights (OCR), a new Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidance to support the use of audio-only telehealth.<sup>20</sup> The new HIPAA guidance clarified that remote communication technologies may be used to provide audio-only telehealth services in compliance with the HIPAA rules, as long as reasonable safeguards are put in place to protect the privacy and integrity of protected health information (PHI).<sup>21</sup> Also, although the HIPAA Security Rule does not apply to audio-only telehealth services provided via a traditional telephone landline, it applies to audio-only telehealth services provided via electronic communication technologies such as web based applications and cellular phones (which transmit or maintain electronic data, as oppose to a traditional telephone landline).<sup>22</sup>

## C. California Telehealth Law

### 1. Legislative History

In 1996, through the passage of the Telemedicine Development Act, California became the first state to regulate the provision of telemedicine.<sup>23</sup> For many years and like most states, California laws imposed a lot of limitations on the use of telehealth in Medi-Cal, including requiring providers to have at least one in-person visit with a patient before initiating a telehealth visit, mandating special written consent from the patient, and allowing telehealth visits to occur only in or from a provider's office or a hospital site.<sup>24</sup> Also, only synchronous modality was covered.<sup>25</sup> In 2011, AB 415, the Telehealth Advancement Act was signed into law and eased several of these previous limitations on telehealth provision in California—waiving the in-person visit and location requirement, allowing verbal consent, and adding store-and-forward technology.<sup>26</sup> In 2015, AB 809 was passed to allow verbal or written consent from the patient before a telehealth interaction.<sup>27</sup>

In 2019, the California Department of Health Care Services (DHCS) published a Medi-Cal Telehealth Provider Manual (*updated in August 2020*) to inform Californians of telehealth related Medi-Cal covered benefits, services, and health care provider requirements.<sup>28</sup> AB 1494 was signed into law to require that telehealth services, telephonic services (defined as “health services provided via telephone with audio component only”), and other specified services be reimbursable when provided during or immediately following a state of emergency.<sup>29</sup> Additionally, AB 744 was enacted to mandate payment parity for health care services that are provided via telehealth “on the same basis and to the same extent” as in-person, effective January 1, 2021.<sup>30</sup>

Following HHS Secretary's declaration of the COVID-19 PHE on March 13, 2020, California *temporarily* expanded its existing telehealth service provisions for Medi-Cal beneficiaries.<sup>31</sup> For example, Medi-Cal began to reimburse providers for medically appropriate services rendered over the phone at the same rate as via video.<sup>32</sup> Out-of-state licensed providers were also allowed to apply for enrollment in the Medi-Cal Fee-for-Service (FFS) program to fill the needs for additional providers during the PHE.<sup>33</sup> Moreover, Medi-Cal temporarily allowed for expanded access to telehealth through non-public technology platforms, such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, WhatsApp video chat, Zoom, or Skype.<sup>34</sup> Essentially, providers were allowed to render all applicable Medi-Cal services that can be appropriately provided via telehealth modalities – even those historically not identified or regularly provided via telehealth to new and established patients.<sup>35</sup>

As the COVID-19 PHE continued to impact Medi-Cal service delivery, telehealth laws were enacted to continue telehealth policies and services that were



available to Medi-Cal beneficiaries during the PHE after the pandemic ends.<sup>36</sup> On July 27, 2021, AB 133 was signed into law.<sup>37</sup> Under AB 133, coverage of remote patient monitoring became permanent and many Medi-Cal telehealth flexibilities that were temporarily available during the PHE (including payment parity for audio-only modality) were to remain available at least until December 31, 2022.<sup>38</sup> It also mandated DHCS to create a stakeholder advisory group to strategize ways to increase access and equity and reduce disparities in the Medi-Cal program.<sup>39</sup>

In December 2021, after convening the stakeholder workgroup, DHCS published a Medi-Cal Telehealth Advisory Workgroup report.<sup>40</sup> On June 30, 2022, as part of the California 2022-2023 State Budget, SB 184, the Health Budget Trailer Bill was signed into law to require permanent coverage of and payment parity of synchronous video, synchronous audio-only, and asynchronous telehealth modalities, starting January 1, 2023.<sup>41</sup>

## 2. Current Medi-Cal Telehealth Laws and Policies

### *Requirements*

A health care provider at the **distant site** (“a site where a health care provider who provides health care services is located while providing these services via a telecommunications system”) may render **Medi-Cal covered benefits via telehealth** to a patient located at the originating site (“a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates”) when:<sup>42</sup>

- A health care provider determines that a particular benefit or service is **clinically appropriate** based upon evidence-based medicine or/ and best practice to be delivered via telehealth;
- The benefits or services delivered via telehealth meet the procedural definitions and components of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes; and
- The benefits or services delivered via telehealth meet all state and federal laws regarding **confidentiality, privacy, and patient’s rights**.

A health care provider rendering Medi-Cal covered services via telehealth (unless employed by a tribal health program to provide services for the tribal health program) must be **licensed** in California, enrolled as a Medi-Cal provider or non-physician medical practitioner, and affiliated with an enrolled Medi-Cal provider group that is located in California or a border community.<sup>43</sup> The **standard of care** is the same whether the patient is seen in-person or via telehealth.<sup>44</sup>

Before the delivery of health care via telehealth, the health care provider initiating the use of telehealth must inform the patient about the use of

telehealth and obtain verbal or written **consent** from the patient, and the consent for the use of telehealth must be documented in the patient's medical file (a general consent agreement that specifically mentions the use of telehealth as an acceptable modality for delivery of services is sufficient).<sup>45</sup> All health care providers providing Medi-Cal covered benefits or services to patients via telehealth must meet the **same documentation standard** as in-person services and must maintain appropriate documentation utilizing the corresponding CPT and HCPCS codes.<sup>46</sup> A patient **may not** at any time be precluded from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.<sup>47</sup>

Medi-Cal **does not limit the setting or location** of the distant site or the originating site, but it requires providers to use a specific Place of Service (POS) code 02 to indicate that service was provided through telehealth—except for services provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Services (IHS) clinics.<sup>48</sup> In addition, providers need to use a specific modifier for services or benefits provided via a specific telehealth modality.<sup>49</sup> Medi-Cal covers telehealth services provided in FQHCs, RHCs, and IHS clinics under different billing requirements.<sup>50</sup>

Medi-Cal **may not require pre-existing in-person contact or relationship** before services are rendered via telehealth and may not require documentation of a barrier to an in-person visit for Medi-Cal coverage of services provided via telehealth.<sup>51</sup>

### **Network Adequacy**

Medi-Cal gives providers flexibility to use telehealth as a modality for delivering medically necessary services to their patients, and currently, as part of the PHE flexibilities, providers are allowed to offer services via telehealth only.<sup>52</sup> To ensure that all Medi-Cal managed care covered services are available and accessible to beneficiaries in a timely manner, all Medi-Cal Managed Care Health Plans (MCPs) are required to meet **network adequacy** standards, which include provider-to-member ratios and the time and distance requirements.<sup>53</sup> Currently, DHCS allows MCPs to utilize telehealth providers to meet **physician and provider-to-member ratios**.<sup>54</sup> Although providers who provide services via *telehealth* only may be counted as an additional provider to meet provider-to-member ratio network adequacy requirement, those who provide services *both in-person and via telehealth* may only be counted once in any given specialty.<sup>55</sup>

DHCS allows MCPs to use telehealth to meet the **time and distance standards**.<sup>56</sup> However, before using a telehealth provider to fulfill network adequacy requirements for time and distance standards in a defined service

area, the MCP must make reasonable attempts to contract with an in-person provider.<sup>57</sup> Also, MCP cannot require members to utilize telehealth in place of in-person services.<sup>58</sup>

### ***Covered Modalities***

Currently, Medi-Cal covers the following telehealth modalities: (1) **Synchronous interactions** (“real-time interaction between a patient and a health care provider located at a distant site”); (2) **Asynchronous store and forward transfers** (“the transmission of a patient’s medical information from an originating site to the health care provider at a distant site”); (3) **Remote patient/physiologic monitoring (RPM)** (“a type of telehealth that involves the secure transfer of personal health and medical data to a provider for remote monitoring, care, and support”).<sup>59</sup>

#### *(1) Synchronous*

Synchronous **video and audio-only** modalities are currently covered by Medi-Cal across multiple services and delivery systems, including physical health, dental, specialty mental health, and Drug Medi-Cal Organized Delivery System (DMC-ODS).<sup>60</sup>

During the COVID-19 PHE, DHCS allowed many services to be provided via **audio-only or telephone** for the first time and has since made some of these PHE flexibilities permanent. For example, prior to the PHE, a person under the age of 21 could only submit an in-person application or renewal for the Medi-Cal Minor Consent Program, a program that allows minors to consent to services related to family planning, sexual assault, pregnancy, sexually transmitted diseases, substance use, and outpatient mental health.<sup>61</sup> Starting June 2021, minors permanently have the option to apply or renew Medi-Cal Minor consent eligibility in-person or by phone.<sup>62</sup> Prior to the PHE, California’s family planning Medicaid program, Family Planning, Access, Care and Treatment (FPACT) were already permitted to utilize telehealth modalities to deliver family planning services.<sup>63</sup> As a result of the PHE, DHCS broadened the use of telehealth to temporarily allow (i) eligible individuals to virtually or telephonically enroll and recertify for FPACT, and (ii) access to subcutaneous Depo-Provera (DMPA-SQ) directly from their pharmacy for self-administration.<sup>64</sup> DMPA-SQ has now been made a permanent Pharmacy Benefit.<sup>65</sup>

#### *(2) Asynchronous*

Under the Medi-Cal Telehealth policy, asynchronous store and forward transfers between health care providers (“E-Consults”) are covered, but consultations via asynchronous transmission initiated directly by patients (including through mobile phone applications) are not.<sup>66</sup>

### *(3) Remote patient/ physiologic monitoring (RPM)*

As of July 1, 2021, RPM is permanently an allowable telehealth modality for Medi-Cal covered health care services for fee-for-service and managed care beneficiaries with full scope Medi-Cal or pregnancy-only coverage.<sup>67</sup> RPM services are provided for established patients ages 21 and older, and they are reimbursable when ordered by and billed by physicians or other qualified health professionals.<sup>68</sup>

Currently, as a response to the COVID-19 PHE, Medi-Cal temporarily covers **brief virtual/ telephonic communications** (e.g. web-based modalities, such as web-based interfaces, live chats, etc) in physical health for brief virtual or telephonic communications between health care providers or between a health care provider and a patient (both new and established).<sup>69</sup>

#### ***Payment Parity***

Medi-Cal currently pays the **same rate** for health care services provided via **synchronous video, synchronous audio-only, and asynchronous** as it pays for services provided in-person.<sup>70</sup> While payment parity for synchronous video is mandated by California law, payment parity for synchronous audio-only and asynchronous is required by DHCS only as part of the temporary COVID-19 telehealth flexibilities that will remain available through December 31, 2022.<sup>71</sup> Effective January 1, 2023, in addition to synchronous video, California law will also begin mandating payment parity for synchronous audio-only and asynchronous telehealth modalities.<sup>72</sup>

Payment parity does not apply to virtual communications, such as web-based interfaces, live-chats, or e-consults.<sup>73</sup>

#### ***Medi-Cal Special Programs***

Currently, Medi-Cal may cover telehealth services used for: California Children's Services (CCS) Program, Genetically Handicapped Person's Program (GHPP), and Child Health and Disability Prevention (CHDP) Program.<sup>74</sup> Medi-Cal does not cover telehealth services used for: Newborn Hearing Screening Program (NHSP) or private duty nursing for the CCS, GHPP, or CHDP programs.<sup>75</sup>

### **3. Medi-Cal Telehealth Laws and Policies Effective January 1, 2023**

Several of the temporary Medi-Cal telehealth flexibilities that were made available to Medi-Cal beneficiaries during the COVID-19 PHE will remain available through December 31, 2022.<sup>76</sup> On June 30, 2022, the Health trailer bill, SB 184, was signed into law to permanently implement many of the temporarily available Medi-Cal telehealth policies after 2022.<sup>77</sup>

Effective January 1, 2023:

- **Coverage of and payment parity for synchronous video, synchronous audio-only, and asynchronous**—Medi-Cal will permanently require coverage of and payment parity for synchronous video, synchronous audio-only, and asynchronous for all providers, including in FQHCs and RHCs.<sup>78</sup> Drug Medi-Cal Treatment Program (Drug Medi-Cal) providers must also receive reimbursement for health care services provided via synchronous video or synchronous audio-only interaction.<sup>79</sup>
- **Network Adequacy requirements**—DHCS will authorize MCPs to use clinically appropriate synchronous video interaction (*instead of any telehealth modalities*) as a means of demonstrating compliance with the network adequacy time and distance standards.<sup>80</sup>
- **New provider-patient relationships**—Medi-Cal providers may not establish new patient relationships via synchronous audio-only, asynchronous, RPM, or other virtual communication modalities except when the visit is related to “sensitive services” or “when the patient requests an audio-only modality or attests they do not have access to video.”<sup>81</sup> Sensitive services, as defined in Cal. Civ. Code § 56.05(n), include “all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.”<sup>82</sup>
- **Medi-Cal beneficiaries will receive an informational notice from DHCS about telehealth**—DHCS must distribute to Medi-Cal beneficiaries with information that include, but not be limited to, all of the following: (i) The availability of Medi-Cal covered telehealth services; (ii) The beneficiary’s right to access all medically necessary covered services through in-person, face-to-face visits, and a provider’s and Medi-Cal managed care plan’s responsibility to offer or arrange for that in-person care, as applicable; (iii) An explanation that use of telehealth is voluntary and that consent for the use of telehealth can be withdrawn by the Medi-Cal beneficiary at any time without affecting their ability to access covered Medi-Cal services in the future; (iv) An explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and (v) The beneficiary’s right to make complaints about the offer of telehealth services in lieu of in-person care or about the quality of care delivered through telehealth.<sup>83</sup> DHCS is currently developing a patient consent form to incorporate the required information.

Additionally, no sooner than January 1, 2024, health care providers (including FQHC and RHC providers, unless exceptions apply) furnishing applicable health

care services via synchronous audio-only interaction must also offer those same health care services via **synchronous video interaction**. Also, a provider furnishing services through synchronous video or synchronous audio-only interaction must also offer those services through **in-person face-to-face contact or arrange for a referral to in-person care**, unless exceptions apply.<sup>84</sup>

Finally, on or before January 1, 2023, DHCS is required to: (1) propose strategies to analyze the relationship between telehealth and access to care, access to in-person care, quality of care, and Medi-Cal program costs, utilization, and program integrity; (2) examine issues using an equity framework that includes stratification by available geographic and demographic factors, including, but not limited to, race, ethnicity, primary language, age, and gender, to understand inequities and disparities in care; and (3) prioritize research and evaluation questions that directly inform Medi-Cal policy.<sup>85</sup>

## D. Telehealth Resources

Federal Resources	
Resource	Agency/Source
<a href="#">Telemedicine webpage</a>	CMS
<a href="#">CMS Telehealth Toolkit: COVID-19 Version and Supplement #1</a>	CMS
<a href="#">Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth</a>	CMS
<a href="#">Affordable Connectivity Program</a> (provides financial benefits toward internet services for eligible households and discounts towards purchase of equipment)	Federal Communications Commission (FCC)
<a href="#">Office of Inspector General Telehealth Page</a>	HHS
<a href="#">Telehealth.HHS.gov</a> (provides information for health care providers and patients about the latest federal efforts to support and promote telehealth—such as <a href="#">telehealth policy changes after the COVID-19 PHE</a> , <a href="#">HIPAA and audio-only telehealth</a> , <a href="#">legal considerations</a> and <a href="#">best practice</a> when providing services via telehealth)	HHS
Report on <a href="#">telehealth and substance use disorder services</a>	White House Office of National Drug Control Policy (ONDCP)



<b>California Resources</b>	
<a href="#">California Telehealth Policy Coalition</a>	California Center for Connected Health Policy (CCHP)
<a href="#">Policy Finder Look-up Tool</a>	California Center for Connected Health Policy (CCHP)
<a href="#">Policy Trend Maps</a>	California Center for Connected Health Policy (CCHP)
<a href="#">DHCS Medi-Cal &amp; Telehealth Webpage</a>	Department of Health Care Services (DHCS)
<a href="#">Medi-Cal Telehealth Policy Manual (last updated in Aug. 2020)</a>	DHCS
<a href="#">Telehealth Definitions, Resources, &amp; Frequently Asked Questions</a>	DHCS
<a href="#">Telehealth Advisory Workgroup Page</a>	DHCS
<a href="#">California Interactive Broadband Map</a>	
<a href="#">California Telehealth Resource Center (CTRC)</a>	
<b>Other Resources</b>	
<a href="#">Medicaid Principles on Telehealth</a> (May 2020),	National Health Law Program

# Endnotes

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- <sup>1</sup> Fabiola Carrión, Nat'l Health Law Prog., *Medicaid Principles on Telehealth* (May 11, 2020), [www.healthlaw.org/wp-content/uploads/2020/05/Medicaid-Telehealth-Principles-FINAL.FORMATTED.pdf](http://www.healthlaw.org/wp-content/uploads/2020/05/Medicaid-Telehealth-Principles-FINAL.FORMATTED.pdf).
- <sup>2</sup> CAL. BUS. & PROF. CODE §2290.5(a)(6).
- <sup>3</sup> *Id.*
- <sup>4</sup> Synchronous care is a “real time interaction for patient health communication,” which may include video calls to share progress or check on healing, audio-only calls to confirm instructions, and text messaging to answer patient questions. Asynchronous is communication between providers, patients, and caregivers stored for future reference or response. Examples may include emails or text messages with follow-up instructions or confirmations, images for evaluation, and lab results or vital statistics. Remote patient monitoring consists of transmitting and storing patient data and clinical measurements from in-home devices to patient portals. Data examples may include: blood pressure monitors, pacemakers, glucose meters, and oximeters. See HHS, *Getting Started with Telehealth*, [www.telehealth.hhs.gov/providers/getting-started/](http://www.telehealth.hhs.gov/providers/getting-started/) (last visited Nov. 8, 2022).
- <sup>5</sup> Ctr. for Connected Health Pol'y, *State Telehealth Laws and Medicaid Program Policies* (2022), [www.cchpca.org/2022/05/Spring2022\\_ExecutiveSummaryfinal.pdf](http://www.cchpca.org/2022/05/Spring2022_ExecutiveSummaryfinal.pdf).
- <sup>6</sup> *Id.*
- <sup>7</sup> CAL. BUS. & PROF. CODE § 2290.5(a).
- <sup>8</sup> *Id.*; see also Cal. Dep't Health Care Servs., *Revised Medi-Cal Telehealth Provider Manual* (2020), <https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part2/mednetele.pdf> [hereinafter *Medi-Cal Telehealth Manual*]; see also Andrew Broderick et al., *Remote Patient Monitoring in the Safety Net: What Payers and Providers Need to Know* (July 9, 2021), [www.chcf.org/wp-content/uploads/2021/07/RemotePatientMonitoringSafetyNetNeedKnow.pdf](http://www.chcf.org/wp-content/uploads/2021/07/RemotePatientMonitoringSafetyNetNeedKnow.pdf).
- <sup>9</sup> Sanuja Bose et al., *Medicare Beneficiaries in Disadvantaged Neighborhoods Increased Telemedicine Use During The COVID-19 Pandemic*, 41 HEALTH AFF. 5 (2022).
- <sup>10</sup> Jeongyoung Park et al., *Associated With The Use Of Telehealth Services Among Underserved Populations?*, 37 HEALTH AFF. 12 (2018), [www.doi.org/10.1377/hlthaff.2018.05101](http://www.doi.org/10.1377/hlthaff.2018.05101).
- <sup>11</sup> Madjid Karimi et al., HHS Office of Health Policy, *National Survey Trends in Telehealth Use in 2021: Disparities in Utilization and Audio vs. Video Services* (Feb. 1, 2022), [www.aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf](http://www.aspe.hhs.gov/sites/default/files/documents/4e1853c0b4885112b2994680a58af9ed/telehealth-hps-ib.pdf).

- <sup>12</sup> *Id.* at 9. See also Cal. Dep't Pub. Health et al., *Community Strategies to Address California's Digital Divide and Its Impact on Children and Families* (April 2022), [www.pacesconnection.com/fileSendAction/fcType/5/fcOid/525718672527258968/fodoid/525718672527258964/DigitalDivide\\_FIN.pdf](http://www.pacesconnection.com/fileSendAction/fcType/5/fcOid/525718672527258968/fodoid/525718672527258964/DigitalDivide_FIN.pdf).
- <sup>13</sup> Karimi et al., *supra* note 11, at 2; see also California Interactive Broadband Map (2019), [www.broadbandmap.ca.gov/EOY2019/](http://www.broadbandmap.ca.gov/EOY2019/) (last visited Nov. 8, 2022).
- <sup>14</sup> Karimi et al., *supra* note 11, at 2.
- <sup>15</sup> Health Res. & Servs. Admin., Health Literacy, [www.hrsa.gov/about/organization/bureaus/ohe/health-literacy](http://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy) (last visited Nov. 8, 2022).
- <sup>16</sup> See Carrión, *supra* note 1, at 4–10.
- <sup>17</sup> HHS & DOJ, *Guidance on Nondiscrimination in Telehealth: Federal Protections to Ensure Accessibility to People with Disabilities and Limited English Proficient Persons* (July 28, 2022), [www.hhs.gov/sites/default/files/guidance-on-nondiscrimination-in-telehealth.pdf](http://www.hhs.gov/sites/default/files/guidance-on-nondiscrimination-in-telehealth.pdf).
- <sup>18</sup> 42 C.F.R. § 410.78; see also CMS, Telemedicine, [www.medicare.gov/medicaid/benefits/telemedicine/index.html](http://www.medicare.gov/medicaid/benefits/telemedicine/index.html) (last visited Nov. 8, 2022).
- <sup>19</sup> FCC, Affordable Connectivity Program, [www.fcc.gov/acp](http://www.fcc.gov/acp) (last visited Nov. 8, 2022).
- <sup>20</sup> HHS, Guidance on How the HIPAA Rules Permit Covered Health Care Providers and Health Plans to Use Remote Communication Technologies for Audio-Only Telehealth, [www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html#footnote23\\_hr34jrg](http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hipaa-audio-telehealth/index.html#footnote23_hr34jrg) (last visited Nov. 8, 2022).
- <sup>21</sup> *Id.*
- <sup>22</sup> *Id.*
- <sup>23</sup> Telemedicine Dev. Act, Senate Bill 1665 (1996).
- <sup>24</sup> *Id.*
- <sup>25</sup> *Id.*
- <sup>26</sup> Telehealth Advancement Act, Assem. Bill 415 (2011).
- <sup>27</sup> Healing Arts: Telehealth, Assem. Bill 809 (2015).
- <sup>28</sup> *Medi-Cal Telehealth Manual*, *supra* note 8.
- <sup>29</sup> Medi-Cal: Telehealth: State of Emergency, Assem. Bill 1494 (2019); see also CAL. WELF. & INST. CODE §§ 14132.723 & 14132.724.
- <sup>30</sup> Health Care Coverage: Telehealth, Assem. Bill 744 (2019); see also CAL. HEALTH & SAFETY CODE § 1374.14(a)(1) & (b)(1).
- <sup>31</sup> The COVID-19 Public Health Emergency was last renewed on October 13, 2022. HHS, Public Health Emergency Declarations, <https://aspr.hhs.gov/legal/PHE/Pages/default.aspx> (last visited Nov. 8, 2022).

- <sup>32</sup> Cal. Dep't Managed Health Care Servs., All Plan Letter 20-009 (March 18, 2020), [www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2020-009%20\(OPL\)%20-%20Reimbursement%20for%20Telehealth%20Services%20\(3\\_18\\_20\).pdf?ver=2020-03-18-105612-547](http://www.dmhc.ca.gov/Portals/0/Docs/OPL/APL%2020-009%20(OPL)%20-%20Reimbursement%20for%20Telehealth%20Services%20(3_18_20).pdf?ver=2020-03-18-105612-547).
- <sup>33</sup> Cal. Dep't Health Care Servs., *Requirements and Procedures for Emergency Medi-Cal Provider Enrollment* (March 24, 2020), [files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom\\_30339\\_12.aspx](http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_12.aspx).
- <sup>34</sup> Cal. Dep't Health Care Servs., *Post-COVID-19 Public Health Emergency Telehealth Policy Recommendations* (Feb. 3, 2022), <https://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Policy-Paper-2-3-22.pdf> [hereinafter *Post-PHE Telehealth Policy Proposal*]; see also HHS, *FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency* (Oct. 2, 2020), [hhs.gov/sites/default/files/telehealth-faqs-508.pdf](https://hhs.gov/sites/default/files/telehealth-faqs-508.pdf).
- <sup>35</sup> HHS, *supra* note 34
- <sup>36</sup> Telehealth, Assem. Bill 32 (2022).
- <sup>37</sup> Health Trailer Bill, Assem. Bill 133 (2021).
- <sup>38</sup> *Id.*
- <sup>39</sup> *Id.*; See also Cal. Dep't Health Care Servs., Telehealth Advisory Workgroup, [www.dhcs.ca.gov/provgovpart/Pages/TelehealthAdvisoryWorkgroup.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/TelehealthAdvisoryWorkgroup.aspx) (last visited Nov. 8, 2022).
- <sup>40</sup> Cal. Dep't Health Care Servs., *DHCS Medi-Cal Telehealth Advisory Workgroup Report* (Dec. 2021), [www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Advisory-Workgroup-Report-2021-12-02.pdf](http://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-Telehealth-Advisory-Workgroup-Report-2021-12-02.pdf).
- <sup>41</sup> Health, Senate Bill 184 (2022).
- <sup>42</sup> CAL. BUS. & PROF. CODE § 2290.5(a); see also *Medi-Cal Telehealth Manual*, *supra* note 8, at 6.
- <sup>43</sup> CAL. BUS. & PROF. CODE § 2290.5(a); see also *Medi-Cal Telehealth Manual*, *supra* note 8, at 3; see also CAL. BUS. & PROF. CODE § 719.
- <sup>44</sup> Medical Board of California, Resources: Practicing Medicine Through Telehealth Technology, [www.mbc.ca.gov/Resources/Medical-Resources/telehealth.aspx](http://www.mbc.ca.gov/Resources/Medical-Resources/telehealth.aspx) (last visited Nov. 11, 2022); see also Fed'n State Med. Boards, *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (April 2022), [www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf](http://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf).
- <sup>45</sup> CAL. BUS. & PROF. CODE § 2290.5(b).
- <sup>46</sup> *Medi-Cal Telehealth Manual*, *supra* note 8, at 4.
- <sup>47</sup> *Id.* at (c).
- <sup>48</sup> *Id.* at 5.
- <sup>49</sup> Cal. Dep't Health Care Servs., Payment and Claims, [www.dhcs.ca.gov/provgovpart/Pages/FAQ-Telehealth-Payments.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/FAQ-Telehealth-Payments.aspx) (last visited Nov. 8, 2022).

- <sup>50</sup> *Id.*
- <sup>51</sup> CAL. WELF. & INST. CODE § 4132.72(c).
- <sup>52</sup> *Post-PHE Telehealth Policy Proposal*, *supra* note 34, at 12.
- <sup>53</sup> CAL. WELF. & INST. CODE § 14197.
- <sup>54</sup> *Post-PHE Telehealth Policy Proposal*, *supra* note 34, at 12; see also Cal. Dep't Health Care Servs., All Plan Letter 21-006 (April 27, 2021), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-006.pdf>.
- <sup>55</sup> *Id.* at 4.
- <sup>56</sup> *Id.* at 6.
- <sup>57</sup> *Id.* at 9.
- <sup>58</sup> *Id.*; See also CAL. WELF. & INST. CODE § 14132.72(f).
- <sup>59</sup> CAL. BUS. & PROF. CODE § 2290.5(a)(2022); see also *Medi-Cal Telehealth Manual*, *supra* note 8, at 6–7; see also Broderick et al., *supra* note 8.
- <sup>60</sup> Cal. Dep't Health Care Servs., *Highlights of Current and Planned Medi-Cal Telehealth Coverage* (Sept. 27, 2021), [www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-2021-Telehealth-Policies-Commitments-and-Workgroup-Charge-Summary.pdf](http://www.dhcs.ca.gov/services/medi-cal/Documents/DHCS-2021-Telehealth-Policies-Commitments-and-Workgroup-Charge-Summary.pdf).
- <sup>61</sup> Cal. Dep't Health Care Servs., Medi-Cal Eligibility Division Information Letter No: 21-09: Continuing Telephonic Flexibilities for the Minor Consent Program Beyond the COVID-19 PHE (June 24, 2021), [www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I21-09.pdf](http://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I21-09.pdf); see also Cal. Dep't Health Care Servs., *Minor Consent Program* (2020), [files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/minor.pdf](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/minor.pdf) [hereinafter *Minor Consent Program*].
- <sup>62</sup> *Minor Consent Program*, *supra* note 61.
- <sup>63</sup> Cal. Dep't Health Care Servs., *Update to Information on Coronavirus (COVID-19) for Family PACT* (March 26, 2020), [www.dhcs.ca.gov/services/ofp/Documents/OFP-Notice-COVID19-Update.pdf](http://www.dhcs.ca.gov/services/ofp/Documents/OFP-Notice-COVID19-Update.pdf).
- <sup>64</sup> *Id.*; see also Cal. Dep't Health Care Servs., *Information Regarding the Use of Subcutaneous Depot Medroxyprogesterone Acetate During the 2019 Novel Coronavirus Public Health Emergency* (April 9, 2020), [www.dhcs.ca.gov/Documents/COVID-19/Medi-Cal-FFS-Depo-Provera-SQ-Temp-Policy.pdf](http://www.dhcs.ca.gov/Documents/COVID-19/Medi-Cal-FFS-Depo-Provera-SQ-Temp-Policy.pdf).
- <sup>65</sup> Cal. Dep't Health Care Servs., *Family PACT Update: DMPA-SQ as Permanent Pharmacy Benefit*, [https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom\\_30339\\_31.aspx](https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30339_31.aspx) (last visited Nov. 8, 2022).
- <sup>66</sup> *Medi-Cal Telehealth Manual*, *supra* note 8, at 1.
- <sup>67</sup> CAL. WELF. & INST. CODE § 14124.12(f)(1)(B); see also Cal. Dep't Health Care Servs., *Telehealth Coverage Questions*, [www.dhcs.ca.gov/provgovpart/Pages/FAQ-Telehealth-Service.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/FAQ-Telehealth-Service.aspx) (last visited Nov. 8, 2022).

- <sup>68</sup> Cal. Dep't Health Care Servs., *supra* note 67
- <sup>69</sup> Virtual/telephonic communications services may be billed under HCPCS codes G2012 for “new” and “established patients. See Cal. Dep't Health Care Servs., *Medi-Cal Payment for Telehealth and Virtual/Telephonic Communications Relative to the 2019-Novel Coronavirus* (Jan. 5, 2021), [www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications.pdf](http://www.dhcs.ca.gov/Documents/COVID-19/Telehealth-Other-Virtual-Telephonic-Communications.pdf).
- <sup>70</sup> Cal. Dep't Health Care Servs., Telehealth Frequently Asked Questions, [www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/TelehealthFAQ.aspx) (last visited Nov. 8, 2022); see also *Post-PHE Telehealth Policy Proposal*, *supra* note 34, at 6.
- <sup>71</sup> *Post-PHE Telehealth Policy Proposal*, *supra* note 34, at 6.; see also AB 744.
- <sup>72</sup> AB 133; AB 744; SB 183; see also *Post-PHE Telehealth Policy Proposal*, *supra* note 34.
- <sup>73</sup> *Post-PHE Telehealth Policy Proposal*, *supra* note 34, at 6.
- <sup>74</sup> Cal. Dep't Health Care Servs., Telehealth Medi-Cal Special Programs, [www.dhcs.ca.gov/provgovpart/Pages/FAQ\\_Telehealth\\_Medi-Cal-Special-Programs.aspx](http://www.dhcs.ca.gov/provgovpart/Pages/FAQ_Telehealth_Medi-Cal-Special-Programs.aspx) (last visited Nov. 8, 2022).
- <sup>75</sup> *Id.*
- <sup>76</sup> AB 133.
- <sup>77</sup> SB 184.
- <sup>78</sup> *Id.* at (13).
- <sup>79</sup> *Id.* at (31).
- <sup>80</sup> *Id.* at (14).
- <sup>81</sup> *Id.* at (31).
- <sup>82</sup> See Telehealth, Assem. Bill 32 (2022); see also CAL. CIV. CODE § 56.05(n).
- <sup>83</sup> SB 184.
- <sup>84</sup> *Id.* at (12).
- <sup>85</sup> *Id.*