NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

2025-2026

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Foreword

The National Health Law Program (NHeLP) is pleased to present *An Advocate's Guide to Medi-Cal Services*. This Guide is intended to be a resource for health care and low-income advocates, legal aid attorneys, and other health care stakeholders in California to understand the Medi-Cal program and defend the health rights of low-income individuals in the State. The 2025-2026 update emphasizes policy changes implemented pursuant to the California Advancing and Innovating Medi-Cal (CalAIM) initiative, including new chapters on Care Coordination and Community Supports. In addition, some chapters have been updated to reflect the changing landscape of behavioral treatment, by incorporating a description of the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) program.

We hope that this publication will serve to improve your understanding of the benefits covered by Medi-Cal and the important role that Medi-Cal plays in improving the health and well-being of low-income individuals and families in California.

About NHeLP

Founded in 1969, NHeLP protects and defends the health rights of low-income and underserved individuals and communities 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

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Medicaid is the nation's largest public health coverage program, covering 83 million people including 14.3 million—or one in three—people in California.[1] 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, also known as Medi-Cal.[2]

While not discussed in this Manual, advocates should be aware of changes to the Medicaid program as a result of the so-called "One Big Beautiful Bill" Act ("OBBBA"), which negatively impacts eligibility and enrollment for Medicaid in myriad ways.[3]

Changes include, but are not limited to:

Effective October 1, 2026:

- OBBBA limits federal Medicaid funding to the following immigrant groups: lawful permanent residents (LPRs) or "green card holders" who have met or are exempt from the 5-year waiting period, certain Cuban and Haitian entrants, and citizens of Compact of Free Association (COFA) nations.[4]

Effective January 1, 2027:

- Individuals covered under the Medicaid expansion population or similar section 1115 waivers must participate in mandatory work activities unless they meet certain exemptions;[5]
- Instead of once a year, mandatory six-month renewals for Medicaid expansion enrollees will be required;[6]
- Retroactive coverage for Medicaid applications will be limited to two months for individuals in the non-MAGI Medicaid group and one month for individuals in the Medicaid expansion population.[7]

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.[8] 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 most of the regulations at Title 22 of the California Code of Regulations Section 50000 et seq. The California Department of Health Care Services (DHCS) is the state agency that administers the Medi-Cal program. DHCS provides policy guidance in the form of All County Welfare Directors Letters (ACWDLs), All Plan Letters (APLs) to Medi-Cal Managed Care Plans, Mental Health and Substance Use (MHSUDs) Information Notices to Mental Health Plans and SUD Programs, Provider Bulletins, and various manuals such as the Medi-Cal Provider Manual. The Medi-Cal program, as a governmental entitlement program, is also governed by California's constitutional protections and other state laws. Laws prohibiting discrimination also apply.

2. Structural Framework for Medicaid and Medi-Cal

Medicaid is a federal and state cooperative program. This means that both the federal government and the state government provide payment for the administration of the program and provision of services covered under the

state's Medicaid plan. The federal portion is called "federal financial participation" (FFP) and the rate at which it is paid, which varies state to state, is called the Federal Medical Assistance Percentage (FMAP).[9] Currently, California receives FMAP at the rate of 50 percent for most services covered under Medi-Cal.[10] 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.[11] 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.[12] States may also seek authority to waiver 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.[13]

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.[14] 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.[15] 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.[16]

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.[17] 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 IV 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.[18]

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.[19] 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.[20] 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:[21]

- 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.[22] In fee-for-service Medicaid, a beneficiary may obtain services from any health care provider who participates in the Medicaid program.[23] 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 approximately 5% of Medi-Cal beneficiaries remain in the non-managed care FFS Medi-Cal delivery system.[24]

Managed Care

Today, the majority of Medi-Cal beneficiaries (over 95%) receive services through some type of managed care arrangement.[25] 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.[26]

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 95% 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.[27] 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.[28]

In Medi-Cal, managed care is delivered using five different models in various counties.[29] 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 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 The Regional model, serves rural counties that have not elected to participate as a COHS or Two-Plan. In the Regional model, there are two commercial plans for each county.[30]

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 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.[31] Because COHS Medi-Cal plans are exempt from DMHC licensure, currently only one COHS, Health Plan of San Mateo, is Knox-Keene licensed.[32] Medi-Cal Managed Care Plans licensed under the Knox-Keene Act are also regulated by DMHC.

- *Network Adequacy*

As previously mentioned, Medi-Cal managed care plans are capitated—i.e., they receive a set payment per enrollee per month in exchange for providing services.[33] 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.[34]

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.[35]

Federal Medicaid regulations require states to develop and publish quantitative network adequacy standards, for certain types of providers.[36] 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.[37] 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.[38] 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.[39] 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*.[40]

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.[41] 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.[42] 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.[43] Individuals covered by their state Medicaid expansion program under the ACA (including California), are also included in this category.[44] 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);[45]
- Outpatient hospital services;[46]

- Physician services;[47]
- Rural health clinic services, including ambulatory services offered by a rural health clinic and otherwise included in the state's Medicaid plan;[48]
- Federally-qualified health center services;[49]
- Laboratory and X-ray services;[50]
- Nursing facility services (other than in an institution for people with mental health diagnoses) for individuals 21 or older;[51]
- EPSDT services for recipients under age 21;[52]
- Pregnancy-related services and services for conditions that might complicate pregnancy;[53]
- Family planning services and supplies;[54]

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;[55]
- Physical therapy and related services;[56]
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses;[57]
- Other diagnostic, screening, preventive, and rehabilitative services;[58]
- Dental services;[59] and
- Intermediate care facility services for the developmentally disabled (other than institutions for people with mental health diagnoses).[60]

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.[61] 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.[62] The state must also cover ambulatory services for children under age 18 and for individuals entitled to institutional services.[63] Individuals entitled to nursing facility services must also have access to home health services.[64]

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.[65] These services are described in detail in subsequent chapters of this Guide.

Limited Scope Services for Immigrant Adults

In addition to the changes required by OBBBA, there are California specific changes to coverage for immigrants.[66] Despite this, certain immigrants are exempt from those changes. They include:

- Children up to their 19th birthday;
- Current foster youth, former foster youth up to their 26th birthday, and nonminor dependents; and
- Pregnant people, including 12 months after the pregnancy ends.[67]

In terms of California specific changes, beginning January 1, 2026, the state will impose a freeze on expansion populations of applicants 19 years and older who are who are undocumented and are not claiming to fit within a Medi-Cal eligibility category. This means these new applicants will no longer qualify for full scope Medi-Cal. Current Medi-Cal enrollees with the same status who enrolled prior to January 1, 2026 can remain enrolled with almost all Medi-Cal benefits with the exception of non-emergency dental care services (now called "full scope Medi-Cal with no dental").[68] Those current enrollees who continue their coverage after January 1st will shift to the "full scope Medi-Cal with no dental" category subject to additional requirements.[69]

OBBBA further restricts immigrant access to Medicaid by eliminating federal funding for many immigrants.[70] Starting on October 1, 2026, full scope federally funded Medi-Cal will only be available to: U.S. citizens, lawful permanent residents (LPR), Cuban and Haitian Entrants, individuals present under a Compact of Free Association (COFA), as well as pregnant individuals and children if the state chooses.[71]

Adults seeking to enroll in full-scope Medi-Cal must meet California's Medi-Cal eligibility requirements.[72] 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:

- Hospital Presumptive Eligibility;[73]
- Pregnancy Presumptive Eligibility;[74]
- Breast & Cervical Cancer Treatment Program (BCCTP);[75]
- Prostate Cancer Treatment Program (IMPACT);[76]
- Family Planning, Access, Care & Treatment Program (FPACT);[77]
- Medi-Cal's 213% FPL Pregnancy Program;[78]
- Medi-Cal Access Program (MCAP);[79]
- County safety-net programs;[80]
- Emergency room screening & care;[81]
- Hospital financial assistance (charity care);[82]
- Kaiser Permanente's Community Health Coverage Program.[83]

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.[84] 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.[85] These standards must be consistent with the objectives of the Medicaid Act.[86] 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."[87] 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."[88] 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.[89] 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.[90] Some exceptions exist; for example, children are entitled to receive additional services.[91] 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.[92] 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.[93]

Reasonable Promptness

The Medicaid Act requires that state "medical assistance . . . be furnished with reasonable promptness to all eligible individuals."[94] 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."[95] 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.[96] 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. If a state fails to determine Medicaid eligibility with reasonable promptness, beneficiaries can appeal.[97] See below 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."[98] The state Medicaid plan must be continuously in operation throughout the state.[99] 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.[100] 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.[101]

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.[102] 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).[103] 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.[104] 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.[105] 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.[106] 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.[107] 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.[108] Through Executive Order 13166, Title VI applies to federal agencies themselves.[109]

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.[110] The regulations implementing Section 1557 outline requirements for notifying clients/patients of language services, providing oral interpreting and including taglines on significant written documents.[111] 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.[112] 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.[113]

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.[114]

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.[115]

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."[116] 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.[117] 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.[118]

In addition to the federal requirements, Medi-Cal participating providers and Medi-Cal managed plans must also comply with state requirements.[119] For those who receive their health care through managed care plans, there are added requirements to ensure access to language assistance services.[120] 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.[121]

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 individual 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.[122]

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*.[123] 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.[124]

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.[125] 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.[126] Applicants and beneficiaries are also entitled to cross-examine witnesses, have access to their case file, and to present a case without interference.

Federal regulations on managed care provide additional protections for Medicaid enrollees. 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.[127] The regulations provide specifics as to the requirements for notice of an adverse benefit determination.[128] They also specify procedures for the opportunity for a hearing if a state agency or plan makes an adverse benefit determination.[129] California has specific state laws, regulations and guidance that govern managed care plans obligations concerning notice and appeal rights involving benefit determinations.[130]

4. Utilization Controls, Prior Authorization, Limits to Services

The Medicaid Act allows states to impose utilization controls on the delivery of services.[131] 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.[133] 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.[133] Medicaid managed care plans may adopt their own utilization controls, subject to certain limitations. 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.[135] DHCS does place some limits of Medi-Cal plans authorization of services.[136]

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.

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.[137] 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.[138] DHCS began implementation of CalAIM in January 2022, with various programs being phased in through 2027. CMS approved most of these requests in December 2021 pursuant to Section 1115 and Section 1915(b) authority.[139]

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

Endnotes

[1] Drew Altman, Kaiser Fam. Found., T*he Mystery of How Many People Are on Medicaid* (June 2025),https://www.kff.org/from-drew-altman/the-mystery-of-how-many-people-are-on-medicaid/; Cal. Dep't Health Care Servs, Medi-Cal Enrollment and Renewals Dashboard, December 2025, https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/Medi-Cal-Enrollment-and-Renewals-Dashboard-December2025.aspx.

[2] This manual does not address eligibility for Medicaid. In depth coverage of eligibility is addressed in NHeLP's Advocates Guide to the Medicaid Program. *See* Amanda Avery, Arielle Linsey, Catherine McKee, Jane Perkins, and Sarah Somers, Nat'l Health Law Prog., *The Advocate's Guide to the Medicaid Program – 5th Edition* (Dec. 17, 2024), https://healthlaw.org/resource/the-advocates-guide-to-the-medicaid-program-5th-edition/ [hereinafter *The Advocate's Guide to the Medicaid Program – 5th Edition*]. *See also* 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.

[3] Pub. L. No. 119-21, 139 Stat. 72 (2025) ["OBBBA"]. More information about the changes to Medicaid as a result of OBBBA can be found at the National Health Law Program's website, https://healthlaw.org/prepare/ (national focus) and https://healthlaw.org/protect-california-health-care/ (California focus).

[4] OBBBA § 71109.

[5] 42 U.S.C. §1396a(xx)(2).

[6] 42 U.S.C. §1396a(e)(14)(L).

[7] 42 U.S.C. §1396a(a)(34), 1396d(a)).

[8] *See generally* CMS, *State Medicaid Manual*, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927 (last visited Feb. 17, 2026) [hereinafter *State Medicaid Manual*].

[9] *See* 42 U.S.C. § 1301(a)(8).

[10] Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2025, Through September 30, 2026, 89 Fed. Reg. 94742, 94744 (Nov. 29, 2024), https://www.govinfo.gov/content/pkg/FR-2024-11-29/pdf/2024-27910.pdf. Some Medi-Cal services are eligible for an enhanced FMAP.

[11] 42 C.F.R. § 430.10; *see also generally* 42 U.S.C. § 1396a.

[12] 42 C.F.R. § 430.12(c).

[13] *See* 42 U.S.C. § 1396c; 42 C.F.R. §§ 430.15, 430.35.

[14] 42 U.S.C. §1396a(a)(5) 42 C.F.R. § 431.10.

[15] For more information on consumer protections in Medicaid, see Kim Lewis, Wayne Turner, & Skyler Rosellini, Nat'l Health Law Prog. *What Makes Medicaid, Medicaid? – Consumer Protections and Due Process* (2023), https://healthlaw.org/resource/what-makes-medicaid-medicaid-consumer-protections-and-due-process/.

[16] Cal. Dep't Health Care Servs, Medi-Cal Waivers, https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx (last visited Feb. 17, 2026).

[17] *See 42* U.S.C. § 1396n(b).

[18] *See* 42 U.S.C. §§ 1396n(c), 1396a(a)(10)(A)(ii)(VI), 1396n(b)–(e).

[19] 42 U.S.C. § § 1315(a).

[20] 42 U.S.C. § 1396.

[21] 42 U.S.C. § 1315(a).

[22] 42 U.S.C. § 1396a(a)(25)(C); 42 C.F.R. §§ 447.15, 447.20.

[23] 42 U.S.C. § 1396a(a)(23); 42 C.F.R. § 431.51.

[24] Cal. Dep't Health Care Servs., *Medi-Cal Monthly Eligible Fast Facts January 2026 (Date Represented: October 2025)*, https://www.dhcs.ca.gov/dataandstats/reports/Documents/Fast-Facts.pdf [hereinafter *Medi-Cal Monthly Eligible Fast Facts*].

[25] *Id.* Almost 14 million beneficiaries receive care from a managed care plan as of October 2025. 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/.

[26] Kim Lewis, Wayne Turner, & Skyler Rosellini, *supra* note 15.

[27] *Medi-Cal Monthly Eligible Fast Facts, supra* note 24, at 10 (managed care enrollment at 95.2% as of October 2025).

[28] *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; Cal. Dep't Health Care Servs., Statewide Medi-Cal Managed Care Enrollment for Dual Eligible Beneficiaries in 2023, https://www.dhcs.ca.gov/services/Pages/Statewide-Medi-Cal-Managed-Care-Enrollment-for-Dual-Eligible-Beneficiaries.aspx (last visited Feb. 17, 2026).

[29] 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* (2024), https://www.dhcs.ca.gov/services/Documents/MMCD/MMCD-Model-Fact-Sheet.pdf.

[30] For more information, 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 Feb. 17, 2026). https://www.dhcs.ca.gov/services/Documents/MMCD-Cnty-Map.pdf.

[31] *See generally* Cal. Health & Safety Code §§ 1340–1399.818.

[32] Cal. Welf. & Inst. Code § 14087.95; *see also*, e.g., Gil Rojas, Cal. Dep't Managed Health Care, *Financial Summary of Local Initiative of Medi-Cal Managed Care Plans: Quarter Ending June 30, 2023* at 12 (2023), https://www.dmhc.ca.gov/Portals/0/Docs/DO/FSSBNov2023/AgendaItem6.FinancialSummaryofMedi-CalManagedCareHealthPlansReport.pdf.

[33] In Medi-Cal, the capitation rate is paid by the state to the plans directly. Cal. Dep't Health Care Servs., Medi-Cal Managed Care Financial Reports, https://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDFinancialReports.aspx (last visited Feb. 17, 2026). 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* Cal. Dep't Health Care Servs., *External Quality Review Technical Report* 17 (2019), https://www.dhcs.ca.gov/dataandstats/reports/Documents/CA2017-18_EQR_Technical_Report_F1.pdf.

[34] *See* 42 C.F.R. § 438.2 (defining "comprehensive risk contract" and "capitation payment" for Medi-Cal plans).

[35] 42 U.S.C. § 1396u-2(b)(5).

[36] 42 C.F.R. § 438.68.

[37] *Id.* § 438.207(a).

[38] *Id.* § 438.207(d).

[39] Cal. Welf. & Inst. Code § 14197.

[40] *See generally* Coursolle, *supra* note 25.

[41] *An Advocate's Guide to the Medicaid Program – 5th Edition, supra* note 2 (providing additional information about mandatory and optional Medicaid covered services, including citations to the Act and the Code of Federal Regulations).

[42] 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.

[43] For a comprehensive list of groups covered under the mandatory categorically needy, see *The Advocate's Guide to the Medicaid Program – 5th Edition, supra* note 2.

[44] 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.

[45] 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).

[46] 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 8, at § 4221 (discussing outpatient psychiatric services as outpatient hospital or clinic service).

[47] 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.

[48] 42 U.S.C. §§ 1396d(a)(2)(B), 1396d(l)(1); 42 C.F.R. § 440.20(b), (c).

[49] 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 8, at §§ 4231, 6303.

[50] 42 U.S.C. § 1396d(a)(3); 42 C.F.R. § 440.30.

[51] 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).

[52] 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). Mandatory EPSDT services include pre-release screening, including behavioral screening and case management for children and youth. 42 U.S.C. § 1396a(a)(84).

[53] 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 8, at §§ 3311.2, 3571.2, 4421.

[54] 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R § 441.20; *see State Medicaid Manual, supra* note 8, 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].

[55] 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 8, at § 4221 (discussing outpatient psychiatric services as clinic or outpatient hospital service); *Id.* § 4320.

[56] 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).

[57] 42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.120.

[58] 42 U.S.C. § 1396d(a)(13); 42 C.F.R. § 440.130; *State Medicaid Manual, supra* note 8, at § 4385 (preventive services).

[59] 42 U.S.C. § 1396d(a)(10); 42 C.F.R. § 440.100.

[60] 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 8, at §§ 4395–4397, 4398 (discussing persons with related conditions and regulatory history of including individuals with developmental disabilities).

[61] 42 U.S.C. §§ 1396a(a)(10)(C)(iii); 42 C.F.R. § 440.220(a)(1).

[62] 42 C.F.R. § 440.220(a)(5).

[63] 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).

[64] 42 U.S.C. § 1396a(a)(10)(D); 42 C.F.R. § 440.220(a)(3) (designating home health services as a required service).

[65] *See* Cal. Welf. & Inst. Code § 14132.

[66] Skyler Rosellini, Nat'l Health Law Prog, *Medi-Cal Changes Under OBBBA and CA Budget: Immigrant Eligibility & Benefits* (2025), https://healthlaw.org/wp-content/uploads/2025/09/2025.09.02-Medi-Cal-OBBBA-changes-Immigrant-Health-fact-sheet-FINAL.pdf.

[67] 42 U.S.C. § 1396b(v)(3); 42 C.F.R. §§ 440.225, 435.926; Cal. Welf. & Inst. Code §§ 14005.25, 14007.2, 14007.5(d), 14007.8; *see* Cal. Welf. & Inst. Code §§ 15800 et seq. (Medi-Cal Access Program for pregnant individuals with income over 213% to 322% FPL); *see also* Cal. Dep't Health Care Servs., All County Welfare Directors Letter No. 22-23, American Rescue Plan Act Postpartum Care Extension (Oct. 17, 2022), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/22-23.pdf, Cal. Dep't Health Care Servs., All County Welfare Directors Letter No. 14-05, Continuous Eligibility For Children (CEC) (Feb. 20, 2014), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c14-05.pdf, Cal. Dep't Health Care Servs., All County Welfare Directors Letter No. 24-03, CEC Accelerated Enrollment (Feb. 16, 2024), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/24-03.pdf.

[68] Cal. Welf. & Inst. Code §§ 14007.8; 14007.5.

[69] Cal. Welf. & Inst. Code § 14007.8(c)(3); Cal. Dep't Health Care Servs., All County Welfare Directors Letter No. 25-13, Medi-Cal Expansion Freeze For Adults 19 and Older Without Satisfactory Immigration Status (June 30, 2025), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/25-13.pdf.

[70] OBBBA; *see also* Cal. Dep't Health Care Servs., Medi-Cal Eligibility Div. Info. Letter No. I 25-18, Medi-Cal Impacts From House Resolution 1 at 3 (Aug. 7, 2025), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I25-18.pdf.

[71] OBBBA at § 71109.

[72] For information about who is covered, see Cal. Dep't Health Care Servs., Immigration Status and Changes to Medi-Cal Eligibility, https://www.dhcs.ca.gov/Medi-Cal/Pages/immigration-status-categories.aspx (last visited Feb. 17, 2026).

[73] Cal. Dep't Health Care Servs., Hospital Presumptive Eligibility Program, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/HospitalPE.aspx (last visited Feb. 17, 2026). (Includes full scope Medi-Cal services).

[74] Cal. Dep't Health Care Servs., Presumptive Eligibility for Pregnant People, https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE.aspx (last visited Feb. 17, 2026).

[75] Cal. Dep't Health Care Servs., Breast and Cervical Cancer Treatment Program, https://www.dhcs.ca.gov/services/medi-cal/Pages/BCCTP.aspx (last visited Feb. 17, 2026). (Includes full scope Medi-Cal services).

[76] Cal. Dep't Health Care Servs., Prostate Cancer Treatment Program (IMPACT), https://www.dhcs.ca.gov/services/cancer/PCTP (last visited Feb. 17, 2026).

[77] Family Planning, Access, Care & Treatment Program (FPACT), https://familypact.org/ (last visited Feb. 17, 2026).

[78] Cal. Dep't Health Care Servs., Full Scope Medi-Cal Coverage and Affordability and Benefit Program for Low-Income Pregnant Women and Newly Qualified Immigrants, https://www.dhcs.ca.gov/services/medi-cal/Pages/Affordability-and-Benefit-Program.aspx (last visited Feb. 17, 2026). (Includes full scope Medi-Cal services).

[79] Cal. Dep't Health Care Servs., Medi-Cal Access Program (MCAP), https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/Medi-CalAccessProgram.aspx (last visited Feb. 17, 2026) (includes full scope Medi-Cal services).

[80] Health Access California, County Health Care Access for Uninsured Californians, https://health-access.org/county-health-care-access-for-uninsured-californians/ (last visited Feb. 17, 2026). Note, not all counties cover immigrants without documentation.

[81] Centers for Medicare & Medicaid Services, You have rights in an emergency room under EMTALA, https://www.cms.gov/priorities/your-patient-rights/emergency-room-rights, (last visited Feb. 17, 2026).

[82] Health Consumer Alliance, *Hospital Debt FAQ* (2025), https://healthconsumer.org/wp/wp-content/uploads/2025/08/Hospital-Debt-FAQ-1.pdf. Note, not all hospitals provide financial assistance to immigrants without documentation.

[83] Kaiser Permanente, Community Health Coverage Program, https://charitablehealth.kaiserpermanente.org/california/eligibility/ (last visited Feb. 17, 2026).

[84] *See* 42 U.S.C. § 1396a(a)(10) (including text following subsection (G) of a(a)(10)).

[85] 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.").

[86] 42 U.S.C. § 1396a(a)(17).

[87] 42 C.F.R. § 440.230(b); *see* 42 U.S.C. § 1396a(a)(10)(B).

[88] 42 C.F.R. § 440.230(c); *see* 42 U.S.C. § 1396a(a)(10)(B).

[89] 42 U.S.C. § 1396a(a)(10)(B)(ii).

[90] *Id.* § 1396a(a)(10)(B)(i).

[91] *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).

[92] *See* 42 U.S.C. §§ 1396n(c), 1396a(a)(10)(A)(ii)(VI), 1396n(b)–(e).

[93] 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).

[94] 42 U.S.C. § 1396a(a)(8).

[95] 42 C.F.R. § 435.930(a).

[96] *Id.* §§ 435.912, 435.930.

[97] Advocates should be aware that courts are increasingly finding the Reasonable Promptness provision of the Medicaid Act not to be privately enforceable.

[98] 42 U.S.C. §1396a(a)(1); *see also* 42 CFR § 431.50.

[99] 42 CFR § 431.50(b)(3).

[100] *Id.* § 431.50(c).

[101] *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.

[102] 42 U.S.C. § 1396a(23); 42 CFR § 431.51.

[103] *Id.* § 1396u-2(a)(1).

[104] *Id.* § 1396a(23); 42 C.F.R. § 431.51(a)(3).

[105] CMS, Dear State Medicaid Director Letter 2 (Apr. 19, 2016) (SMD # 16-005), https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf.

[106] *Id.*

[107] *Id.*

[108] 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, https://www.hhs.gov/civil-rights/for-providers/laws-regulations-guidance/guidance-federal-financial-assistance-title-vi/index.html. 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* (2013), http://healthlaw.org/resource/federal-laws-and-policies-to-ensure-access-to-health-care-services-for-people-w.

[109] *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*. Note that a March 2025 executive order sets English as the official language of the U.S. and revokes Executive Order 13166. Despite this, language access remains the law. *See* Mara Youdelman, Nat'l Health Law Prog., *Despite new Executive Order, Language Access Is Still the Law!* (Mar. 3, 2025), https://healthlaw.org/despite-new-executive-order-language-access-is-still-the-law/.

[110] 42 U.S.C. § 18116.

[111] *See* 45 C.F.R. §§ 92.8(f)(1), 92.201.

[112] 42 U.S.C. § 291c(e); *see also* 42 C.F.R. § 124.603(a)(1).

[113] *See* U.S. Dep't Health & Hum. Servs., *Know Your Rights Under the Community Service Assurance Provisions of the Hill-Burton Act* 1 (1990), https://www.hhs.gov/sites/default/files/knowyourrightshillburtonfactsheet.pdf.

[114] *See* 42 U.S.C. § 1395dd; *see also* 42 C.F.R. § 489.24.

[115] *See* 28 C.F.R. § 35.160

[116] 42 C.F.R. § 435.905(b).

[117] 42 U.S.C. § 1396u-2(a)(5)(A).

[118] *See* 42 C.F.R. § 483.10(g) (residents of long-term care facilities); 42 U.S.C. § 1396a(a)(43)(A) (ESPDT).

[119] As of September 2019, 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/. *See also* Cal. Dep't Health Care Servs., Non-Discrimination Policy and Language Access, https://www.dhcs.ca.gov/Pages/Language_Access.aspx (last visited Feb. 17, 2026).

[120] *See generally* Cal. Dep't Health Care Servs., All Plan Letter 17-011 (June 30, 2017), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-011.pdf.

[121] *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.

[122] *See* U.S. Const. amend. XIV, § 1.

[123] *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).

[124] 42 C.F.R. §§ 431.206, 431.210.

[125] *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).

[126] *Goldberg,* 397 U.S. at 267; *see also* 42 C.F.R. § 431.230.

[127] *Id.* §§ 438.228, 438.400-24. These provisions have been implemented in state law at Cal. Welf. & Inst. Code § 14197.3; *see also* Cal. Dep't Health Care Servs., All Plan Letter 17-006 at 2 (May 9, 2017), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf [hereinafter All Plan Letter 17-006]; Cal. Dep't Health Care Servs., Mental Health and Substance Use Disorder Services Information Notice No. 18-010E at 5 (Mar. 27, 2018), 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].

[128] 42 C.F.R. § 438.404.

[129] 42 C.F.R. §§ 438.402(c), 431.220, 431.244.

[130] Cal. Welf. & Inst. Code § 14197.3; All Plan Letter 17-006, *supra* note 127; Mental Health and Substance Use Disorder Services Information Notice No. 18-010E, *supra* note 127.

[131] 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 440.230(d); *id.* §§ 456.1–456.6.

[132] 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).

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

[134] 42 C.F.R. § 438.210(a)(4).

[135] 42 C.F.R. § 438.210(a)(4)(ii)(C); *see also* SHO # 16-008, *supra* note 54. 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.

[136] *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.

[137] 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 Feb. 17, 2026). *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.

[138] These initiatives have been authorized in California law and are outlined at Cal. Welf. & Inst. Code §§ 14184.100–.800.

[139] 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 Feb. 17, 2026).

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated April 2026

Chapter II: Preventive Services

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Outline of Medi-Cal Preventive Services*
A. EPSDT Preventive Services B. Vaccines 1. Vaccines for Children Program 2. Vaccines for Adults 3. Other Vaccines Pursuant to AB 144 C. United States Preventive Services Task Force-Recommended Services D. Health Resources and Services Administration-Recommended Preventive Services for Women E. Expedited Partner Therapy for the Prevention of STI Reinfections F. Asthma Preventive Services (APS) G. Diabetes Prevention Program (DPP) H. Certified Wellness Coach Program

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

Medi-Cal covers a wide array of preventive services. Some of these services are covered, without cost-sharing, pursuant to federal requirements, while others are covered under the State's authority to cover optional benefits in the Medicaid program.

Under the Affordable Care Act (ACA), states are required to ensure that all individuals eligible for Medicaid as part of the Medicaid expansion (covered under a Medicaid Alternative Benefit Plan (ABP)) get access to preventive and wellness services as part of the requirement to cover essential health benefits (EHBs).[1] Using the authority to define EHBs, the Secretary of HHS has interpreted this EHB requirement to incorporate the ACA's coverage mandate for preventive services, which applies to non-grandfathered private plans.[2] In turn, this mandate requires coverage, without cost-sharing, of all of the following:[3]

- Services recommended by the United States Preventive Services Task Force (USPSTF) with an "A" or "B" rating;
- Immunizations approved by the Centers for Disease Control and Prevention (CDC) recommended by the Advisory Committee on Immunization Practices (ACIP), and their administration;

- Preventive care and screening for infants, children, and adolescents in guidelines supported by the Health Resources and Services Administration (HRSA);
- Additional preventive care and screenings for women as provided in guidelines supported by HRSA.

The Medicaid Act also makes these and other preventive services available to other Medicaid populations under the category of "other diagnostic, screening, preventive, and rehabilitative services" and, in the case of the cost of vaccine products, under the prescription drug category.[4] Coverage of these preventive services outside of the Medicaid expansion is optional for states, except for immunizations for minors under the Vaccines for Children (VFC) Program, other preventive services for Medicaid beneficiaries under 21 pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandatory benefit, and coverage of ACIP-recommended vaccines for adults and their administration, which became a requirement without cost-sharing after the enactment of the Inflation Reduction Act of 2022.[5]

In California, services for the Medicaid expansion population have been aligned with benefits covered for the rest of Medicaid beneficiaries. In the case of preventive services, the State has opted to cover, in addition to ACIP-recommended vaccines and their administration: A or B services recommended by the USPSTF; preventive care and screening for infants, children, and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women as recommended by the Institute of Medicine (IOM).[6] Medi-Cal also covers preventive services that target specific conditions, such as sexually transmitted conditions, asthma, and diabetes.[7]

EPSDT Preventive Services

As part of the EPSDT mandatory benefit, Medi-Cal covers specific preventive services for beneficiaries under 21. These services include periodic screening assessments for infants, children, and adolescents, as specified in the American Academy of Pediatrics (AAP) Bright Futures preventive health care periodicity schedule.[8] Screenings include comprehensive preventive visits for children that are age and gender appropriate and extend to physical examination, counseling, developmental surveillance, risk factor reduction interventions, and ordering of laboratory or diagnostic testing when indicated. Aside from assessments at regular intervals, Medi-Cal also covers inter-periodic assessments when medically necessary.

The following is a list of covered screening and services for individuals under 21 in Medi-Cal:[9]

- Physical Examination: Performed annually from newborn to 21 years of age.
- Sensory Screening: Vision and hearing screenings and risk assessments performed on a periodic basis from newborn to 21 years of age.

- Developmental Screening: Performed at 9, 18, and 30 months and when medically indicated. Screening services are limited to twice a year for children ages 0 to 5 and must be performed using a validated screening tool that tests for all four developmental domains (motor, language, cognitive, and social/emotional).
- Autism Spectrum Disorder Screening: Performed at 18 and 24 months and when medically indicated. A validated screening tool must be used and screening does not count towards the twice-a-year limit for general screenings.
- Developmental Surveillance: Performed at every preventive visit.
- Psychosocial/Behavioral Assessment: Reimbursable when performed using a standardized tool and performed from newborn to age 21.
- Tobacco, Alcohol, or Drug Use Assessment: Performed annually beginning at age 12.
- Newborn Testing: Blood, bilirubin, and critical congenital health defect testing performed on newborns only, with blood testing being repeated between 3 and 5 days after birth.
- Anemia Testing: Performed at 12 months of age with additional risk assessment performed after that. A preliminary risk assessment performed at 4 months of age is also reimbursable.
- Blood Lead Testing: Federal EPSDT policy and California regulations require that all children enrolled in Medi-Cal be subject to blood lead testing at 12 and 24 months (under California regulations, children in Medi-Cal are presumed to be at risk of lead poisoning).[10] Additionally, under the Bright Futures schedule, a risk assessment should be performed at ages 6, 9, and 18 months followed by risk assessments at ages 3 to 6 years.
- Tuberculosis Testing: Risk assessment performed within the first month after birth and thereafter at 6 months, 9 months, 12 months, 24 months, and annually after age 3.
- Dyslipidemia Testing: Risk assessment performed at 2, 4, 6, and 8 years, followed by testing between ages 9 and 11. After that, risk assessment should be performed annually between ages 12 and 16, followed by testing at any point between ages 17 and 21.
- Testing for Sexually Transmitted Conditions: Risk assessment performed annually between ages 11 and 21.
- Human Immunodeficiency Virus (HIV) Testing: Risk assessment performed annually between ages 11 and 14, followed by testing as needed between ages 15 and 21.
- Hepatitis B Virus Testing: Risk assessment as needed between newborn and age 21.
- Hepatitis C Virus Testing: Testing as needed between ages 18 and 21.
- Sudden Cardiac Arrest Screening: Risk assessment as needed between ages 11 and 21.
- Cervical Dysplasia: Testing at age 21.
- Fluoride Varnish: Provided at any point between 6 months and 5 years.

- Fluoride Supplementation: Risk assessment for need at 6, 9, 12, 18, 24, 30 months and at ages 3 to 16.
- Dyadic Services: Dyadic Behavioral health (DBH) services are reimbursable when taking place during well-child-visits.
- Obesity Screening: Clinicians should screen for obesity in children and adolescents 6 years and older and should offer them comprehensive, intensive behavior intervention to promote improvement in weight status.

Immunizations Pursuant to Bright Futures/AAP Periodicity Schedule

In addition to all vaccines recommended by ACIP that are covered under the VFC program (discussed below), EPSDT requires coverage of all vaccines included in the Bright Futures/AAP Periodicity Schedule for individuals up to age 21.[11] Vaccines in the Bright Futures/AAP Periodicity Schedule currently essentially mirror those recommended by ACIP. However, VCF only covers vaccines for individuals under age 19. Therefore, individuals aged 19 or 20 can access vaccines that are not recommended for adults under EPSDT as long as those vaccines are included in the Bright Futures/AAP Periodicity Schedule.

Vaccines

The funding source and mechanism of Medi-Cal coverage of vaccines varies depending on the age of the beneficiary. For children and adolescents up to age 18, most vaccines and their administration are covered through the VCF program, which is administered by the federal government. For adults, the cost of most vaccines is covered by states with federal financial participation (FFP), similar to most other Medi-Cal benefits. Except for the COVID-19 vaccine, which has been carved out of Managed Care Plan (MCP) contracts, MCPs are responsible for ensuring timely access to all FDA-approved immunizations for enrollees of all ages and are required to cover vaccines and their administration.[12] However, vaccines may be administered by pharmacists to individuals aged 3 and older and billed as a pharmacy benefit to the Medi-Cal Rx program.[13]

While they differ in their payment mechanisms on the front end, in practice, the same coverage standard applies to Medi-Cal beneficiaries of all ages: under federal law, they can access without cost-sharing and without prior authorization all vaccines recommended by ACIP (and approved by the CDC). As explained in more detail below, recently enacted state law extends coverage to vaccines recommended by other professional organizations and the California Department of Public Health (CDPH).

Vaccines for Children Program

The VFC program is a federally administered and mandated program that supplies vaccines at no cost to providers treating Medi-Cal beneficiaries (and other uninsured and underinsured individuals) from birth to age 18. The federal government, through the CDC, purchases vaccines from manufacturers and

distributes them to state public health agencies, which then distribute the vaccines to local providers. In California, the agency charged with administering and distributing the vaccines is CDPH.[14] To be eligible to receive coverage for a vaccine through the VFC program, beneficiaries must be under the age of 19 and seeking immunization with one of the vaccines recommended by ACIP and approved by the CDC for individuals under 19.[15]

Specifically, vaccines available under the VFC include:[16]

- COVID-19
- Dengue
- Diphtheria, Tetanus and Pertussis
- *Haemophilus influenza type b*
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Influenza
- Meningococcal
- Mpox
- Measles, mumps, and rubella (MMR)
- Varicella
- Mumps
- Outbreak controls
- Pneumococcal
- Polio
- Rotavirus
- Respiratory syncytial Virus (RSV)

The VFC program will cover these vaccines when administered pursuant to the schedule recommended by ACIP and approved by the CDC. In addition to reimbursing providers for the cost of administering these vaccines, the VFC program may reimburse providers for the cost of a vaccine product purchased from a non-VFC source only when there is valid justification.[17] Valid justification includes documented cases of a VFC vaccine supply shortage due to a disease epidemic, vaccine manufacturing or delivery problems, or instances when the beneficiary does not meet special circumstances required by the VFC program for the vaccine billed.

Vaccines for Adults as Recommended by ACIP

For beneficiaries over 18, Medi-Cal covers all vaccines that have been recommended by ACIP and approved by the CDC.[18] ACIP-recommended vaccines for adults include:

- Hepatitis A
- Hepatitis A-Hepatitis B
- Hepatitis B
- Haemophilus influenzae type b conjugate

- Human papillomavirus
- Herpes zoster
- Influenza
- Meningococcal conjugate A, C, Y, W-135 quadrivalent
- Meningococcal serogroup B
- Measles, mumps, and rubella (MMR)
- Meningococcal polysaccharide A, C, Y, W-135 quadrivalent
- Pneumococcal conjugate 13-valent
- Pneumococcal polysaccharide 23-valent
- Tetanus and diphtheria toxoids
- Tetanus and diphtheria toxoids and acellular pertussis
- Varicella

When provided on a separate date from the date of the vaccine administration, Medi-Cal also covers immunization counseling related to these vaccines.[19]

ADVOCACY TIP:

✓ The CDC has adopted three major changes in recommendations from ACIP: COVID-19, hepatitis B, and the measles, mumps, rubella, and varicella (MMRV) vaccine for children under 4 (the MMRV vaccine changes are discussed below). The changes to the recommendations regarding the COVID-19 and hepatitis B vaccines have little bearing on coverage of those vaccines for both children and adults because the recommendations maintain access to the vaccines based on shared clinical decision-making. For purposes of Medi-Cal coverage under the VFC program and under the mandatory coverage of vaccines for adults, shared decision-making is considered part of the ACIP recommendation, triggering mandatory coverage.

Vaccine Coverage Under California Law (AB 144)

Pursuant to a state law enacted in 2025, AB 144, Medi-Cal will now also cover vaccines that are recommended for both children and adults by the AAP, the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Family Physicians, (AAFP) or through "any modification or supplement to a recommendation adopted by the [CDPH]" regardless of whether the vaccine has also been recommended by ACIP and approved by the CDC.[20] For coverage in Medi-Cal MCPs, California also maintains coverage for vaccines that were recommended by ACIP and approved by the CDC as of January 2025.[21] That is, even if ACIP removes a previous recommendation, California law would still require Medi-Cal MCPs to cover such vaccine if ACIP recommended the vaccine as of January 2025.

AB 144 is part of California's efforts to counter actions taken by the CDC and ACIP that may limit currently available vaccines in the future. So far, the AB 144 vaccine coverage requirement has only been applied to the combined measles, mumps, rubella, and varicella (MMRV) vaccine in children under 4. In 2025, ACIP changed its recommendation for children under 4 to receive a combined

MMRV vaccine. Instead, ACIP now recommends that children receive a first dose of the MMR vaccine and, separately, a first dose of the varicella vaccine between 12 and 15 months.[22] Pursuant to the ACIP recommendations (subsequently adopted by the CDC), the combined MMRV vaccine remains an option for the second dose after age 4. In finalizing this new recommendation, ACIP also voted to exclude the combined MRV vaccine for children under 4 from coverage under the VFC program. Importantly, the AAP continues to recommend the combined MMRV vaccine for children under age 4. For that reason, the Department of Health Care Services (DHCS) has clarified that the combined MMRV vaccine remains available as part of the Medi-Cal Rx program pursuant to the requirements of AB 144.[23]

USPSTF A and B Recommendations

Medi-Cal covers all preventive services that have an "A" or "B" rating from the USPSTF for all eligibility categories and without cost-sharing. The populations eligible to receive such services depend on the specific recommendations from the USPSTF.

ADVOCACY TIP:

✓ Medi-Cal coverage without cost-sharing of USPSTF recommendations is limited to the specific situations covered under the description for each A- or B-rated service. Advocates should closely monitor the specific language for each service to determine the level and scope of coverage. When new products become available, they may not automatically be incorporated into the recommendations and, absent updates from USPSTF, coverage is not automatically triggered and may require separate action from Medi-Cal.

For example, in late 2024, the FDA approved the medication Yeztugo as preexposure prophylaxis for the prevention of HIV. Despite the fact that the USPSTF recommends Preexposure Prophylaxis for adolescents and adults at increased risk of HIV, the language of the recommendation is specific to the medications that were previously approved by the FDA. That is, newly approved medications do not automatically fit into the USPSTF recommendation. In the case of Yeztugo, the medication is covered by Medi-Cal as part of the program's prescription drug coverage under Medi-Cal Rx.

The following list includes all the preventive services that have an A or B rating from USPSTF as of April 2026:[24]

- Abdominal Aortic Aneurysm: Screening: men aged 65 to 75 years who have ever smoked
- Anxiety Disorders in Adults: Screening: adults 64 years or younger, including pregnant and postpartum persons
- Anxiety in Children and Adolescents: Screening: children and adolescents aged 8 to 18 years
- Aspirin Use to Prevent Preeclampsia and Related Morbidity and Mortality: Preventive Medication: pregnant persons at high risk for preeclampsia
- Asymptomatic Bacteriuria in Adults: Screening: pregnant persons
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer or an ancestry associated with brca1/2 gene mutation
- Breast Cancer: Medication Use to Reduce Risk: women at increased risk for breast cancer aged 35 years or older
- Breast Cancer: Screening: women aged 40 to 74 years
- Breastfeeding: Primary Care Behavioral Counseling Interventions: pregnant and postpartum women
- Cervical Cancer: Screening: women aged 21 to 65 years
- Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons
- Chlamydia and Gonorrhea: Screening: sexually active women, including pregnant persons
- Colorectal Cancer: Screening: adults aged 45 to 49 years
- Colorectal Cancer: Screening: adults aged 50 to 75 years
- Depression and Suicide Risk in Adults: Screening: adults, including pregnant and postpartum persons, and older adults (65 years or older)
- Depression and Suicide Risk in Children and Adolescents: Screening: adolescents aged 12 to 18 years
- Falls Prevention in Community-Dwelling Older Adults: Interventions: community-dwelling adults 65 years or older
- Folic Acid Supplementation to Prevent Neural Tube Defects: Preventive Medication: persons who plan to or could become pregnant
- Gestational Diabetes: Screening: asymptomatic pregnant persons at 24 weeks of gestation or after
- Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors
- Healthy Weight and Weight Gain in Pregnancy: Behavioral Counseling Interventions: pregnant persons

- Hepatitis B Virus Infection in Adolescents and Adults: Screening: adolescents and adults at increased risk for infection
- Hepatitis B Virus Infection in Pregnant Women: Screening: pregnant women
- Hepatitis C Virus Infection in Adolescents and Adults: Screening: adults aged 18 to 79 years
- High Body Mass Index in Children and Adolescents: Interventions: children and adolescents 6 years or older
- Human Immunodeficiency Virus (HIV) Infection: Screening: adolescents and adults aged 15 to 65 years
- Human Immunodeficiency Virus (HIV) Infection: Screening: pregnant persons
- Hypertension in Adults: Screening: adults 18 years or older without known hypertension
- Hypertensive Disorders of Pregnancy: Screening: asymptomatic pregnant persons
- Intimate Partner Violence and Caregiver Abuse of Older or Vulnerable Adults: Screening: women of reproductive age, including pregnant and postpartum women
- Latent Tuberculosis Infection in Adults: Screening: asymptomatic adults at increased risk of latent tuberculosis infection (ltbi)
- Lung Cancer: Screening: adults aged 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
- Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum: Preventive Medication: newborns
- Osteoporosis to Prevent Fractures: Screening: postmenopausal women younger than 65 years with 1 or more risk factors for osteoporosis
- Osteoporosis to Prevent Fractures: Screening: women 65 years or older
- Perinatal Depression: Preventive Interventions: pregnant and postpartum persons
- Prediabetes and Type 2 Diabetes: Screening: asymptomatic adults aged 35 to 70 years who have overweight or obesity
- Prevention of Acquisition of HIV: Preexposure Prophylaxis: adolescents and adults at increased risk of HIV
- Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years
- Prevention of Dental Caries in Children Younger Than 5 Years: Screening and Interventions: children younger than 5 years
- Rh(D) Incompatibility: Screening: pregnant women, during the first pregnancy-related care visit
- Rh(D) Incompatibility: Screening: unsensitized rh(d)-negative pregnant women
- Sexually Transmitted Infections: Behavioral Counseling: sexually active adolescents and adults at increased risk
- Skin Cancer Prevention: Behavioral Counseling: young adults, adolescents, children, and parents of young children

- Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years who have 1 or more cardiovascular risk factors and an estimated 10-year cardiovascular disease (cvd) risk of 10% or greater
- Syphilis Infection During Pregnancy: Screening: asymptomatic pregnant women
- Syphilis Infection in Nonpregnant Adolescents and Adults: Screening: asymptomatic, nonpregnant adolescents and adults who are at increased risk for syphilis infection
- Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: nonpregnant adults
- Tobacco Smoking Cessation in Adults, Including Pregnant Persons: Interventions: pregnant persons
- Tobacco Use in Children and Adolescents: Primary Care Interventions: school-aged children and adolescents who have not started to use tobacco
- Unhealthy Alcohol Use in Adolescents and Adults: Screening and Behavioral Counseling Interventions: adults 18 years or older, including pregnant women
- Unhealthy Drug Use: Screening: adults age 18 years or older
- Vision in Children Ages 6 Months to 5 Years: Screening: children aged 3 to 5 years
- Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults

Other Preventive Services Covered Under California Law (AB 144)
Similar to vaccines, AB 144 requires Medi-Cal MCPs to cover of all preventive services that received an A or B rating from the USPSTF as of January 2025.[25] This means that, if the USPSTF backtracks on a recommendation in the future, Medi-Cal would still be required to cover such preventive service as long as the service had an A or B rating from the USPSTF as of January 2025. Similarly, AB 144 required Medi-Cal MCPs to also cover additional preventive services that are recommended through "any modification or supplement to a recommendation adopted [by the CDPH]" regardless of whether the service has also been recommended by the USPSTF.[26]

HRSA-Recommended Services

In addition to all USPSTF A and B recommendations that target adults and children generally, Medi-Cal covers preventive services included in guidelines from HRSA, which specifically target children and adolescents and women. The recommendations for children are part of the Bright Futures program and are discussed in the EPSDT section above.

Pursuant to HRSA's Women Preventive Services Guidelines, Medi-Cal covers the following services subject to the limitations described in the guidelines:[27]

Service	Recommended Age Rance	Frequency
Screening for cervical cancer	Women between 21 and 29 years (using cervical cytology (Pap test) Women between 30 to 65 with Pap test and human papillomavirus test (hrHPV)	For women between 21 and 29, every 3 years For women between 30 and 65, every 5 years if hrHPV test is available; otherwise, every 3 years
Patient Navigation Services for Breast and Cervical Cancer Screening	No age range	As needed
Breast Cancer Screening for Women at Average Risk	Screening should start no earlier than age 40, but no later than age 50 and continue until at least age 74	At least biennially and as frequently as annually
Screening and Counseling for Intimate Partner and Domestic Violence	No age range	As needed
Screening for Anxiety	No age range	As needed
Obesity Prevention in Midlife Women	Between 40 and 60	As needed
Breastfeeding Services and Supplies (including double electric pumps and breast milk storage supplies)	Between 40 and 60	As needed
Contraception[28]	No age range	As needed
Counseling for Sexually Transmitted Infections (STIs)	No age range, but being under 25 is considered a risk factor	As needed

Service	Recommended Age Rance	Frequency
HIV Infection	Ages 15 and older (but starting at age 13 when needed)	At least once during lifetime and annually when there is an increased risk of infection
Well-Woman Preventive Visits	Beginning in adolescence	At least once per year
Screening for Diabetes in Pregnancy	No age range, but after 24 weeks of gestation or before (ideally during first prenatal visit) for individuals with risk factors for type 2 diabetes	Once during pregnancy
Screening for Diabetes after Pregnancy	No age range, but within the first year after pregnancy	After the initial screen within a year after pregnancy, every 3 years for at least 10 years after pregnancy if initial screen was negative
Screening for Urinary Incontinence	No age range	Annually

Expedited Partner Therapy for the Prevention of STI Reinfections

Medi-Cal covers Expedited Partner Therapy (EPT) for partners of beneficiaries being treated for sexually transmitted conditions in order to prevent retransmission.[29] EPT involves treating sex partners of beneficiaries diagnosed with a treatable sexually transmitted condition without the health care provider first examining the partner. This second-hand treatment often involves the patient delivering medication or a prescription to their partner(s). Medi-Cal covers EPT for beneficiaries being treated for gonorrhea, chlamydia, and/or trichomoniasis and providers may either dispense sufficient medication for the beneficiary to provide to their partner(s) or write a prescription in the name of the beneficiary for a sufficient amount and duration for their partner(s)' use.[30]

Asthma Preventive Services

Asthma Preventive Services (APS) under Medi-Cal are covered when they prevent disease progression, prolong life, and promote physical health.[31] APS is defined as "information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-

management techniques and self-monitoring skills, and actions to mitigate or controls environmental exposure that exacerbate asthma symptoms."[32] APS includes the following services:[33]

- Clinic-based asthma self-management education available to all beneficiaries with an asthma diagnosis
- Home-based asthma self-management education available to all beneficiaries with an asthma diagnosis
- In-home environmental trigger assessment for beneficiaries with a current diagnosis of poorly controlled asthma, or on the recommendation of a licensed physician, nurse practitioner (NP), or physician assistant (PA)
  - In-home environmental trigger assessment is defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants, to guide education about actions to mitigate or control environmental exposures
  - Poorly controlled asthma is defined as having a score of 19 or lower on the Asthma Control test, or an asthma-related emergency department visit or hospitalization or two instances of sick or urgent care asthma-related visits in the past year

APS may be provided by physicians, NPs, or PAs, or by unlicensed providers such as community health workers, promotores, or community health representatives who meet certain qualifications.[34] The self-management education services are limited to two services per year, while assessments are limited to two assessments per year, though additional assessment may be provided with prior authorization or when there has been a change of primary residence.[35]

Diabetes Prevention Program

Medi-Cal's Diabetes Prevention Program (DPP) covers a range of services recommended by a provider to prevent or delay the onset of type 2 diabetes for beneficiaries with indications of prediabetes (defined as higher-than-normal blood sugar levels, but not high enough yet to be diagnosed as type 2 diabetes).[36] To be eligible for the DPP services, beneficiaries must be at least 18 years of age; have a body mass index (BMI) of at least 23 if the beneficiary does not self-identify as Asian or a BMI of at least 23 if self-identified as Asian; no previous diagnosis of type 1 or type 2 diabetes (with the exception of gestational diabetes); free of end-stage renal disease; and must have one of the following within the 12-month period prior to being referred to DPP:[37]

- A hemoglobin A1c test with a value between 5.7% and 6.4%
- A fasting plasma glucose of 110-125 mg/dL
- A two-hour plasma glucose of 140-199 mg/dL

Covered services include individual or group nutrition or behavioral counseling and physical activity and fitness assessment to help beneficiaries change certain aspects of their lifestyle, like eating healthier, reducing stress, and

getting more physical activity.[38] Services are provided at periodic intervals over the course of one year or, if needed, at periodic intervals for another year.[39] The first year includes at least 22 peer-coaching sessions. In addition, beneficiaries who achieve a weight loss of at least five percent from the first session are eligible for ongoing maintenance sessions after the initial 12-month period.[40]

DPP services are provided by lifestyle coaches based in an organization enrolled in Medi-Cal that has pending, preliminary, or full CDC recognition to provide diabetes services. These organizations may be Home Health Agencies, pharmacies, physician groups, Indian Health Services (HIS), Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), community clinics, community hospitals, home and community-based services (HCBS) nursing facilities, among others.[41] Lifestyle coaches may be physicians, licensed nonphysician practitioners (nurses, physical therapists, etc.), or unlicensed practitioners under the supervision of a DPP services provider or a licensed Medi-Cal practitioner.[42] All lifestyle coaches must complete at least 12 hours of training in DPP services from an organization recognized by the CDC and must be trained to the specific curriculum being used by the recognized organization.[43]

DPP services are covered by MCPs, which are responsible for ensuring contracted DPP providers meet the minimum requirements to provide the services. MCPs have flexibility to cover services delivered via the methods: in-person, distance learning, online, or a combination of these methods.[44]

Certified Wellness Coach Program

In 2025, California received approval from CMS to begin covering certified wellness coach services as preventive services, including when provided by a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).[45] These services support behavioral health needs and promote physical and mental health and include:[46]

- Wellness promotion and education;
- Screening not requiring a licensed provider;
- Care coordination and navigation services;
- Individual and group behavioral health coaching (wellness education, coping skills, goal setting and planning, teaching life skills, stress management, and problem solving);
- Crisis referral (including identifying potential risk, providing emotional support, and engaging in warm handoffs with licensed, credentialed, or associate behavioral health providers).

Certified Wellness Coaches must be supervised by a licensed practitioner or by an individual holding a valid Pupil Personnel Services (PPS) credential issued by the Commission on Teacher Credentialing.[47]

Endnotes

[1] 42 U.S.C. §§ 18022(b)(1)(I), 1396u-7(b)(5). 42 C.F.R. § 440.347(a)(9).

[2] 45 C.F.R. § 156.115(a)(4) (tying the EJB category of preventive health services to the requirement to cover preventive services without cost-sharing under 45 C.F.R. § 147.130).

[3] *See* CMS, CMCS Informational Bulletin: Alternative Benefit Plan Conforming Changes 4 (Jan. 28, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-28-16.pdf.

[4] 42 U.S.C. § 1396d(a)(12)–(13); 42 C.F.R. § 440.130(c).

[5] 42 U.S.C. §§ 1396s, 1396a(a)(10)(A), 1396a(a)(43)(A)–(B) ,1396d(r), 1396a(a)(10)(C)(iv), 1396o(a)(2)(J), 1396o(b)(2)(J).

[6] Cal. Dep't Health Care Servs., Cal. State Plan Chart, Limitations on Attachment 3.1-A 18a, https://www.dhcs.ca.gov/SPA/Documents/Limitations-to-Attachment-3-1A.pdf [hereinafter State Plan Limitations on Attachment 3.1-A].

[7] Medi-Cal also cover various other preventive services that are discussed in other chapters of this guide. Specifically, Alcohol and Drug Use Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) is discussed in Chapter V on Substance Use Disorder Services; Doula Preventive Services are discussed in Chapter VII on Reproductive and Sexual Health Services; Behavioral Health Treatment (BHT) is discussed in Chapter XIV on Children's Health Services; and Community Health Worker (CHW) services are discussed in Chapter XII on Care Coordination.

[8] Am. Acad. Pediatrics, Preventive Care/Periodicity Schedule, https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity schedule/?srsltid=AfmBOoptHDPRcCTxWNrd RIAwNrp5Q2V9HilS81mFD_1XGdpaCbsgFPz3 (last visited Apr. 8, 2026).

[9] *See* Dep't Health Care Servs., *Medi-Cal Provider Manual: Preventive Services* 19–22, 24 (Sept. 2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/DDBB7BD0-9D06-4B3C-9597-7FAFF5471E6F/prev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual: Preventive Services*]; *See* also Am. Acad. Pediatrics, Recommendations for Preventive Pediatric Health Care (Dec. 2024), https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?

[10] CMS, *CMCS Informational Bulletin: Coverage of Blood Lead Testing for Children Enrolled in Medicaid and the Children's Health Insurance Program* (Nov. 30, 2016), https://www.medicaid.gov/federal-policy-guidance/downloads/cib113016.pdf.; Cal. Code Regs. § 37100. *See also* Cal. Dep't Health Care Servs., *Blood Lead Testing and Anticipatory Guidance* (July 2023), https://www.dhcs.ca.gov/services/chdp/Documents/2023-Blood-Lead-Testing-and-Anticipatory-Guidance.pdf.

[11] *Medi-Cal Provider Manual: Preventive Services*, *supra* note 9, at 23.

[12] Cal. Dep't Health Care Servs., All Plan Letter No. 24-008 (June 21, 2021), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-008.pdf.

[13] *See* Cal. Dep't Health Care Servs., *Medi-Cal Reimbursement of Vaccines for VFC and Non-VFC Enrolled Pharmacy Providers – Frequently Asked Questions (FAQs), Version 6.0* (Mar. 1, 2026), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/faq/Medi-Cal_Reimbursement_VFC_FAQ.pdf.

[14] Dep't Health Care Servs., *Medi-Cal Provider Manual: Vaccines for Children (VFC) Program 2* (June 2024), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/C08C7E98-AA63-4BC8-BA3C-BE8E06ED9A31/vaccine.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[15] *Id.*

[16] *Id.* at 1 (Nov. 2024).

[17] *Id.* at 2.

[18] *Medi-Cal Provider Manual: Preventive Services*, *supra* note 9, at 17–18 (Jan. 2026).

[19] *Id.* at 18.

[20] Cal. Welf. & Inst. Code § 14132.995(a).

[21] Cal. Health & Safety Code § 1342.3(a)(1)(B), (c). *See also* Cal. Dep't Health Care Servs., *Medi-Cal Coverage of Vaccines* (Oct. 2025), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/publications/2025.09_A_Medi-Cal_Coverage_Vaccines.pdf.

[22] CDC, Recommended Vaccinations for Children (Feb. 2026), https://www.cdc.gov/vaccines/imz-schedules/child-easyread.html.

[23] Cal. Dep't Health Care Servs., *Coming Soon: MMRV Vaccine Reimbursement for Children Younger Than Age 4 Years of Age* (Mar. 24, 2026), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/2026/03_A_Coming_Soon_MMRV_Reimbursement_Children.pdf.

[24] U.S. Preventive Servs. Task Force, A & B Recommendations, https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations (last visited Apr. 8, 2026).

[25] Cal. Health & Safety Code § 1342.3(a)(1)(A), (c).

[26] *Id.*

[27] HRSA, Women's Preventive Services Guideline, https://www.hrsa.gov/womens-guidelines (last visited Apr. 8, 2026). Consult the HRSA webpage for more detailed guidelines.

[28] Contraception extends to the full range of contraceptives currently listed in the FDA's Birth Control Guide: (1) sterilization surgery for women, (2) implantable rods, (3) copper intrauterine devices, (4) intrauterine devices with progestin (all durations and doses), (5) injectable contraceptives, (6) oral contraceptives (combined pill), 7) oral contraceptives (progestin only), (8) oral contraceptives (extended or continuous use), (9) the contraceptive patch, (10) vaginal contraceptive rings, (11) diaphragms, (12) contraceptive sponges, (13) cervical caps, (14) condoms, (15) spermicides, (16) emergency contraception (levonorgestrel), and (17) emergency contraception (ulipristal acetate), and any additional contraceptives approved, granted, or cleared by the FDA. *Id.*

[29] *Medi-Cal Provider Manual: Preventive Services*, *supra* note 9, at 24–25 (Sept. 2025).

[30] *Id.* at 25.

[31] State Plan Limitations on Attachment 3.1-A, *supra* note 6, at 18h–18i.

[32] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: Asthma Preventive Services (APS)* 1 (Apr. 2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/B30BA13C-7A4F-47B9-9403-760091E44ADC/asthprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[33] *Id.*

[34] *Id.* at 3

[35] *Id.* 2 – 3.

[36] State Plan Limitations on Attachment 3.1-A, *supra* note 6, at 18c–18d. *See also* Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: Diabetes Prevention Program (DPP)* (Mar. 2022), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7C316612-0D8F-4103-97C7-62F3670656C6/diabetes.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter Medi-Cal Provider Manual: Diabetes Prevention Program (DPP)].

[37] Medi-Cal Provider Manual: Diabetes Prevention Program (DPP), *supra* note 36, at 3.

[38] State Plan Limitations on Attachment 3.1-A, *supra* note 6, at 18c–18d.

[39] *Id.* at 18c.

[40] *Medi-Cal Provider Manual: Diabetes Prevention Program (DPP), supra* note 36. See also Cal. Dep't Health Care Servs., Diabetes Prevention Program (DPP), https://www.dhcs.ca.gov/services/medi-cal/Pages/Diabetes-Prevention-Program.aspx (last visited Apr. 10, 2026).

[41] *Medi-Cal Provider Manual: Diabetes Prevention Program (DPP), supra* note 36, at 1–2.

[42] State Plan Limitations on Attachment 3.1-A, *supra* note 6, at 18c.

[43] *Id.* at 18d.

[44] *Medi-Cal Provider Manual: Diabetes Prevention Program (DPP), supra* note 36, at 2 (specifying the delivery methods DPP providers may use). For more information on MCP's responsibilities regarding DPP, see Cal. Dep't Health Care Servs., All Plan Letter No. 18-018 (Nov. 16, 2018), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-018.pdf.

[45] CMS, Approval Letter for Cal. State Plan Amendment # 25-0014 (June 24, 2025), https://www.dhcs.ca.gov/SPA/Documents/SPA-25-0014-Approval.pdf.

[46] State Plan Limitations on Attachment 3.1-A, *supra* note 6, at 18l.

[47] *Id.*

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter III: Prescription Drugs

Chapter III: Prescription Drugs

Outline of Medi-Cal Prescription Drug Services*
A. Prescription Drugs Covered by Medi-Cal B. Other Items Covered by Medi-Cal Rx 1. Over-the-counter medications 2. Vaccines 3. Certain medical supplies 4. Certain enteral nutrition products C. Medi-Cal Contract Drug List (CDL) D. Prior Authorization E. Other Utilization Controls F. Prescription Drugs for Dual Eligibles

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

Medi-Cal benefits include coverage of prescription drugs, which are an optional service under the federal Medicaid Act.[1] Subject to certain narrow limitations, Medi-Cal must cover nearly every 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 Prime Therapeutics State Government Solutions LLC.[2] 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.[3] 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.[4] 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.[5] Medi-Cal Rx uses a uniform approval process as well as uniform authorization and scope-of-coverage rules for Medi-Cal prescription drugs.[6] 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.[7]

A. Prescription Drugs Covered by Medi-Cal[8]

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.[9] 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.[10]

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.[11] Medi-Cal, however, covers both prescription and over-the-counter tobacco cessation products for all beneficiaries.[12]

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.[13] Consistent with federal Medicaid law, Medi-Cal only covers over-the-counter medications dispensed when they are prescribed by an authorized prescriber.[14] 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.[15]

The 2026-2027 California budget introduced several changes to Medi-Cal Rx's coverage of over-the-counter products. First, beginning on January 1, 2026, multivitamin combination products will be excluded from coverage. Second, certain single-ingredient vitamins and dry eye products will require a prior authorization showing medical necessity. Third, first- and second-generation antihistamines will be restricted to generic formulations only. Finally, OTC

prenatal vitamins will be limited to use during pregnancy or lactation for beneficiaries between 10 and 60 years of age.[16]

Medi-Cal Rx also covers over-the-counter antigen tests and vaccines when they are billed on a pharmacy claim, including those indicated for COVID-19.[17] Prior to 2026, most health plans in California, including Medi-Cal plans, were prohibited from imposing cost-sharing and utilization management, such as prior authorization, on COVID-19 screening, testing, immunizations, and therapeutics. The enacted 2025-2026 budget excluded Medi-Cal plans from this prohibition. As such, Medi-Cal managed care plans now have authority to limit access to COVID-19 antigen tests when these are billed on a medical claim and DHCS has authority to impose utilization management when billed on a pharmacy claim to Medi-Cal Rx.[18]

ADVOCACY TIP:

✓ Beginning in January 2026, all OTC COVID-19 antigen tests covered by Medi-Cal Rx are subject to prior authorization, unless prescribed to an individual under 21 years of age by a California Children's Services (CSS) Paneled Provider.[19] Approvals will be limited to 4 tests per month, but a prior authorization cannot be renewed; that is, a new prior authorization will be required for each antigen test.[20] Advocates and enrollees should keep in mind that other testing for COVID-19 may be available without prior authorization. For more information, see Chapter XIV on Ancillary Services.

Medi-Cal Rx also covers certain medical supplies, including insulin syringes, pen needles, lancets, and diabetic test strips.[21] Other medical supplies, including condoms, diaphragms / cervical caps, heparin / saline flush, continuous glucose monitoring systems, blood pressure monitoring devices and cuffs, and COVID-19 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.[22] 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.[23]

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.[24] In addition, related supplies, including intubation tubing and pumps, are always covered by Medi-Cal managed care plans, not Medi-Cal Rx.[25]

C. Medi-Cal Contract Drug List

DHCS maintains the Medi-Cal Contract Drugs List (CDL), which operates as a preferred drug list.[26] 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.[27] 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.[28] Medi-Cal covered drugs that do not appear on the CDL require prior authorization from Medi-Cal.[29]

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.[30] 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.[31]

Pursuant to the 2026-2027 California budget, Medi-Cal Rx will exclude from coverage prescription drugs used for weight loss and weight-loss-related indications for all Medi-Cal members beginning January 1, 2026.[32] However, Medi-Cal will continue to cover GLP-1 drugs (such as Ozempic, Wegovy, Trulicity, and Rybelsus) when prescribed for treatment of type 2 diabetes or other non-weight loss-related indications.[33]

When a Medi-Cal beneficiary is taking a drug that Medi-Cal will remove from the CDL, as it is the case with prescriptions drugs for weight loss, 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.[34] Starting in 2026, when a drug is removed from the CDL, a Medi-Cal beneficiary may only receive the drug with prior authorization.[35] In some cases, however, 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.[36]

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.[37] 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.[38]

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."[39] 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.[40] 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.[41] 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.[42] 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.[43]

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.[44] 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.[45]

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.[46]

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.[47]

- California has adopted policies to promote the use of generic drugs.[48] Although the Medi-Cal program does not require generic substitution, the program is required to purchase the most cost-effective drug.[49]

Medi-Cal no longer charges any copayments for prescription drugs.[50] In addition, co-payments are not permitted for contraceptive drugs and devices.[51]

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.[52] These beneficiaries are entitled to and should be automatically enrolled in the Low-Income Subsidy (LIS) program.[53] Dual eligibles may receive Medi-Cal coverage for medications that are categorically excluded under Medicare Part D but are covered by Medi-Cal.[54] 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.[55]

Endnotes

[1] Cal. Welf. & Inst. Code § 14132(d); Cal. Code Regs. tit. 22, § 51313. *See also* 42 U.S.C. §§ 1396d(a)(12) (prescription drugs), 1396a(a)(54) (outpatient drugs), 1396r-8 (outpatient drugs); 1396b(i)(5) and (10) (federal payments); 42 C.F.R. § 440.120(a) (defining prescribed drugs).

[2] Cal. Dep't Health Care Servs., *Medi-Cal Rx: Transitioning Medi-Cal Pharmacy Services from Managed Care to Fee-for-Service Frequently Asked Questions* 3 (V. 19.0, 2025), 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 drugs and pharmacist services are still covered by managed care plans 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 No. 22-020 at 4, 6, 9 (Dec. 30, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-012.pdf [hereinafter All Plan Letter No. 22-020].

[3] California Executive Department, Executive Order N-01-19, https://www.gov.ca.gov/wp-content/uploads/2019/01/EO-N-01-19-Attested-01.07.19.pdf.

[4] Cal. Dep't Health Care Servs., *Medi-Cal Rx Scope* (V. 7.0, 2024), https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Medi-Cal-Rx-Scope.pdf.

[5] Cal. Dep't Health Care Servs., *Medi-Cal Rx Provider Manual* § 2.1 (2025), 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.

[6] See *Medi-Cal Rx FAQs, supra* note 2, at 4.

[7] *See id.* at 16–17; *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.

[8] 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.

[9] 42 U.S.C. § 1396r-8(d)(1)(B), (4).

[10] *Compare Medi-Cal Rx Provider Manual, supra* note 5, at § 4.6.11 with 42 U.S.C. § 1396r-8(d)(2)(D).

[11] 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.

[12] Cal. Welf. & Inst. Code § 14134.25(b)(2).

[13] All Plan Letter No. 22-020, *supra* note 2, at 7.

[14] 42 U.S.C. § 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 L. Prog., *Coverage of Over-the-Counter Drugs in Medicaid* (Rev. Ed. 2022), https://healthlaw.org/resource/coverage-of-over-the-counter-drugs-in-medicaid.

[15] 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 and Cough/Cold Preparations* (2025), 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.

[16] Ca. Dep't Health Care Servs., *90-Day Countdown: Upcoming Changes to Medi-Cal Rx* 2 (Dec. 1, 2025), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/2025/12_A_30-Day_Upcoming_Changes_Medi-Cal_Rx.pdf [hereinafter *Upcoming Changes to Medi-Cal Rx*].

[17] *See* Cal. Dep't Health Care Servs., *Medi-Cal Rx Contract Drugs List* (2025), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf; Cal. Dep't Health Care Servs., Covered Products Lists, https://medi-calrx.dhcs.ca.gov/provider/forms (last visited Nov. 4, 2025) [hereinafter Covered Products Lists]. Cal. Dep;t Health Care Servs., All Plan Letter No. 24-008 at 3 (June 21, 2024), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-008.pdf. Vaccines provided in a facility or institution billed on a medical claim must be covered by the beneficiary's managed care plan. *Id.* at 2. Medi-Cal will cover the Monkeypox vaccine, and providers should administer the vaccine to people when it is administered consistent with FDA and CDC. Cal. Dep't Health Care Servs., *Policy Update of Mpox Vaccines as a Medi-Cal Benefit* (Apr. 5, 2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/31823_18.

[18] Cal. Health & Safety Code § 1342.2(h)(6) (excluding Medi-Cal plans from the requirement that health plans in California cover COVID-19 screening and diagnostic services without imposing cost-sharing or utilization management); Cal. Welf. & Inst. Code § 14132.994 (requiring Medi-Cal plans to cover COVID-19 screening, testing, immunizations, and therapeutics subject to all other applicable Medi-Cal laws and regulations).

[19] *Upcoming Changes to Medi-Cal Rx, supra* note 16 at 2.

[20] *Id.*

[21] Cal. Dep;t Health Care Servs., All Plan Letter No. 25-013 at 2 (Sept. 18, 2025), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/APL25-013.pdf [hereinafter All Plan Letter No. 25-013]; Cal. Dep't Health Care Servs., Covered Products Lists, *supra* note 16.

[22] *Medi-Cal Rx Provider Manual, supra* note 5, at § 13.0; Covered Products List, *supra* note 17.

[23] Covered Products Lists, *supra* note 17.

[24] All Plan Letter No. 25-013, *supra* note 21, at 12; Covered Products Lists, *supra* note 17.

[25] All Plan Letter No. 22-020, *supra* note 2, at 30; Covered Products Lists, *supra* note 17.

[26] The Contract Drugs List may be found at Cal. Dep't Health Care Servs., Contract Drug List, https://medi-calrx.dhcs.ca.gov/home/cdl (last visited Nov. 4, 2025). Medications are listed by their generic name.

[27] 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*].

[28] Cal. Code Regs. tit. 22, § 51313.3(b); *see generally Medi-Cal Contract Drugs List, supra* note 27; *see also Medi-Cal Rx Provider Manual, supra* note 5, at § 11.

[29] Cal. Code Regs. tit. 22, § 51313(c); *see also Medi-Cal Rx Provider Manual, supra* note 5, at § 14.

[30] *See Medi-Cal Rx Provider Manual, supra* note 5, at § 11.0.

[31] Cal. Welf. & Inst. Code § 14105.39(c)(1); Cal. Code Regs., tit. 22, § 51313.6(a).

[32] See *Upcoming Changes to Medi-Cal Rx, supra* note 16 at 2.

[33] *Id.*

[34] Cal. Welf. & Inst. Code § 14105.33(i).

[35] Cal. Welf. & Inst. Code § 14105.33(r), (s). 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. [hereinafter *Medi-Cal Rx Pharmacy Transition Policy*]

[36] *See Medi-Cal Rx Pharmacy Transition Policy, supra* note 35.

[37] *See Medi-Cal Rx Provider Manual, supra* note 5, at §§ 11, 14.

[38] Cal. Code Regs. tit. 22, § 51313(c)(1).

[39] 42 U.S.C. § 1396r-8(d)(1)(B)(i), (5).

[40] 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.

[41] *Medi-Cal Rx Provider Manual, supra* note 5, at § 14.1.

[42] 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.

[43] 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 Nov. 4, 2025).

[44] *See Medi-Cal Rx Provider Manual, supra* note 5, at § 2.1.3.4.

[45] Medi-Cal fraud by providers or beneficiaries may be reported by calling the statewide Medi-Cal Fraud Hotline at 1-800-822-6222.

[46] S.B. 1053, Contraceptive Coverage Equity Act (2014).

[47] Cal. Code Regs. tit. 22, § 51313(b).

[48] Cal. Bus. & Prof. Code § 4073; Cal. Health & Safety Code § 1367.22(a).

[49] Cal. Code Regs. tit. 22, § 51313(c)(1)(B).

[50] Cal. Welf. & Inst. Code § 14134(a)(3).

[51] 42 U.S.C. §§ 1396o(a)(2), (b)(2); 42 C.F.R. § 447.56(a)(2)(ii).

[52] Cal. Welf. & Inst. Code § 14133.23(a).

[35] 42 C.F.R. §§ 423.772, 423.773(c)(1)(i), 423.780, 423.782.

[54] Cal. Welf. & Inst. Code § 14133.23(b) & (c).

[55] See Randolph T. Boyle, Nat'l Health Law Prog., *Medicare Part D and Dual Eligibles: A Guide for California Advocates* (revised 2008), https://healthlaw.org/wp-content/uploads/2018/09/medicare_ptD_dualsadvocates_guide.pdf.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated February 2026

Chapter IV:
Mental Health Services

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Mental Health Services

Outline of Medi-Cal Mental Health Services*
A. Specialty Mental Health Services 1. 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 2. Inpatient mental health services • Psychiatric inpatient hospital services • Acute psychiatric inpatient hospital services • Psychiatric health facility services • Psychiatric inpatient hospital professional services 3. Targeted case management 4. Psychiatric services 5. Psychologist services 6. Psychiatric nursing facility services 7. Peer Support Services (available in certain counties) 8. EPSDT Specialty Mental Health Services 9. BH-Connect Initiative Services 10. Short Term Residential Therapeutic Program (STRTP) and Psychiatric Residential Treatment Facility (PRTF) Services for Beneficiaries Under 21 B. Non-specialty Mental Health Services 1. Mental health evaluation and treatment 2. Psychological and neurological testing 3. Outpatient services 4. Outpatient laboratory, drugs, supplies, and supplements 5. Psychiatric consultation 6. Dyadic services for families C. Eating Disorder Services D. Psychotherapeutic/Psychiatric Medications E. CalAIM Justice-Involved Initiative

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

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

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.[5] Under the No Wrong Door policy, beneficiaries may concurrently receive non-SMHS via a FFS or MCP provider and SMHS via a County MHP provider, when the services are clinically appropriate, coordinated, and not duplicative.[6] Also, MCPs and County MHPs are required to coordinate care for Medi-Cal

ADVOCACY TIP:

✓ County MHPs, MCPs and FFS providers have different criteria for service eligibility and available providers in their networks, which can be confusing. For more complete information about County MHPs services and providers, as well as other information, look at the county's behavioral health website. MCP information should be on the plan's website or in its' handbook. You can also call the plans for more information or to obtain a copy of materials.

While MCPs and County MHPs 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.[7] 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. The MOU should be posted on the County MHP and MCP website, and available from either plan upon request.

beneficiaries receiving SMHS through a County MHP and non-SMHS or/and physical health services through a MCP.[8] Moreover, if beneficiaries choose to transition from one service type to another (such as from receiving SMHS to non-SMHS and vice versa), County MHPs and MCPs must facilitate care transitions and guide referrals for beneficiaries.[9] DHCS has developed a set of statewide Screening and Transition of Care tools that took effect in 2023 to facilitate screenings and transitions care for the SMHS, Medi-Cal Managed Care, and FFS.[10]

ADVOCACY TIP:

✓ MCPs cannot require prior authorization for an initial mental health assessment. Psychological services are covered services when ordered by a primary care provider (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.[11]

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.[12] These PIHPs are known as County MHPs in California.

Currently, SMHS covered by all County MHPs include:[13]

- 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);
- inpatient mental health services;[14]
- targeted case management;
- psychiatrist services;
- psychologist services;
- psychiatric nursing facility services;
- peer support services; and

ADVOCACY TIP:

✓ Because the Title 9 regulations governing SMHS have not been updated in many years, more up-to-date information can be found in Mental Health/ Substance Use Disorder Services Information Notices or other state guidance documents provided by DHCS. These important documents can be found at https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx.

- EPSDT services (including intensive care coordination, intensive home-based services, therapeutic behavioral services, and therapeutic foster care).

1. Specialty Mental Health Services Access 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.[15] These beneficiaries are eligible for SMHS when meeting both of the following access criteria:[16]

- 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.[17]

County 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.[18] County MHPs also must disclose to beneficiaries, upon request, the utilization management or utilization review policies and procedures that the County MHP (or any entity that the County MHP contracts with) uses to authorize, modify, or deny SMHS.[19]

All County 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.[20] If a County MHP modifies, denies, or delays an authorization request, the County MHP shall notify the beneficiary in writing of the adverse benefit determination.[21]

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

Consistent with the EPSDT benefit, County 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,

County MHPs must provide services when they are necessary to correct or ameliorate a child or adolescent's mental health condition.[22] Furthermore, pursuant to state guidance implementing federal EPSDT and state law requirements, County MHPs are required to provide all medically necessary SMHS to any beneficiary under age 21 who meet either of the following access 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.[23]

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 non-SMS 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."[24] 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.

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.[25] In addition, County 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. Each County MHP must make these services available in all geographic service areas served by the County MHP and may not restrict eligibility to children who have open child welfare services cases.[27]

ADVOCACY TIP:

✓ County 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 County MHP and the receiving County MHP are working together to ensure the child is receiving all medically necessary specialty mental health services.

When a child or youth in foster care is placed outside of their county of original jurisdiction, the provision of SMHS is governed by "presumptive

ADVOCACY TIP continued

transfer" rules.[28] Generally, the responsibility to provide and pay for SMHS must promptly transfer to the County MHP where the child or youth now lives. However, on a case-by-case basis, when it is in the best interest of the child or youth, presumptive transfer can be waived. This includes when the transfer would disrupt continuity of care, delay access to care, or interfere with family reunification efforts; if the new placement is expected to last less than six months or is within 30 minutes of an established SMHS provider; or if the child or youth is placed in certain out-of-county residential settings.

When there is a dispute between a County 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.[29] Advocates can assist people to request medically necessary services during a dispute by calling either the MCP or County MHP, as set forth in the MOU, and requesting the prompt provision of services. If the MCP or County MHP fails to provide services during a dispute, advocates can assist people to file a grievance with the plan.

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: https://www.dhcs.ca.gov/services/MH/Pages/mh-ombudsman.aspx.

The County of Responsibility listed in MEDs, MEDSLITE, and Automated Eligibility Verification System (AEVS) file determines which county's County 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 County MHP is determined responsible.[30]

General County MHP Obligations for SMHS

County MHPs must operate a utilization management program that ensures beneficiaries have appropriate access to SMHS and must follow all clinical documentation requirements for SMHS.[31] County MHPs also must make SMHS available 24 hours a day, seven days a week, as needed to treat a beneficiary's urgent condition.[32] An urgent psychiatric condition exists when, without timely intervention, the beneficiary's condition is "highly likely to result in an immediate emergency psychiatric condition."[33] In addition, each County 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.[34]

While prior authorization or County 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.[35] Additionally, each County MHP is financially responsible for payment of emergency psychiatric services provided to its enrollees.[36] County MHPs cannot require prior authorization for emergency services.[37] Emergency psychiatric services are covered by the County 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.[38]

ADVOCACY TIP:

✓ Behavioral health services can be accessed by calling the County MHP Access line (available 24/7) in your county or talking to your MCP doctor or clinic. This should result in screening, assessment, eligibility determination and referral to appropriate services and providers. Additionally, emergency services should be available by visiting your hospital emergency room or calling your county crisis line. To find your county MHP Access line go to: https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx

County MHPs have additional obligations to certain Medi-Cal beneficiaries. For example, County 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 County MHP.[39] Also, each County MHP must make a good faith effort to contract with all IHCPs located in the County MHP's county and document those efforts.[40]

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:[41]

- 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.[42]

Crisis Intervention Services

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."[43] In addition to the "crisis intervention services," Medi-Cal also covers "community-based mobile crisis intervention service" for all ages.[44] Mobile crisis services must be available to beneficiaries experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.[45] County MHPs are required to cover crisis intervention services, including mobile crisis intervention, as part of the requirements pursuant to their contract with DHCS.[46] Crisis intervention services are also required to be provided to all beneficiaries under age 21 pursuant to the EPSDT mandate.[47]

Peer Support Services

Effective July 1, 2022, Peer Support Services are an optional behavioral health Medi-Cal benefit in California.[48] Peer Support Services are a distinct service type under the SMHS System for counties that opt in to cover the service.[49] The benefit also adds Peer Support Specialists as a distinct Medi-Cal provider type. As with all Medi-Cal SMHS, the EPSDT mandate requires all County MHPs to provide medically necessary Peer Support Services to any beneficiaries under age 21, even if a County does no cover it for adults.[50] 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."[51] 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.[52]

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:[53]

- 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.[54] A county or an agency representing the county is responsible for developing, overseeing, and enforcing a peer support specialist certification program.[55] 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.[56] Certified Peer Support Specialists must be over the age of 18.[57]

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative [58]

BH-CONNECT is a 5-year Initiative designed to expand evidence-based practices (EBPs) and to strengthen behavioral health guidance and principles to Medi-Cal services statewide. In December 2024, the Centers of Medicare and Medicaid Services (CMS) approved key components of BH-CONNECT through a new Section 1115 demonstration and a series of new State Plan Amendments (SPAs).[59] Other components of BH-CONNECT leverage existing federal Medicaid authorities and state-level guidance.

ADVOCACY TIP:

✓ Under BH-CONNECT, services in each county may differ. To find out which services are available in your county and for a list of providers, see the county's behavior health website or plan.

One component of BH-CONNECT allows each County MHP to cover key Evidence Based Practices (EBPs) at county option. These EBPs are designed to support adult Medi-Cal beneficiaries living with significant behavioral health needs. The optional EBPs are: (1) Assertive Community Treatment (ACT): (2) Forensic ACT (FACT); (3) Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); (4) Individual Placement and Support (IPS) Supported Employment; (5) Enhanced Community Health Worker Services; and (6) Clubhouse Services.[60]

To opt-in to providing any of the above EBPs to adult Medi-Cal beneficiaries, MHPs must apply to DHCS and commit to providing the selected service(s).[61] MHPs can opt to provide any combination of these adult EBPs services as a bundled benefit and can add additional benefits at any time.[62] While EBPs services must already be provided to children and youth under age 21 years of age when necessary under the EPSDT mandate, DHCS is issuing guidance to support counties in implementing the following EBPs with fidelity: (1) Multi Systemic Therapy (MST); (2) Functional Family Therapy (FFT); (3) Parent-Child Interaction Therapy (PCIT); and (4) High-Fidelity Wrap Around (HFW).[63]

To support implementation of EBPs across the state, DHCS has also contracted with Centers of Excellence (COEs) to provide training, technical assistance and fidelity monitoring support to county behavioral health delivery systems and behavioral health practitioners.[64]

BH-CONNECT will also allow MHPs to bill for mental health services provided to adults during short-term stays in Institutions for Mental Disease (IMDs), larger residential treatment facilities with 16 or more beds.[65] Generally, the Medicaid Act prohibits the use of federal funding for services provided to adult beneficiaries residing in these facilities. Under BH-CONNECT, MHPs can apply for reimbursement for IMD services provided they submit an IMD Federal Financial Participation (FFP) Plan and meet the stated requirements.[66] These include providing the full suite of EBPs, only billing IMD services when medically necessary and for short-term stays, and reinvesting reimbursement in patient care and service expansion.[67]

Additionally, BH-CONNECT makes available a new transitional rent benefit. This benefit provides coverage for short-term rental assistance that extends to room and board without clinical assistance for MCP enrollees experiencing or at risk of homelessness.[68] Transitional Rent will be available for up to 6 months, which may be used during different intervals or sequentially, for the entire duration of the five-year BH-CONNECT demonstration (i.e., 2025–2029).[69] The benefit joins other room-and-board Community Support services available through CalAIM (Short-Term Post-Hospitalization Housing and Recuperative Care). Together, a managed care enrollee may receive up to a maximum of 6 months of any of these 3 services during a 12-month period.

Beginning January 1, 2026, all MCPs must cover Transitional Rent for individuals who meet all of the following 3 categories:[70]

1. The enrollee meets the access criteria for SMHS, DMC, or DMC-ODS;

AND

2. The enrollee is part of one of the following transitioning populations:

- **Individuals transitioning out of an institutional or congregate residential setting,** including but not limited to an inpatient hospital stay, an inpatient or residential SUD treatment facility, an inpatient or residential mental health treatment facility, or a nursing facility.
- **Individuals transitioning out of a carceral setting,** including those transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been involuntarily held in custody through operation of law enforcement authorities.
- **Individuals transitioning out of interim housing,** including those transitioning out of transitional housing, rapid re-housing. a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing, whether funded or administered by HUD, or at the State or local level.
- **Individuals transitioning out of recuperative care or short-term post-hospitalization housing,** whether the stay was covered by Medi-Cal managed care or another source.
- **Individuals transitioning out of foster care:** Youth having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.
- **Individuals experiencing unsheltered homelessness:** Individuals or families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground.
- **Individuals eligible for Full-Service Partnership (FSP):** FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.

AND

3. The enrollee is experiencing or at risk of homelessness.

Plans also have the option of offering the service to individuals with one or more of the following clinical risk factors: (1) pregnant or up to 12-months postpartum, (2) have one or more serious chronic physical health conditions, or (3) have one or more physical, intellectual, or developmental disabilities.[71]

Individuals must always be part of one of the transiting populations described above (criteria #2) and be experiencing or at risk of homelessness (criteria #3). These additional eligibility pathways for Transitional Rent, while currently optional, will become mandatory for managed care plans to cover no sooner than January 1, 2027.[72]

Under BH-CONNECT, county MHPs also have the option to provide Community Transition In-Reach Services to individuals with significant behavioral health needs who are returning to the community after long-term stays in inpatient, subacute, and residential facilities, such as IMDs.[73] To be eligible for these services, individuals must be enrolled in Medi-Cal, be 21 years of age or older or an emancipated minor, meet the SMHS access criteria, receive care through a BHP that has elected to provide community transition in-reach services, reside in a facility that partners with the BHP to provide the services, and be experiencing or at risk of experiencing a stay of 120 days or more in a qualifying facility.[74] Community transition in-reach services will be available up to 180 days prior to the discharge date.[75]

Finally, the BH-CONNECT also includes an Activity Fund benefit no sooner than January 1, 2026 that can cover the costs of certain activities and items to support the health and wellbeing of children and youth involved in child welfare.[76] The Activity Funds initiative is a key component of BH-CONNECT and a required SMHS benefit while the approved BH-CONNECT Section 1115 Demonstration waiver remains in effect. The initiative will cover some, or all, of the cost of allowable activities and specified items beyond traditional therapies to support eligible Medi-Cal enrolled children and youth under age 21 with a behavioral health condition or at high risk of a behavioral health condition who are involved in the child welfare system.[77] The MHP must ensure that eligible members are assessed as part of the standardized SMHS assessment process and that members are ultimately connected to activity providers.[78] The services and/or items provided under the Activity Funds initiative must clearly link to an assessed need established in an eligible member's clinical record and must be determined to meet the member's needs by a qualified service provider.[79]

Short Term Residential Therapeutic Program (STRTP) and Psychiatric Residential Treatment Facility (PRTF) Services for Beneficiaries Under 21

Beneficiaries under 21 under may also be able to access services through the Short Term Residential Therapeutic Program (STRTP). The 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.[80] Importantly, an STRTP is considered an IMD if it has 16 or more beds providing intensive mental health treatment for youth. While in those situations STRTP triggers the IMD Exclusion,

California has processes to review and sometimes allow exceptions for STRTPs to serve youth with severe mental health needs.[81]

A Qualified Individual Assessment must be completed any time a child or youth is placed in an 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.[82] County 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.[83] 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.[84]

Pursuant to AB 2317 (2022), Medi-Cal beneficiaries under 21 may also access mental health services treatment at Psychiatric Residential Treatment Facilities (PRTFs).[85] PRTFs are a category of residential psychiatric facilities that have been excluded from the IMD exclusion under federal law, as long as they abide by strict federal and state requirements regarding quality of services and residents' plan of treatment and comply with regulations limiting the use of restrain and seclusion practices.[86] Individuals may access PRTF services if the services are necessary to correct or ameliorate a mental health condition.[87] AB 2317 gives DHCS the authority to license and monitor PRTFs, and the department exercised that authority by issuing interim regulations in June 2025.[88]

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

Since 2014, MCPs have been required to deliver non-SMHS to their enrollees. As part of the ACA, starting on January 1, 2014, California was required to provide behavioral health services, including mental health services, to the Medicaid Expansion population.[89] 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.[90] For Medi-Cal beneficiaries who are not enrolled in a Medi-Cal MCP, non-specialty mental health services are delivered through FFS Medi-Cal.

To implement the alignment, California requires MCPs to cover the following mental health services:[91]

- 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.

Non-SMHS 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 non-SMHS or SMHS access criteria are met; 2) services are not included in an individual treatment plan; 3) the members has a co-occurring substance use disorder (SUD); or 4) non-SMHS and SMHS services are already provided concurrently, as long as those services are coordinated and not duplicated.[92] Further information on SUD services can be found in Chapter V of this Guide.

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

MCPs must provide non-SMHS 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."[93] For this reason, the scope of services provided by the Medi-Cal plans to adult enrollees is sometimes referred to as "mild to moderate." Non-SMHS 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."[94]

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.[95]

ADVOCACY TIP:

✓ Both the county MHPs and the MCPs have grievance and appeal procedures which are available if there is a dispute or complaint about services or a provider. This process should be informal and can be done orally, by calling the grievance or plan number, or in writing. See your local plan provisions for specific procedures, including where to call, any forms and timelines. You should be able to access this online or request a copy of your beneficiary handbook.

In addition, if you disagree with a service denial, termination or reduction of benefits, you have the right to file for Medi-Cal fair hearing. For more information about this process, and whether aid paid pending applies, see page 1.16 of Chapter I of this Guide on Overview of Medicaid and Medi-Cal.

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 youth's illness or condition.[96] Therefore, children and youth are entitled to non-specialty and specialty mental health services regardless of the severity of their condition.[97]

MCPs have obligations to provide EPSDT screening services and non-SMHS to all members under age 21.[98] 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.[99]

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.[100] The Dyadic Services benefit will allow providers to offer family and caregiver focused services at the child's medical visits.[101] 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).[102]

C. Eating Disorders Services

Eating Disorders are complex conditions that involve both physical and psychological symptoms and complications.[103] Thus, MCPs and County 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), County 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.[104] These medications may be prescribed by either an MCP or County MHP provider, and fulfilled by a participating pharmacy.[105] In general, MCPs are responsible for coordinating the provision of these carved-out medications to their enrollees.[106] Prescribing and administration of psychotropic medications requires specific procedures and informed consent from the beneficiary or appropriate authorizing entity.[107]

E. CalAIM Justice-Involved Initiative: Pre-Release Medi-Cal Services

The CalAIM Justice-Involved Re-Entry Initiative aims to improve access to and quality of health care for justice-involved populations as they re-enter their communities and are important for individuals with mental conditions who are involved in the criminal justice system.[108] In 2023, California became the first state to receive federal approval from CMS of California's Section 1115 request to cover a package of reentry services for certain groups of incarcerated individuals 90 days prior to release (hereinafter, "pre-release Medi-Cal services"). This approval is the first to include a partial waiver of the statutory Medicaid inmate exclusion policy, which prohibits Medicaid from paying for services provided during incarceration (except for inpatient services).[109] Justice-involved individuals are disproportionately low-income and often have complex and/or chronic conditions, including behavioral health needs (mental health conditions and/or substance use disorder (SUD)). Reentry services aim to improve care transitions for these high-need Medi-Cal enrollees upon release and increase continuity of health coverage, prevent disruptions in care, and lead to improved health outcomes.

Pre-release Medi-Cal services are available to eligible individuals in the following correctional agencies: state prisons, county jails/detention facilities, and county youth correctional facilities.[110] Adults who are incarcerated in these qualified facilities are eligible to receive pre-release services if they (1) the standard Medicaid eligibility criteria, and (2) experience one or more of the following health care needs: mental illness, SUD, chronic condition or significant clinical condition, intellectual or developmental disability, traumatic brain injury, HIV/AIDS, and/or be pregnant or postpartum.[111] Youth (including former foster youth under age 26) who are incarcerated are able to receive pre-release services without needing to demonstrate a particular health care need.[112] In addition, pursuant to the EPSDT benefit, pre-release services are available for youth under age 21 when they are necessary to correct or ameliorate a physical or behavioral health condition.[113] Correctional facilities and prisons are required to screen all Medi-Cal eligible adults and youth for physical and behavioral health needs to ensure that all eligible individuals who meet the pre-release access criteria are able to receive Medi-Cal services.[114]

Pre-release Medi-Cal services include:

- **Case Management:** intended to facilitate reentry planning into the community in order to (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community.[115] Although the care management services provided under the pre-release services are similar to Enhanced

Care Management (ECM) services, these are two separate benefits due to the context the services are administered and the type of providers that may be providing these services.[116]

- **Physical and behavioral health clinical consultation services:** include targeted preventive, physical, and behavioral health clinical consultation services, such as clinical assessments, patient education, therapy and counseling, and peer support services.[117]
- **Laboratory and radiology services:** pursuant to California's state plan, laboratory and radiology services are covered on order of a licensed practitioner except laboratory services in renal dialysis centers and community hemodialysis units.[118]
- **Medications and medication management:** pursuant to California's state plan, coverage extends to all medications, including over-the-counter medications, in the Medi-Cal Prescription Drug Contract Drugs List, and includes access to medications that are difficult to obtain in correctional facilities and helping individuals access medications that will stabilize their chronic conditions.[119]
- **Medication-Assisted Treatment (MAT):** provided for opioid use disorder (OUD), alcohol use disorder (AUD) and non-opioid substance use disorder, along with other psychosocial services delivered in conjunction with MAT for both OUD, AUD, and non-opioid SUD.[120]
- **Community Health Workers/Promotores/Representatives (CHWPR) services:** includes preventive health services to prevent disease, help control chronic conditions or infectious diseases, and other conditions that may impact health.[121]
- **Services provide upon release:** a minimum 30-day supply of prescribed and prescription OTC medication and durable medical equipment.[122]

Pre-release services can be provided via telehealth or in-person.[123] Correctional facilities are allowed to conduct appointments by video or audio only, as clinically appropriate, and consistent with Medi-Cal's telehealth policy.[124] DHCS requires that providers offering telehealth services to incarcerated individuals comply with the Health Insurance Portability and Accountability Act (HIPAA).[125] Pre-release services will be delivered through Medi-Cal's FFS delivery system and all pre-release providers must enroll in Medi-Cal as an FFS provider.[126] While the targeted set of Medi-Cal pre-release services will be billed FFS, MCPs will be essential to establish a smooth transition for the individual from pre-release services into post-release (regular) Medi-Cal services upon reentry. However, this transition is only necessary if upon release the formerly incarcerated individual is enrolled into a Medi-Cal MCP.

DHCS' launch date for the pre-release services was set for October 1, 2024.[127] DHCS anticipates a two-year implementation period that would allow

correctional facilities, county partners, MCPs, and community-based organizations to better prepare for the implementation of targeted pre-release services as required by state law and CMS. DHCS maintains a website with a list of counties and their status in the justice-involved program.[128] As of the end of 2025, 22 counties are already providing pre-release services to eligible individuals. By October 1, 2026, pre-release Medi-Cal services must be implemented in every county jail, youth correctional facility, and state prison within California.[129]

Endnotes

[1] 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(d)) 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)).

[2] 42 U.S.C. 1396d(r); Cal. Welf. & Inst. Code § 14132(v); *see also* Cal. Dep't Health Care Servs., All Plan Letter 14-017 (Dec. 12, 2014), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf; Cal. Dep't Health Care Servs., 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 [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 16-061].

[3] For the requirement to comply with parity with regards to Medicaid MCPs, see 42 U.S.C. § 1396u-2(b)(8). *See also* 42 C.F.R. §§ 438.900–438.930.

[4] 42 U.S.C. § 300gg-26.

[5] Cal. Welf. & Inst. Code § 14184.402(f)(1). Cal. Dep't Health Care Servs., CalAIM, https://www.dhcs.ca.gov/calaim (last visited Feb. 17, 2026); *see also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-011 (Mar. 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 (Mar. 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. 26-002 at 4–6 (Jan. 20, 2026), https://www.dhcs.ca.gov/Documents/BHIN-26-002-Access-Criteria.pdf [hereinafter Behavioral Health Information Notice No. 26-002].

[6] All Plan Letter 22-005, *supra* note 5.

[7] 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 (Apr. 8, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-006.pdf [hereinafter All Plan Letter 22-006].

[8] *Id.*

[9] *See generally* Cal. Dep't Health Care Servs., Screening and Transition of Care Tools for Medi-Cal Mental Health Services, https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx (last visited Feb. 17, 2026); *see also* Cal. Dep't Health Care Servs., All Plan Letter 25-010 (June 3, 2025), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/APL25-010.pdf [hereinafter Behavioral Health Information Notice No. 25-010]; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-020 (June 3, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-020-Adult-and-Youth-STTs-for-Medi-Cal-Mental-Health-Services.pdf.

[10] *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.

[11] 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.

[12] 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.

[13] 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 [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 Feb. 17, 2026) [hereinafter Peer Support Services].

[14] 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_Notice_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 13, at 10. For more information on the medical necessity criteria for psychiatric inpatient or facility-based services, see Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 26-001 (Jan. 20, 2026), https://www.dhcs.ca.gov/Documents/BHIN-26-001-Inpatient-Criteria.pdf. Starting in 2025, County MHPs may opt-in to provide services in an Institution for Mental Disease (IMD) for up to 60 days if they offer certain community-based services. *See* Logan Kelly, Ctr. Health Care Strategies, *How California's 1115 Demonstration, BH-CONNECT, Will Impact Behavioral Health Care for Medi-Cal Members* 2-3 (2025), https://www.chcs.org/media/How-Californias-1115-Demonstration-BH-CONNECT-Will-Impact-Behavioral-Health-Care-for-Medi-Cal-Members.pdf.

[15] Cal. Welf. & Inst. Code § 14184.402(a).

[16] Cal. Welf. & Inst. Code § 14184.402(c); Behavioral Health Information Notice No. 26-002, *supra* note 5, at 3–4.

[17] Cal. Welf. & Inst. Code § 14184.402(f)(1)(A). *See also* Behavioral Health Information Notice No. 26-002, *supra* note 5, at 8.

[18] Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-017 at 4–5 (Apr. 15, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-017-Concurrent-Review-Standards-and-Updated-Criteria-for-Psychiatric-Inpatient-Hospital.pdf.

[19] *Id.* at 5.

[20] *Id.* at 9.

[21] *See* Cal Welf. & Inst. Code §§ 10950(g), 14197.3; *see also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-014 (Apr. 24, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-014-Mental-Health-Plan-and-Drug-Medi-Cal-Organized-Delivery-System-Plan-Grievance-and-Appeal-Requirements-with-Revised-Member-Notice-Templates.pdf. For more information about the notice and appeal requirements, see Abbi Coursolle, Nat'l Health L. Prog., *Internal and External Review: Medi-Cal Managed Care Plans* (2025 ed.), https://healthlaw.org/resource/internal-and-external-review-medi-cal-managed-care-plans-managed-care-in-california-series-issue-no-4-revised-october-2019/.

[22] 42 U.S.C. § 1396d(r)(5); Cal Welf. & Inst. Code §§ 14059.5(a), 14184.402(a). *See also* Behavioral Health Information Notice No. 26-002, *supra* note 5, at 7.

[23] Behavioral Health Information Notice No. 26-002, *supra* note 5, at 5.

[24] *Id.*

[25] *See generally* Cal. Dep't Health Care Servs., *Medi-Cal Manual: For Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), and Therapeutic Foster Care (TFC) Services for Medi-Cal Beneficiaries* (3d. ed. 2018), https://www.dhcs.ca.gov/Documents/ChildrensMHContentFlaggedForRemoval/Manuals/Medi-Cal_Manual_Third_Edition.pdf; *see also* Cal. Dep't Health Care Servs., 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 IX of this Guide on Children's Health Services.

[26] *See generally* Behavioral Health Information Notice No. 21-058, *supra* note 25.

[27] *Id.* at 2.

[28] *See* Cal. Welf. & Inst. Code §§ 14717.1, 14717.2; Cal. Dep't Soc. Servs. & Cal. Dep't Health Care Servs., All County Letter No. 17-77 / Mental Health and Substance Use Disorder Information Notice No. 17-032 (July 14, 2017), https://www.cdss.ca.gov/Portals/9/ACL/2017/17-77.pdf; Cal. Dep't Soc. Servs. & Cal. Dep't Health Care Servs., All County Letter No. 18-60 / Mental Health and Substance Use Disorder Information Notice No. 18-027 (June 22, 2018), https://www.cdss.ca.gov/Portals/9/ACL/2018/18-60.pdf; Cal. Dep't Health Care Servs. & Cal. Dep't Soc. Servs., All County Letter No. 24-43 / Behavioral Health Information Notice No. 24-045 (June 28. 2024), https://www.dhcs.ca.gov/Documents/BHIN%2024-025-ACL%2024-43%20Presumptive%20Transfer%20Policy.pdf.

[29] 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; *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.

[30] Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 24-008 at 5 (Feb. 8, 2024), https://www.dhcs.ca.gov/Documents/BHIN-24-008-County-of-Responsibility-and-Reimbursement-for-SMHS-DMC-and-DMC-ODS.pdf.

[31] 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. 23-068 (Nov. 20, 2023), https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf.

[32] Cal. Code Regs. tit. 9, § 1810.405(c); Mental Health and Substance Use Disorder Services Information Notice No. 18-054, *supra* note 13, at 4.

[33] Cal. Code Regs. tit. 9, § 1810.253.

[34] Cal. Code Regs. tit. 9, § 1810.405(d).

[35] Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-016 (Apr. 15, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-016-Authorization-of-Outpatient-Specialty-Mental-Health-Services.pdf.

[36] 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.

[37] 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 [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 19-026]

[38] 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 37, at 8; Mental Health and Substance Use Disorder Services Information Notice No. 18-054, *supra* note 13, Enclosure 1, at 3.

[39] 42 C.F.R. § 438.14(b); *see also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-020 (Apr. 27, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-020-County-Mental-Health-Plan-Obligations-Related-to-Indian-Health-Care-Providers.pdf.

[40] *Id.*

[41] 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.

[42] *Id.*

[43] 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.

[44] Cal. Dep't Health Care Servs., Mobile Crisis Services, https://www.dhcs.ca.gov/Pages/CalAIM-Mobile-Crisis-Services-Initiative.aspx (last visited Feb. 17, 2026). *See also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice 23-025 (June 19, 2023) https://www.dhcs.ca.gov/Documents/BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf [hereinafter Behavioral Health Information Notice No. 23-025].

[45] Behavioral Health Information Notice No. 23-025, supa note 44, at 4.

[46] Cal. Dep't Health Care Servs., *Mental Health Plan Boilerplate Contract,* Exhibit A, Attachment 2 (2025-26), https://www.dhcs.ca.gov/services/MH/Documents/Mental-Health-Plan-Contract-2025-2026.pdf.

[47] DHCS has received 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). *See* 42 U.S.C. § 1396w-6. *See also* CMS, Approval Letter for Cal. State Plan Amendment # 22-0043 (July 20, 2023), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0043-Approval.pdf. 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. 42 U.S.C. § 1396w-6(b). *See also* Behavioral Health Information Notice No. 23-025, *supra* note 44, at 4.

[48] Cal Welf. & Inst. Code § 14045.14; *See also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-018 (Apr. 21, 2022), 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.

[49] *See* Peer Support Services, *supra* note 13. 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].

[50] Behavioral Health Information Notice No. 22-026, *supra* note 49, at 3.

[51] *Id.* at 2.

[52] *Id.*

[53] *Id.* at 3.

[54] Cal. Dep't Health Care Servs., *Peer Support Specialists- FAQs* (Feb. 10, 2021), https://www.dhcs.ca.gov/Documents/CSD_KS/Peer%20Support/FAQ-Peer-Support-Specialists.pdf [hereinafter *Peer Support Specialists- FAQs*]. *See also* Behavioral Health Information Notice No. 25-010, *supra* note 9.

[55] *Peer Support Specialists- FAQs, supra* note 54, at 1.

[56] 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.

[57] *Id.*

[58] For in-depth information about the services available under the BH-CONNECT initiative, see Héctor Hernández-Delgado & Carly Myers, Nat'l Health Law Prog., *Advocates Guide to the BH-CONNECT Initiative: Services* (Feb. 2026), https://healthlaw.org/resource/advocates-guide-to-the-bh-connect-initiative-services/.

[59] Cal. Dep't Health Care Servs., Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative, https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx (last visited Feb. 11, 2026); CMS, Approval Letter for California's Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration (Dec. 16, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-ca-12162024.pdf [hereinafter BH-CONNECT Approval Letter]; CMS, Approval Letter for California State Plan Amendment 24-0042 (Dec. 19, 2024), https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0042-Approval.pdf; CMS, Approval Letter for California State Plan Amendment 24-0051 (Dec. 18, 2024), https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0051-Approval.pdf; CMS, Approval Letter for California State Plan Amendment 24-0052 (Dec. 16, 2024), https://www.dhcs.ca.gov/Documents/Approval-CA-24-0052-SPA-Redacted.pdf; CMS, Approval Letter for California State Plan Amendment 22-0001 (July 26, 2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf [hereinafter Approval Letter for SPA # 22-0001].

[60] For more in-depth information about these EBPs, see Cal. Dep't Health Care Servs., Adult Evidence-Based Practices, https://www.dhcs.ca.gov/CalAIM/Pages/Adult-Evidence-Based-Practices.aspx (last visited Feb. 17, 2026). *See also* Cal. Dep't Health Care Servs., *BH-CONNECT Evidence-Based Practice Policy Guide,* https://www.dhcs.ca.gov/Documents/EBP-Policy-Guide.pdf; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-009 at 2 (Apr. 11, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-009-Coverage-of-BH-CONNECT-Evidence-Based-Practices.pdf.

[61] *See* Cal. Dep't Health Care Servs., Opt-In to BH-CONNECT, https://www.dhcs.ca.gov/CalAIM/Pages/Opt-in-to-BH-CONNECT.aspx (last visited Feb. 17, 2026) [hereinafter Opt-In to BH-CONNECT].

[62] *Id.*

[63] For more in-depth information about these ECPs, see Cal. Dep't Health Care Servs., Children and Youth Evidence-Based Practices, https://www.dhcs.ca.gov/CalAIM/Pages/Children-and-Youth-Evidence-Based-Practices.aspx (last visited Feb. 11, 2026). At some point in 2026, DHCS will be issuing guidance to support counties in implementing these EBPs for children with fidelity.

[64] Cal. Dep't Health Care Servs., Centers for Excellence, https://www.dhcs.ca.gov/CalAIM/Pages/Centers-of-Excellence.aspx (last visited Feb. 11, 2026).

[65] BH-CONNECT Approval Letter, *supra* note 59, at 4–5.

[66] Opt-In to BH-CONNECT, *supra* note 61. *See also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-011 (Apr. 11, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-011-BH-CONNECT-Option-to-Receive-FFP-for-SMHS-in-IMDs.pdf [hereinafter Behavioral health Information Notice No. 25-011].

[67] Behavioral health Information Notice No. 25-011, *supra* note 66, at 3.

[68] BH-CONNECT Approval Letter, *supra* note 59, at 6–7; *DHCS, Community Supports Policy Guide Volume 2* at 24–42 (Apr. 2025), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf [hereinafter *CS Policy Guide Vol. 2*].

[69] *CS Policy Guide Vol. 2*, *supra* note 68, at 57.

[70] *Id.* 57–61.

[71] *Id.* 61–63.

[72] BH-CONNECT Approval Letter, *supra* note 59, at 52, Special Terms and Conditions.

[73] *Id.* at 5; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-041 at 2–3 (Nov. 25, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-041-Community-Transition-In-Reach-Services.pdf [hereinafter Behavioral Health Information Notice No. 25-041].

[74] Behavioral Health Information Notice No. 25-041, *supra* note 73, at 3–4.

[75] *Id.* at 8.

[76] *See* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-037 (Nov. 21, 2025), https://www.dhcs.ca.gov/Documents/Final-Activity-Funds-BHIN-25-037.pdf.

[77] *Id.* at 2.

[78] *Id.* at 3–4.

[79] *Id.* at 3.

[80] 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.

[81] *See* Cal. Dep't Health Care Servs., STRTP Frequently Asked Questions (Dec. 2022), https://www.dhcs.ca.gov/provgovpart/Documents/STRTP-IMD-FAQ.pdf; For a current list of IMDs, see Cal. Dep't Health Care Servs., Institutions for Mental Diseases List, https://www.dhcs.ca.gov/services/MH/Pages/IMD-List.aspx (last visited Feb. 12, 2026).

[82] *Id.* at 5.

[83] Behavioral Health Information Notice No. 21-058, *supra* note 25, at 6.

[84] *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.

[85] AB 2317 (Ramos, 2022), https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2317.

[86] 42 U.S.C. § 1396d(a)(16)(A); 42 C.F.R. § 483.354.

[87] *See* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-024 (June 23, 2025), https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-25-024-Interim-Regulations-for-Licensure-of-PRTF.pdf.

[88] Cal. Dep't Health Care Servs., Psychiatric Residential Treatment Facility: Interim Regulations (June 2025), https://www.dhcs.ca.gov/provgovpart/Documents/PRTF-Interim-Regulations.pdf. For more information on PRTFs, including a list of licensed facilities, see Cal. Dep't Health Care Servs., Licensed Facilities, https://www.dhcs.ca.gov/Pages/Licensed-Facilities.aspx (last visited Feb. 12, 2026).

[89] 42 U.S.C. §§ 1396a(k)(1),1396u-7(b)(5) (benefits for expansion population must include essential health benefits and behavioral health services are an essential health benefit per 42 U.S.C. § 18022(b)(1)(E)); *see also* Michelle Lilienfeld, Nat'l Health Law Prog., *Alternative Benefit Plans for the Medicaid Expansion Population* (2014), https://healthlaw.org/resource/alternative-benefit-plans-for-the-medicaid-expansion-population.

[90] CMS, Approval Letter for Cal. State Plan Amendment # 13-035 (Mar. 28, 2014), https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-13-035.pdf; *see also* Lilienfeld, *supra* note 89, at 2–3 (discussing benefit alignment).

[91] All Plan Letter 17-018, *supra* note 13, at 4; Behavioral Health Information Notice No. 26-002, *supra* note 5, at 9. *See also* Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: Non-Specialty Mental Health Services: Psychiatric and Psychological Serves* (Dec. 2021), https://tinyurl.com/5ymn5c3h; 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.

[92] All Plan Letter 22-006, *supra* note 7, at 4.

[93] *Id.* at 4.

[94] Cal. Welf. & Inst. Code § 14059.5(a).

[95] Cal. Dep't Health Care Servs., All Plan Letter 22-006, *supra* note 7, at 4.

[96] 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. 26-002, *supra* note 5, at 7.

[97] Behavioral Health Information Notice No. 26-002, *supra* note 5, at 9.

[98] Cal. Dep't Health Care Servs., All Plan Letter 23-005 (Mar. 16, 2023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf.

[99] All Plan Letter 22-006, *supra* note 7, at 4.

[100] 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* (Mar. 2022), https://www.dhcs.ca.gov/Documents/DHCS-Medi-Cal%27s-Strategy-to-Support-Health-and-Opportunity-for-Children-and-Families.pdf; Cal. Dep't Health Care Servs., Frequently Asked Questions (FAQs) for Medi-Cal Dyadic Services, https://www.dhcs.ca.gov/provgovpart/Pages/Dyadic-Services-FAQ.aspx (last visited Feb. 11, 2026).

[101] Cal. Welf. & Inst. Code § 14132.755(b).

[102] *Id.* For a more in-depth description of Medi-Cal dyadic services, see T. Nancy Lam, Nat'l Health Law Prog. Medi-Cal Dyadic Services (Feb. 2023), https://healthlaw.org/wp-content/uploads/2023/02/Dyadic-Services-Factsheet-Advocates_2.8.23-3.pdf.

[103] Cal. Dep't Health Care Servs., All Plan Letter 22-003 (Mar. 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 (Mar. 16, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-009-Eating-Disorders.pdf.

[104] See Chapter III of this Guide for more information about Medi-Cal Rx.

[105] *See* Cal. Dep't Health Care Servs., *Medi-Cal Rx Provider Manual* § 2.1 (2026), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/manuals/Medi-Cal_Rx_Provider_Manual.pdf.

[106] *See* Cal. Dep't Health Care Servs., All Plan Letter 25-013 at 3-4, (Sept. 18, 2025), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/APL25-013.pdf.

[107] *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.

[108] Cal. Dep't Health Care Servs., *Transformation of Medi-Cal: Justice Involved*, https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-JI-a11y.pdf (last visited Feb. 12, 2026). *See also* Cal. Dep't Health Care Servs., DHCS Justice-Involved Waiver Stakeholder Toolkit, https://www.dhcs.ca.gov/CalAIM/Pages/JI-Stakeholder-Toolkit.aspx (last visited Feb. 12, 2026).

[109] Cal. Welf. & Inst. Code § 14184.402. *See* CMS, Approval Letter for California Advancing and Innovating Medi-Cal (CalAIM) Reentry Demonstration Initiative Amendment (Jan. 26, 2023), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf.

[110] Cal. Dep't Health Care Servs., *Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative* at 62–66 (Oct. 2023), https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf [hereinafter *CalAIM Justice-Involved Initiative Policy Guide*]. Individuals residing in low-security institutions, which include g camps and two honor farms, are deemed "inmates" and do not have the freedom of movement, therefore pre-release services will be available to individuals confined in these facilities. *Id.* at 61.

[111] *Id.* at 62–66.

[112] *Id.* at 63. Under the federal SUPPORT Act and CMS guidance, California requires counties to implement unlimited suspension for individuals under age 21 who were incarcerated prior to January 1, 2023. *See* CMS, Dear State Medicaid Director Letter (Jan. 19, 2021) (SMD # 21-002) (guidance on Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act)), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf. *See also CalAIM Justice-Involved Initiative Policy Guide*, *supra* note 110, at 16, FN 19.

[113] 42 U.S.C. § 1396d(r)(5); Cal. Welf. & Inst. Code § 14059.5(b)(1).

[114] *CalAIM Justice-Involved Initiative Policy Guide, supra* note 110, at 67–72.

[115] *Id.* at 75–76.

[116] *Id.* at 93–107.

[117] *Id.* at 108–110. For more information about coordination services to which Medi-Cal beneficiaries are entitled, see Chapter XII of this Guide on Care Coordination.

[118] *CalAIM Justice-Involved Initiative Policy Guide, supra* note 110, at 77; Cal. Dep't Health Care Servs., Cal. State Plan Chart, Limitations on Attachment 3.1-A 4, https://www.dhcs.ca.gov/SPA/Documents/Limitations-to-Attachment-3-1A.pdf. [hereinafter State Plan Limitations on Attachment 3.1-A]

[119] Cal. Dep't Health Care Servs., Medi-Cal Rx Contract Drugs List (2026), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf; *See also* Cal. Dep't Health Care Servs., Medi-Cal Rx Contract Drugs List – Over-the-Counter Drugs and Cold/Cough Preparations (2026), 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. State Plan Limitations on Attachment 3.1, *supra* note 118, at 17. and Cal. Dep't Health Care Servs., Cal. State Plan Chart, Attachment 3.1.A.1, https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Attachment-3-1-A-1-3.pdf.

[120] CMS, Approval Letter for Cal. State Plan # 20-0006 (Dec. 20, 2021), https://www.dhcs.ca.gov/Documents/CA-20-0006-B-MAT-SPA-Approval-Package.pdf.

[121] Approval Letter for SPA # 22-0001, *supra* note 59.

[122] *CalAIM Justice-Involved Initiative Policy Guide*, *supra* note 110, at 78.

[123] *Id.* at 93.

[124] *Id.*

[125] *Id.*

[126] *Id.* at 131.

[127] *Id.* at 47.

[128] Cal. Dep't Health Care Servs., Justice-Involved Reentry Initiative Go Live Partners and Status, https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/County-readiness-status.aspx (last visited Feb. 17, 2026).

[129] For more information on services and supports available through the Justice-Involved Initiative, see Jasmine Young & Héctor Hernández-Delgado, Nat'l Health Law Prog., *Medi-Cal Services & Supports for Californians Transitioning Out of Incarceration* (2024), https://healthlaw.org/resource/medi-cal-services-supports-for-californians-transitioning-out-of-incarceration/.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated February 2026

Chapter V:
Substance Use Disorder Services

Chapter V:
Substance Use Disorder Services

Outline of Medi-Cal Substance Use Disorder Services*
A. SUD Preventative Services 1. Alcohol and Drug Use Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) 2. Services for Prevention of Tobacco Use B. Prescription Drug Services for Alcohol and Opioid Use Disorders C. Drug Medi-Cal 1. Methadone Maintenance Treatment at Narcotic Treatment Programs 2. Outpatient Drug Free Treatment 3. Intensive Outpatient Treatment 4. Perinatal Residential SUD Services 5. Naltrexone Treatment Services 6. Peer Support Services D. Drug Medi-Cal Organized Delivery System 1. Early Intervention Services 2. Additional Treatment at Narcotic Treatment Programs 3. Partial Hospitalization 4. Residential Services 5. Withdrawal Management 6. Medication-Assisted Treatment 7. Recovery Services 8. Care Coordination 9. Clinician Consultation 10. Contingency Management Services for Stimulant Use Disorders 11. Peer Support Services 12. Crisis Intervention Services (including mobile crisis services) 13. Traditional Health Care Practices E. Voluntary Inpatient Detoxification F. CalAIM Justice-Involved Initiative G. BH-Connect Initiative Services

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

Medi-Cal covers a variety of services that are part of the continuum of care for substance use disorders (SUD). Since the enactment of the Affordable Care Act (ACA), which requires Medicaid plans to cover mental health and SUD services to Medicaid expansion populations, California has significantly expanded the scope and availability of SUD services.[1] However, the SUD system in Medi-Cal continues to be highly fragmented. The majority of SUD services have been carved out from Medi-Cal managed care plans' (MCPs) contracts and are provided through county behavioral health plans. Availability of those carved-out services varies depending a beneficiary's county of residence. MCPs are generally responsible for coverage and provision of emergency SUD services and SUD services within the scope of practice of primary care practitioners, particularly extending to preventive services and care coordination.[2] The ACA also requires county behavioral health plans and MCPs to provide these services in compliance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).[3] As a result, SUD services cannot be subject to limitations that are more onerous than limitations typically imposed on physical and surgical benefits.[4]

Specialty SUD services in Medi-Cal are covered through a variety of legal authorities and initiatives. Most basic SUD services are provided through California's Medi-Cal State Plan and are part of California's Drug Medi-Cal (DMC) program. 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, extended with some modifications in 2021, is now 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 though the California Advancing and Innovating Medi-Cal (CalAIM) initiative through renewed Section 1115 and 1915(b) Medi-Cal waivers. As a result of the 2022 renewal, the majority of the DMC-ODS services are now part of California's State Plan, though the accompanying waiver continues to limit their scope and beneficiary eligibility.

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.[8] When an EPSDT screening and assessment shows a risk of developing an alcohol use disorder (AUD) or an SUD, beneficiaries under 21 in all counties may receive early intervention services under the outpatient services modality of the DMC-ODS program (described in more detail below).

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 that have received a grade "A" or "B" recommendation from

the United States Preventive Services Task Force (USPSTF).[5] Pursuant to USPSTF recommendation, preventive alcohol and drug use services are available for beneficiaries 11 years of age and older through the SABIRT benefit.[6] 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.[7]

The SABIRT 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.[9]
- **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).*[10]
- **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.[11]

2. Services for Prevention of Tobacco Use

The USPSTF also recommends tobacco smoking cessation services.[12] As a result, Medi-Cal provides coverage for the following services:[13]

- **Assessment of tobacco use during initial medical visit and annually thereafter**
- **Food and Drug Administration (FDA)-approved tobacco cessation medications for non-pregnant adults:**[14]
  - Bupropion SR (Zyban®)
  - Varenicline (Chantix®)
  - Nicotine gum
  - Nicotine inhaler
  - Nicotine lozenge
  - Nicotine nasal spray
  - Nicotine patch
- **Individual, group, and telephone counseling:** at least four counseling sessions of at least ten minutes are covered regardless of whether the beneficiary is also undergoing medication treatment.[15] 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.[16]

- **Services for pregnant tobacco users:** Beneficiaries who are pregnant are eligible for tailored, one-on-one counseling for tobacco cessation.[17] 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 use disorders (AUD) and opioid use disorders (OUD) has historically been carved out of MCP contracts and the carve out precedes the establishment of the Medi-Cal Rx Pharmacy Benefit carve out.[18] Medi-Cal covers the following SUD medications:[19]

- Methadone, buprenorphine (Subutex® or Suboxone®), and injectable naltrexone (Vivitrol®) for medication-assisted treatment (MAT) of OUD;[20]
- Naloxone (Narcan® or Evzio®) as an opioid overdose reversal medication, including the formulations approved by the FDA for over-the-counter sale;[21] and
- Disulfiram (Antabuse®), acamprosate (Campral®), and oral and injectable naltrexone (Vivitrol®) for treatment of AUD.

When these medications are administered in a provider's office or in a clinical setting, Medi-Cal pays for the medications under the medical provider benefit.[22] 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.[23]

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.[24] In addition, pharmacists across the state are allowed to dispense naloxone without a prescription.[25] 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.[26]

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 SUD providers certified by the Department of Health Care Services (DHCS).[27] These services have been carved out of MCP contracts. Instead, county behavioral health programs (in some counties still known as county drug and alcohol and programs) are responsible for contracting with Medi-Cal-certified providers to arrange, provide, or subcontract the provision of DMC services.

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.[28] 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.[29]

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.[30] 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.[31]

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. 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."[32]

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.[33] 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:[34]

- 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).

DMC Services

Services covered as part of the DMC program include:

1. *Narcotic Treatment Program (NTP) Services:* Pursuant to federal law, only specialized licensed clinics can dispense methadone for OUD treatment.[35] In California, these clinics are called narcotic treatment programs (NTPs) and provide treatment with any medication approved by the FDA for OUD treatment.[36]
2. *Outpatient Drug Free Treatment:* Outpatient services directed at stabilizing and rehabilitating persons with SUD diagnoses.[37]
3. *Intensive Outpatient Treatment (IOT):* "Outpatient counseling and rehabilitation services provided at least three hours per day, three days per week..."[38]
4. *Perinatal Residential SUD Services:* "Non-institutional, non-medical residential programs which provide rehabilitation services."[39]
5. *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.[40]
6. *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.[41] 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	Residential Services	Naltrexone Treatment
Intake[42]	✓	✓	✓	✓	✓
Body specimen screening	✓	✓	✓	✓	✓
Admissions physical exams and laboratory tests	✓	✓	✓	✓	✓
Treatment Planning	✓	✓	✓	✓	✓
Physician/Nursing Services	✓				✓
Medical Direction	✓	✓	✓	✓	✓
Medical Psychotherapy[43]	✓	✓			
Individual/Group Counseling[44]	✓[45]	✓[46]	✓[47]	✓[48]	✓[49]
Medication Services[50]	✓	✓	✓	✓	✓
Provision of MMT and/or LAAM	✓				
Crisis Intervention[51]		✓	✓	✓	✓
Collateral Services[52]		✓	✓	✓	✓
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 and adolescents (under 18): Parental/legal guardian consent Confirmed history of 2 or more unsuccessful attempts in withdrawal treatment or short-term detoxification within one year.[53]
Outpatient Drug Free Treatment	None
IOT	None[54]
Perinatal Residential	Pregnant and postpartum individuals only. Beneficiaries must live on the premises of the facility and be supported, 24-hours and seven days a week, in an effort to "restore, maintain, and apply interpersonal and independent living skills and access community support systems."[55] 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.[56] 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.[57]
Naltrexone Treatment	Limited to beneficiaries who are at least 18 years old, have a confirmed, documented history of OUD, have undergone detoxification (i.e., they are opiate free), and are not pregnant.[58]

D. Drug Medi-Cal Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) was first adopted as part of a Section 1115 waiver in 2015 and it sought to increase integration and coordination of SUD services.[59] The demonstration also adopted the American Society of Addiction Medicine (ASAM) continuum of care.[60] The DMC-ODS is a managed care program (with similar responsibilities as other managed care plans in California) for substance use disorder (SUD) services that expands treatment options for Medi-Cal beneficiaries, and is therefore part of the county behavioral health plans. This program was renewed and extended effective in

2022 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 still authorized under a Section 1115 waiver.[61] The DMC-ODS program enables counties to cover 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.[62]

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.

Access and Patient Placement Criteria

Eligibility for DMC-ODS program services is restricted to Medi-Cal beneficiaries who meet specific service access 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.[64] However, DMC-ODS services provided while an initial assessment is ongoing are reimbursable regardless of whether an SUD diagnosis is ultimately made.[65]

ADVOCACY TIP:

✓ DMC-ODS programs are considered Prepaid Inpatient Health Plans (PIHPs), which means they effectively function as managed care programs. As such, DMC-ODS programs must comply with all Medi-Cal managed care laws and regulations, including requirements around due process protections (e.g., requirement to provide a Notice of Adverse Benefit Determination (NOABD) and a system to evaluate patients' grievances and appeals).[63]

Despite the use of this access criteria as part of DMC-ODS, nothing in the demonstration overrides EPSDT requirements.[66] This means that, for

beneficiaries under 21, 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.[67] 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.[68]

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. 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."[69]

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	Narcotic Treatment Program
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)*
	Inpatient services (optional for counties)
	Recovery Services
	Care Coordination
	Physician Consultation

Figure 3 continued

	Partial Hospitalization (optional for counties)
	Medication-Assisted Treatment Services
	Contingency Management for Stimulant Use Disorders (optional for counties)
	Peer Support Services (optional for counties)
	Traditional Health Care Practices

1. 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.[70] 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.[71]

2. Treatment at Narcotic Treatment Programs

The DMC-ODS program continues to cover treatment at NTPs. The program provides coverage for treatment at NTPs with the medications buprenorphine, disulfiram, and naloxone.[72] NTPs are required to offer all FDA-approved medications for OUD when they can be readily purchased by the NTP.[73] The DMC-ODS program also clarifies that activities covered as part of NTP include the ordering, prescribing, administering, and monitoring of the medication regime.[74] 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.[75]

3. Partial Hospitalization

Partial hospitalization services are available as optional services for counties participating in the DMC-ODS waiver.[76] 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.[77] 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.[78] 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.[79]

4. Residential and Inpatient 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.[80] 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.[81]

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.[82] 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.[83]

DMC-ODS Counties also have the option to offer SUD inpatient services in general acute care hospitals, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health (DPH), and Freestanding Acute Psychiatric Hospitals (FAPHs) licensed by DPH.[84] When counties take up this option, they must provide the same components as residential services described above.[85]

5. 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."[86] Counties participating in the DMC-ODS waiver must provide coverage for at least one ASAM level of withdrawal management.[87] 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.[88]

6. Medication-Assisted Treatment (MAT)

As part of a new no-wrong-door approach implemented through CalAIM, DHCS has clarified that counties may offer MAT, which is otherwise covered through the Rx carve out, as a standalone service in addition to being a component of other DMC-ODS services.[89] When offered as a standalone service, counties must ensure that they provide assessment, care coordination, individual and group counseling, family therapy, medication services, patient education, recovery services, SUD crisis intervention services, and withdrawal management services.[90]

7. 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.[91] 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.[92] 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.[93] Services may be provided face-to-face, by telephone, or by telehealth and include the following components:[94]

- 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.

8. 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."[95] 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.[96] Services may be provided face-to-face, by telephone, or by telehealth with the beneficiary.[97]

The specific components of the DMC-ODS program care coordination benefit are:[98]

- 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.

9. Clinician Consultation

Clinician consultation services allow DMC physicians to consult with addiction medicine physicians, addiction psychiatrists, licensed clinicians or clinical pharmacists.[99] 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.[100] Services can only be billed by and reimbursed to DMC-ODS providers.[101]

10. 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.[102] This time-limited pilot program, called Recovery Incentives Program, allows counties to offer contingency management to beneficiaries with a diagnosed stimulant use disorder beginning in early 2023.[103] Stimulants include illicit substances such as cocaine and methamphetamine, as well as prescription medications, like amphetamine. As of 2025, there were 109 sites offering the contingency management benefits in a total of 21 counties participating in the Recovery Incentives Program.[104] The program is slated to end in December 2027, but DHCS has stated its intention to seek a renewal from CMS.

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.[105] Participants can also receive additional support during their participation like counseling, MAT for OUD, patient education, peer support, withdrawal management, and recovery services.[106] 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.[107]

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.[108]

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.[109]

11. Peer Support Services

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."[110] 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.[111]

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:[112]

- 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.

12. Crisis Intervention Services and Mobile Crisis Services

DMC-ODS programs are required to provide crisis intervention services, which 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."[113] 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, Medi-Cal covers qualifying community-based mobile crisis services statewide.[114] States may elect to provide coverage for behavioral health mobile crisis services pursuant to Section 9813 of the American Rescue Plan Act of 2021 (ARPA).[115] 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.[116] To receive federal matching funding under 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.[117] As with other DMC-ODS services, mobile crisis services are required to be provided under EPSDT, which means that beneficiaries under 21 are entitled to 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.

13. Traditional Health Care Practices

In 2025, CMS approved an amendment to California's section 1115 waiver under CalAIM that enables Medi-Cal to cover traditional health care practices.[118] Beginning March 21, 2025, DMC-ODS counties are required to provide these services to Medi-Cal beneficiaries who reside in their county, are able to receive services through an eligible provider entity, and meet the DMC-ODS access criteria (described above).[119] As with other services, however, application of the access criteria does not override counties' responsibilities under EPSDT.[120] Therefore, beneficiaries under 21 who are determined to need traditional health care services to correct or ameliorate a condition are entitled to the services regardless of their county of residence.

Traditional health care practices extend to two sets of services:[121]

- Traditional healer services: use interventions such as music therapy (traditional songs, dancing, drumming), spirituality (ceremonies, rituals, herbal remedies), and other integrative approaches. These services must be

provided by a person currently recognized as a spiritual leader in good standing with the community.
- Natural healer services: assist in navigating support, psychosocial skill building, self-management, and trauma support to restore health. These services are provided by a health advisor contracted or employed by an eligible provider facility.

Traditional health care practices may only be provided by participating Indian Health Care Providers (IHCPs), which include Indian Health Service (IHS) facilities, facilities operated by Tribes or Tribal organizations, and facilities operated by urban Indian organizations.[122] Providers may opt in to provide traditional health care services to Medi-Cal beneficiaries, but they must be enrolled as Medi-Cal providers.[123] They may also offer other DMC-ODS services, in which case the providers must complete a DMC certification.[124] All IHCPs are required to coordinate access to additional SUD services and to ensure that beneficiaries have timely access to the full continuum of DMC-ODS services, including MAT.[125]

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.[126] 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.[127]

At county option, DMC-ODS covers the cost of ordering and purchasing FDA-approved medications for SUD.[128] 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.[129] Medi-Cal also requires counties that opt into this benefit to ensure that providers offer counseling or other behavioral health therapy.[130]

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.[131] Both MCP enrollees and FFS beneficiaries are entitled to the service, subject to approval of a Treatment Authorization Request (TAR).[132]

To receive VID, the beneficiary must meet at least one of the following criteria:[13]

- 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.[134]

F. CalAIM Justice-Involved Initiative: Pre-Release Medi-Cal Services

The CalAIM Justice-Involved Initiative is part of the CalAIM 1115 waiver and aims to improve access to and quality of health care for justice-involved populations as they re-enter their communities.[135] In 2023, California became the first state to receive federal approval from the CMS to offer and obtain federal funding for a targeted set of Medi-Cal services to youth and adults in correctional facilities for up to 90 days prior to release (hereinafter, "pre-release Medi-Cal services").[136] This time-limited program is slated to expire at the end of 2027, although DHCS has expressed its intention to seek a waiver renewal from CMS.

Pre-release Medi-Cal services are available to eligible individuals in the following correctional agencies: state prisons, county jails/detention facilities, and county

youth correctional facilities.[137] Adults who are incarcerated in these qualified facilities are eligible to receive pre-release services if they (1) meet the standard Medicaid eligibility criteria, and (2) experience one or more of the following health care needs: mental illness, SUD, chronic condition or significant clinical condition, intellectual or developmental disability, traumatic brain injury, HIV/AIDS, and/or be pregnant or postpartum.[138] Youth who are incarcerated are able to receive pre-release services without needing to demonstrate a particular health care need.[139] In addition, pursuant to the EPSDT benefit, pre-release services are available for youth under age 21 when they are necessary to correct or ameliorate a physical or behavioral health condition.[140] Correctional facilities and prisons are required to screen all Medi-Cal eligible adults and youth for physical and behavioral health needs to ensure that all eligible individuals who meet the pre-release access criteria are able to receive Medi-Cal services.[141]

Pre-release Medi-Cal services include:

- **Case Management:** intended to facilitate reentry planning into the community in order to (1) support the coordination of services delivered during the pre-release period and upon reentry; (2) ensure smooth linkages to social services and supports; and (3) ensure arrangement of appointments and timely access to appropriate care and pre-release services delivered in the community.[142] Although the care management services provided under the pre-release services are similar to Enhanced Care Management (ECM) services, these are two separate benefits due to the context the services are administered and the type of providers that may be providing these services.[143]
- **Physical and behavioral health clinical consultation services:** include targeted preventive, physical, and behavioral health clinical consultation services, such as clinical assessments, patient education, therapy and counseling, and peer support services.[144]
- **Laboratory and radiology services:** pursuant to California's state plan, laboratory and radiology services are covered on order of a licensed practitioner except laboratory services in renal dialysis centers and community hemodialysis units.[145]
- **Medications and medication management:** pursuant to California's state plan, coverage extends to all medications, including over-the-counter medications, in the Medi-Cal Prescription Drug Contract Drugs List, and includes access to medications that are difficult to obtain in correctional facilities and helping individuals access medications that will stabilize their chronic conditions.[146]
- **Medication-Assisted Treatment (MAT):** provided for opioid use disorder (OUD), alcohol use disorder (AUD) and non-opioid substance use disorder, along with other psychosocial services delivered in conjunction with MAT for both OUD, AUD, and non-opioid SUD.[147]

- **Community Health Workers/Promotores/Representatives (CHWPR) services:** includes preventive health services to prevent disease, help control chronic conditions or infectious diseases, and other conditions that may impact health.[148]
- **Services provide upon release:** a minimum 30-day supply of prescribed and prescription OTC medication and durable medical equipment.[149]

Pre-release services can be provided via telehealth or in-person.[150] Correctional facilities are allowed to conduct appointments by video or audio only, as clinically appropriate, and consistent with Medi-Cal's telehealth policy.[151] DHCS requires that providers offering telehealth services to incarcerated individuals comply with the Health Insurance Portability and Accountability Act (HIPAA).[152] Pre-release services will be delivered through Medi-Cal's FFS delivery system and all pre-release providers must enroll in Medi-Cal as an FFS provider.[153] While the targeted set of Medi-Cal pre-release services will be billed FFS, Managed Care Plans (MCPs) will be essential to establish a smooth transition for the individual from pre-release services into post-release (regular) Medi-Cal services upon reentry. However, this transition is only necessary if upon release the formerly incarcerated individual is enrolled into a Medi-Cal MCP.

DHCS' launch date for the pre-release services was set for October 1, 2024.[154] DHCS anticipates a two-year implementation period that would allow correctional facilities, county partners, MCPs, and community-based organizations to better prepare for the implementation of targeted pre-release services as required by state law and CMS. DHCS maintains a website with a list of counties and their status in the justice-involved program.[155] As of the end of 2025, 22 counties are already providing pre-release services to eligible individuals. By October 1, 2026, pre-release Medi-Cal services must be implemented in every county jail, youth correctional facility, and state prison within California.[156]

G. Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative

BH-CONNECT is a 5-year initiative designed to expand evidence-based practices (EBPs) and to strengthen behavioral health guidance and principles to Medi-Cal services statewide. [157] One component of BH-CONNECT allows DMC and DMC-ODS counties to opt-in to cover Enhanced Community Health Worker (CHW) services and Individual Placement and Support (IPS) Supported Employment.[158] Counties may cover these services independently or as part of a bundled set of services that also includes EBPs specific for mental health conditions under the Specialty Mental Health Services (SMHS) system.[159]

Enhanced CHW Services are "preventive services to prevent disease, disability, and other health conditions or their progression; to prolong life; and promote

physical and behavioral health."[160] Enhanced CHW Services include all of the same components and requirements as CHW preventive services but are tailored to members who meet the access criteria for specialty mental health and/or SUD services.[161]

The IPS model of Supported Employment is "a community-based intervention that supports members living with significant behavioral health needs to find and maintain competitive employment." This program supports improved employment outcomes as well as improved self-esteem, independence, sense of belonging, and overall health and well-being.[162]

Additionally, BH-CONNECT makes available a new transitional rent benefit. This benefit provides coverage for short-term rental assistance that extends to room and board without clinical assistance for MCP enrollees experiencing or at risk of homelessness.[163] Transitional Rent will be available for up to 6 months, which may be used during different intervals or sequentially, for the entire duration of the five-year BH-CONNECT demonstration (i.e., 2025–2029).[164] The benefit joins other room-and-board Community Support services available through CalAIM (Short-Term Post-Hospitalization Housing and Recuperative Care). Together, a managed care enrollee may receive up to a maximum of 6 months of any of these 3 services during a 12-month period.

Beginning January 1, 2026, all MCPs must cover Transitional Rent for individuals who meet all of the following 3 categories:[165]

1. The enrollee meets the access criteria for SMHS, DMC, or DMC-ODS;

AND

2. The enrollee is part of one of the following transitioning populations:
   - **Individuals transitioning out of an institutional or congregate residential setting,** including but not limited to an inpatient hospital stay, an inpatient or residential SUD treatment facility, an inpatient or residential mental health treatment facility, or a nursing facility.
   - **Individuals transitioning out of a carceral setting,** including those transitioning out of a state prison, county jail, youth correctional facility, or other state, local, or federal penal setting where they have been involuntarily held in custody through operation of law enforcement authorities.
   - **Individuals transitioning out of interim housing,** including those transitioning out of transitional housing, rapid re-housing. a domestic violence shelter or domestic violence housing, a homeless shelter, or other interim housing, whether funded or administered by HUD, or at the State or local level.
   - **Individuals transitioning out of recuperative care or short-term post-hospitalization housing,** whether the stay was covered by Medi-Cal managed care or another source.

- **Individuals transitioning out of foster care:** Youth having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.
- **Individuals experiencing unsheltered homelessness:** Individuals or families with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or campground.
- **Individuals eligible for Full-Service Partnership (FSP):** FSP is a comprehensive behavioral health program for individuals living with significant mental health and/or co-occurring substance use conditions that have demonstrated a need for intensive wraparound services.

AND

3. The enrollee is experiencing or at risk of homelessness.

Plans also have the option of offering the service to individuals with one or more of the following clinical risk factors: (1) pregnant or up to 12-months postpartum, (2) have one or more serious chronic physical health conditions, or (3) have one or more physical, intellectual, or developmental disabilities.[166] Individuals must always be part of one of the transiting populations described above (criteria #2) and be experiencing or at risk of homelessness (criteria #3). These additional eligibility pathways for Transitional Rent, while currently optional, will become mandatory for managed care plans to cover no sooner than January 1, 2027.[167]

Endnotes

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

[2] *See* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-011 at 4 (Mar. 31, 2022), https://www.dhcs.ca.gov/Documents/BHIN-22-011-No-Wrong-Door-for-Mental-Health-Services-Policy.pdf [hereinafter Behavioral Health Information Notice No. 22-011].

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

[4] 42 U.S.C. § 300gg-26.

[5] 42 U.S.C. § 1396d(a)(13)(A).

[6] 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 Dec. 1, 2025); Cal. Dep't Health Care Servs., All Plan Letter No. 21-014 (Oct. 11, 2021), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-014.pdf [hereinafter All-Plan Letter 21-014]. *See also* Dep't Health Care Servs., *Medi-Cal Provider Manual: Preventive Services* 12–17 (Sept. 2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/DDBB7BD0-9D06-4B3C-9597-7FAFF5471E6F/prev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[7] Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 24-001 at 10 (Dec. 21, 2023), https://www.dhcs.ca.gov/Documents/BHIN-24-001-DMC-ODS-Requirements-for-the-Period-of-2022-2026.pdf [hereinafter Behavioral Health Information Notice No. 24-001].

[8] 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 No. 21-014, *supra* note 6, at 5–6 and Behavioral Health Information Notice No. 24-001, *supra* note 7, at 4–5, 10–11.

[9] All Plan Letter No. 21-014, *supra* note 6, at 4.

[10] *Id.*

[11] *Id.* at 4–5.

[12] 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 Dec. 1, 2025).

[13] Cal. Welf. & Inst. Code § 14134.25(a); Cal. Dep't Health Care Servs., All Plan Letter No. 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].

[14] Cal. Welf. & Inst. Code § 14134.25(b)(2); All Plan Letter No. 16-014, *supra* note 13, 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.

[15] Cal. Welf. & Inst. Code § 14134.25(b)(1); All Plan Letter No. 16-014, *supra* note 13, at 4–5.

[16] All Plan Letter No. 16-014, *supra* note 13, at 5.

[17] *Id.* at 5–6.

[18] For information on the original carved-out medications, see Cal. Dep't Health Care Servs., All Plan Letter No. 16-004 (Feb. 19, 2016), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-004.pdf.

[19] *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 [hereinafter Mental Health and Substance Use Disorder Services Information Notice No. 15-033].

[20] MCPs cover MAT when provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings. *See* Behavioral Health Information Notice No. 22-011, *supra* note 2, at 4.

[21] Cal. Dep't Health Care Servs., Medi-Cal Rx Contract Drugs List – Over the-Counter Drugs and Cough/Cold Preparations at 2, 4 (Sept. 1, 2025), 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. [hereinafter Medi-Cal Rx Contract Drugs List - OTC Drugs and Cough/Cold Preparations] *See also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 23-064 (Nov. 13, 2023), https://www.dhcs.ca.gov/Documents/BHIN-23-064-Naloxone-Use-Funding-Sources-and-Best-Practices.pdf [hereinafter Behavioral Health Information Notice No. 23-064].

[22] *See generally* Mental Health and Substance Use Disorder Services Information Notice No. 15-033, *supra* note 19.

[23] *Id.*

[24] 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.

[25] Cal. Bus. & Prof. Code § 4052(a)(13).

[26] For more information on coverage and availability of naloxone products in Medi-Cal, see Behavioral Health Information Notice No. 23-064, *supra* note 21.

[27] 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)).

[28] 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.

[29] *Id.* at 2.

[30] *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) (extending the state law requirement to use the EPSDT medical necessity criteria to behavioral health services).

[31] Behavioral Health Information Notice No. 22-003, *supra* note 8, at 4.

[32] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 9.

[33] Cal. Code Regs. tit. 22, § 51341.1(c).

[34] *Id.*

[35] 42 C.F.R. § 8.12.

[36] Cal. Welf. & Inst. Code § 14124.24(a)(1); Cal. Welf. & Inst. Code § 14021.51(a)(5)

[37] Cal. Welf. & Inst. Code § 14124.24(a)(5); Cal. Code Regs. tit. 22, § 51341.1(b)(18). *See also* Cal. Code Regs. tit. 22, § 51341.1(d)(2).

[38] Cal. Welf. & Inst. Code § 14124.24(a)(2); 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.

[39] Cal. Welf. & Inst. Code § 14124.24(a)(3); Cal. Code Regs. tit. 22, § 51341.1(b)(20). *See also* Cal. Code Regs. tit. 22, § 51341.1(d)(4).

[40] Cal. Welf. & Inst. Code § 14124.24(a)(4); Cal. Code Regs. tit. 22, § 51341.1(b)(16). *See also* Cal. Code Regs. tit. 22, § 51341.1(d)(5).

[41] Cal. Welf. & Inst. Code § 14124.24(a)(6); 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].

[42] 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).

[43] 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).

[44] 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).

[45] 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.

[46] 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).

[47] 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).

[48] At least two counseling sessions per month. Cal. Code Regs. tit. 22, § 51341.1(h)(4)(A).

[49] At least two counseling sessions per month. Cal. Code Regs. tit. 22, § 51341.1(h)(4)(A).

[50] 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).

[51] 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).

[52] 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).

[53] 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.

[54] 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.

[55] Cal. Code Regs. tit. 22, § 51341.1(b)(20).

[56] 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).

[57] Cal. Code Regs. tit. 22, § 51341.1(d)(4)(A).

[58] Cal. Code Regs. tit. 22, § 51341.1(d)(5).

[59] 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 Dec. 1, 2025).

[60] 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 Dec. 1, 2025).

[61] 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].

[62] Under federal law, unless the Centers for Medicare and Medicaid Services (CMS) waives 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.

[63] *See* Cal. Dep't Health Care Servs., Quality and Performance, https://www.dhcs.ca.gov/provgovpart/Pages/qualityandperformance.aspx (last visited Oct. 24, 2025).

[64] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 7; 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].

[65] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 8; Behavioral Health Information Notice No. 21-019, *supra* note 64, at 2.

[66] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 8; Behavioral Health Information Notice No. 21-019, *supra* note 64, at 2; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 2–4.

[67] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 8; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 3.

[68] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 8. *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.

[69] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 9.

[70] Behavioral Health Information Notice No. 21-019, *supra* note 64, at 2.

[71] Behavioral. Health Information Notice No. 24-001, *supra* note 7, at 10–11; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 3.

[72] State Plan Amendment # 21-0058, *supra* note 61, at 6q; Behavioral. Health Information Notice No. 24-001, *supra* note 7, at 15–16.

[73] Behavioral. Health Information Notice No. 24-001, *supra* note 7, at 15–16; 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].

[74] State Plan Amendment # 21-0058, *supra* note 61, at 6h, 6q; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 16; Behavioral Health Information Notice No. 21-024, *supra* note 73, at 2.

[75] State Plan Amendment # 21-0058, *supra* note 61, at 6q; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 16–17.

[76] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 12.

[77] *Id.*

[78] *Id.*

[79] State Plan Amendment # 21-0058, *supra* note 61, at 6p; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 12.

[80] State Plan Amendment # 21-0058, *supra* note 61, at 6p; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 13–15; Behavioral Health Information Notice No. 21-019, *supra* note 64, at 3.

[81] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 14; 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.

[82] State Plan Amendment # 21-0058, *supra* note 61, at 6p–6q; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 13.

[83] Behavioral Health Information Notice No. 21-024, *supra* note 73, at 2; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 22-025, (May 11, 2022), https://www.dhcs.ca.gov/provgovpart/Documents/BHIN-22-025.pdf. For additional information on the requirement for facilities to offer or connect beneficiaries with MAT services, see Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 23-054 (Oct. 6, 2023), https://www.dhcs.ca.gov/formsandpubs/Documents/BHIN-23-054.pdf.

[84] State Plan Amendment # 21-0058, *supra* note 61, at 6p–6q; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 15.

[85] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 15.

[86] State Plan Amendment # 21-0058, *supra* note 61, at 6j.

[87] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 17–18, 34.

[88] State Plan Amendment # 21-0058, *supra* note 61, at 6j–6k; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 18.

[89] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 18.

[90] *Id.*

[91] State Plan Amendment # 21-0058, *supra* note 61, at 6i–6j; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 20. *See also* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 21-020 (May14, 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].

[92] State Plan Amendment # 21-0058, *supra* note 61, at 6j; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 20; Behavioral Health Information Notice No. 21-020, *supra* note 91, at 2.

[93] State Plan Amendment # 21-0058, *supra* note 61, at 6j; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 20; Behavioral Health Information Notice No. 21-020, *supra* note 91, at 3.

[94] State Plan Amendment # 21-0058, *supra* note 61, at 6j; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 20–21; Behavioral Health Information Notice No. 21-020, *supra* note 91, at 2.

[95] State Plan Amendment # 21-0058, *supra* note 61, at 6g; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 21.

[96] State Plan Amendment # 21-0058, *supra* note 61, at 6g; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 21.

[97] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 21.

[98] State Plan Amendment # 21-0058, *supra* note 61, at 6g; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 21.

[99] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 22.

[100] *Id.*

[101] *Id.*

[102] *See* Approval Letter for CalAIM Section 1115(b) Waiver, *supra* note 61, at Expenditure Authority 2.

[103] *See generally* Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 24-031 (Aug. 22, 2024), https://www.dhcs.ca.gov/Documents/BHIN-24-031-Updated-Guidance-for-the-RI-Program.pdf [hereinafter Behavioral Health Information Notice No. 24-031]. *See also* Cal. Dep't Health Care Servs., The Recovery Incentives Program: California's Contingency Management Benefit Frequently Asked Questions (revised 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: Background, Training, and Evaluation of California's Recovery Incentives Program* (Nov. 2022), https://www.dhcs.ca.gov/Documents/CM-Background-Training-and-Evaluation-12-5-2022.pdf [hereinafter *Contingency Management Background, Training, and Evaluation*].

[104] Cal. Dep't Health Care Servs., DMC-ODS Counties Participating in the Recovery Incentives Program, https://www.dhcs.ca.gov/Pages/DMC-ODS-Counties-Participating-in-the-Incentives-Recovery-Program.aspx (last visited Dec. 1, 2025).

[105] Behavioral Health Information Notice No. 24-031, *supra* note 103, at 2, 18; Recovery Incentives Program FAQs, *supra* note 103; *Contingency Management Background, Training, and Evaluation, supra* note 103, at 4.

[106] Behavioral Health Information Notice No. 24-031, *supra* note 103, at 8.

[107] *Id.* at 5.

[108] *Id.* at 8–10.

[109] *Id.* at 9, 11.

[110] State Plan Amendment # 21-0058, *supra* note 61, at 6h; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 19, 35; Behavioral Health Information Notice No. 22-026, *supra* note 41, at 2.

[111] State Plan Amendment # 21-0058, *supra* note 61, at 6h; Behavioral Health Information Notice No. 24-001, *supra* note 7, at 19; Behavioral Health Information Notice No. 22-026, *supra* note 41, at 2.

[112] State Plan Amendment # 21-0058, *supra* note 61, at 6i; Behavioral Health Information Notice No. 22-026, *supra* note 41, at 2–3.

[113] State Plan Amendment # 21-0058, *supra* note 61, at 6j.

[114] *See generally,* Cal. Dep't Health Care Servs., Mobile Crisis Services, https://www.dhcs.ca.gov/Pages/CalAIM-Mobile-Crisis-Services-Initiative.aspx (last visited Dec. 1, 2025); CMS, Approval Letter for Cal. State Plan Amendment # 22-0043 (July 20, 2023), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0043-Approval.pdf [hereinafter State Plan Amendment # 22-0043]; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 23-025 (June 19, 2023), https://www.dhcs.ca.gov/Documents/BHIN-23-025-Medi-Cal-Mobile-Crisis-Services-Benefit-Implementation.pdf [hereinafter Behavioral Health Information Notice No. 23-025].

[115] 42 U.S.C. § 1396w-6.

[116] See CMS, Dear State Health Off. Letter (Dec. 28, 2021) (SHO # 21-008) 2, https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf; Behavioral Health Information Notice No. 23-025, *supra* note 114, at 4.

[117] 42 U.S.C. § 1396w-6(b). *See also* Behavioral Health Information Notice No. 23-025, *supra* note 114, at 4.

[118] CMS, Approval Letter for California's California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Waiver Amendment (Jan. 17, 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dmnstrn-appvl-thncl-crctn-atchmnt-c-aa-01172025.pdf.

[119] Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-007 at 2, 4 (March 21, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-007-Traditional-Health-Care-Practices-Benefit-Implementation.pdf [hereinafter Behavioral Health Information Notice No. 25-007].

[120] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 8; Behavioral Health Information Notice No. 21-019, *supra* note 64, at 2; Behavioral Health Information Notice No. 22-003, *supra* note 8, at 2–4.

[121] *Id.* at 3.

[122] *Id.* at 2.

[123] *Id.* at 5, 8.

[124] *Id.* at 4–5.

[125] *Id.* at 7.

[126] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 23; Behavioral Health Information Notice No. 21-024, *supra* note 73, at 2.

[127] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 24; Behavioral Health Information Notice No. 21-024, *supra* note 73, at 3.

[128] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 23; Behavioral Health Information Notice No. 21-024, *supra* note 73, at 3.

[129] Behavioral Health Information Notice No. 24-001, *supra* note 7, at 23; Behavioral Health Information Notice No. 21-024, *supra* note 73, at 3.

[130] Behavioral Health Information Notice No. 21-024, *supra* note 73, at 3.

[131] See Cal. Dep't Health Care Servs., All Plan Letter No. 18-001 (Jan. 11, 2018), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-001.pdf.

[132] *Id.* at 3.

[133] *Id.* at 1–2.

[134] *Id.* at 2.

[135] Cal. Dep't Health Care Servs., *Transformation of Medi-Cal: Justice Involved,* https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-JI-a11y.pdf (last visited Feb. 12, 2026). See also Cal. Dep't Health Care Servs., DHCS Justice-Involved Waiver Stakeholder Toolkit, https://www.dhcs.ca.gov/CalAIM/Pages/JI-Stakeholder-Toolkit.aspx (last visited Feb. 12, 2026).

[136] Cal. Welf. & Inst. Code § 14184.402. See CMS, Approval Letter for California Advancing and Innovating Medi-Cal (CalAIM) Reentry Demonstration Initiative Amendment (Jan. 26, 2023), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf.

[137] Cal. Dep't Health Care Servs., *Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative* (Oct. 2023), at 62-66, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf [hereinafter, *DHCS CalAIM Justice-Involved Initiative Policy Guide*]. Individuals residing in low-security institutions, which include g camps and two honor farms, are deemed "inmates" and do not have the freedom of movement, therefore pre-release services will be available to individuals confined in these facilities. *See Id.* at 61.

[138] *Id.* at 62–66.

[139] *Id.* at 63. Under the federal SUPPORT Act and CMS guidance, California requires counties to implement unlimited suspension for individuals under age 21 who were incarcerated prior to January 1, 2023. See CMS, Dear State Medicaid Director Letter (Jan. 19, 2021) (SMD # 21-002) (guidance on Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act)), https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21002.pdf. See also CalAIM Justice-Involved Initiative Policy Guide, supra note 148, at 16, FN 19.

[140] 42 U.S.C. § 1396d(r)(5); Cal. Welf. & Inst. Code § 14059.5(b)(1).

[141] *DHCS CalAIM Justice-Involved Initiative Policy Guide, supra* note 137, at 67–72.

[142] *Id.* at 75–76.

[143] *Id.* at 93–107.

[144] *Id.* at 108–110. For more information about coordination services to which Medi-Cal beneficiaries are entitled, see Chapter XII of this Guide on Care Coordination.

[145] *DHCS CalAIM Justice-Involved Initiative Policy Guide, supra* note 137, at 77; Cal. Dep't Health Care Servs., Cal. State Plan Chart, Limitations on Attachment 3.1-A 4, https://www.dhcs.ca.gov/SPA/Documents/Limitations-to-Attachment-3-1A.pdf. [hereinafter State Plan Limitations on Attachment 3.1

[146] Cal. Dep't Health Care Servs., Medi-Cal Rx Contract Drugs List (2026), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf; See also Cal. Dep't Health Care Servs., Medi-Cal Rx Contract Drugs List – Over-the-Counter Drugs and Cold/Cough Preparations (2026), 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. State Plan Limitations on Attachment 3.1, *supra* note 118, at 17, and Cal. Dep't Health Care Servs., Cal. State Plan Chart, Attachment 3.1.A.1, https://www.dhcs.ca.gov/formsandpubs/laws/Documents/Attachment-3-1-A-1-3.pdf.

[147] CMS, Approval Letter for Cal. State Plan # 20-0006 (Dec. 20, 2021), https://www.dhcs.ca.gov/Documents/CA-20-0006-B-MAT-SPA-Approval-Package.pdf.

[148] CMS, Approval Letter for Cal. State Plan # 22-0001 (July 26, 2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf.

[149] DHCS CalAIM Justice-Involved Initiative Policy Guide, *supra* note 137, at 78.

[150] *Id.* at 93.

[151] *Id.*

[152] *Id.*

[153] *Id.* at 131.

[154] *Id.* at 47.

[155] Cal. Dep't Health Care Servs., Justice-Involved Reentry Initiative Go Live Partners and Status, https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/County-readiness-status.aspx (last visited Dec. 1, 2025).

[156] For more information on services and supports available through the Justice-Involved Initiative, see Jasmine Young & Héctor Hernández-Delgado, Nat'l Health Law Prog., *Medi-Cal Services & Supports for Californians Transitioning Out of Incarceration* (2024), https://healthlaw.org/resource/medi-cal-services-supports-for-californians-transitioning-out-of-incarceration/.

[157] Cal. Dep't Health Care Servs., Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative, https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.aspx (last visited Feb. 11, 2026); CMS, Approval Letter for California's Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115 Demonstration (Dec. 16, 2024), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-ca-12162024.pdf [hereinafter BH-CONNECT Approval Letter].

[158] CMS, Approval Letter for California State Plan Amendment 24-0051 (Dec. 18, 2024), https://www.dhcs.ca.gov/SPA/Documents/SPA-24-0051-Approval.pdf;

CMS, Approval Letter for California State Plan Amendment 24-0052 (Dec. 16, 2024), https://www.dhcs.ca.gov/Documents/Approval-CA-24-0052-SPA-Redacted.pdf; CMS, Approval Letter for California State Plan Amendment 22-0001 (July 26, 2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf. For more in-depth information about these EBPs, see Cal. Dep't Health Care Servs., Adult Evidence-Based Practices, https://www.dhcs.ca.gov/CalAIM/Pages/Adult-Evidence-Based-Practices.aspx (last visited Feb. 17, 2026). *See also* Cal. Dep't Health Care Servs., *BH-CONNECT Evidence-Based Practice Policy Guide*, https://www.dhcs.ca.gov/Documents/EBP-Policy-Guide.pdf; Cal. Dep't Health Care Servs., Behavioral Health Information Notice No. 25-009 at 2 (Apr. 11, 2025), https://www.dhcs.ca.gov/Documents/BHIN-25-009-Coverage-of-BH-CONNECT-Evidence-Based-Practices.pdf [hereinafter Behavioral Health Information Notice No. 25-009].

[159] *See* Behavioral Health Information Notice No. 25-009, *supra* note 158. For additional information on SMHS EBPs under BH-CONNECT, see Chapter IV of this Guide on Mental Health Services.

[160] Behavioral Health Information Notice No. 25-009, *supra* note 158, at 3.

[161] For specific information about the Medi-Cal CHW service, see Chapter XII of this Guide on Care Coordination.

[162] Behavioral Health Information Notice No. 25-009, *supra* note 158, at 3–4.

[163] BH-CONNECT Approval Letter, *supra* note 157, at 6–7; Cal. Dep't Health Care Servs., *Community Supports Policy Guide Volume 2* at 24–42 (Apr. 2025), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf [hereinafter *CS Policy Guide Vol. 2*].

[164] *CS Policy Guide Vol. 2*, *supra* note 163, at 57.

[165] *Id.* 57–61.

[166] *Id.* 61–63.

[167] BH-CONNECT Approval Letter, *supra* note 157, at 52, Special Terms and Conditions.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter VI:
Gender-Affirming Services

Chapter VI: Gender-Affirming Services

Outline of Medi-Cal Gender-Affirming Services*
A. Mental Health Services (in addition to other Mental Health services: see Chapter IV of this Guide) 1. Gender dysphoria assessments 2 Counseling and support regarding gender expression and gender-affirming care options B. Hormone Therapy C. Surgical Care 1. Chest reconstruction surgery 2. Genital reconstruction surgeries 3. Gonadectomy 4. Other surgeries to feminize/masculinize the body D. Other interventions and considerations 1. Accessing services when gender marker does not match presupposed anatomy 2. Accessing services when plan deems care "cosmetic" 3. Identifying experienced providers and accessing culturally competent care

*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.[1] 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.[2] Together, these interventions are known as gender-affirming care. Gender-affirming care is a Medi-Cal covered benefit regardless of a beneficiary's gender identity, gender expression, and sex characteristics.

Gender-affirming health care interventions may include hormone therapy (including puberty blocking agents), 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 covered by Medi-Cal when treatment is consistent with the standards of care and the medical necessity standard.[3]

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."[4] Care must be provided according to nationally recognized clinical guidelines; the most used source is the "Standards of Care for the Health of Transgender and Gender Diverse People," published by the World Professional Association for Transgender Health, or the WPATH *Standards of Care*.[5]

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, cisgender, and binary individuals. However, transgender, gender diverse, and non-binary individuals face barriers in accessing care and discrimination.[6] 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.Managed Care Plans are required to provide cultural competency training in providing trans-affirming care to all staff and subcontractors in direct contact with members. For more information, see section D(3) of this chapter.

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.[7] Medi-Cal coverage of many gender-affirming procedures requires a diagnosis of gender dysphoria.[8] Gender dysphoria is a mental health condition defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5).[9] As defined in the DSM-5, gender dysphoria is the distress a person experiences as a result of the incongruence between the person's gender identity and the sex and gender they were assigned at birth.[10]

Medi-Cal considers mental health services a "core service in treatment for gender dysphoria."[11] Licensed mental health providers may support transgender, gender diverse, and non-binary beneficiaries seeking surgical interventions with documentation that the services they are requesting are medically necessary.[12] In pursuing gender-affirming services, transgender, gender diverse, and non-binary Medi-Cal beneficiaries may seek mental health services such as gender dysphoria assessments, support with managing social and emotional changes related to gender transition and navigating the process of accessing gender-affirming care, diagnosis and treatment of co-occurring mental health conditions, and referrals to other providers.[13]

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 *Standards of Care*, which sets forth criteria for initiation of hormone therapy. For adults seeking hormone therapy, the criteria are:[14]

- Gender incongruence is marked and sustained;
- Meets applicable diagnostic criteria—for Medi-Cal, the person must have a diagnosis of gender dysphoria;
- Demonstrates capacity to consent for the specific gender-affirming hormone treatment;
- Other possible causes of apparent gender incongruence have been identified and excluded;
- Mental health and physical conditions that could negatively impact the outcome of treatment have been assessed, with risks and benefits discussed;
- Understands the effect of gender-affirming hormone treatment on reproduction and they have explored reproductive options.

There are separate criteria for initiation of puberty blocking agents or hormone therapy if the individual is an adolescent. The criteria for adolescents seeking puberty blocking agents or hormone therapy are:[15]

- Gender diversity/incongruence is marked and sustained over time;
- Meets the applicable diagnostic criteria—for Medi-Cal, the person must have a diagnosis of gender dysphoria;
- Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally;

- Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
- For puberty blocking agents, has reached Tanner stage 2.[16]

Since the implementation of Medi-Cal Rx in 2022 (see Chapter III 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."[17] 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."[18] 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).[19]

The most common categories of hormone medications used to treat gender dysphoria are testosterone, estrogen, anti-androgens, and gonadotropin-releasing hormone (GnRH) agonists (puberty blocking agents).[20] Medi-Cal Rx covers at least some preparations of each of these categories of hormone drugs.[21]

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.[2] 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 vary widely from one person to another, depending on their particular clinical needs.[23]

Medi-Cal typically follows the WPATH *Standards of Care* criteria for initiation of surgical treatment. For adults seeking surgical procedures, the criteria are:[24]

- Gender incongruence is marked and sustained;
- Meets applicable diagnostic criteria—for Medi-Cal, the person must have a diagnosis of gender dysphoria;
- Demonstrates capacity to consent for the specific gender-affirming surgical intervention;
- Understands the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options;
- Other possible causes of apparent gender incongruence have been identified and excluded;

- Mental health and physical conditions that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits have been discussed;
- Stable on their gender affirming hormonal treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).*

*Suggested criterion

For adolescents seeking surgical procedures, the criteria are:[25]

- Gender diversity/incongruence is marked and sustained over time;
- Meets the applicable diagnostic criteria—for Medi-Cal, the person must have a diagnosis of gender dysphoria;
- Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment;
- Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally.
- Informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility;
- At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

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, including ancillary services, such as hair removal, incident to those services [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.'"[26]

State policy differentiates between "reconstructive surgery," which is covered by Medi-Cal, and "cosmetic surgery," which is not.[27] 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."[28] 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."[29] 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*.[30] Medi-Cal policy further explains that, in analyzing whether a requested service is medically necessary and/or qualifies as a reconstructive surgery, an MCP must "consider the knowledge and expertise of providers qualified to treat gender dysphoria," including the member's own providers.[31]

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. Below is a non-exhaustive list of surgical treatment options that are generally accepted in the medical community and are consistent with the WPATH *Standards of Care* include:[32]

- Chest reconstruction surgery: augmentation mammoplasty (breast implants);
- Genital reconstruction surgeries: vaginoplasty, clitoroplasty, and/or vulvoplasty (creation of female genitalia including the labia minora and majora), and hair removal as part of a preoperative process;
- Gonadectomy: orchiectomy (removal of the testes); and
- Other surgeries to feminize the body, such as: reduction thyroid chondroplasty (reduction of the Adam's apple), vocal cord surgery, liposuction and/or lipofilling (body contouring), hair transplantation, hair removal via electrolysis and/or laser epilation, and facial feminization procedures (including brow, nose, cheek, lip, jaw, and chin treatments).
- Chest reconstruction surgery: subcutaneous mastectomy (creation of a male chest) including liposuction where necessary, with or without nipple-areola preservation/reconstruction as determined necessary for the specific patient;
- Genital reconstruction surgeries: metoidioplasty or phalloplasty (creation of a penis), vaginectomy (removal of the vagina), scrotoplasty (creation of the scrotum), urethral reconstruction and/or lengthening, and/or implantation of erectile device and/or testicular prostheses, and hair removal as part of a preoperative process;
- Gonadectomy: hysterectomy and/or salpingo-oophorectomy (removal of the uterus, fallopian tubes, and/or ovaries); and
- Other surgeries to masculinize the body, such as: liposuction and/or lipofilling (body contouring), monsplasty/mons reduction, pectoral implants, and facial masculinization procedures.

ADVOCACY TIP:

✓ When a MCPs denies medically necessary treatments for gender dysphoria as "cosmetic," consider an appeal of such denials, 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 "cosmetic," issues receiving care due to providers refusing treatment for religious reasons, 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.[33] 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 indicate that all procedures that are medically necessary to treat gender dysphoria are covered, MCPs may still deny coverage of certain treatments on the grounds that they are "cosmetic." This is most prevalent with certain gender-affirming surgical and hair removal treatments, including but not limited to tracheal shaves, breast augmentation, body contouring procedures, and electrolysis. The California Courts of Appeal held in 1978 that gender-affirming surgeries are not "cosmetic" when medically necessary to treat gender dysphoria.[34] The WPATH *Standards of Care* provides that gender-affirming interventions—including hormone therapy, body modification surgery, facial hair removal, and speech therapy—when sought by transgender and non-binary individuals are medically necessary.[35] Thus, any denial of services as "cosmetic" should be appealed through the proper channels.

ADVOCACY TIP:

✓ When providers refuse to provide covered services to transgender, gender diverse, and non-binary beneficiaries due to their religious or moral beliefs, 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. California law, however, prohibits health care providers and insurers from discriminating or denying healthcare services to a patient for being transgender, nonbinary, gender nonconforming, or intersex, or due to a diagnosis of gender dysphoria. You can learn more about these anti-discrimination protections through the Office of the Attorney General, which has issued guidance outlining protections under California law for medical providers and patients seeking gender-affirming care.[36]

3. Identifying experienced providers and accessing culturally competent care

In response to the ongoing challenges transgender, gender diverse, and non-binary Medi-Cal recipients face in accessing experienced and culturally competent health care, California passed SB 923 (Chapter 822, Statutes of 2022), the TGI Inclusive Care Act.[37]

Under this law, MCPs are required to ensure that all staff and subcontractors in direct contact with members receive evidence-based cultural competency training in working with transgender, gender diverse, and non-binary communities.[38] This requirement is not limited to providers offering gender-affirming care and must be completed within 45 days of hire and every two years thereafter.[39] MCPs must also have a system to monitor grievances by members alleging failure to provide trans-inclusive care; if a grievance is resolved in a member's favor, the applicable individual must retake the training.[40]

MCPs must also ensure their provider directories indicate which in-network providers offer and have provided gender-affirming services and that the provider lists meet time and distance standards defined in statute. They must keep these directories up to date and resolve any grievances asserting that providers on the directory are not currently offering gender-affirming care.[41]

Finally, MCPs must submit reports of grievances received to DHCS and ensure their members are aware of their rights to submit grievances for failure to provide trans-affirming care to the MCP and to the Department of Managed Health Care.[42]

Endnotes

[1] Am. Psychiatric Ass'n, *What Is Gender Dysphoria?*, https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria (last visited Nov 6, 2025).

[2] World Pro. Ass'n for Transgender Health, *Standards of Care for the Health of Transgender and Gender Diverse People* (V. 8, 2022), https://www.wpath.org/publications/soc [hereinafter WPATH *Standards of Care*].

[3] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transgender and Gender Diverse Services* 2 (June 2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/F81D2354-BA35-4415-9B82-8B2DF9A505FA/transgender.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (citing Cal. Code Regs. tit. 22, § 51303) [hereinafter *Medi-Cal Provider Manual, Transgender and Gender Diverse Services*].

[4] *Id.* at 1.

[5] *Id. See also* WPATH *Standards of Care*, *supra* note 2.

[6] See, e.g., Jamie Feldman & Madeline B. Deutsch, *Primary Care of Transgender Individuals*, UpToDate (June 30, 2023), https://www.uptodate.com/contents/primary-care-of-transgender-individuals.

[7] WPATH *Standards of Care*, *supra* note 2, at 171.

[8] *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].

[9] *See* "Gender Dysphoria" in Am. Psychiatric Ass'n, *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. 2013) (DSM-5).

[10] *Id.*

[11] *Medi-Cal Provider Manual, Transgender and Gender Diverse Services, supra* note 3, at 2.

[12] See All Plan Letter 20-018, *supra* note 8, at 3.

[13] WPATH *Standards of Care*, *supra* note 2, at 171. For more information about the scope and accessibility of mental health services in Medi-Cal, see Chapter IV of this Guide on Mental Health Services.

[14] WPATH *Standards of Care*, *supra* note 2, at 256.

[15] *Id.* at 256– 57 (also recommending a complete biopsychosocial assessment from medical and mental health providers and involvement by parents or guardians in the assessment process if feasible).

[16] 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. See generally Lawrence S. Neinstein, *Adolescent Health Care: A Practical Guide* (5th ed. 2008).

[17] *Medi-Cal Provider Manual, Transgender and Gender Diverse Services, supra* note 3, at 1. 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), https://transcare.ucsf.edu/guidelines/initiating-hormone-therapy.

[18] *Medi-Cal Provider Manual, Transgender and Gender Diverse Services, supra* note 3, at 2.

[19] *Id.*

[20] 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 November 17, 2025).

[21] Cal. Dep't Health Care Servs., *Medi-Cal Rx Contract Drugs List* 67, 146, 161, 174–75, 190– 91 (2025), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf.

[22] WPATH *Standards of Care*, *supra* note 2, at 128.

[23] *Id.* at 7, 128-29.

[24] *Id.* at 256; *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).

[25] WPATH *Standards of Care*, *supra* note 2, at 257 (also recommending a complete biopsychosocial assessment from medical and mental health providers and involvement of parents or guardians in the assessment process if feasible).

[26] *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.

[27] All Plan Letter 20-018, *supra* note 8, at 2-3.

[28] *Id.* (quoting Cal. Health & Safety Code § 1367.63(c)(1)(B)).

[29] *Id.* at 3.

[30] *Id.* at 3– 4.

[31] *Id.*

[32] WPATH *Standards of Care*, *supra* note 2, at 258.

[33] *Medi-Cal Provider Manual, Transgender and Gender Diverse Services, supra* note 3, at 1.

[34] *GB v. Lackner,* 80 Cal. App. 3d 64 (1978); *JD v. Lackner,* 80 Cal. App. 3d 90 (1978).

[35] WPATH *Standards of Care*, *supra* note 2; *see also* Advocates for Trans Equality, *Medical Necessity Literature Reviews,* https://transhealthproject.org/resources/medical-necessity-literature-reviews/ (last visited July 16, 2025).

[36] Cal. Dep't Just., Know Your Rights: Attorney General Bonta Issues Guidance on Gender-Affirming Care Rights in California (Nov. 13, 2025), https://oag.ca.gov/news/press-releases/know-your-rights-attorney-general-bonta-issues-guidance-gender-affirming-care.

[37] Cal. Dep't Health Care Servs., All Plan Letter 24-017 at 1 (Dec. 5, 2024), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-017.pdf.

[38] *Id.* at 2.

[39] *Id.* at 3.

[40] *Id.* at 3.

[41] *Id.* at 3–4.

[42] *Id.* at 4–5.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter VII:
Sexual and Reproductive Health Services

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Outline of Medi-Cal Coverage of Sexual and Reproductive Health Services*
A. Family Planning and Family Planning-Related Services 1. Access to Family Planning Services and Supplies 2. Patient Visits & Counseling Services 3. Contraceptives 4. Sexually Transmitted Infections 5. Sterilization 6. Other Services B. Abortion Services C. Pregnancy Services 1. Pregnancy Services Overview – Prenatal, Labor/Delivery, Postpartum Care 2. Doula Services During and After Pregnancy 3. Comprehensive Perinatal Services Program D. Sexual and Reproductive Health Care in Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) E. Assisted Reproduction Services F. Additional Coverage Categories for Sexual and Reproductive Health Services 1. Family Planning, Access, Care, and Treatment (Family PACT) 2.Minor Consent Medi-Cal 3.Medi-Cal Access Program 4.Presumptive Eligibility for Pregnant Women G. Breast and Cervical Cancer Screening and Treatment Programs H. Sexual and Reproductive 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 sexual and reproductive health of all Californians. Under federal law, all states must offer coverage to certain low-income populations, including pregnant people and parents. In the 41 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.[1] Medi-Cal therefore plays a major role in the financing of sexual and reproductive health care services for millions of low-income people and other individuals in California.

This chapter focuses on the range of sexual and reproductive health services available to Medi-Cal beneficiaries. It highlights services such as contraception and family planning, abortion, and pregnancy care.

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.[2] 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.[3]

1. Access to Family Planning Services and Supplies

Since 1972, the Social Security Act has required all states to cover family planning services and supplies without co-payments or cost sharing for beneficiaries of childbearing age (including minors).[4] To promote access to family planning services and supplies, a Medicaid beneficiary receiving services from a Medi-Cal managed care plan (MCP) can obtain family planning services from a particular provider even if the provider is out-of-network. 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 allows 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.[5]

Individuals covered under another person's health plan–such as a parent's, caregiver's, or spouse's–may also seek contraceptive services, abortions, and other "sensitive services" confidentially without notifying or involving a parent or spouse.[6] Medi-Cal sensitive services include services related to STIs, pregnancy, family planning, abortions, HIV, sexual assault and rape, and other minor consent services.[7] 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.[8]

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.

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.[9]

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 contraceptive methods, such as oral contraceptives or "the pill"; transdermal hormonal patch; injectable contraceptives; vaginal rings; diaphragms; vaginal foam, gel, jelly, and cream; internal and external condoms; long-acting reversible contraceptives (LARCs) including intrauterine devices (commonly known as IUDs) and implantable subdermal contraceptives; and emergency contraception.[10]

The emergency contraception (EC) pill is often referred to as "Plan B" and is a method of pregnancy prevention. Instead of taking EC consistently before intercourse like with other oral contraception, EC is taken after sexual intercourse. EC should be taken as soon as possible after 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.[11] 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.[12] 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.[13]

Medi-Cal requires a prescription before it will cover contraceptive supplies that are available over-the-counter (OTC) such as EC pills, external condoms, internal condoms, spermicides, and sponges.[14] Beneficiaries may obtain a prescription for OTC contraceptives from a participating pharmacist.[15] Medi-Cal also imposes quantity limits for certain OTC contraceptives. For example, beneficiaries are allowed up to one pack of emergency contraception per month.[16]

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 family planning-related services.[17] 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.[18]

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.[19] Medi-Cal will cover a hysterectomy as a treatment option for a medical issue; however, it is not covered as a sterilization procedure.[20]

Coverage of sterilization is subject to stringent state and federal legal requirements that limit both who may be sterilized and establishes strict informed consent procedures.[2] 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.[22] 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.[23] 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).[24] In addition, a person cannot consent to sterilization if they are 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.[25]

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).[26] The information must be effectively communicated in order to overcome any language or communication barrier.[27] 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.[28]

The consent form itself also must include that the person securing the consent certifies that they believed that the individual to be sterilized appears to be mentally competent and voluntarily consents to the sterilization.[29] 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.[30]

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.[31] 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.[32]

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.[33] Pregnancy tests are also covered under Medi-Cal.[34]

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, requires the use of federal Medicaid funds to cover abortions in three narrow circumstances: when necessary to save the life of a pregnant person or in pregnancies resulting from rape or incest.[35] 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.[36] 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.[37]

Medi-Cal covers procedural abortion services regardless of the gestational age of the fetus. Medi-Cal also covers medication abortions (including the misoprostol-only protocol) through the 70th day from the first day of the beneficiary's last menstrual period.[38] This coverage includes medication abortion care delivered via synchronous video or audio-only telehealth and there are no restrictions on the use of a mail-order pharmacy for dispensing mifepristone or misoprostol to beneficiaries.[39]

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.[40] 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.[41] 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.[42] To ensure timely care, abortions are covered under the presumptive eligibility program, discussed in more detail below.

ADVOCACY TIP:

✓ In the fall of 2022, the State of California launched 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.[43]

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.[44] 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.[45]

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.[46] The burden is not on the Medi-Cal MCP to find a replacement provider.[47]

The so-called "One Big Beautiful Bill Act" contains a provision that designates a certain type of abortion provider as a "prohibited entity" and forbids them from receiving any payments from the state Medicaid agency that include federal funding for a one year period starting on July 4th (the date of enactment).[48] This provision is currently being litigated but if it is implemented, it will bar certain abortion providers from receiving Medi-Cal reimbursement for all covered services that are eligible for federal funding. The impacted providers are, however, allowed to continue to submit claims to Medi-Cal for state-funded abortion services.[49]

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).[50] Medi-Cal postpartum coverage lasts for 12 months following the end of the pregnancy, regardless of changes in income during that time. It is also available regardless of citizenship or immigration status. 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 end of the pregnancy falls.[51]

The state budget for 2025-2026, enacted in June 2025, scales back a number of health benefits for low-income immigrants without legal status, including a freeze on new enrollments and elimination of dental benefits effective January 1, 2026, and imposition of $30 monthly premiums effective July 1, 2027.[52] Notably, pregnant people without sufficient immigration status will still be eligible for full-scope Medi-Cal, including dental coverage and 12-month postpartum coverage. They will also be exempt from the proposed $30 monthly premiums.[53] For more details on changes to Medi-Cal services impacting immigrants, please see Chapter I of the Advocates Guide to Medi-Cal Services (Overview of Medicaid and Medi-Cal).

Pregnant people may choose to receive their prenatal care, labor and delivery, and postpartum care in a hospital setting or a freestanding birth center, and from an OB/Gyn, a Certified Nurse Midwife, or a Licensed Midwife.[54] Throughout their pregnancy and post-pregnancy period, Medi-Cal beneficiaries are also eligible for full spectrum doula care.[55]

Adolescents can receive pregnancy testing, prenatal care, and labor and delivery services, among other services, without permission or notifying a parent or guardian.[56] Pregnant adolescents–individuals who are under the age of 18 years old—may face unique challenges when seeking health care services as compared to adults who become pregnant. Some adolescents and young people report difficulty finding a provider, encounter provider stigma, and/or are unaware of the confidentiality protections in Medi-Cal. This is particularly true for pregnant youth who are foster youth or former foster youth.

ADVOCACY TIP:

✓ The Reproductive Health Equity Project for Foster Youth (fosterreprohealth.org) has resources for foster youth, former foster youth, and advocates who work with them on accessing services and navigating health coverage, including pregnancy coverage, family planning, abortion care, and other sexual and reproductive health care services.

Medi-Cal offers prenatal services such as prescribed medication, laboratory services, radiology, and dental services.[57] Other services covered by Medi-Cal during pregnancy include home blood glucose monitors for patients with diabetes including gestational diabetes, genetic screening counseling, tobacco cessation services, mental health services, and substance use disorder services.[58] Medi-Cal covers both vaginal and cesarean deliveries, as well as external and internal fetal monitoring during delivery.[59]

Effective July 2024, hospitals and clinics that participate in Children's Presumptive Eligibility, Hospital Presumptive Eligibility, and Presumptive Eligibility for Pregnant People, are required to use the Newborn Gateway to report births of Medi-Cal-linked newborns in their facilities within 72 hours after the birth, or within one day after discharge, whichever is sooner.[60] Otherwise, after a baby is born, the parent, guardian, or a provider who has obtained written consent from the parent or guardian, may establish Medi-Cal eligibility by completing the Newborn Referral Form and sending it to the county of residence.[61]

Medi-Cal also offers services provided after the end of a pregnancy, including hospital and scheduled office visits, assessment of uterine involution, and contraceptive counseling.[62] Medi-Cal covers the purchase or rental of lactation aids, including manual or electronic breast pumps, as well as Haberman Feeders for babies up to one year of age with impaired sucking abilities.[63]

2. Doula Services During and After Pregnancy

Doula care is a relatively new benefit for Medi-Cal beneficiaries, having been rolled out on January 1, 2023.[64] As of this writing, California is one of 23 states

that provide Medicaid coverage for doula care.[65] Doulas provide non-medical emotional, physical, and informational support and guidance for pregnant people during the prenatal, labor and delivery, postpartum, and post-pregnancy periods. Medi-Cal covers full spectrum doula care, which includes doula care for pregnant and postpartum people before, during, and after the end of the pregnancy, including support during abortion, miscarriage, and stillbirth.[66]

Pregnant, postpartum, and post-pregnant Medi-Cal beneficiaries can receive up to eleven visits during the perinatal period, excluding support during labor and delivery which is covered separately. Of the eleven visits, the initial visit is expected to be longer, and up to two extended three-hour postpartum visits can be provided after the end of the pregnancy. 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.[67] Pregnant people do not need a separate recommendation to access these services, as the Department of Health Care Services issued a statewide standing recommendation in November 2023.[68]

In March 2025, the California Department of Public Health released guidance for all hospitals in the state on the Medi-Cal doula benefit, including the benefits of doula care, and recommendations that hospitals specifically update their visitation policies and procedures to allow doula access.[69]

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.[70] The program, which is jointly managed by the California Department of Health Care Services and the California Department of Public Health, includes nutrition services, health education, and care coordination.[71]

To receive these services, the beneficiary must first undergo assessments conducted by their provider.[72] 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.[73]

4. Birthing Care Pathway

In 2024, the Department of Health Care Services launched its Birthing Care Pathway, a policy and care model to cover Medi-Cal beneficiaries during the perinatal period and through 12 months postpartum. The program's explicit goals are to address maternal mortality and morbidity, as well as racial and

ethnic disparities in maternal care. The Birthing Care Pathway aims to achieve this by improving provider access, improved coordination of care, providing whole-person care, and modernization of maternity care payment. The Pathway is intended to integrate the work for state agencies, managed care plans, county agencies, providers, social service entities, philanthropic partners, and other stakeholders that work with pregnant and postpartum Medi-Cal beneficiaries.[74]

The Department published its Birthing Care Pathway Report in February 2025, which summarizes the current state of Medi-Cal maternal health and ongoing work to implement the Birthing Care Pathway, and also shares the Department's future vision for the Pathway and opportunities for partners to engage with the Department in this work.[75] Specifically, the Report detailed eight main focus areas where the Department will be implementing Birthing Care Pathway policy solutions in the coming years:

- Expanding access to maternity care providers and enhancing oversight of maternity services delivered through Medi-Cal managed care plans;
- Improving access to behavioral health care including trauma-informed care, mental health, and substance use services;
- Conducting risk assessment for Medi-Cal members to connect them with services and supports, including intimate partner violence screening;
- Delivering whole-person care and addressing social health needs including housing and nutrition;
- Facilitating enrollment in Medi-Cal and access to care before and after release from prison and jail;
- Increasing reimbursement rates for maternity care providers and supporting value-based maternity care;
- Building integrated systems for data sharing and cross-enrollment, and creating metrics to improve the quality of care; and
- Partnering with other state agencies to develop a statement Maternal Health Strategic Plan to reduce maternal mortality and morbidity.[76]

D. Sexual and Reproductive 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.[77] 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.[78]

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.[79] Bright Futures recommends providers deliver sexual and reproductive health services including STI screenings, HPV vaccines, pregnancy testing, HIV testing, family planning, and sexuality

education and counseling.[80] 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.[81] The comprehensive health and developmental history assessment should also include a discussion of sexuality, healthy relationships, and sexual health.[82]

E. Assisted Reproductive Services

Assisted reproduction (AR) refers to treatments, interventions, or procedures that are intended to cause or assist in causing pregnancy through means other than by sexual intercourse.[83] While the Medicaid Act allows states to exclude fertility drugs from coverage, states like California are slowly moving to offer more assisted reproduction care to beneficiaries.[84] For example, Medi-Cal now covers fertility preservation services when a covered treatment causes iatrogenic infertility.[85]

F. Additional Coverage Categories for Sexual and Reproductive Health Services

A Medi-Cal beneficiary can access the sexual and reproductive health services described above if the beneficiary has full-scope Medi-Cal. However, there are several programs that provide access to sexual and reproductive 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, have a medical necessity for family planning services, and reside in California.[86] Family PACT covers FDA approved contraceptive methods including emergency contraception and sterilization, health education and counseling, physical exams, pregnancy testing, sexually transmitted infection testing and treatment, cervical cancer screening, and HIV testing and counseling.[87] As of July 1, 2022, Family PACT covers the HPV-9 vaccine as a clinic benefit.[88] Family PACT does not cover prenatal services, labor and delivery, or abortion.[89] 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.[90]

2. Minor Consent Medi-Cal

The Medi-Cal Minor Consent program is a source minors can use for coverage of sexual and reproductive health services. 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 may consent for pregnancy and pregnancy-related care, family planning services including contraception and abortion, and sexual assault services.[91] Minors age 12 and older can also consent for STI screenings and treatment, services to treat substance use disorders, outpatient mental health services, other disease diagnosis and treatment, residential shelter services, and intimate partner violence services.[92]

For minors who are not enrolled in full-scope Medi-Cal, the Medi-Cal Minor Consent program provides temporary coverage. Coverage must be renewed monthly for services except for pregnancy services and outpatient mental health services.[93] Beneficiaries are permitted to apply or renew by telephone or in-person, and counties must accept telephonically recorded, electronic signatures and/or handwritten signatures.[94]

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).[95] 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).[96] Minors do not have to provide any identification when they apply. If the minor is employed, however, they must provide pay stubs to verify income.[97] 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.[98]

3. Medi-Cal Access Program

The Medi-Cal Access Program (MCAP) provides comprehensive pregnancy and postpartum services for individuals whose incomes are too high for Medi-Cal, and who either do not have other health insurance or do not have health insurance that adequately covers maternity care services. MCAP coverage is comprehensive, including maternity care, doula care, family planning services, hospital services, prescription drugs, medical transportation, durable medical equipment, mental health care, substance use disorder treatment, and more.[99] Individuals who qualify for MCAP receive services at no cost, with no copayments or deductibles.[100]

In order to qualify for MCAP, a person must be pregnant or in their postpartum period, a California resident, not covered by other health insurance (unless their insurance does not cover maternity services or has a maternity-only deductible or copayment greater than $500), and have income between 213% and 322% of the federal poverty level.[101]

Individuals qualify for MCAP regardless of citizenship or immigration status. MCAP coverage lasts for 12 months following the end of the pregnancy,

regardless of changes in income during that time.[102] Infants born to pregnant people on MCAP, who are not otherwise enrolled in employer-sponsored insurance or no-cost Medi-Cal, are eligible for the Medi-Cal Access Infant Program, which provides health coverage until the infant's first birthday.[103]

4. Presumptive Eligibility for Pregnant Women

The Presumptive Eligibility for Pregnant People (PE4PP program allows pregnant people to obtain temporary Medi-Cal coverage prior to submitting an application for Medi-Cal coverage. Under the program, individuals who are pregnant or believe they are pregnant can visit specific qualified providers who participate in the PE4PP program and provide information about their income. If their income appears to be low enough to qualify, then the individual's coverage under PE4PW begins immediately and services can be provided on the same day.[104]

Only outpatient prenatal services are covered, including abortion care and prescription drugs for conditions related to the pregnancy. Inpatient care, including labor and delivery, is not covered, and neither are family planning services.[105] Moreover, coverage is temporary, lasting only until a determination is made on the Medi-Cal application. If the individual does not submit a Medi-Cal application, their coverage under the PE4PP program will end the last day of the month following the month in which the individual obtained PE4PP coverage.[106]

ADVOCACY TIP:

✓ Individuals interested in PE4PP must go to a qualified provider to obtain coverage. To find a qualified provider, visit the Department of Health Care Services' list of qualified providers by county at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Find-a-Qualified-Provider-to-Enroll.aspx.

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.[107] As mentioned earlier, 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. This coverage is available regardless of gender. 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. [108]

Individuals who do not otherwise qualify for federal BCCTP can still receive Medi-Cal coverage under the state-only BCCTP. Many of the eligibility requirements that apply to the federal BCCTP also apply to state-only BCCTP, but the programs differ in that individuals over 65 years of age, undocumented immigrants, and those with health insurance can qualify for the state-only BCCTP. Unlike the federal program, the state-only BCCTP covers only breast and cervical cancer treatment, services related to such treatment, and reimbursement of insurance premiums under certain circumstances. Moreover, the state-only BCCTP is time limited. It covers breast cancer treatment services for up to 18 months, and cervical cancer treatment services for up to 24 months, although the coverage period can be extended if cancer reoccurs.[109] In addition, the state has a BCCTP Presumptive Eligibility Program that provides temporary full-scope no Share Cost of Medi-Cal services to eligible individuals under the age of 65 who have been diagnosed with breast and/or cervical cancer.[110]

H. Sexual and Reproductive 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 receiving sexual and reproductive health care.

Medicare does not include comprehensive coverage of contraception or abortion. For example, Medicare covers abortions, but only in the case of rape, incest, or life-threatening circumstances to the pregnant person.[111] 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.[112] Obtaining a coverage denial may be difficult as many reproductive health providers are not Medicare providers. To this end, the Department of Health Care Services no longer requires a Medicare denial when billing for selected abortion services.[113] Such a step prevents a dual eligible from having to go through hoops to access a Medi-Cal covered abortion to which they are entitled.

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) clarified that since Medicare does not pay for LARCS, a provider seeing dual-eligible patients does not need to obtain a Medicare denial. Instead, the provider can directly submit a claim to Medicaid.[114]

Endnotes

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[95] Eligibility Procedures Manual Letter No. 183, *supra* note 92, at 4V-2.

[96] *Id.* at 4V-2, 4V-3.

[97] *Id.* at 4V-2, 4V-3; *see also* Cal. Code Regs. tit. 22, §§ 50147.1, 50167(a)(6)(D)(4).

[98] Cal. Dep't Health Servs., *Medi-Cal Provider Manual, Minor Consent Program* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/E6EF9FF8-1C71-4B2D-A677-A32F098CCF5C/medicaminor.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[99] Cal. Welf. & Inst. Code § 15822; Cal. Dep't Health Care Servs., Welcome to the Medi-Cal Access Program (accessed August 16, 2025), https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/Medi-CalAccessProgram.aspx.

[100] Cal. Dep't Health Care Servs., California State Plan Amendment 22-0041 (2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA-22-0041.pdf.

[101] Cal. Dep't Health Servs., Who Qualifies for MCAP? (accessed August 16, 2025), https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/Qualifying.aspx.

[102] Cal. Dep't Health Care Servs., California State Plan Amendment 22-0030 (2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/CA-SPA-22-0030-Approval.pdf.

[103] Cal. Dep't Health Care Servs., How do I register my baby for the Medi-Cal Access Infant Program? (accessed Aug. 16, 2025), https://www.dhcs.ca.gov/services/medi-cal/eligibility/MCAP/Pages/RegisterYourbaby-MCAP.aspx.

[104] Cal. Dep't Health Servs., Information on the Presumptive Eligibility for Pregnant Women, (accessed Aug. 16, 2025), https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/PE_Info_women.aspx.

[105] *Id.*

[106] Cal. Welf. & Inst. Code § 14148.7.

[107] Cal. Dep't Health Servs., 2025 Income Eligibility Guidelines for the Every Woman Counts Program, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/news/33314 (last visited May 29, 2025).

[108] 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 May 29, 2025). *see also* 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII), (aa).

[109] *Id.*

[110] Cal. Dep't Health Servs., Breast and Cervical Cancer Treatment Program: Directions to Apply for Medi-Cal, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/E9B47982-1A88-47F5-85F2-652B9059D5E5/Directions-to-Apply-For-Medi-Cal-English-and-Spanish.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO (last visited May 29, 2025).

[111] 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 May 29, 2025).

[112] Cal. Dep't Health Servs., *Medi-Cal Provider Manual, Medicare/Medi-Cal Crossover Claims Overview* (2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/C8D9183F-C7E4-426E-9CC7-DA063E361473/medicare.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[113] Cal. Dep't Health Servs., Medicare Denial Requirement Eliminated for Certain Abortion CPT Codes (Originally Published Dec. 30, 2020) (on file with NHeLP).

[114] CMS, *Frequently Asked Questions (FAQs) Medicaid Family Planning Services and Supplies* (2017), https://www.medicaid.gov/federal-policy-guidance/downloads/faq11117.pdf.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated April 2026

Chapter VIII: Dental Services

Chapter VIII: Dental Services

Outline of Medi-Cal Dental Services*
A. Adult dental coverage 1. Full-scope dental benefits 2. Full-scope Medi-Cal with no dental benefits 3. Restricted-scope dental benefits 4. Dental benefits for pregnant individuals B. Children Dental Coverage C. Tele-dentistry D. General Anesthesia Services

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

While comprehensive dental coverage is mandatory for children enrolled in Medicaid, dental services are not a required benefit for adults over age 21.[1] Therefore, the state has flexibility in determining the scope of dental services it covers. The Medi-Cal Dental Program (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.[2] However, due to Medi-Cal cuts in last year's state budget, California will remove non-emergency dental benefits for certain immigrant beneficiaries starting on July 1, 2026.[3]

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 a third party entity to serve as the fiscal intermediary and as the administrative services

organization. This entity processes claims and TARs submitted by dental health providers, as well as provides dental administrative services including network management.[4]

In the fee-for-service system, beneficiaries can access any dental provider who participates in Medi-Cal. In managed care, beneficiaries are restricted to those providers participating in the dental plan in which the beneficiary is enrolled.[5]

Resources:

- Medi-Cal Dental Provider Handbook: https://www.dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Provider_Publications/ProviderHandbook
- Medi-Cal Dental Beneficiary Handbook: https://dental.dhcs.ca.gov/MCD_documents/members/member_handbook_english.pdf
- Dental Credit Card Debt: California Advocates Toolkit: https://healthlaw.org/resource/dental-credit-card-debt-california-advocates-toolkit/

Prior authorization

Prior approval of certain dental services must be sought through a Treatment Authorization Request (TAR).[6] Services subject to prior authorization include restorative services, endodontics, periodontics, prosthodontics, implant services, oral and maxillofacial surgery and orthodontics services.[7] Services provided to patients in hospitals, skilled nursing facilities and other intermediate care facilities require prior authorization unless exempted as emergency services.[8] 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.[9]

Prior authorization is not transferable from one provider to another. If for some reason the provider who

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.[10]

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:

✓ 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.

A. Adult Dental Coverage

1. Full-Scope Dental Benefits

Adults with full-scope Medi-Cal are eligible for comprehensive dental services.[11]

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)
- Posterior Lab-Processed Crowns

2. Full-Scope with No Dental Benefits

Starting July 1, 2026, many immigrant beneficiaries, including those without documented status and certain qualified noncitizens, will no longer qualify for non-emergency dental benefits.[12] Beneficiaries in this eligibility group can still access emergency-related dental services, however pregnant immigrants in California with Medi-Cal maintain full-scope dental coverage, regardless of immigration status, during pregnancy and for one year postpartum. So, while other adults without documented status will face limited, emergency-only dental coverage starting July 1, 2026, pregnant individuals are exempt from this restriction.[13] Impacted beneficiaries enrolled in or who applied for Medi-Cal prior to January 1, 2026, will be moved to full scope Medi-Cal coverage with no dental.[14]

In addition, starting on October 1, 2026, federal changes will restrict additional immigrants with qualified legal status from qualifying for federal Medicaid funding and full scope Medi-Cal coverage.[15]

3. Restricted Scope Dental Benefits

Adults with restricted-scope Medi-Cal will continue to have limited coverage with only extractions and emergency services covered. "Emergency" for purposes of those with restricted 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:[16]
    - Placing the patient's health in serious jeopardy.
    - Serious impairment to bodily functions.
    - Serious dysfunction of any bodily organ or part.

4. Dental Benefits for Pregnant Individuals

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).[17] 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.[18]

Cap on Adult Dental Services

Dental services for individuals 21 years or older are limited to $1,800 per beneficiary for each calendar year.[19] 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.[20] 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. [21]

Certain services are exempt from the cap, including:[22]

- 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.[23] So even if there was a partial payment, the provider must consider it to be payment in full.[24] 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.[25]

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
- Caries Risk Assessment bundle
- Silver Diamine Fluoride

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."[26] 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, coverage must, at a minimum, include "relief of pain and infections, restoration of teeth, and maintenance of dental health."[27]

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.[28] The initiative includes benefits such as the Caries Risk Assessment (CRA) bundle and Silver Diamine Fluoride (SDF).[29] 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 0-6.[30] 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.[31]

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.[32] This benefit is reimbursable for children (ages 0-6) 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.[33] 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).[34] The SDF benefit is available except if the tooth is nonrestorable or near exfoliation.[35]

C. Teledentistry

DHCS permits the use of teledentistry as an alternative way to provide dental services. Therefore, enrolled Medi-Cal Dental providers may render certain services via teledentistry, 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.[36] Synchronous or live transmission "is a real-time interaction between a beneficiary and a provider located at a distant site."[37] Eligible teledentistry 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".

D. 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.[38] 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.[39]

Endnotes

[1] 42 U.S.C. § 1396d(a)(10).

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

[3] Cal. Welf. & Inst. Code § 14007.5(l)(1).

[4] 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/Pages/CSBfidboHome.aspx.

[5] 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.

[6] Cal. Dep't Health Care Servs., *Medi-Cal Dental Program Provider Handbook* 2-11 (Dec. 2025), https://www.dental.dhcs.ca.gov/Providers/Medi_Cal_Dental/Provider_Publications/ProviderHandbook [hereinafter *Medi-Cal Dental Provider Handbook*].

[7] *Id.* at 2-12.

[8] *Id.* at 2-12; *see also* Cal. Code Regs. tit. 22, § 51056 (a), (b).

[9] *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 5-1 to 5-126.

[10] *See* Michelle Lillienfeld, 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*).

[11] *Restoration of Adult Dental Benefits FAQs*, *supra* note 2.

[12] Cal. Welf. & Inst. Code § 14007.5(c) (beneficiaries ineligible for federally-funded coverage, and Permanently Residing Under Color of Law (PRUCOL)); Welf. & Inst. Code § 14007.8(k) (beneficiaries enrolled in state-funded Medi-Cal coverage); Beneficiaries who are transitioned to Full Scope Medi-Cal with no dental include: those who are not enrolled in federally-funded Medi-Cal coverage, such as adults without documented status, unverified status, and those with PRUCOL status, DACA recipients, and certain non-immigrant visas such as student, tourist, and work visas, and more. See Cal. Dep't Health Care Servs., Immigrant Status and Changes to Medi-Cal, https://www.dhcs.ca.gov/Medi-Cal/Pages/immigration-status-categories.aspx (last visited Apr. 28, 2026).

[13] Welf. & Inst. Code, §§ 14007.5(d), (l)(1).

[14] Cal. Dep't of Health Care Servs., *Provider Bulletin Vol. 42, No. 02* (Jan. 2026), https://dental.dhcs.ca.gov/MCD_documents/providers/provider_bulletins/Volume_42_Number_02.pdf.

[15] H.R. 1 (2025) Section 71109 amended 42 U.S.C. 1396b(v); Beneficiaries eligible to remain on federally-funded Medi-Cal are restricted to: Lawful Permanent Residents, certain Cuban and Haitian entrants, and individuals residing in the U.S. under a Compact of Free Association (COFA) with Palau, Micronesia, and the Marshall Islands; Cal. Dep't of Health Care Servs., Budget Information 2026-27 Budget Act (Jan. 9, 2026), https://www.dhcs.ca.gov/Budget/Pages/Budget-Information.aspx; While current state law would require impacted beneficiaries to transition to full scope Medi-Cal with no dental, the Governor's proposed budget for FY 2026-2027 plans to move this group to restricted scope Medi-Cal if the proposal is adopted in the final budget.

[16] Welf. & Inst. Code, § 14007.5(d).

[17] Welf. & Inst. Code, § 14007.5(l)(1); *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 4-12.

[18] 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 VII of this Guide on Sexual and Reproductive Health Services.

[19] Cal. Welf. & Inst. Code § 14080(a).

[20] *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 4-11 and 4-12.

[21] 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 [hereinafter *Medi-Cal Dental Provider Bulletin, Vol. 37, No. 01*].

[22] *Id.*

[23] *Medi-Cal Dental Provider Handbook*, *supra* note 6, at 4-11.

[24] *Id.*

[25] *Id.*

[26] 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.

[27] 42 C.F.R. § 441.56(c)(2); Cal. Code Regs. tit. 17, § 6843(a)(1). *See also* Chapter IX of this Guide on Children's Health Services.

[28] Cal. Dep't of Health Care Servs., CalAIM Dental Initiative, https://www.dhcs.ca.gov/services/Pages/DHCS-CalAIM-Dental.aspx (last visited Apr. 28, 2026).

[29] 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.

[30] Cal. Dep't Health Care Servs., Caries Risk Assessment, https://www.dhcs.ca.gov/services/Pages/caries-risk-assessment.aspx (last visited Apr. 28, 2026). *See also* Dental All Plan Letter 21-005, *supra* note 29, at 2–3.

[31] Dental All Plan Letter 21-005, *supra* note 29, at 2–3.

[32] Cal. Dep't Health Care Servs., Silver Diamine Fluoride, https://www.dhcs.ca.gov/services/Pages/silver-diamine-fluoride.aspx (last visited Apr. 28, 2026). *See also* Dental All Plan Letter 21-005, *supra* note 29, at 3.

[33] Dental All Plan Letter 21-005, *supra* note 29, at 3.

[34] *Id.*

[35] *Medi-Cal Dental Provider Bulletin, Vol. 37, No. 01*, *supra* note 21, at 5.

[36] Cal. Dep't of Health Care Servs., Provider Bulletin Vol. 32, No. 04 (Mar. 2016), https://www.dental.dhcs.ca.gov/MCD_documents/providers/provider_bulletins/archive/Volume_32_archive.zip.

[37] Each transmission is "limited to 90 minutes per beneficiary per provider, per day." *Id.*

[38] 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/MDSD/2017%20DAPLs/APL17_004.pdf.

[39] Cal. Dep't Health Care Servs., Dental All Plan Letter 15-005 at 2 (Apr. 1, 2015), https://www.dhcs.ca.gov/services/Documents/MDSD/2015%20DAPLs/APL%2015-005.pdf.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated April 2026

Chapter IX:
Children's Health Services

Chapter IX: Children's Health Services

Outline of Medi-Cal Children's Health Services (in addition to general Medi-Cal services)*
A. Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) 1. Generally, all medically necessary services 2. 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 B. California Children's Services 1. Whole Child Model 2. Traditional Counties C. Children's Presumptive Eligibility Program [formerly known as the Child Health and Disability Prevention Program (CHDP)] D. Minor Consent Medi-Cal E. Behavioral Health Treatment (BHT) Program F. Enhanced Care Management and Community Supports G. CalAIM Justice-Involved Initiative: Medi-Cal Pre-Release Services

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

Federal law requires state Medicaid programs to provide coverage for all children in families with incomes up to 138% of the federal poverty level (FPL).[1] California elects to cover all children up to 19 years old in families with incomes up to 266% FPL.[2] Additionally, in 2016, California extended full-scope Medi-Cal benefits to all eligible children under age 19 regardless of immigration status.[3] Currently, Medi-Cal covers health services for more than 5.4 million children.[4]

Medi-Cal coverage of services for children is more robust than the services available to adults to ensure that children receive early detection and care. Children under age 21 can obtain all Medicaid covered services, whether or not the service is covered under California's Medicaid State Plan or available for adults.[5] This chapter addresses the Medi-Cal services that are available to children, some of which are offered through different parts of the Medi-Cal program. This chapter focuses broadly on services provided exclusively to children. Advocates should review other chapters of this guide for specific services commonly used by children and youth. In particular, Chapter II on Preventive Services includes further information about services to prevent development of certain conditions, including vaccines, for children and adolescents.

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

1. In General

Federal and state laws require Medi-Cal to offer Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services to enrolled children and youth under age 21.[6] In California, EPSDT services are also referred to as "Medi-Cal for Kids and Teens."[7] 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.[8]

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.[9] For example, while Medi-Cal covers limited chiropractic services for adults (see Chapter XIV 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 or behavioral health conditions.[10] 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.[11] 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.[12] 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.[13] When a screening indicates the need for further evaluation and follow-up, EPSDT covers diagnostic and treatment services.[14] Medically necessary referrals should be made without delay to ensure a child receives a complete diagnostic evaluation whenever a potential risk is identified.[15]

Beyond screenings and preventive measures, EPSDT ensures that children have access to adequate services and treatments. EPSDT includes services such as pediatric day health care services, which are skilled nursing, occupational therapy, and other therapeutic services provided in a day program.[16] EPSDT also covers all behavioral health services that are medically necessary.[17] See Chapter IV (Mental Health Services) and Chapter V (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.[18] 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.[19] TCM is also a specialty mental health service, and may be provided to beneficiaries through a contract with the Mental Health Plan (MHP).[20] TCM services are carved out of Medi-Cal managed care plans (MCPs), but MCPs are responsible for determining whether an enrollee requires TCM services and referring the enrollee to the appropriate type of case management service.[21] EPSDT also covers assistance with scheduling appointments and arranging transportation for Medi-Cal-covered appointments.[22]

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 receive.[23] 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.[24] 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.[25] 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.[26] MCPs must provide NMT for all medically necessary services, including those services carved out of the MCP.[27]

ADVOCACY TIP:

✓ If the Medi-Cal managed care plan (MCP) fails to coordinate medically necessary services that are carved out of the MCP contract, you can file a grievance or appeal as necessary. MCPs are ultimately responsible for coordination of care for *all* medically necessary EPSDT services delivered within and outside the MCP's network.

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.[28] 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.[29] This information must meet all language and accessibility standards.[30]

B. California Children's Services (CSS)

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.[31] Approximately 90% of children enrolled in CCS are Medi-Cal eligible.[32] As a result, Medi-Cal pays for the cost of CCS care for these children and the services provided to the remaining 10% of CCS beneficiaries are funded equally by county and state funds.[33]

Medi-Cal MCPs are required to refer all children with certain medical conditions to CCS.[34] Until the child's CCS eligibility is confirmed, the MCP remains responsible for providing all medically necessary EPSDT services.[35] 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.[36]

1. Whole Child Model

The Whole Child Model (WCM) program currently authorizes MCPs to administer the CCS program in 37 California counties.[37] 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.[38] As a result, the MCP assumes full responsibility for authorization and payment of CCS eligible medical services, including service authorizations, claim processing and payment, case management, and quality oversight.[39] 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.[40]

2. Traditional Counties

In traditional counties, Medi-Cal beneficiaries with CCS continue to access services as they did before the implementation of the WCM program and the county size determines who administers the program. In traditional counties with populations *greater than* 200,000 people, the county is responsible for administering the CCS program independently.[41] In traditional counties with populations *less than* 200,000, the Children's Medical Services (CMS), a part of DHCS, provides medical case management, eligibility, and benefit determinations.[42] Even if a child in a traditional 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 MCP.[43]

ADVOCACY TIP:

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

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.[44] 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, *California Children's Services Due Process Toolkit.*[45]

C. The Children's Presumptive Eligibility Program (formerly known as the Child Health and Disability Prevention Gateway)

The 2022–2023 California state budget approved the sunset of the Child Health and Disability Prevention program (CHDP) and implemented the Children's Presumptive Eligibility (CPE) program, as of July 1, 2024.[46] The goal of the program is to simplify and streamline Medi-Cal eligibility for children and youth under the age of 21. Similar to CHDP, the CPE program provides immediate,

temporary access to Medi-Cal for up to 60 days prior to completing a full Medi-Cal application.[47] The CPE program is available to all children and youth up to age 21 who are eligible for Medi-Cal and have not exceeded 2 presumptive eligibility periods in the last 12 months.[48] Once the family completes a full Medi-Cal application for the child, the child will access services through FFS Medi-Cal or their Medi-Cal MCP.

D. 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.[49] In this program, minors can provide legal consent for sensitive services.[50] Minors of any age may consent to receive family planning, pregnancy and pregnancy-related care, and sexual assault services.[51] Minors 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.[52] However, a child or youth cannot receive replacement narcotic therapy, psychotropic drugs, convulsive therapy, psychosurgery or sterilization without parental consent.[53] Importantly, the law provides an exception for minors over 16 years of age or older, who may receive medications for opioid use disorders from Narcotic Treatment Programs (NTPs) without parental consent.[54] Additionally, 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.[55]

Children or youth enrolled in a Medi-Cal MCP will automatically get access to minor consent services. However, if a child or youth is enrolled in FFS Medi-Cal or is not enrolled in Medi-Cal at all, they must apply each month to the Medi-Cal Minor Consent Program to receive minor consent services, except for covered outpatient mental health services as recommended by a mental health professional. Outpatient mental health services may be provided for up to six months, if recommended by the mental health professional, without the need for the minor to re-establish eligibility on a monthly basis.[56] Beneficiaries are permitted to apply or renew by telephone or in-person, and counties must accept telephonically recorded, electronic signatures and/or handwritten signatures.[57]

To be eligible for the Medi-Cal Minor Consent Program, the child or youth must be under age 21 and a minor under the legal responsibility of a public agency (foster care, adoption assistance, probate, etc.) does not disqualify them from enrolling in the program.[58] Eligibility is based on the minor's income and resources and, if the minor is employed, they must provide pay stubs to verify income.[59] Minors do not have to provide any identification when they apply.[60] 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.[61] If a child or youth is enrolled in a MCP, the MCP must abide by these Minor Consent services program rules, and MCPs must ensure access to these services from any network or out-of-network provider without prior authorization.[62]

E. Behavioral Health Treatment (BHT) Program

Medi-Cal covers all medically necessary Behavioral Health Treatment (BHT) services for eligible Medi-Cal members under 21 years old as both a preventative service and EPSDT benefit.[63] BHT services include Applied Behavioral Analysis (ABA) and other behavioral intervention services that have been identified as evidence-based approaches to help individuals navigate and manage behaviors that may interfere or impact learning and social interactions, and better promote the functioning of an individual.[64] These services are most often recommended for individuals with autism spectrum disorder (ASD), and sometimes are also recommended by providers for other conditions.[65]

Medi-Cal covers BHT services when medically necessary, as determined by a physician or psychologist. Under state and federal law, only a physician or psychologist can determine whether BHT services are medically necessary, but any health care provider can send a referral to a physician or psychologist for evaluation for BHT services.[66] BHT services are medically necessary when the services are needed to correct or ameliorate any physical and/or behavioral condition. Once determined medically necessary, BHT services can be provided by Qualified Autism Service (QAS) providers through Medi-Cal MCPs and through Medi-Cal FFS from the individual's local Regional Center, or, as of July 1, 2025, from enrolled Medi-Cal QAS providers.[67]

F. Enhanced Care Management and Community Supports

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

1. Enhanced Care Management

As part of CalAIM, some children and youth on Medi-Cal are entitled to Enhanced Care Management (ECM) services, as of 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.[68]

ECM is delivered through Medi-Cal MCPs, which 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.[69] ECM services will be available to children and youth in select populations of focus, as follows:[70]

- 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 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.

For more information on ECM, see Chapter XII of this Guide.

2. Community Supports

Through CalAIM, children on Medi-Cal may also be eligible for Community Supports. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services that address social drivers of health.[71] Effective January 2022, all Medi-Cal MCPs are encouraged, but not required, to offer the 14 Community Supports, and use of Community Supports is optional for members.[72] For more information on Community Supports, see Chapter XIII of this Guide.

G. CalAIM Justice-Involved Initiative: Medi-Cal Pre-Release Services

The CalAIM Justice-Involved Initiative is part of the CalAIM 1115 waiver and aims to improve access to and quality of health care for justice-involved populations as they re-enter their communities.[73] In 2023, California became the first state to receive federal approval from the CMS to offer and obtain federal funding for a targeted set of Medi-Cal services to youth and adults in correctional facilities for up to 90 days prior to release (hereinafter, "pre-release Medi-Cal services").[74] This time-limited program is slated to expire at the end of 2026, however DHCS is seeking a waiver renewal from CMS and has sought stakeholder input on its renewal proposal.

Pre-release Medi-Cal services are available to eligible youth in the following correctional agencies: state prisons, county jails/detention facilities, and county youth correctional facilities.[75] Unlike adults, juvenile youth are automatically

eligible to receive pre-release services without needing to demonstrate a particular health care need.[76] In addition, pursuant to the EPSDT benefit, pre-release services are available for youth under age 21 when they are necessary to correct or ameliorate a physical or behavioral health condition.[77] Correctional facilities and prisons are required to screen all Medi-Cal eligible youth for physical and behavioral health needs to ensure that all eligible youth are able to receive Medi-Cal services in a timely manner.[78]

Pre-release Medi-Cal services include:

- Case Management: intended to facilitate reentry planning into the community to support the coordination of services delivered during the pre-release period and upon reentry; ensure smooth linkages to social services and supports; and help arrange appointments and timely access to appropriate care and pre-release services delivered in the community;[79]
- Physical and behavioral health clinical consultation services: including, but not limited to, clinical assessments, patient education, therapy and counseling, and peer support services;[80]
- Laboratory and radiology services;[81]
- Medications and medication management: coverage extends to all medications, including over-the-counter medications, in the Medi-Cal Prescription Drug Contract Drugs List, and includes access to medications that are difficult to obtain in correctional facilities, helping individuals access medications that will stabilize their chronic conditions;[82]
- Medication-Assisted Treatment (MAT): provided for opioid use disorder (OUD), alcohol use disorder (AUD) and non-opioid substance use disorder, along with other psychosocial services delivered in conjunction with MAT for both OUD, AUD, and non-opioid SUD;[83]
- Community Health Workers/Promotores/Representatives (CHWPR) services;[84]
- Services provided upon release: a minimum 30-day supply of prescribed and prescription over-the-counter medication and durable medical equipment.[85]

Pre-release services can be provided via telehealth or in-person.[86] Correctional facilities are allowed to conduct appointments by video or audio, consistent with Medi-Cal's telehealth policy.[87] Pre-release services will be delivered through Medi-Cal's FFS delivery system.[88] Every county jail, youth correctional facility, and state prison within California are required to implement pre-release services by October 1, 2026.[89] DHCS maintains a website with a list of counties and their status in implementing its justice-involved program.[90]

Endnotes

[1] 42 U.S.C. §1396a(l)(2)(C); 42 U.S.C. 1396a(e)(14)(I)(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).

[2] Cal. Welf. & Inst. Code § 14005.26(d)(1)(B) (California implemented the federal optional Targeted Low-Income Children's Program (TLICP) pursuant to 42 U.S.C. §§1396a(a)(10)(A)(ii)(XIV)), 14005.26(b), 1396a(e)(14)(I)(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).

[3] Cal. Welf. & Inst. Code § 14007.8; see Cal. Dep't Health Care Servs., *Senate Bill 75 Full Scope Medi-Cal for All Children: Eligibility and Enrollment Plan* (2016), https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/SB75/SB75_EE_Plan_032116_Final.PDF. Due to the passage of H.R. 1, Medi-Cal will undergo numerous immigrant eligibility changes. However, youth (under age 19) will not be affected by H.R. 1 changes and will remain eligible for full-scope Medi-Cal with full dental benefits, regardless of their immigration status.

[4] Cal. Dep't Health Care Servs., *Medi-Cal Children's Health Dashboard* 2 (2025), https://www.dhcs.ca.gov/services/Documents/Childrens-Health-Dashboard-June-2025.pdf.

[5] 42 U.S.C. § 1396d(r)(5).

[6] 42 U.S.C. §§ 1396a(a)(10)A, 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); Cal. Welf. & Inst. Code §§ 14059.5(b)(1), 14132(v); *see* Cal. Code Regs. tit. 22, §§ 51184, 51340, 51340.1.

[7] Cal. Dep't Health Care Servs., Medi-Cal for Kids and Teens, https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/home.aspx (last visited Apr. 28, 2026).

[8] 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 No. 23-005 (Mar. 16, 2023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf [hereinafter All Plan Letter 23-005]; *see also* 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.

[9] 42 U.S.C. §§ 1396d(r)(5), 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(xvii)(4)(B).

[10] 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).

[11] 42 U.S.C. § 1396d(r)(1); Cal. Code Regs. tit. 22, § 51184; see 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 [hereinafter *Medi-Cal Coverage for EPSDT*]; *see also* Cal. Dep't Health Care Servs., Medi-Cal for Kids and Teens: Provider Information, https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Provider-Information.aspx (last visited Apr. 23, 2026).

[12] *Medi-Cal Coverage for EPSDT*, *supra* note 11; *see also* All Plan Letter 23-005, *supra* note 8, at 4.

[13] 42 U.S.C. § 1396d(r)(1); *see also* All Plan Letter 23-005, *supra* note 8, at 2–4.

[14] 42 U.S.C. § 1396d(r)(5); Cal. Code Regs. tit 22, § 51184.

[15] All Plan Letter 23-005, *supra* note 8, at 6.

[16] 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).

[17] Cal. Welf. & Inst. Code §§ 14184.402(d), 14184.402(e)(2).

[18] Cal. Code Regs. tit. 22, § 51184(g).

[19] Id. §§ 51184(h), 51340(f)(1).

[20] Cal. Code Regs. tit. 9, § 1810.249.

[21] Cal. Code Regs. tit. 22, § 51340(k); *see also* All Plan Letter 23-005, *supra* note 8, at 8.

[22] 42 C.F.R. § 441.62; *see also Medi-Cal Coverage for EPSDT*, *supra* note 11.

[23] *See generally* All Plan Letter 23-005, *supra* note 8; *see also*, e.g., Cal. Dep't Health Care Servs., *Two-Plan Boilerplate Contract,* Exhibit A, Attachment III at 388 (2024), https://www.dhcs.ca.gov/provgovpart/Documents/Managed-Care-Boilerplate-Contract.pdf [hereinafter *Two-Plan Boilerplate Contract*].

[24] All Plan Letter 23-005, *supra* note 8, at 9.

[25] *Id.* at 7; *Two-Plan Boilerplate Contract*, *supra* note 23, at 392–393.

[26] All Plan Letter 23-005, *supra* note 8, at 7.

[27] *Id.*; Cal. Dep't Health Care Servs., All Plan Letter No. 22-008 (May 18, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008.pdf [hereinafter All Plan Letter 22-008].

[28] All Plan Letter 23-005, *supra* note 8, at 8.

[29] 42 U.S.C. § 1396d(r)(1)(B)(v); *see also* All Plan Letter 22-008, *supra* note 27.

[30] All Plan Letter No. 23-005, *supra* note 8, at 8.

[31] Cal. Health & Safety Code § 123800-123995 (enabling legislation); Cal. Welf. & Inst. Code § 14094–14094.3; Cal. Code Regs. tit. 22, § 51013.

[32] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: California Children's Services Program* 1 (2024), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/353B9F8A-A464-4953-A615-25A27DB2DD48/calchild.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[33] *Id.*

[34] Cal. Code Regs. tit 22, § 51013; *see also* All Plan Letter 23-005, *supra* note 8, at 8–9; Cal. Dep't Health Care Servs., All Plan Letter No. 23-034 at 3-4 (Dec. 27, 2023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-034.pdf [hereinafter All Plan Letter 23-034].

[35] All Plan Letter 23-005, *supra* note 8, at 8–9.

[36] *Id.*

[37] Cal. Welf. & Inst. Code § 14094.5 (as amended by SB 586-Hernandez in 2016); see Cal. Dep't Health Care Servs., California Children's Services Whole Child Model, https://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx; *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*].

[38] Cal. Welf. & Inst. Code § 14094.6; *see also* All Plan Letter 23-034, *supra* note 34, at 1.

[39] All Plan Letter 23-034, *supra* note 34, at 2; *see also* Cal. Dep't Health Care Servs., CCS Numbered Letter 10-1224 at 2 (Dec. 2, 2024), https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-10-1224.pdf.

[40] *See CCS Whole Child FAQ*, *supra* note 37, at 3.

[41] Cal. Health & Safety Code § 123850(a).

[42] *Id.*

[43] All Plan Letter 23-005, *supra* note 8, at 8.

[44] *Id.* at 7.

[45] Alicia Emanuel *et al.,* Nat'l Health Law Prog., *California Children's Services Due Process Toolkit* (2025), https://healthlaw.org/resource/california-childrens-services-due-process-toolkit/.

[46] Cal. Welf. & Inst. Code § 14011.7; *see also* 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 generally* 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.

[47] Cal. Welf. & Inst. Code § 14011.7; *see also* Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual: Children's Presumptive Eligibility (CPE) Process* (2024), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7D4F2FB2-F046-4172-8456-77D1FBE22CA2/cpeprocess.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[48] *Id.*

[49] See Cal. Dep't Health Care Servs., *Medi-Cal Eligibility Procedures Manual § 4V: Minor Consent Services* (2025), https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEPM/4V-Minor-Consent.pdf [hereinafter *Minor Consent Services Eligibility Manual*].

[50] 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.

[51] Cal. Family Code § 6925.

[52] Cal. Family Code § 6924, 6926, 6927, 6928, 6929; *Minor Consent Services Eligibility Manual*, *supra* note 49, at § 4V-1.

[53] *Minor Consent Services Eligibility Manual*, *supra* note 49, at § 4V-1–4V-2.

[54] *Id. see also* Cal. Family Code § 6929(e)(2) (permitting minors 16 and older to consent to medications for opioid use disorders at narcotic treatment program when federal law allows), and 42 C.F.R. § 8.12(e)(2) (restricting access to treatment at opioid treatment programs to individuals 18 and older, except when state law permits younger individuals to access services).

[55] 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).

[56] *Minor Consent Services Eligibility Manual*, *supra* note 49, at § 4V-3.

[57] 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.

[58] *Minor Consent Services Eligibility Manual*, *supra* note 49, at § 4V-2. See 22 CCR § 50030(a) (Child means a person under the age of 21 except for those persons who are specified as adults in 22 CCR § 50014).

[59] Id at § 4V-2–4V-3.

[60] *Id.* at § 4V-2; *see also* Cal. Code Regs. tit. 22, § 50167(a)(6)(D)(4).

[61] Cal. Dep't Health Servs., *Medi-Cal Provider Manual, Minor Consent Program* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/E6EF9FF8-1C71-4B2D-A677-A32F098CCF5C/medicaminor.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[62] *See, e.g., Two-Plan Boilerplate Contract*, *supra* note 23, at 359. *See also* Cal. Dep't Health Care Servs., All Plan Letter No. 24-019 (Dec. 31, 2024), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-019.pdf.

[63] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Behavioral Health Treatment* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/79D4E83F-FAA4-41C1-9D9F-E7B8A75B4BDF/bht.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, BHT*].

[64] *Id.*

[65] *Id.*

[66] 42 USC 1396d (r)(5); Cal. Wel. & Inst. Code § 14059.5(b)(1).

[67] *Medi-Cal Provider Manual, BHT, supra* note 63.

[68] Cal. Dep't Health Care Servs., All Plan Letter No. 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/ECM-Community-Supports-Dec-FAQ.pdf [hereinafter *CalAIM ECM FAQs*].

[69] *CalAIM ECM FAQs, supra* note 68.

[70] All Plan Letter 21-012, *supra* note 68, at Attachment 1, https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-012-ECM-Att.pdf.

[71] Cal. Dep't Health Care Servs., All Plan Letter No. 21-017 (Mar. 1, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-017.pdf.

[72] *Id.*

[73] Cal. Dep't Health Care Servs., *Transformation of Medi-Cal: Justice Involved,* https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-JI-a11y.pdf (last visited Apr. 23, 2026).

[74] Cal. Welf. & Inst. Code § 14184.402. See CMS, Approval Letter for California Advancing and Innovating Medi-Cal (CalAIM) Reentry Demonstration Initiative Amendment (Jan. 26, 2023), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-ca1.pdf.

[75] Cal. Dep't Health Care Servs., *Policy and Operational Guide for Planning and Implementing the CalAIM Justice-Involved Initiative* (Oct. 2023), at 62–66, https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/CalAIM-JI-Policy-and-Operations-Guide-FINAL-October-2023-updated.pdf [hereinafter *DHCS CalAIM Justice-Involved Initiative Policy Guide*]. Individuals residing in low-security institutions, which include g camps and two honor farms, are deemed "inmates" and do not have the freedom of movement, therefore pre-release services will be available to individuals confined in these facilities. See *Id.* at 61.

[76] *Id.* at 63. Whereas, adults who are incarcerated in these qualified facilities are eligible to receive pre-release services if they (1) meet the standard Medicaid eligibility criteria, and (2) experience one or more of the following health care needs: mental illness, SUD, chronic condition or significant clinical condition, intellectual or developmental disability, traumatic brain injury, HIV/AIDS, and/or be pregnant or postpartum. *Id.* 62–66.

[77] 42 U.S.C. § 1396d(r)(5); Cal. Welf. & Inst. Code § 14059.5(b)(1).

[78] *DHCS CalAIM Justice-Involved Initiative Policy Guide, supra* note 75, at 67–72.

[79] *Id.* at 75–76.

[80] *Id.* at 108–110. For more information about coordination services to which Medi-Cal beneficiaries are entitled, see Chapter XII of this Guide on Care Coordination.

[81] *DHCS CalAIM Justice-Involved Initiative Policy Guide, supra* note 75, at 77; Cal. Dep't Health Care Servs., Cal. State Plan Chart, Limitations on Attachment 3.1-A 4, https://www.dhcs.ca.gov/SPA/Documents/Limitations-to-Attachment-3-1A.pdf [hereinafter State Plan Chart Limitations on Attachment 3.1-A]. Laboratory and radiology services are covered on order of a licensed practitioner except for laboratory services in renal dialysis centers and community hemodialysis units. *Id.*

[82] Cal. Dep't Health Care Servs., Medi-Cal Rx Contract Drugs List (2026), https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf; *See also* Cal. Dep't Health Care Servs., Medi-Cal Rx Contract Drugs List – Over-the-Counter Drugs and Cold/Cough Preparations (2026), 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. State Plan Chart Limitations on Attachment 3.1-A, *supra* note 81, at 17.

[83] CMS, Approval Letter for Cal. State Plan # 20-0006 (Dec. 20, 2021), https://www.dhcs.ca.gov/Documents/CA-20-0006-B-MAT-SPA-Approval-Package.pdf.

[84] CMS, Approval Letter for Cal. State Plan # 22-0001 (July 26, 2022), https://www.dhcs.ca.gov/formsandpubs/laws/Documents/SPA-22-0001-Approval.pdf.

[85] *DHCS CalAIM Justice-Involved Initiative Policy Guide, supra* note 75, at 78.

[86] *Id.* at 93.

[87] *Id.*

[88] *Id.* at 131.

[89] *Id.* at 47. For more information on services and supports available through the Justice-Involved Initiative, see Jasmine Young & Héctor Hernández-Delgado, Nat'l Health Law Prog., *Medi-Cal Services & Supports for Californians Transitioning Out of Incarceration* (2024), https://healthlaw.org/resource/medi-cal-services-supports-for-californians-transitioning-out-of-incarceration/.

[90] Cal. Dep't Health Care Servs., Justice-Involved Reentry Initiative Go Live Partners and Status, https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/County-readiness-status.aspx (last visited Apr. 23, 2025).

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter X:
Long-Term Services and Supports

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Outline of Medi-Cal Long-Term Services and Supports*
A. Medi-Cal Funding for Long-Term Services and Supports (LTSS) through CalAIM 1. Long-Term Care (LTC) Carve-In 2. Mandatory Managed Care Plan (MCP) Enrollment for Dual Eligible B. Facility-Based Long-Term Care (LTC) 1. Skilled Nursing Facilities (SNFs) 2. Skilled Nursing Facility Special Treatment Programs (SNF/STPs) 3. Subacute-Care Facilities 4. Intermediate-Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) C. Home and Community-Based Services (HCBS) 1. HCBS Waiver Programs 2. In-Home Services and Supports (IHSS) 3. California Community Transitions 4. Community-Based Adult Services (CBAS) 5. Community Supports through CalAIM 6. Program of All Inclusive Care for the Elderly (PACE)

*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, which includes both facility-based care (long-term care, LTC) and home and community-based services.[1] Medi-Cal pays for 61% of LTC, and 85% of LTSS users receive these services at home or in the community.[2] 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.[3] Since Medicare's coverage of LTSS is very limited, most low-income Californians rely on Medi-Cal for these services.

A. Medi-Cal Funding for Long-Term Services and Supports through CalAIM

Historically, LTC was delivered through the Medi-Cal Fee for Service (FFS) system. The California Advancing and Innovating Medi-Cal (CalAIM) initiative includes multi-phased changes to the delivery of facility-based LTC services.[4] By 2027, almost all LTC benefits will be provided by Medi-Cal managed care plans (MCPs).[5]

1. LTC Carve-In

Starting January 1, 2023, Medi-Cal managed care plans began covering LTC benefits for skilled nursing facilities (including a distinct part or unit of a hospital), intermediate care facilities, and subacute facilities.[6] Prior to CalAIM, except for certain counties, Medi-Cal managed care only covered LTC for a limited time before individuals were disenrolled from their Medi-Cal MCP and transferred to FFS Medi-Cal. Now, accessing LTC services is 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

Beginning in January of 2023, people who were dually eligible for both Medi-Cal and Medicare began experiencing changes in the way they received LTC benefits.

First, dual eligible beneficiaries who were not already enrolled in a Medi-Cal MCP have been transitioned to managed care.[7] This statewide enrollment in managed care was designed to 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 changed. Individuals are now 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 is operated by the same parent insurer as the beneficiary's Medi-Cal plan. For individuals residing in the counties of Los Angeles, Santa Clara, San Bernardino, Riverside, San Mateo,

ADVOCACY TIP:

✓ Dual eligible beneficiaries can choose to remain in their original Medicare plan rather than enroll in a MMP. In some cases, people with disabilities or more complex health conditions may benefit from staying enrolled in original Medicare in order to access tertiary care hospitals and additional specialists.

Orange, or San Diego (i.e., the Coordinated Care Initiative (CCI) counties), the transition to MMPs occurred in 2023.[8] For individuals in all other counties, the transition will occur by 2026.[9] This change will align the beneficiaries' Medi-Cal and Medicare benefits into the same managed care organization, with the goal of making access to care simpler. Under this model, dual eligible beneficiaries will receive a single health plan card.

B. 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.[10] Medi-Cal does not pay for room and board expenses in assisted living facilities, which differ from skilled nursing facilities because residents in such assisted living 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 C of this chapter or through CalAIM community supports, discussed in detail in Chapter XIII of this guide.

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.[11] 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.[12]

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," "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).[13] 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.[14]

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 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.[15]

ADVOCACY TIP:

✓ Individuals in LTC who have a Share of Cost (SOC) can pay for necessary, non-covered, medical or remedial-care services, supplies, equipment and drugs that are prescribed by their physician and part of their plan of care as a way of eliminating their share of cost.[16]

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

SNF/STPs are skilled nursing facilities that serve patients who have a chronic mental health disability 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, and use of community resources.[17]

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.[18] SNFs/STPs 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.[19]

3. Subacute care facilities

Subacute care facilities are specialized units which are often in a distinct part of a nursing facility or hospital. The focus of these facilities is on intensive rehabilitation, complex wound care, and post-surgical recovery for individuals who do not require hospital acute care but require more intensive care than is generally provided in a skilled nursing facility.[20] Subacute care facilities provide care for individuals who are medically fragile and require special services, such as inhalation therapy, tracheotomy care, intravenous tube feeding, use of a ventilator to breathe, 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.[21] Children are also served in Pediatric Subacute Facilities. Pediatric Subacute care is available for children under 21 years of age who use a medical technology that compensates for the loss of a vital bodily function.[22]

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

ICFs/IID are health facilities that provide ongoing evaluation, planning, 24-hour supervision, care coordination, and integration of health or rehabilitative services to individuals with intellectual or developmental disabilities. 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.[23]
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.[24]
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.[25]
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.[26]

C. Home and Community-Based Services (HCBS)

HCBS programs are intended to serve individuals who need services and supports to remain living at home and in the community, or to return home from institutions. California has a number of HCBS programs, including six 1915(c) HCBS waiver programs, the California Community Transitions (CCT) Program, Community-Based Adult Services (CBAS), Community Supports, the In-Home Supportive Services (IHSS) program, and the Program of All-Inclusive Care for the Elderly (PACE). These services provide supports that enable people to live and participate in their communities rather than institutions.[27]

The scope of HCBS varies based on the specific program in which an individual is enrolled. For instance, the HCBA Waiver offers the following services:[28]

- Case Management
- Habilitation Services
- Home Respite
- Waiver Personal Care Services (WPCS)
- Paramedical Services
- Assistive Technology
- Community Transition Services
- Comprehensive Care Management
- Continuous Nursing and Supportive Services
- Environmental Accessibility
- Respite
- Family/Caregiver Training
- Medical Equipment Operating Expense
- Personal Emergency Response (PERS) Installation and Testing
- Personal Emergency Response Systems (PERS)
- Private Duty Nursing - Including Home Health Aide and Shared Services
- Transitional Case Management

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. Section 1915(c) waivers allow states to "waive" certain Medicaid rules, including a waiver of the "comparability" requirement that typically mandates that states provide comparable services to all Medicaid beneficiaries; a waiver of requirement that services be statewide; and a waiver of income and resource rules.[29]

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, California has long waiting lists for some of the HCBS waiver programs. HCBS waiver services and eligibility requirements are summarized in the table below.[30] 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
General/ Physical Disability Waivers		
Assisted Living Waiver[31]	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 individuals living in independent publicly subsidized housing.	· Adults with disabilities age 21 or older · Nursing facility level of care · Waiting List
Multipurpose Senior Services Program Waiver[32]	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.	· Individuals age 65 or older · Nursing facility level of care · Waiting List
Medically Fragile/ Technology Dependent Waivers		
Home and Community-Based Alternatives Waiver[33]	Case Management. Habilitation Services, Home Respite, Waiver Personal Care Services (WPCS), Paramedical Services, Assistive Technology, Continuous Nursing and Supportive Services, Environmental Accessibility, Respite, Private Duty Nursing - Including Home Health Aide and Shared Services and other HCBS.	· Individuals who are medically fragile or technology dependent of any age · Hospital, subacute, nursing facility, or intermediate care facility level of care · Waiting List
Developmentally/ Intellectually Disabled Waivers		
HCBS Waiver for Californians with Developmental Disabilities[34]	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.	· Individuals with autism, a developmental disability, or an intellectual disability of any age · Intermediate care facility level of care · Regional Center Eligible · No Waiting List[35]

Figure 2 (continued)

Self-Determination Program for Individuals with Developmental Disabilities[36]	Community living supports, employment supports, homemaker, live-in caregiver, prevocational supports, respite services, acupuncture services, financial management service, independent facilitator, behavioral intervention services, communication support, community integration supports, and other HCBS. This waiver is self-directed, and participants have a set budget that pays for services.	· Individuals with autism, a developmental disability, or an intellectual disability of any age · Intermediate care facility level of care · Regional Center Eligible · No Waiting List[37]
HIV/AIDS Waivers		
Medi-Cal Waiver Program (MCWP)[38]	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.	· Individuals with HIV or AIDS of any age · Hospital or nursing facility level of care · Waiting List

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-DD Waiver. 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.[39] Services provided include, but are not limited to, Habilitation; Respite Care; Behavioral Intervention Services;Personal Care; Personal Emergency Response Systems; and Vehicle Modification and Adaptation.[40]

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.[41] IHSS currently serves over 850,000 recipients in California.[42] 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.[43] To be eligible for IHSS, individuals must be 65 years or older, disabled, or blind. Children with disabilities are also eligible for IHSS.[44] Eligibility for IHSS is not impacted by 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. The four programs are:

- The Personal Care Services Program (PCSP), which serves people who are categorically eligible for Medi-Cal. Approximately 42% IHSS recipients are enrolled in PCSP.[45] Individuals in PCSP cannot have a spouse or parent provider.
- The Community First Choice Option (CFCO), which serves individuals who meet a nursing facility level of care.[46] Approximately 52% of IHSS beneficiaries are enrolled in the program.[47]
- The IHSS Plus Option (IPO), which serves 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).[48] Approximately 3 percent of California's IHSS population is enrolled in IPO.[49]
- IHSS-R, which serves individuals who do not qualify for federally-funded Medi-Cal, including those who do not qualify due to immigration status. IHSS-R 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. Approximately 3 percent of California's IHSS population is enrolled in IHSS-R.[50]

IHSS services are provided under California's Medicaid State Plan, not under waivers, and therefore different legal requirements apply to IHSS than waiver programs.[51] 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. Additionally, Medi-Cal beneficiaries can qualify for State Plan HCBS covered under IHSS even if they do not meet an institutional level of care.[52]

The IHSS program generally covers non-medical personal care services. This means that medical services available under some HCBS waivers, such as nursing care, are not covered under IHSS. However, IHSS does include paramedical services, which are skilled tasks necessary to maintain the recipient's health and which but for their disability, the recipients would perform themselves.[53] Examples are administration of medication, inserting medical devices, and puncturing the skin. Finally, in terms of eligibility, IHSS is available only to individuals receiving care in their own home.[54] IHSS does not cover services for those residing in institutional settings, such as assisted living facilities and congregate living health 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 skilled nursing facilities).[55] For more information about the IHSS program, please consult Justice in Aging's and Disability Rights California's IHSS advocates manual.[56]

ADVOCACY TIP:

✓ As of February 19 2024, there are no longer rules restricting when a parent can be an IHSS provider for their child.[57] This means that any eligible provider can be hired to provide care to a recipient, which significantly simplifies the IHSS provider process for parents.

3. California Community Transitions (CCT)

CCT is California's Federal Money Follows the Person (MFP) Rebalancing Demonstration Program.[58] Through CCT, individuals who have been in an institution for 90 days[59] can receive services to assist them to move into the community with supports.[60] CCT essentially reaches in to the institution to provide intensive case management to connect eligible Medi-Cal beneficiaries with HCBS programs in the community (e.g., IHSS, MSSP, the HCBA Waiver, and Community Based Adult Services (CBAS)). CCT can pay for the cost of setting up a house or apartment, home modifications, vehicle adaptations, and assistive devices, as well as help people search for housing and apply for HCBS programs.[61]

4. Community-Based Adult Services

Community-Based Adult Services (CBAS) is a community-based day health program which provides services to individuals with disabilities who are 18 and older. To be eligible for CBAS, individuals must have health conditions and/or disabilities that make them at risk of needing institutional care. CBAS provides professional nursing services, physical, occupational, and speech therapies, mental health services, case management, meals, and transportation to and from the CBAS center.[62] CBAS is authorized through the CalAIM 1115 Waiver.[63]

5. Community Supports

Under CalAIM, In Lieu of Services (ILOS), known in California as Community Supports, are available to help individuals leave institutional settings, or get the services that they need to stay in the community.[64] MCPs may offer Community Supports as alternatives to services covered under the Medi-Cal State Plan. Community Supports are designed to help managed care members meet social needs, such as housing, food support, and community transition services. Community Supports that may benefit members in the LTC 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; Personal Care and Homemaker Services; transitional rent; and medically supportive meals.[65] Community Supports are discussed in detail in Chapter XIII of this Guide.

6. Program of All-Inclusive Care for the Elderly (PACE)

The PACE program[66] provides all-inclusive care for individuals who are 55 and older and qualify for nursing facility level of care but are able to live safely in the community with PACE services.[67] Individuals who are dually eligible, or Medi-Cal only or Medicare only can enroll in PACE. Individuals enrolled in PACE receive all of their care through PACE. PACE services include but are not limited to adult day health care (including transportation to and from home), dental services, home care, physical and occupational therapies, emergency services and hospital coverage, and nursing facility care. PACE programs provide social and medical services primarily in an adult day health care center, supplemented by in-home and referral services in accordance with the participant's needs.[68] The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the interdisciplinary team for the care of the PACE participant.

ADVOCACY TIP:

✓ Because the PACE program is all inclusive, individuals who enroll in PACE cannot access other services outside the program like IHSS or HCBS Waivers. For individuals who need a high number of hours of IHSS, PACE may not be the best option.

Endnotes

[1] Congressional Research Service IN FOCUS, *Who Pays for Long-Term Services and Supports?* (Sept. 2023), https://www.congress.gov/crs-product/IF10343.

[2] Kaiser Fam. Found., Medicaid in California (May 2025), https://files.kff.org/attachment/fact-sheet-medicaid-state-CA; Cal. Dep't Health Care Servs., *California Long Term Services and Supports Dashboard: Initial Release Fact Sheet* (Dec. 2022), https://www.dhcs.ca.gov/services/Documents/LTSS-Dashboard-Fact-Sheet-Dec2022.pdf.

[3] Cal. Dep't Health Care Servs., Medi-Cal Long Term Services and Supports Dashboard, https://www.dhcs.ca.gov/dataandstats/dashboards/Pages/LTSS-Dashboard.aspx (55% of LTSS users are dual eligible) (last visited Nov. 3, 2025).

[4] *See* CMS, *CalAIM Demonstration Approval Technical Correction Attachment* (Jan. 17 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dmnstrn-appvl-thncl-crctn-atchmnt-c-aa-01172025.pdf [hereinafter *CalAIM Demonstration Approval*]; *see also* Cal. Dep't Health Care Servs., CalAIM: Transforming Medi-Cal, https://www.dhcs.ca.gov/CalAIM/Pages/CalAIM.aspx (last visited Nov. 3, 2025). In addition to facility-based LTC, a number of HCBS benefits are now part of CalAIM, through the provision of Community Supports, discussed in detail in Chapter XIII of this Guide.

[5] Cal. Dep't. Health Care Servs., Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM) (2023), https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915bWaiver-CA-0017-R10-01-Application.pdf [hereinafter CalAIM 1915(b) Waiver].

[6] Skilled Nursing Facilities were carved into managed care starting January 1, 2023. As of January 1, 2024, Medi-Cal managed care plans (MCP) are required to cover care in ICF/DD, ICF/DD-H, ICF/DD-N, Adult Subacute Care, and Pediatric Subacute Care facilities. 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 Nov. 3, 2025); Cal. Dep't Health Care Servs., All Plan Letter No. 22-018 (Oct. 25, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-018.pdf.

[7] Cal. Dep't Health Care Servs., All Plan Letter No. 21-015 (Oct. 2021), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015.pdf.

[8] 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 Nov. 3, 2025).

[9] CalAIM 1915(b) Waiver, *supra* note 5. Note that DHCS refers to MMPs as Medi-Medi Plans, *see*, Cal. Dep't Health Care Servs., California Expands Medi-Medi Plans to 29 New Counties as Medicare Open Enrollment Begins, https://www.dhcs.ca.gov/formsandpubs/publications/oc/Pages/2025/25-25-Medi-Medi-Plan-Expansion-10-15-25.aspx#:~:text=Medi%2DMedi%20Plans%20combine%20Medicare,and%20home%20modifications%20when%20available (last visited Nov. 3, 2025).

[10] 42 U.S.C. § 1396r(a)(1).

[11] *See* Cal. Code Regs. tit. 22, §§ 51334 (ICFs), 51335 (SNFs).

[12] 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* (2024), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/12012877-1AAE-426D-A77D-10EDB30F9D3E/tarcompltc.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; Cal. Dep't Health Care Servs., DHCS Medi-Cal Authorizations for Long-Term Care Providers (2024) https://www.dhcs.ca.gov/Documents/MCQMD/Medi-Cal-LTC-Authorizations-LTC-Resource.pdf; Cal. Dep't Health Care Servs., All Plan Letter No. 24-009, (Sept. 16, 2024), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-009.pdf.

[13] Cal. Code Regs. tit. 22, § 51123.

[14] Cal. Code Regs. tit. 22, § 51335; Dep't Health Care Servs., All Plan Letter No. 25-002 (Jan. 2025), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202025/APL25-002.pdf.

[15] Cal. Code Regs. tit. 22, § 51335(j).

[16] Cal. Dep't Health Care Servs., Skilled Nursing Facility Long-Term Care Carve-In Frequently Asked Questions (FAQ) (2024), https://www.dhcs.ca.gov/Documents/MCQMD/SNF-Carve-In-FAQs.pdf; Cal. Dep't Health Servs., *Medi-Cal Provider Manual, Share of Cost (SOC): UB-04 for Long Term Care* (2024), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/B45119CA-A84B-4828-A38D-2638562E19A6/shareltc.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; Cal. Dep't Health Care Servs., All County Welfare Director's Letter No. 89-54 (July 24, 1989), https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/c89-54.pdf.

[17] Cal. Code Regs. tit. 22, § 72445.

[18] 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 V of this Guide on SUD Services provides more information on the current waiver.

[19] Cal. Code Regs. tit. 22, § 72443(b).

[20] Cal. Code Regs. § 51124.5; Cal. Dep't Health Care Servs., All Plan Letter No. 23-027 (Sept. 2023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-027.pdf; Cal. Dep't Health Care Servs., CalAIM Subacute Care Facility Long-Term Care Carve-In, https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM-Subacute-Care-Facility-Long-Term-Care-Carve-In.aspx (last visited Nov. 3, 2025).

[21] Cal. Code Regs. tit. 22, §51124.5.

[22] Cal. Welf. & Inst. Code § 14132.25(e.)

[23] Cal. Health & Safety Code § 1250(g); Cal. Code Regs. tit. 22 § 51343.

[24] Cal. Health & Safety Code § 1250(e); Cal. Code Regs. tit. 22 § 51343.1.

[25] Cal. Health & Safety Code § 1250(h); Cal. Code Regs. tit. 22 § 51343.2.

[26] Cal. Welf. & Inst. Code § 14495.10. ICF DD-CNC facilities are not carved into managed care but are provided through the Home and Community Based Alternatives (HCBA) Waiver. In 2025 DHCS submitted an amendment to the HCBA Waiver as well as a State Plan Amendment to remove ICF DD-CNCs from the Waiver and make coverage available as a State Plan benefit.

[27] With the exception of Community Supports and PACE, none of these HCBS programs are administered through Managed Care.

[28] Cal. Dep't Health Care Servs., Application for a § 1915(c) Home and Community-Based Services Waiver (2024), https://www.dhcs.ca.gov/services/ltc/Documents/HCBA-Waiver-CAR0605.pdf [hereinafter, HCBA Waiver].

[29] 42 U.S.C. §§ 1396a(a)(10)(B)); 1396a(a)(1); 1396a(a)(10)(C)(i)(III).

[30] For a description of all approved waivers in California, see CMS, State Waivers List, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html and select "California" (last visited Nov. 3, 2025).

[31] Cal. Dep't Health Care Servs., Application for Assisted Living Waiver (ALW) (2024), https://www.dhcs.ca.gov/services/ltc/Documents/Application-for-1915c-HCBS-Waiver-CA0431R0400-March2024.pdf.

[32] *See* Cal. Dep't Health Care Servs., Application for Multipurpose Senior Services Program (MSSP) (2024), https://www.dhcs.ca.gov/services/medi-cal/Documents/CA0141R0700-MSSP-Waiver-Renewal.PDF.

[33] HCBA Waiver, *supra* note 28.

[34] Cal. Dep't Health Care Servs., Application for Home and Community-Based Services Developmental Disability Waiver (2025), https://www.dhcs.ca.gov/services/ltc/Documents/CA-0336R05-10-HCBS-Waiver.PDF [hereinafter HCBS-DD Waiver].

[35] While the HCBS-DD Waiver technically has a cap, DDS increases slots as necessary. *Id.* at 47.

[36] CMS, CA Self Determination Program for Individuals with Developmental Disabilities, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81096 (last visited Nov. 4, 2025) [hereinafter Self Determination Waiver].

[37] While the Self Determination Waiver technically has a cap, DDS increases slots as necessary. *Id.* at 33.

[38] Cal. Dep't Health Care Servs., Application for Medi-Cal Waiver Program (2023), https://www.dhcs.ca.gov/services/ltc/Documents/MCWP-Renewal-2023-2027.pdf [hereinafter MCWP]; *see also* Cal. Dep't Pub. Health, Office of Aids Medi-Cal Waiver Program, https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_mcwp.aspx# (last visited Nov. 4, 2025).

[39] Cal. Dep't Health Care Servs., 1915(i) State Plan (2024), https://www.dhcs.ca.gov/SPA/Documents/Attachment-3-1-i-169p-full-file.pdf.

[40] *Id.*

[41] Cal. Welf. & Inst. Code § 12300; Cal. Dep't Soc. Servs., *Manual of Policies and Procedures* § 30-700, https://www.cdss.ca.gov/inforesources/letters-regulations/legislation-and-regulations/adult-services-regulations (last visited Nov. 4, 2025) [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 Nov. 4, 2025) [hereinafter IHSS Program Webpage].

[42] Cal. Dep't Soc. Servs., In-Home Supportive Services (IHSS) Program Data, May 2025, https://www.cdss.ca.gov/inforesources/ihss/program-data (last visited Nov. 4, 2025) [hereinafter IHSS Data Webpage].

[43] Cal. Wel. & Inst. Code § 12300; *Manual of Policies and Procedures, supra* note 41, at § 30-756.

[44] Cal. Wel. & Inst. Code §§ 12305.5–12305.6.

[45] Cal. Wel. & Inst. Code § 14132.95; *Manual of Policies and Procedures, supra* note 41, at § 30-780, and 42 U.S.C. § 1396n(i)(1). Dep't Soc. Servs., All County Letter No. 93-21 (Mar. 16, 1993), https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl93/93-21.PDF; IHSS Program Webpage, *supra* note 41.

[46] 42 U.S.C. § 1396n(k)(1); 42 C.F.R. § 441.510(c). Cal. Dep't Soc. Servs., All County Letter No. 14-60 (Aug. 29, 2014), https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-60.pdf.

[47] Cal. Wel. & Inst. Code §§ 12305.5–12305.6.

[48] Cal. Welf. & Inst. Code § 14132.952; *Manual of Policies and Procedures, supra* note 41, at § 30-700; Cal. Dep't Soc. Servs., All County Letter No. 11-19 (Feb. 23, 2011) https://cdss.ca.gov/lettersnotices/entres/getinfo/acl/2011/11-19.pdf.

[49] Cal. Wel. & Inst. Code §§ 12305.5–12305.6.

[50] *Id.*

[51] 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 No. I-33-10 (April 21, 2010), https://www.cdss.ca.gov/lettersnotices/entres/getinfo/acin/2010/I-33_10.pdf.

[52] *See* 42 U.S.C. § 1396n(i)(1).

[53] Cal. Welf. & Inst. Code § 12300.1.

[54] *Manual of Policies and Procedures, supra* note 41, at § 30-755.11; Cal. Dep't Soc. Servs., All County Information Notice No. I-19-20 https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACINs/2020/I-19_20.pdf.

[55] Under the HCBA Waiver, Waiver Personal Care Services (WPCS) are available for a limited time when a beneficiary is hospitalized. Cal. Dep't Health Care Servs., Waiver Personal Care Services Frequently Asked Questions 3, https://www.dhcs.ca.gov/services/ltc/Documents/WPCS-FAQ-Providers.pdf (last visited Nov. 4, 2025).

[56] Disability Rts. Cal. & Justice in Aging, *In-Home Supportive Services (IHSS): A Guide for Advocates* (2019), https://www.disabilityrightsca.org/publications/in-home-supportive-services-ihss-advocates-manual.

[57] Cal. Dep't Soc. Servs., All County Letter No. 23-106 (Dec. 21, 2023), https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2023/23-106.pdf?ver=2023-12-29-152322-403.

[58] Section 6071 of Public Law 109-171; *see also* Cal. Dep't Health Care Servs., California Community Transition Program, https://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx (last visited Nov. 4, 2025) [hereinafter CCT Program Website].

[59] Cal. Welf. & Inst. Code § 14196.2 provides that individuals who have resided in a facility for 60 days can access state only funded CCT through the end of 2025.

[60] To find a CCT program, see Cal. Dep't Health Care Servs., California Community Transitions (CCT) Lead Organizations' Contact Information (updated Mar. 2025), https://www.dhcs.ca.gov/services/ltc/Documents/CCT-LO-Website-List.pdf.

[61] CCT Program Website, *supra* note 58.

[62] To find a local CBAS Center, see Cal. Dep't Aging, Community-Based Adult Services (CBAS), https://aging.ca.gov/Programs_and_Services/Community-Based_Adult_Services/ (last visited Nov. 4, 2025).

[63] *See CalAIM Demonstration Approval, supra* note 4, at 23.

[64] Cal. Welf. & Inst. Code § 14184.206.

[65] *See* Cal. Dep't Health Care Servs., *Medi-Cal Community Supports Policy Guide Volume 1, Updated* (updated April 2025), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.

[66] Cal. Welf. & Inst. Code § 14591; 42 U.S.C. § 1395eee.

[67] Cal. Dep't Health Care Servs., PACE Policy Letter 02-14 (2014), https://www.dhcs.ca.gov/services/ltc/Documents/PACE-PL-02-14.pdf.

[68] To find a PACE program, see CalPACE, PACE Organizations, https://calpace.org/our-members/pace-organizations/ (last visited Nov. 4, 2025).

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter XI: Durable Medical Equipment, Orthotics and Prosthetics, and Other Medical Supplies

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Outline of Medi-Cal Durable Medical Equipment, Orthotics and Prosthetics, and Other Medical Supplies*
A. Durable Medical Equipment (DME) 1. Prescribed by a licensed practitioner 2. Medi-Cal covers the lowest cost item that meets the beneficiary's needs 3. Covered DME, and items excluded from coverage 4. Prior authorization 5. Replacement and repair of DME B. Orthotics and Prosthetics 1. Covered Orthotics and Prosthetics 2. Prior Authorization 3. Other coverage issues C. Medical Supplies 1. Covered medical supplies 2. Prescription required 3. Prior authorization generally not needed if below a certain quantity D. Enteral Nutrition 1. Prescription required 2. 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),
- Orthotics and Prosthetics,
- 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.[1] The definition of DME excludes prosthetics and orthotics, which are discussed in Section B of this chapter.[2]

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.[3] Therefore, a Medi-Cal beneficiary can obtain coverage of DME even if the equipment has an expected life of less than three years and is intended for use outside the home. For example, a beneficiary who needs a wheelchair to travel to doctor's appointments, but does not need a wheelchair for moving about the house, may be entitled to Medi-Cal coverage of that wheelchair.
- ✓ For individuals who are eligible for both Medi-Cal and Medicare and need DME, Medi-Cal must process an authorization request in the same manner as a Medi-Cal only beneficiary, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed.[4]

Medi-Cal will only cover "the lowest cost item that meets a patient's medical needs."[5] For example, individuals who have sufficient strength and ability to propel a manual wheelchair during a typical day may not meet the medical necessity criteria for a power wheelchair. In contrast, if the individual lacks the arm strength to self-propel a manual wheelchair, a power wheelchair may be covered.[6] 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.[7] (See Chapter IX of this Guide on Children's Health Services for more information.)

1. Types of Covered DME

Medi-Cal covers many different types of items as DME, including, but not limited to:[8]

- Ambulation devices such as walkers and gait trainers
- Assistive Robotic Arm Device
- 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 Wonder 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.[9]

Medi-Cal excludes a number of items from coverage as DME:[10]

- 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

ADVOCACY TIP:

✓ The Medi-Cal Provider Manual includes helpful information on covered DME services, which includes 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.[11]

- Household items
- Modification of automobiles/or other highway motor vehicles
- Orthopedic mattresses, recliners, rockers, seat lift chairs, or other furniture items
- Reading lamps, or other lighting devices
- Television sets
- Waterbeds

2. Prior Authorization of DME

Medi-Cal has detailed rules regarding DME approval. While Medi-Cal Provider Manual DME guidelines[12] state that 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," for individuals who are 21 years and older, state law defines a service as "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.[13] Advocates should keep the statutory definition of medical necessity in mind if an item of DME is denied. DME is only covered if a beneficiary has a prescription for the DME, and often prior authorization is also required.[14] For example, all DME above certain price thresholds is subject to prior authorization. If the beneficiary is prescribed 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).[15] If the DME is being rented, authorization is required if the cost of renting will exceed $50 in a 15-month period.[16] Repair and/or maintenance of DME are subject to prior approval if the cost exceeds $250.[17] 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.[18] 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."[19] 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.[20]

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.[21] For instance, while Medi-Cal now lists "Assistive Robotic Arms" as a type of DME, beneficiaries were previously able to argue that they needed these devices based on medical necessity (e.g., an assistive robotic arm allowed them to adjust their positioning in their wheelchair, and adjust their ventilator for suctioning, which alleviated severe pain and prevented significant illness) and receive coverage.

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 for use with a nebulizer in a given month, but wheelchairs and speech generating devices may be replaced only once every five years.[22] 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."[23] 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.[24]

Beneficiaries are responsible for the appropriate use and care of DME.[25] 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.[26] 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.[27] 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.[28] 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. As of January 1, 2025, state law requires that power wheelchair providers have access to the parts, tools, repair manuals, and documentation from manufacturers at fair and reasonable prices.[29]

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.[30]

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."[31] A "prosthesis" is "an externally applied appliance used to replace wholly, or in part, an absent or deficient body part."[32] 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.[33]

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."[34] In addition, the appliance must be "essential to performing activities of daily living or instrumental activities of daily living."[35] 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.[36]

1. Types of Covered Orthotics and Prosthetics

Covered orthotic appliances include:[37]

- 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 limit orthotic devices, such as shoulder or elbow orthoses

Covered prosthetic appliances include:[38]

- 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.[39]

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.[40] 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.[41] 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.[42] In addition, prior authorization is always required if the item is furnished by a podiatrist.[43] 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.[44]

3. Other Coverage Issues

As is the case with DME, Medi-Cal covers replacement of orthotic and prosthetic appliances according to a set schedule.[45] 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.[46]

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.[47] However, for certain categories of prosthetic and orthotic appliances, a Medi-Cal beneficiary can obtain such devices from a pharmacy.[48]

C. Medical Supplies

Common medical supplies covered by Medi-Cal include:[49]

- 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.[50] 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.[51]

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.[52] 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.[53]

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.[54] Regular food, including pureed foods, infant formula, shakes, bars, gels, and products for weight loss assistance are not covered by Medi-Cal.[55] 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.[56]

A beneficiary can only obtain an enteral nutrition product if the beneficiary has obtained a physician's prescription for such product.[57] In addition, such products are always subject to prior authorization.[58]

Beneficiaries can obtain coverage of products on the Medi-Cal list of covered enteral nutrition products.[59] 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.[60] 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.[61]

Endnotes

[1] Cal. Code Regs. tit. 22, § 51160.

[2] Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/3E27D197-BFAC-4236-865F-D938BC445BF0/durawheelguide.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter Wheelchair Guidelines].

[3] *Compare* Cal. Code Regs. tit. 22, § 51160 (Medi-Cal definition of DME) *with* 42 C.F.R. § 414.202 (Medicare definition of DME).

[4] Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Durable Medical Equipment* (DME): Bill for DME 23 (2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/954E2767-A8ED-4412-A7E3-1599FC793A02/durabil.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Provider Manual: Bill for DME*]; *see also* Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Medicare/Medi-Cal Crossover Claims: CMS-1500* 13 (2024) https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/A825DECF-BCB4-41E1-BBCE-3A21560F903B/medicrcms.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; Disability Rts. Cal., *Durable Medical Equipment: Medi-Cal, Medicare, And Dual Eligible Individuals* (2024), https://www.disabilityrightsca.org/publications/durable-medical-equipment-medi-cal-medicare-and-dual-eligible-individuals.

[5] 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 (2024), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/DE2DC0F1-4109-442F-BDB5-E8125DD45EFB/dura.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *DME Overview*].

[6] *Wheelchair Guidelines; see also*, 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.

[7] *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/.

[8] *DME Overview, supra* note 5, 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* (2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/768172CB-9B92-4B2A-BA9E-29BC7E8C9B7E/durainf.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; 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* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/93D7E3AE-AF5C-433C-8518-D7189E038AAE/duraoxy.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; 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 (2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/52484AC3-28E2-4260-BBEE-8AE442B3D21A/durathp.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; 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* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/58152677-9614-44AB-AA0A-1F3F04123E7D/duraother.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Other DME Equipment*]; *Provider Manual: Bill for DME, supra* note 4, at 10–16. *See also* Disability Rts. Cal., *How To Get Medi-Cal To Cover An Assistive Robotic Arm* (2025) https://www.disabilityrightsca.org/publications/how-to-get-medi-cal-to-cover-an-assistive-robotic-arm.

[9] Cal. Welf. & Inst. Code § 14132(m); *see also* Other DME Equipment, *supra* note 8, at 6.

[10] Cal. Code Regs. tit. 22, § 51321(e); *see also DME Overview*, *supra* note 5, at 3.

[11] Cal. Dep't Health Care Servs., Durable Medical Equipment and Medical Supplies Manual, https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual?community=durable-medical-equipment-and-medical-supplies (last visited Dec. 11, 2025).

[12] *DME Overview*, *supra* note 5, at 2.

[13] Cal. Welf. & Inst. Code § 14059.5

[14] Cal. Code Regs. tit. 22, §§ 51160, 51321(b).

[15] *Id.* § 51321(b)(1).

[16] *Id.* § 51321(b)(2).

[17] *Id.*

[18] *Id.* § 51321(b)(3).

[19] *DME Overview*, *supra* note 5, at 6.

[20] *Id.*

[21] Cal. Welf. & Inst. Code § 14059.5(a): 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. *See also*, *Blue v. Bonta*, 99 Cal.App.4th 980, 989 (2002) ("medical" is broadly defined and requires coverage of DME "prescribed to alleviate medical conditions").

[22] 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* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/93EA2E9D-8712-4134-9B94-B1027C644076/duracdfre.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[23] Cal. Welf. & Inst. Code § 14132(m).

[24] Cal. Code Regs. tit. 22, § 51224.5(a)(6)(F).

[25] *Id.* § 51321(i).

[26] Cal. Dep't Health Care Servs., *Medical Supplies Billing Codes, Units, and Quantity Limits* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/2551F33B-449C-46EE-8E14-9152E82AE2D8/duracd.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[27] Cal. Code Regs. tit. 22 § 51224.5(a)(6)(B).

[28] *Id.* § 51521(i).

[29] Cal. Bus. & Prof. Code § 21301(a)

[30] *DME Overview*, *supra* note 5, at 6.

[31] Cal. Code Regs. tit. 22 § 51161(ppp).

[32] *Id.* § 51161(yyy).

[33] *Id.* § 51161(gggg).

[34] *Id.* § 51315(c)(1).

[35] *Id.* § 51315(c)(2).

[36] *Id.* § 51315(c)(3), (d)(3).

[37] *Id.* § 51315.1.

[38] *Id.* § 51315.2.

[39] *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://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7FEB593E-4601-42DD-B9C6-92ABAB819F6B/ortho.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Orthotic and Prosthetic Appliances and Services*].

[40] Cal. Code Regs. tit. 22, § 51315(a).

[41] *Id.* § 51315(b); *see also* Cal. Welf. & Inst. Code § 14132.765.

[42] Cal. Code Regs. tit. 22, § 51315(b).

[43] *Orthotic and Prosthetic Appliances and Services, supra* note 39, at 5.

[44] Cal. Code Regs. tit. 22, § 51315(c)(5) *see also*, 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.

[45] *See* Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Orthotics and Prosthetics, Frequency Limits for Orthotics* (2024), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/2817A35E-CEB8-4684-A6C3-B33239394C8F/orthocdfre1.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO; Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Orthotics and Prosthetics, Frequency Limits for Prosthetics* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/5F094419-19DD-49B2-A25E-BE4590E8AA90/orthocdfre2.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[46] Cal. Welf. & Inst. Code § 14132(k).

[47] *Orthotic and Prosthetic Appliances and Services, supra* note 39, at 3.

[48] Cal. Welf. & Inst. Code § 14105.21(b).

[49] Cal. Dep't Health Care Servs., *Allied Health Provider Manual – Part 2: Durable Medical Equipment and Medical Supplies, Medical Supplies* 1 (2024) https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/321A9C52-62F7-4A9D-ADF9-6045145BADA1/mcsup.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [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 (2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/EE176E40-D10D-4AC3-8F60-C72EE0AAC5CB/incont.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Incontinence Medical Supplies*].

[50] *Medical Supplies, supra* note 52, at 4; *see also* Cal. Code Regs. tit. 22, § 51320(b).

[51] *Medical Supplies, supra* note 52, at 2.

[52] DHCS has posted online a spreadsheet with medical supply billing codes, units, quantity limits, and prior authorization information. *See* Cal. Dep't Health Care Servs., *Medical Supplies Billing Codes, Units, and Quantity Limits* (2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/file/manual?fn=mcsupbilling.xlsx. DHCS has posted online a spreadsheet with medical supply billing codes, units, quantity limits, and prior authorization information.

[53] *Incontinence Medical Supplies, supra* note 52, at 1.

[54] Cal. Code Regs. tit. 22, § 51313.3(e)(2).

[55] Cal. Dep't Health Care Servs., *Medi-Cal Rx Provider Manual* 92 (2025) 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 also* Cal. Dep't Health Care Servs., All Plan Letter 20-020 (Nov. 4, 2020), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf

[56] *Medi-Cal Rx Provider Manual, supra* note 56, at 92.

[57] *Id.* at 92.

[58] Cal. Welf. & Inst. Code § 14105.8(i).

[59] *Medi-Cal Rx Provider Manual, supra* note 56, at 95.

[60] *Id.* § 14105.8(g).

[61] *Id.* § 14105.8(h).

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter XII: Care Coordination: Case Management and Community Health Worker Services

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Outline of Medi-Cal Care Coordination Services*
A. Case Management 1. Targeted Case Management and Similar Programs 2. Population Health Management Program for MCPs a. Basic Population Health Management b. Complex Care Management c. Enhanced Care Management B. 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. Some of these services are available in Fee-for-Service (FFS); however, managed care plans (MCPs) offer a more robust array of care management programs. As described throughout the chapter, case management and community health worker services have significantly expanded under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.[1]

A. Case Management

Case management services—sometimes called "care management" or "care coordination"—are "services which will assist individuals eligible under the [State] plan in gaining access to needed medical, social, educational, and other services, but not the direct delivery of such services."[2] They are exempt from the general federal Medicaid rules about statewideness and comparability.[3] 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.[4] 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.[5]

Medi-Cal covers case management services for beneficiaries enrolled in either Medi-Cal FFS or MCPs. Targeted Case Management services are available to

certain high-needs populations enrolled in either Medi-Cal FFS or managed care. For managed care beneficiaries, the Population Health Management Program requires plans to provide case management for all enrollees, and Complex Case Management or Enhanced Care Management for select populations.

1. Targeted Case Management and Similar Programs

Targeted Case Management (TCM) is a Medi-Cal benefit covered for all beneficiaries who fall within a defined eligibility group. Under Medi-Cal, groups that are eligible to receive TCM include:[6]

- 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.

TCM is also available for beneficiaries receiving Specialty Mental Health Services (SMHS) through county behavioral health plans and for beneficiaries with substance use disorders (SUDs) residing in counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver program.[7]

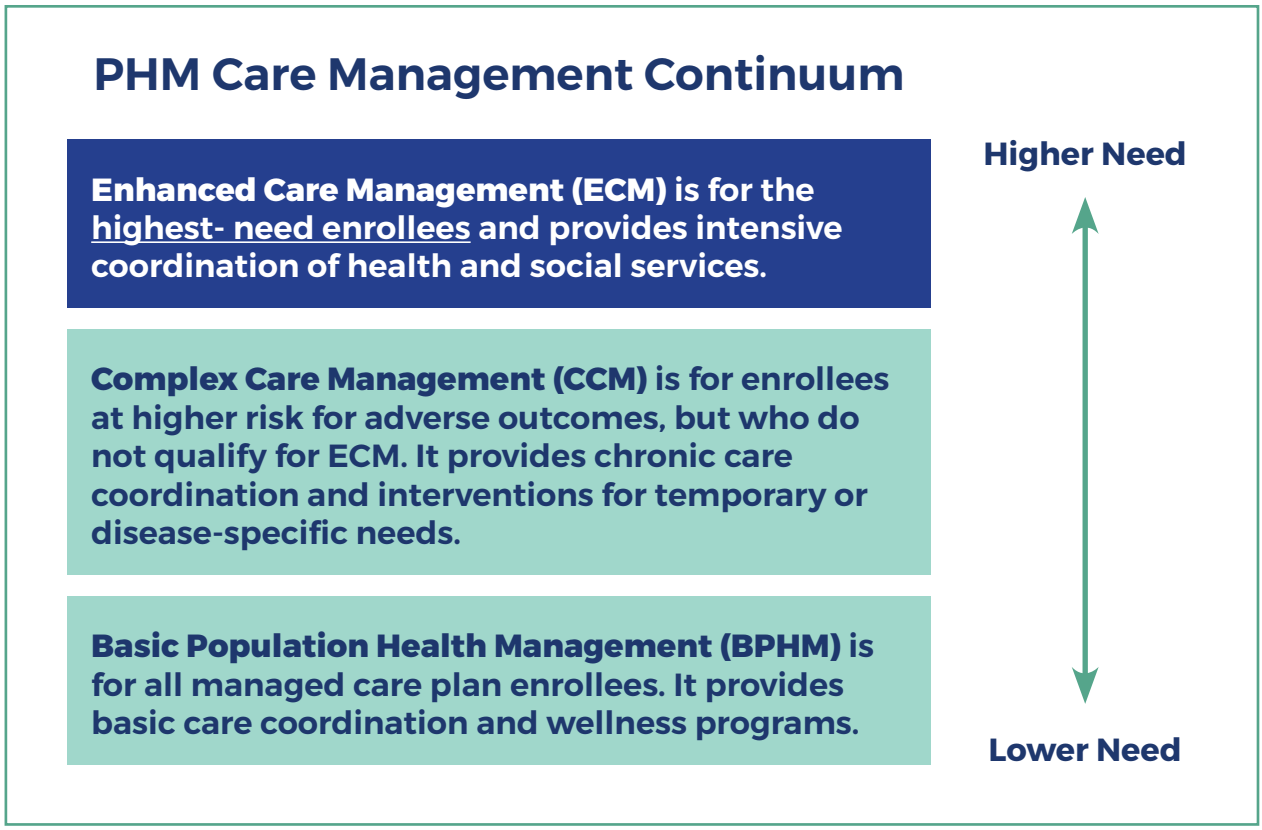
TCM may be provided by counties or through community-based organizations under contract with counties.[8] TCM services include an assessment of the beneficiary's needs, development of a comprehensive service plan, referral to providers for services, arranging appointments and transportation, crisis assistance, and review and modification of the beneficiary's service plan.[9]

In addition to Medi-Cal's TCM 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).[10] Case management is also a part of the California Children's Services (CCS) program, and approved special care centers and beneficiaries enrolled in home- and community-based service programs.[11]

2. Population Health Management Program for MCPs

Medi-Cal MCPs are required to provide services to all of their members pursuant to the Population Health Management (PHM) Program.[12] Launched in January 2023 as a part of the CalAIM Initiative, the PHM Program provides managed care members with case management services at different levels of intensity based on enrollee need. All members receive Basic Population Health

Management; members with a higher level of need or certain health risk factors may receive Complex Care Management; and members with the highest level of need may receive Enhanced Care Management. This care management continuum, as illustrated in the following chart, is designed to provide enrollees with a comprehensive set of case management services that meets their individual needs and preferences.[13]



a. Basic Population Health Management

Basic Population Health Management (BPHM), which replaces DHCS's previous "Basic Case Management" requirements, is a package of care management services that are available to all MCP members, regardless of their level of need.[14] Under BPHM, MCPs must ensure that members have access to a primary care provider (PCP) and ensure that their PCP or other contracted entity provides basic care management services. This includes assessing members for needed services, assisting them with finding providers, facilitating closed loop referrals, and coordinating warm handoffs to other public benefit programs.[15] MCPs are also required to provide comprehensive wellness and prevention programs, chronic disease management programs, and programs to improve maternal health outcomes and birth equity.[16] Further, as with all PHM programs, MCPs must ensure that all children and youth under age 21 receive Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including all needed case management and care coordination services.[17]

b. Complex Care Management

Complex Case Management (CCM) is available to MCP members who need extra support to avoid adverse health outcomes, but who do not qualify for Enhanced Care Management.[18] Under CCM, MCPs must ensure that each member receives a comprehensive assessment and is assigned a care manager, who will help develop and implement a care plan. In addition to all of the services available under BPHM, CCM also provides care coordination focused on chronic conditions, interventions for episodic or temporary needs, disease-specific management programs (e.g., for asthma or diabetes), and referral to Community Supports.[19]

c. Enhanced Care Management

Enhanced Care Management (ECM) provides comprehensive care management and coordination of health and health-related services to MCP members with the highest level of need.[20] Members are eligible for ECM if they meet DHCS's criteria for an ECM "Population of Focus."[21] Notably, there are different criteria for adults (age 21 or older) and children and youth (under age 21). MCPs may not impose additional eligibility requirements beyond those outlined by the State.[22]

ECM Populations of Focus consist of the following:

- Adults who are experiencing or at risk of homelessness and have at least one health condition that they cannot self-manage;[23]
- Children, youth, and families with children or youth under age 21 who are experiencing or at risk of homelessness.[24]
- Adults, children, and youth at risk for avoidable emergency department, hospital, or short-term skilled nursing facility stays;[25]
- Adults with serious mental health or SUD needs, who have at least one social factor impacting their health, and who are at risk for avoidable emergency department, hospital, or inpatient stays;[26]
- Children and youth with serious mental health or SUD needs;[27]
- Adults transitioning from incarceration who have a mental health disorder, SUD, significant health condition, disability, HIV/AIDS, or who are pregnant or postpartum;[28]
- Children and youth, and former foster youth up to age 26, transitioning from incarceration;[29]
- Adults living in the community who are at risk for long-term care institutionalization;[30]
- Adult nursing facility residents who are transitioning into the community;[31]
- Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) who have additional needs beyond their CCS condition;[32]
- Children and youth involved in or recently involved in child welfare, including former foster youth up to age 26;[33] and
- Adults and youth who are pregnant or up to 12 months postpartum and who are subject to racial or ethnic health disparities.[34]

MCPs must proactively identify and offer ECM to members who fall within these Populations of Focus. They must also accept self-referrals and referrals from health and social services providers and community-based organizations.[35]

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.

The ECM benefit offers seven core services for all Populations of Focus:[36]

1. Outreach and Engagement
2. Comprehensive Assessment and Care Management Plan[37]
3. Enhanced Coordination of Care
4. Health Promotion
5. Transitional Care Services
6. Member and Family Supports
7. Coordination of and Referral to Community Supports and Social Support Services

MCPs are responsible for coordinating ECM services. MCPs must contract with a wide range of providers specializing in each of the specific Populations of Focus, and they are encouraged to draw on beneficiaries' pre-existing relationships when building an ECM care team.[38] 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.[39]

ECM providers may include, but are not limited to:[40]

- 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 (CBOs).

ECM providers must enroll as Medi-Cal providers if there is a state-level enrollment pathway for them to do so. However, some ECM providers (e.g., housing agencies) may not have a corresponding state-level enrollment pathway and, therefore, are not required to enroll in Medi-Cal.[41]

B. Community Health Worker Services

Community health worker (CHW) services are Medi-Cal covered coordinated preventive health services.[42] CHWs are frontline public health workers who come from the community they serve or have an intimate understanding and trusting relationship with the communities they serve.[43] CHWs encompass individuals with the following titles: promotores, community health representatives, navigators, and other non-licensed public health worker titles, including, but not limited to, violence prevention professionals.[44] Their role is to help link beneficiaries to health and social services with the goal of improving the overall quality of services delivered.[45] CHWs must have lived experience that aligns with and provides a connection between the CHW and the population(s) they serve, such as experience related to incarceration, disability, foster care system involvement, homelessness, mental health conditions or substance use disorders, etc. Lived experience may also include shared traits such as race, ethnicity, or sexual orientation and having lived or worked in the same geographic community.[46]

1. CHW Services

CHW services are coordinated preventive health services that help manage chronic conditions, infectious diseases, behavioral health conditions, and other health care needs.[47] CHW services can help Medi-Cal enrollees 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.[48]

Covered CHW services include:

- **Health education**, which consists of providing information or instruction on health topics that promote the enrollee's health or address barriers to physical and mental health care;[49]
- **Health navigation**, which consists of a CHW providing information, training, referrals or support to enrollees when assessing healthcare needs or connecting to community health resources;[50]
- **Screening and assessment services**, which consists of connecting the enrollee to appropriate services to improve their health; and[51]
- **Individual support or advocacy**, which assists an enrollee with access to preventive services to avoid the onset or worsening of health condition(s) and preventing injury or violence.[52]

CHWs also provide violence prevention services and asthma preventive services.[53] CHW services are covered through managed care or FFS coverage as individual or group sessions. The services may also be provided virtually or in-person with locations in any setting, including but not limited to, outpatient clinics, hospitals, homes, or community settings.[54]

ADVOCACY TIP:

✓ CHW services may be provided to the legal guardian or parent of enrollees under the age of 21 for the direct benefit of enrollees, as recommended by a licensed provider. Such services must be billed under the enrollees' Medi-Cal ID (i.e., not the parent or legal guardian's Medi-Cal ID).[55]

CHW services do not include the following:[56]

- Any services that require a license, including clinical case management and care management that requires a license;
- Childcare;
- Chore services, including shopping and cooking meals;
- Companion services;
- Employment services;
- Helping with enrollment into government or other assistance programs that are not related to improving their health;
- 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; and
- Transportation.

CHW supervising providers must submit claims for services in order to be covered.[57] The supervising provider can be a licensed provider, outpatient clinic, hospital, community-based organization, local health jurisdiction (LHJ), a pharmacy, or a Local Educational Agency (LEA).[58] A supervising provider must also ensure that a CHW meets the necessary qualifications and oversees the services they provide to enrollees.[59] 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.[60] In some cases, CHWs may provide ECM services and CHW services to the same enrollee. However, they cannot double bill for CHW services that are duplicative of other covered benefits, like ECM services. Therefore, the supervising provider cannot submit a claim for both ECM and the CHW benefit for the same enrollee for the same time period.[61]

2. Medi-Cal Enrollee Eligibility Criteria for CHW Services

Medi-Cal covers CHW services for all eligible enrollees when recommended by a physician or other licensed practitioner of the healing arts acting within their scope of practice under state law.[62] An enrollee can receive CHW services if medically necessary, as determined by the recommending provider.[63] CHW services are considered medically necessary if the enrollee has one or more chronic health conditions (including behavioral health), exposure to violence and trauma, is at risk for a chronic health condition or environmental health exposure, faces barriers meeting their health or health-related social needs, and/or would benefit from preventive services.[64] CHW services are also available to beneficiaries with mental health conditions and/or SUDs.[65]

In 2025, DHCS released a standing recommendation stating that a written recommendation from a physician or other licensed practitioner of the healing arts is only required if it is recommended that the enrollee receive beyond 12 units (equivalent to 6 hours) of service.[66] If an enrollee is receiving beyond 12 units of service, there must be a written plan of care, which is a written document that describes the supports and services the CHW, and potentially other licensed care providers, are furnishing to address the ongoing needs of an enrollee.[67]

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 currently supervises the CHW.[68] A licensed provider must review the plan of care at least every six months from its effective date to determine whether progress is being made toward the planned objectives.[69] The licensed provider should determine whether services are still medically necessary, there is a significant change in the enrollee's condition, and if it is necessary to amend the plan or discontinue services.[70] 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.[71]

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 optimal health and well-being. CHWs provide culturally humble, linguistically appropriate, experientially informed essential services to assist communities in navigating any obstacles that would hinder them from receiving needed health resources.

Endnotes

[1] For the CalAIM approval documents, *see* 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; 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.

[2] 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).

[3] 42 U.S.C. § 1396n(g)(1).

[4] 42 U.S.C. § 1396n(g)(2)(B).

[5] 42 C.F.R. § 441.18(a)(3).

[6] Cal. Dep't Health Care Servs., *Targeted Case Management: Program Overview,* https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM_FactSheet_01212016.pdf.

[7] Cal. Welf. & Inst. Code §§ 14132.48(c), 14021.3. *See also* Cal. Code Regs. tit. 9, § 1810.247(c).

[8] Cal. Code Regs. tit. 22, § 51351.1.

[9] Cal. Welf. & Inst. Code § 14132.44(k); Cal. Code Regs. tit. 22, § 51351(a); 42 U.S.C. § 1396n(g)(2)(A)(ii).

[10] Cal. Welf. & Inst. Code § 14132.48(a)–(b).

[11] 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. 16, 2025); 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 (last visited Dec. 16, 2025).

[12] Cal. Welf. & Inst. Code §§14184.204. *See also ECM Policy Guide* Cal Dep't Health Care Servs., CalAIM Population Health Management Initiative, https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx (last visited Dec. 16, 2025).

[13] Cal. Dep't Health Care Servs., *CalAIM: Population Health Management (PHM) Policy Guide* (July 2025), https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf.

[14] *Id.* at 33.

[15] *Id.* at 34–35.

[16] *Id.* at 36–38.

[17] *Id.* at 38–39.

[18] *Id.* at 39–40.

[19] *Id.* at 39–41

[20] Cal. Welf. & Inst. Code §§ 14184.205. *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 Policy Guide* (Aug. 2024), https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf [hereinafter *ECM Policy Guide*].

[21] *ECM Policy Guide, supra* note 20, at 10–11.

[22] *Id.* at 11.

[23] *Id.* at 12–13.

[24] *Id.* at 14–15 (note that there is no "health condition" requirement for children, youth, and families with children/youth who are experiencing or at risk of homelessness).

[25] *Id.* at 18–24.

[26] *Id.* at 25–26.

[27] *Id.* at 26–27.

[28] *Id.* at 33–34.

[29] *Id.* at 34.

[30] *Id.* at 35–36.

[31] *Id.* at 40.

[32] *Id.* at 45.

[33] *Id.* at 49.

[34] *Id.* at 54.

[35] *Id.* at 103–107.

[36] *Id.* at 60–67.

[37] *Id.* at 61–63.

[38] *Id.* at 95.

[39] *Id.* at 60; Cal. Dep't Health Care Servs., *CalAIM Data Guidance: Billing and Invoicing between ECM/Community Supports Providers and MCPs* (Apr. 2023), https://www.dhcs.ca.gov/Documents/MCQMD/ECM-and-Community-Supports-Billing-and-Invoicing-Guidance.pdf.

[40] *ECM Policy Guide, supra* note 20, at 93–97.

[41] *Id.* at 98. All ECM providers serving the justice-involved Populations of Focus must enroll as a Medi-Cal provider. *Id.* at 98, n. 63.

[42] 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 24-006 (May 13, 2024), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-006.pdf [hereinafter All Plan Letter 24-006]; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Community Health Worker Preventive Services* (Oct. 2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/03BBA223-8762-4A94-A268-209510E15E37/chwprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, CHW*].

[43] *See* The Children's P'ship, *Community Health Workers Advancing Child Health Equity* (2021), https://childrenspartnership.org/wp-content/uploads/2021/07/TCP-Community-Health-Workers-Final-Single-Pages-1.pdf.

[44] *Id.*

[45] *Id.*

[46] *Id.*

[47] All Plan Letter 24-006, *supra* note 42, at 1; *Medi-Cal Provider Manual, CHW, supra* note 42, at 1.

[48] All Plan Letter 24-006, *supra* note 42, at 1; *Medi-Cal Provider Manual, CHW, supra* note 42, at 1.

[49] All Plan Letter 24-006, *supra* note 42, at 9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 3–4.

[50] All Plan Letter 24-006, *supra* note 42, at 9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 3–4.

[51] All Plan Letter 24-006, *supra* note 42, at 9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 3–4.

[52] All Plan Letter 24-006, *supra* note 42, at 9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 3–4.

[53] All Plan Letter 24-006, *supra* note 42, at 9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 3–4.

[54] All Plan Letter 24-006, *supra* note 42, at 9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11.

[55] All Plan Letter 24-006, *supra* note 42, at 10; *Medi-Cal Provider Manual, CHW, supra* note 42, at 4.

[56] All Plan Letter 24-006, *supra* note 42, at 10; *Medi-Cal Provider Manual, CHW, supra* note 42, at 10-11.

[57] All Plan Letter 24-006, *supra* note 42, at 4-5; *Medi-Cal Provider Manual, CHW, supra* note 42, at 2.

[58] All Plan Letter 24-006, *supra* note 42, at 5; *Medi-Cal Provider Manual, CHW, supra* note 42, at 2. 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 FFS 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 Medi-Cal FFS by a licensed provider on staff.

[59] All Plan Letter 24-006, *supra* note 42, at 5; *Medi-Cal Provider Manual, CHW, supra* note 42, at 2.

[60] All Plan Letter 24-006, *supra* note 42, at 5.

[61] *Id.* at 11.

[62] 42 C.F.R. § 440.130(c); All Plan Letter 24-006, *supra* note 42, at 5–6; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11. 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.

[63] All Plan Letter 24-006, *supra* note 42, at 6; *Medi-Cal Provider Manual, CHW, supra* note 42, at 13–14.

[64] All Plan Letter 24-006, *supra* note 42, at 6; *Medi-Cal Provider Manual, CHW, supra* note 42, at 13–14.

[65] All Plan Letter 24-006, *supra* note 42, at 6; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11. 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. To learn more about Peer Support Services, please refer to Chapter IV of this Guide on Mental Health Services.

[66] Cal. Dep't Health Care Servs., *Recommendations for Community Health Workers (CHW) Services for Eligible Medi-Cal Members* (Apr. 2025), https://www.dhcs.ca.gov/services/medi-cal/Documents/Standing-Recommendation-for-CHW-Services.pdf; All Plan Letter 24-006, *supra* note 42, at 6; *Medi-Cal Provider Manual, CHW, supra* note 42, at 1.

[67] All Plan Letter 24-006, *supra* note 42, at 8–9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11–13.

[68] All Plan Letter 24-006, *supra* note 42, at 8–9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11–13.

[69] All Plan Letter 24-006, *supra* note 42, at 8–9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11–13.

[70] All Plan Letter 24-006, *supra* note 42, at 8–9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11–13.

[71] All Plan Letter 24-006, *supra* note 42, at 8–9; *Medi-Cal Provider Manual, CHW, supra* note 42, at 11–13.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter XIII: Community Supports

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Outline of Medi-Cal Community Supports
A. Health and Home and Community-Based Community Supports 1. Respite Services 2. Assisted Living Facility Community Support 3. Community or Home Transition Services 4. Personal Care and Homemaker Services (PCHS) 5. Environmental Accessibility Adaptations (Home Modifications) 6. Medically Tailored Meals/Medically Supportive Food 7. Sobering Centers 8. Asthma Remediation B. Housing-Specific Community Supports 1. Housing Transition Navigation Services (HTNS) 2. Housing Deposits 3. Housing Tenancy and Sustaining Services (HTSS) 4. Day Habilitation Programs 5. Recuperative Care (Medical Respite) 6. Short-Term Post-Hospitalization Housing 7. Transitional Rent

This chapter describes Community Supports, Medi-Cal services offered by Medi-Cal Managed Care plans. Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, California added Community Supports, or in-lieu of services (ILOS) as a benefit offered by MCPs.[1] Community Supports are community-based services or settings that MCPs may offer as alternatives to those covered under the California Medicaid State Plan.[2] Community Supports are designed to reduce health disparities and address unmet health-related social needs (HRSNs), such as housing and nutrition insecurity.[3] Beginning January 1, 2022, MCPs in all counties were encouraged to offer 14 pre-approved Community Supports.[4] As of July 1, 2025, a 15th benefit, Transitional Rent, is available.[5] With the exception of Transitional Rent, which becomes mandatory in January 2026, Community Supports are optional for MCPs to offer and for beneficiaries to use.[6] MCPs cannot require their enrollees to use a Community Support instead of a State-plan covered service.[7]

A. Health and Home and Community-Based Community Supports

1. Respite Services

Respite services provide short-term relief for caregivers of Medi-Cal beneficiaries. This service is for individuals living in the community who need assistance with activities of daily living (ADLs) and rely upon a caregiver who provides most of their support. The service is distinct from medical respite (discussed further below) because it is designed to relieve the caregiver rather than as a service for the beneficiary. Respite includes services provided by the hour on an episodic basis; services provided by the day or overnight on a short-term basis because of the absence of or need for relief for the caregiver; or services that address a beneficiary's basic self-help needs and ADLs including interaction, socialization, and continuation of usual daily routines. Respite is available in an individual's home or in a facility.[8]

Respite services may not exceed 24 hours per day and are limited to 336 hours in a calendar year. The MCP can authorize an exception if the caregiver is unavailable because they are experiencing "an episode, including medical treatment and hospitalization that leaves a [beneficiary] without their caregiver."[9] Respite provided during these episodes can be excluded from the 336-hour limit. Respite is only available to avoid placements for which the MCP would be responsible. Respite may be provided by home health or respite agencies in the home, and a variety of facility types.[10]

2. Assisted Living Facility Community Support

The Assisted Living Facility Community Supports benefit (formerly known as Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly and Adult Residential Facilities) provides an alternative to nursing facility placement and is available to beneficiaries who are at risk of imminent placement in a nursing facility. Assisted Living Facilities are defined as either a Residential Care Facility for the Elderly (RCFE), or an Adult Residential Care Facility (ARF).[11] There are two components of the Assisted Living Facility benefit. First, time-limited transition services to assist a beneficiary in establishing residency in an Assisted Living Facility, including, assessing the individual's need for housing and services; coordinating the application process; paying for moving expenses and personal items; communicating with the facility and coordinating the move; and establishing procedures and contacts so that the individual remains in the Assisted Living Facility.

The second component is ongoing assisted living services for the duration of the time the individual is living at the facility. These ongoing services include assistance with ADLs and Instrumental Activities of Daily Living (IADLs), meal preparation, transportation, medication management, and more.[12] MCPs must

offer both components to the extent that they are appropriate for the beneficiary, although an individual may only require one component. To receive the Assisted Living Community Support, an individual in a facility must:

- Have resided 60+ days in a nursing facility and
- Be willing to live in an assisted living setting as an alternative to a nursing facility; and
- Be able to reside safely in an Assisted Living Facility.

To receive the Assisted Living Community Support, an individual in the community must:

- Be interested in remaining in the community; and
- Be willing and able to reside safely in an Assisted Living Facility; and
- Meet the nursing facility level of care.

3. Community or Home Transition Services

Community or Home Transition Services (formerly known as Community Transition Services/Nursing Facility Transition to a Home) are available for individuals who are transitioning from a licensed nursing facility to living in the community, either in their own home or in publicly funded housing. This service is available to individuals who:

- Are currently receiving medically necessary nursing facility Level of Care (LOC) services, and have lived in a nursing facility or recuperative care setting for more than 60 days;
- Wish to transition to the community with appropriate services; and
- Can reside safely in the community with appropriate services and supports.

Community Transition Services include:

- *Time limited services* to facilitate returning to the community from a facility, including: assessing the individual's housing needs and presenting options; assisting in searching for and securing housing, including the completion of housing applications and securing required documentation; communicating with the landlord as needed and coordinating the move; establishing procedures and contacts to retain housing; identifying, coordinating, securing, or funding non-emergency, nonmedical transportation as needed; identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.
- *One time set-up expenses* including: security deposits required for a lease; set-up fees for utilities or service access and up to six months' payment of back utility bills; services necessary for the individual's health and safety, like one-time cleaning prior to occupancy, and necessary repairs where those costs are not the responsibility of the landlord; air conditioner or heater; adaptive aids like hospital beds, Hoyer lifts, bedside commode, shower chair etc., that are necessary to ensure access

and safety for the individual upon move-in to the home, when they are not otherwise available.

Both time limited services and one-time set-up expenses must be available as needed.

4. Personal Care and Homemaker Services (PCHS)

Personal Care and Homemaker Services (PCHS) are available for beneficiaries who need assistance with ADLs or Instrumental Activities of Daily Living (IADLs). PCHS includes services that are provided through In-Home Supportive Services (IHSS), including house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for individuals with cognitive disabilities.

ADVOCACY TIP:

✓ While individuals can be eligible for Community Supports and the California Community Transitions (CCT) program, Home & Community Based Alternatives (HCBA) Waiver, and/or the Multipurpose Senior Services Program (MSSP), they can only receive services from one program at a time.[13]

MCPs can offer PCHS during the IHSS application process, and PCHS can be authorized before and up until IHSS is actually in place or if IHSS benefits are exhausted. In addition, if an individual meets IHSS eligibility criteria, they must be referred to IHSS. If a beneficiary is not eligible for IHSS, PCHS is still available to prevent a short-term stay in a skilled nursing facility (up to 60 days).[14]

Individuals are eligible for PCHS if:

- They are at risk for hospitalization, or institutionalization in a nursing facility; or
- They have functional deficits and no other adequate support system; or
- They are approved for In-Home Supportive Services.

ADVOCACY TIP:

✓ Although individuals who are enrolled in the HCBA Waiver and are eligible for or receiving Waiver Personal Care Services (WPCS) are not eligible for PCHS, they can receive PCHS while waiting for HCBA Waiver approval.[15] In addition, while home health agencies and personal care agencies are some of the provider types, family members can be paid to provide PCHS to beneficiaries.

5. Environmental Accessibility Adaptations (Home Modifications)

Environmental Accessibility Adaptations (Home Modifications) are available to individuals at risk of

institutionalization who need physical modifications to their home in order to remain there safely.[16] Examples of Home Modifications include:

- Ramps and grab bars;
- Door widening to accommodate a wheelchair;
- Stair lifts;
- Accessible bathroom and shower;
- Specialized electric or plumbing systems for medical equipment and supplies; and
- Personal Emergency Response System

Home Modifications can be made to the home owned or rented by the beneficiary, provided there is written consent from the owner for physical changes to the home. In order to receive a Home Modification, an individual's treating medical professional must submit a written order to the MCP documenting the type of modification and how the modification meets the medical needs of the individual. In addition, a physical or occupational therapy evaluation justifying the medical necessity of the modification is required, unless the MCP determines such an evaluation is not necessary.

ADVOCACY TIP:

✓ If a physical or occupational therapy evaluation is required, the evaluation must describe why the current home or equipment does not meet the individual's needs, including how other attempts to modify/other equipment are inadequate; why the modification is necessary and how the modification reduces the risk of institutionalization; and how the individual and/or their primary caregiver have the ability to appropriately manage or use the modification. Specific examples of failed attempts at other modifications should be included.

The assessment and authorization for Home Modifications must be completed within 90 days, beginning with the request, unless more time is needed to obtain homeowner consent, or if the individual requests a longer timeframe. Home modifications are limited to a $7,500 lifetime maximum unless the individual moves to a new home, or their condition changes so significantly that additional modifications are necessary to ensure their health and safety and to avoid institutionalization.

6. Medically Tailored Meals/Medically Supportive Food

Medically Tailored Meals (MTMs) and Medically Tailored Groceries (MTGs) are intended to address conditions that are impacted by what an individual eats, also known as nutrition sensitive conditions.[17] This benefit is available for Individuals who have chronic or other serious health conditions that are nutrition sensitive.[18] Medically Tailored Meals are defined as "meals that adhere

to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions." Medically Tailored Groceries are defined as "preselected whole food items that adhere to established, evidence-based nutrition guidelines for specific nutrition-sensitive health conditions."

Before an individual can receive MTM or MTGs, they must have an individual assessment from a Registered Dietitian Nutritionist (RDN) who must develop a nutritional plan and connection to the MTM or MTG. MTM and MTG either singularly or through a combination of meals and groceries must meet at least two-thirds of the daily nutrient and energy needs of an average individual as estimated by the RDN.

Medically Supportive Food (MSF) is a package of food that follows national nutrition guidelines to prevent, manage, or reverse nutrition sensitive conditions. MSFs are intended to supplement an individual's diet. Like MTMs and MTGs, an RDN must oversee the selection of food in an MSF package. In addition, MCP and providers of MTM/MSF must take individual's cultural preferences/needs (e.g., halal or kosher meals) and food preparation and storage capabilities (e.g., ability to store frozen meals) into account.

ADVOCACY TIP:

✓ Supplemental Nutrition Assistance Program (SNAP) and Women, Infants and Children (WIC) benefits are not duplicative of MTM/MSF Community Supports because SNAP and WIC are designed to mitigate a household's food insecurity, while MTM/MSF are part of a clinical care plan to address specific chronic or serious health conditions.[19]

7. Sobering Centers

This community support is for individuals who are intoxicated due to alcohol or other drugs in public and would otherwise be taken to an emergency department or to jail. Services at Sobering Centers include medical triage; lab testing; a temporary bed; rehydration and food service; treatment for nausea; wound and dressing changes; shower and laundry facilities; substance use education and counseling; navigation and warm hand-offs for additional substance use services or other necessary health care services; and, for those experiencing homelessness, care support services.[20]

When MCPs offer Sobering Centers they must engage in direct coordination with county behavioral health agencies, and are required to partner with law enforcement, emergency services, and outreach teams to facilitate placement. Sobering Centers also include screening and linkage to ongoing supportive services. This service is covered for a period of less than 24 hours and is targeted at individuals who are 18 and older who are intoxicated but conscious, and do not need immediate medical treatment.

8. Asthma Remediation

Asthma Remediation consists of supplies and/or physical modifications to a home environment to enable a beneficiary to live at home with a reduced likelihood of experiencing acute asthma episodes. Asthma Remediation should supplement the Asthma Preventive Services (APS) Medi-Cal State Plan service which includes clinic-based asthma self-management education, homebased asthma self-management education, and in-home environmental trigger assessments. As of January 1, 2026, APS services must be covered as a state plan benefit, and will no longer be part of Asthma Remediation Community Supports.[21] Asthma Remediation is available to beneficiaries who have a completed in-home environmental trigger assessment within the last 12 months through APS that has identified medically appropriate Asthma Remediations and specified how the interventions meet the individual's needs. There is a lifetime limit of $7,500 for Asthma Remediation services.[22]

B. Housing-Specific Community Supports

There are 7 Community Supports to support individuals who are unhoused, or are at risk of being unhoused.[23] For most of these housing specific community supports, an individual must have a housing support plan.[24] This plan must:

- Identify the permanent housing strategy for the individual, including sources of payment that will support them in maintaining housing after the housing Community Supports are exhausted (e.g., the individual's income, BHSA Housing Interventions, or other long-term subsidies).
- Identify the full range of permanent housing supports that will support the individual in maintaining housing (e.g., tenancy sustaining service, utilities).
- Be informed by the individual's preferences and needs, and reviewed and revised as needed.
- Be based on a housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the individual's approach to meeting the goal, and identifies when other providers or services may be required to meet the goal.
- Be developed in a way that is culturally appropriate and trauma-informed.

Housing Support plans can be developed by a Community Supports Provider, a flex pool or organization that coordinates supportive services,[25] or other housing providers, including county behavioral health agencies. It is not necessary that the developer be a Medi-Cal provider.

1. Housing Transition Navigation Services (HTNS)

Housing Transition Navigation Services (HTNS) assist individuals with finding, applying for, and securing housing.[26] HTNS are available to people who are experiencing or at risk of being unhoused and meet one or more of the

following: the access criteria for Medi-Cal Specialty Mental Health Services (SMHS); the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS); have one or more serious chronic physical health conditions; have one or more physical, intellectual, or developmental disabilities; or are pregnant or through 12 months postpartum. HTNS are also automatically available to individuals who are eligible for Transitional Rent, discussed further below and for individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System (CES) or similar system.[27]

HTNS include:

- Conducting a housing assessment that identifies the individual's preferences and barriers related to successful tenancy.
- Developing a housing support plan based upon the housing assessment.
- Assisting in searching for housing and presenting options.
- Assisting in securing housing, including the completion of housing applications and securing required documentation
- Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI).
- Identifying and securing available resources to assist with attaining housing.
- Identifying and securing resources including but not limited to Housing Deposits, to cover expenses such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
- Providing education to the individual about Fair Housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
- Landlord education and engagement.
- Ensuring that the living environment is safe and ready for move-in.
- Communicating and advocating on behalf of the individual with landlords.
- Assisting in, arranging for, and supporting the details of the move.
- Establishing procedures and contacts to retain housing, including developing a housing support crisis plan.
- Ensuring availability of non-emergency, non-medical transportation as needed.

ADVOCACY TIP:

✓ Managed Care plans must ensure that individuals who are receiving HTNS are offered Enhanced Care Management (ECM), discussed in Chapter XII of this Guide. If an individual chooses to receive HTNS and ECM, the MCP must ensure that ECM coordinates service delivery to minimize confusion and duplication of services.

- Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility.

2. Housing Deposits

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household.[28] Housing Deposits are available to people who meet the same definition of eligibility as HTNS, and who have a Housing Support Plan.

Housing Deposits include:

- Security deposits required to obtain a lease on an apartment or home.
- Set-up fees/deposits for utilities or service access and payment in utility arrears.
- First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
- Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy, along with necessary minor repairs to meet HUD Housing Choice Voucher program quality.
- Application fees to cover the cost of the lease application.
- Medically necessary adaptive aids and services, designed to preserve an individual's health and safety in the home, including items like an air conditioner or heater, unless otherwise available through Medi-Cal.

Housing Deposits do not cover room and board or payment of rent. Housing Deposits are available once, with the possibility of an additional time if there is documentation of why a second attempt to use Housing Deposits to secure housing will be effective.

3. Housing Tenancy and Sustaining Services (HTSS)

Housing Tenancy and Sustaining Services (HTSS) help individuals maintain housing once it is established.[29] The same eligibility criteria for HTNS and Housing Deposits apply to HTSS.[30] HTSS must be identified in the individual's housing support plan. HTSS can include:

- Providing early identification and intervention to minimize jeopardizing housing;
- Providing education and training for individuals on the rights and responsibilities, of tenants and landlords;
- Providing education for individuals about fair housing and anti-discrimination practices, including making requests for necessary reasonable accommodation if necessary.
- Coaching on developing and maintaining key relationships to foster successful tenancy.
- Coordinating with the landlord and care/case management provider, to address issues that could impact housing stability.

- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the individual owes back rent or payment for damage to the unit.
- Advocacy and linkage with community resources to prevent eviction.
- Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process.
- Assistance with the annual housing recertification process.
- Coordinating with the tenant to review, update, and modify their housing support and crisis plan on a regular basis.
- Continuing assistance with lease compliance.
- Health and safety visits, including to ensure the unit remains safe and habitable.
- Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized.
- Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

4. Day Habilitation Programs

Day Habilitation Programs are intended to assist individuals with life skills necessary to live successfully.[31] Individuals are eligible if they are experiencing homelessness, or they exited homelessness and entered housing in the last 24 months, or they are at risk of homelessness or institutionalization and their housing stability could be improved through participation in a Day Habilitation Program. The service can be provided in an individual's home or an out-of-home, non-facility setting. The services are often considered peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. To the extent possible ECM and any other Community Supports should be provided by the same entity that is providing Day Habilitation.

Day Habilitation Program services include, but are not limited to, training on:

- The use of public transportation.
- Personal skills development in conflict resolution.
- Community participation.
- Developing and maintaining interpersonal relationships.
- Daily living skills (cooking, cleaning, shopping, money management).
- Community resource awareness such as police, fire, or local services to support independence in the community.[32]

Day Habilitation services are available for as long as an individual needs them, and can be provided continuously or intermittently, in both individual and group settings.

5. Recuperative Care (Medical Respite)

Recuperative Care, also known as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including a behavioral health condition).[33] Unlike other Community Supports, this service is covered under the CalAIM 1115 waiver.[34] Individuals are eligible for Recuperative Care if they require recovery in order to heal from an injury or illness and are experiencing or are at risk of homelessness.

Recuperative care helps individuals recover from injury and illness and at the same time have primary care, behavioral health, case management, and other supportive social services, such as transportation, food, and housing. Recuperative Care is designed to serve individuals who have medical needs significant enough to result in emergency department visits, hospital admissions, or other institutional care. Individuals do not need to be discharging from an institution, but must have an assessment that they have medical needs significant enough to result in ED visits, hospital admissions, or other institutional care. Recuperative care must include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition. Based on individual needs, the service may also include:

- Limited or short-term assistance with IADLs and/or ADLs to the extent permitted by licensure.
- Coordination of transportation to post-discharge appointments.
- Connection to any other ongoing services an individual may require, including mental health and substance use disorder services.
- Support in accessing benefits and housing.
- Gaining stability with case management relationships and programs.

Recuperative Care cannot last more than six months per rolling 12-month period, which starts from the first date of utilization. It is also subject to a six-month global cap on Room and Board services.[35]

ADVOCACY TIP:

✓ Individuals receiving Recuperative Care in facilities that are not licensed as Community Care Facilities cannot receive ADL or IADL assistance from staff in those facilities. MCPs can coordinate the delivery of Personal Care and Homemaker Services, discussed above, or contract with a licensed third-party provider.

6. Short-Term Post-Hospitalization Housing

Short-Term Post-Hospitalization Housing is available for individuals who are leaving an institution and are at risk of homelessness, and continue to need supports to recuperate from an illness or to support their recovery.[36] Unlike other Community Supports, this service is covered under the CalAIM 1115 waiver.[37] To receive Short-Term Post-Hospitalization Housing, individuals must meet all of the following criteria:

- Individuals who are exiting an institution, which includes recuperative care facilities (including facilities covered under Community Support Recuperative Care or other facilities outside of Medi-Cal), inpatient hospitals (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder or mental health treatment facility, correctional facility, or nursing facility; AND
- Are experiencing or at risk of homelessness; AND
- Meet one of the following criteria:
  - Are receiving ECM;
  - Have one or more serious chronic conditions;
  - Have serious mental illness; or
  - Are at risk of institutionalization or requiring residential services as a result of a substance use disorder; AND
- Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing.

Locations where Short-Term Post-Hospitalization Housing can be provided include recuperative care, inpatient hospitals, residential substance use disorder or mental health treatment facilities, correctional facilities, or nursing facilities. Short-Term Post-Hospitalization Housing must provide individuals with ongoing supports necessary for recuperation and recovery, such as gaining (or regaining) the ability to perform ADLs, receiving necessary care, receiving case management, and beginning to access other housing supports. Short-Term Post-Hospitalization Housing settings may include a private or shared interim housing setting. Like Recuperative Care and Transitional Rent (discussed below), there is a six-month cap on receiving Short-Term Post-Hospitalization Housing on a 12-month rolling basis.[38]

7. Transitional Rent

While as noted above, Community Supports are optional for MCPs, Transitional Rent is a *mandatory* service as of January 1, 2026, and MCPs may begin offering Transitional Rent as early as July 1, 2025.[39] Transitional Rent can provide up to six months of rental assistance in both temporary and permanent settings.[40] Transitional Rent must follow Housing First principles. This means that Transitional Rent cannot be conditioned on sobriety or engagement or completion of certain services, or on "housing readiness."[41]

The eligibility criteria for Transitional Rent are lengthy.[42] Individuals are eligible if they meet all of the following criteria:

- Clinical Risk Factor Requirement: Must have one of more of the following qualifying clinical risk factors:
  - a) Meets the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
  - b) Meets the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS);
  - c) One or more serious chronic physical health conditions;
  - d) One or more physical, intellectual, or developmental disabilities; or
  - e) Individuals who are pregnant up through 12-months postpartum.

AND

- Social Risk Factor Requirement: Experiencing or at risk of homelessness.

AND

- Individuals must meet one of the following requirements:
  - a) Transitioning Population Requirement: Must be included within one of the following transitioning populations:
    - (i) Transitioning out of an institutional or congregate residential setting:
    - (ii) Transitioning out of a carceral setting;
    - (iii) Transitioning out of interim housing;
    - (iv) Transitioning out of recuperative care or short-term post-hospitalization housing;[43]
    - (v) Transitioning out of foster care: Individuals having aged out of foster care up to age 26 (having been in foster care on or after their 18th birthday) either in California or in another state.[44]

OR

  - b) Experiencing unsheltered homelessness;[45]

OR

  - c) Eligible for Full-Service Partnership[46] (FSP).[47]

Transitional Rent can be used to cover:

- Rental assistance in allowable settings
  - These include a permanent or interim setting, or a combination of both. If the setting is interim, the MCP must confirm that an individual has a housing support plan in place and is Behavioral Health Services Act (BHSA)-eligible and will be able to transition to BHSA Housing Interventions at the expiration of Transitional Rent, if the individual is otherwise not able to secure a HUD Housing Choice Voucher, permanent supportive housing subsidy, or other long-term rental subsidy.[48]
  - Storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment.

Transitional Rent can provide up to six months of rental assistance and rent and housing fees subject to the six-month global cap on Room and Board services within a rolling 12-month period. The six months of Transitional Rent are not required to be continuous. DHCS has issued separate guidance on payments to MCPs for Transitional Rent.[49] Transitional Rent has two components: 1) cost of rent or temporary housing; and 2) an administrative fee. MCPs can be reimbursed for the actual cost of rent or temporary housing, which may include the costs of storage fees, amenity fees, and landlord-paid utilities that are charged as part of the rent payment up to applicable reimbursable ceilings.[50] In addition, MCPs will receive reasonable costs for administrative fees. While the cost of rent for different types of housing is fixed, administrative fees are not specified, and MCPs and Transitional Rent Providers are expected to negotiate rates.[51] The Transitional Rent payment is designed to cover the cost of rent or temporary housing for the enrollee for the entire time the individual receives the support, up to six months. Individuals cannot be required to cover a share of the rent. In addition, placements must be to settings where the landlord or property owner accepts the amount of Transitional Rent provided.

ADVOCACY TIP:

✓ Advocates should keep in mind that the Housing Deposits Community Support can be used to cover additional costs that Transitional Rent does not fund. In addition, it is important to note that currently Transitional Rent may not be used to cover eviction prevention—for instance, back rent or prospective rental assistance for individuals who are housed but at risk of being unhoused.

Accessing Community Supports

Information and Referrals

MCPs have a number of obligations to identify individuals who may benefit from Community Supports. MCPs are required to inform plan enrollees as well as plan networks of providers about Community Supports and how an individual can access Community Supports. MCPs must have a process for receiving and responding to referral requests from a wide range of sources, including accepting referrals from individuals and their families, guardians and caregivers, ECM Providers, Community Support Providers and Community-Based Organizations (CBOs), and other providers. MCPs must also train their call centers on how to manage referrals for Community Supports.[52]

In addition, MCPs must comply with Closed-Loop Referral (CLR) requirements, which took effect on July 1, 2025 and apply to community referrals and referrals generated by MCPs.[53] DHCS defines a Closed-Loop Referral (CLR) as a referral

initiated on behalf of a Medi-Cal Managed Care enrollee that is tracked, supported, monitored and results in a "Known Closure."[54] Under CLR requirements, MCPs must track referrals with the goal of having a majority of Community Supports referrals originate from community-based sources, rather than from the MCP itself.

In terms of publicizing the availability of Community Supports, MCPs must ensure that their websites include up-to-date information about Community Supports and ECM, and how to refer for and request those services; a short description of each available service that comports with DHCS' terminology; and a definition of all individuals eligible for Transitional Rent from the MCP.[55]

Authorization Processes

MCPs must have nondiscriminatory authorization procedures that comply with the definitions of Community Supports. MCPs must outline the documentation requirements, including why the Community Support is likely to reduce or prevent the need for acute care or other Medi-Cal services, including, but not limited to, inpatient hospitalizations, skilled nursing facility stays, or emergency department visits.[56]

MCPs must have Policies and Procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate. DHCS has determined that Recuperative Care, Short-Term Post-Hospitalization Housing, and Sobering Centers are inherently time sensitive, and that MCPs that offer these Community Supports must provide expedited authorization if needed.[57]

Continuity of Care

If an individual changes plans and is receiving a Community Support, the new MCP must provide the Community Support if the new MCP offers that support. Where the new MCP offers the same support, the new MCP must:

- Automatically authorize the support in the same amount and duration, consistent with the new MCP's parameters;
- Have a process for engaging the previous MCP, individual, and/or Community Supports Provider to mitigate gaps in care;
- Have a process for reviewing historical utilization data using a 90-day look-back period to identify individuals receiving Community Supports

For Community Supports with a lifetime maximum or the six-month maximum during a 12-month rolling period, MCPs must track and apply Continuity of Care if individuals have not reached their applicable maximums.[58]

Grievances and Appeals

A Notice of Adverse Benefit Determination (NOABD) is required when an MCP plan approves, modifies, or denies a request and individuals have the right to file appeals and/or grievances if they request one or more Community Support

offered by the MCP but are denied. Individuals can also file for a fair hearing to dispute a denial.[59]

Individuals are entitled to a notice of when the Community Support service is ending or discontinuing. However, DHCS states that a NOABD is not needed if an individual was informed at the beginning of the service (e.g., when a Medically Tailored Meal service is authorized for three months, and the individual is informed at the beginning of the authorized period of service that it is time-limited). DHCS also states notice is not necessary if the individual has opted out of the Community Support service.

ADVOCACY TIP:

✓ Advocates should be aware that MCPs are not always issuing a notice when a request for Community Supports is denied. Advocates should request a written notice, and be prepared to file a grievance/appeal and potentially a State Fair Hearing in the event a Community Support is denied without notice. In addition, Advocates should advise individuals who are receiving a time-limited service that if they continue to need the service past the authorization date, a new request should be made before the end of the authorized period.

Endnotes

[1] For the provision of federal regulations authorizing Community Supports, see 42 C.F.R. § 438.3(e)(2). All in lieu of services must be a cost-effective substitute for a service or setting covered under the Medicaid State Plan, voluntary for an MCP to cover and for an individual to use, and the use and actual cost of ILOS must be taken into account in developing the component of the capitation rates that represent the covered state plan services. For the state statutory authority, see Cal. Welf. & Inst. Code § 14184.206.

[2] In April 2025, DHCS issued two Policy Guides, Volume 1 and Volume 2, which contain detailed information about Community Supports. See Cal. Dep't Health Care Servs., *Medi-Cal Community Supports Policy Guide Volume 1* (Apr. 2025), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf [hereinafter *Community Supports Policy Guide Vol.1*] and Cal. Dep't Health Care Servs., *Medi-Cal Community Supports Policy Guide Volume 2 Community Supports to Support Members Experiencing or At Risk of Homelessness* (Apr. 2025), https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide-Volume-2.pdf [hereinafter *Community Supports Policy Guide Vol.2*]. *See also* Cal. Dep't Health Care Servs., All Plan Letter 21-017 (Mar. 1, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-017.pdf.

[3] CMS, Dear State Medicaid Director (Jan. 4, 2023) (SMD #: 23-001) (guidance on use of in lieu of services and settings in Medicaid managed care), https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf.

[4] A list of what Community Supports each MCP plan offers is available at Cal. Dep't Health Care Servs., *CalAIM Community Support – Managed Care Plan Elections* (Updated July 2025), https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf [hereinafter *Community Supports MCP Elections*].

[5] Twelve of the Community Supports are authorized through the CalAIM section 1915(b) waiver. Cal. Dep't. Health Care Servs., Section 1915(b) Waiver Proposal for California Advancing and Innovating Medi-Cal (CalAIM) (2023), https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915bWaiver-CA-0017-R10-01-Application.pdf [hereinafter CalAIM 1915(b) Waiver].The remaining 3 Community Supports are authorized through section 1115 demonstration waivers: Short-Term Post-Hospitalization Housing and Recuperative Care are authorized under the CalAIM 1115 Waiver. *See* CMS, *CalAIM Demonstration Approval Technical Correction Attachment* (Jan. 2025), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-calaim-dmnstrn-appvl-thncl-crctn-atchmnt-c-aa-01172025.pdf [hereinafter *CalAIM Technical Correction Attachment*]. Transitional Rent is authorized under the BH-CONNECT waiver. *See* CMS, *Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Section 1115(a) Demonstration* (Jan. 2025) https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ca-bh-connect-01102025.pdf [hereinafter *BH-Connect Waiver*] In DHCS's July 2025 CalAIM Concept Paper, which discusses the future of CalAIM, DHCS notes that the 12 Community Supports approved as ILOS are authorized under 42 C.F.R. § 438.3(e)(2), "a regulatory authority distinct from authority conferred by Section 1115 and 1915(b) waivers. ILOS is a permanent option for state Medicaid programs enshrined in federal Medicaid managed care regulations and, as required by CMS, memorialized in approved MCP contracts. The 12 Community Supports covered as ILOS are not dependent on DHCS's current CalAIM Section 1115 or 1915(b) waiver approvals." Cal. Dep't Health Care Servs., *Continuing the Transformation of Medi-Cal: Concept Paper* 37 (July 2025), https://www.dhcs.ca.gov/CalAIM/Documents/Medi-Cal-Transformation-Concept-Paper.pdf.

[6] *Community Supports Policy Guide Vol.1, supra* note 2. *See also, BH-Connect Waiver, supra* note 5, at 221. Availability of Transitional Rent is mandatory for MCP enrollees meeting the Behavioral Health Population of Focus as of January 1, 2026 and mandatory for all MCP populations who meet the eligibility criteria for Transitional Rent as of January 1, 2027. Transitional Rent is available through the term of the BH-Connect waiver, which runs from January 1, 2025 through December 31, 2029.

[7] *Community Supports Policy Guide Vol.1, supra* note 2, at 5.

[8] *Id.* at 10.

[9] *Id.*

[10] *Id.* at 11.

[11] *Id.* at 13.

[12] *Id.* at 14.

[13] These programs are discussed in Chapter X of this Guide on Long-Term Services and Supports.

[14] In order to receive short term PCHS, the authorization request should include information about the need for short term stay in a skilled nursing facility in the absence of PCHS being available. *Community Supports Policy Guide Vol.1*, *supra* note 2, at 26.

[15] *Id.* at 26.

[16] *Id.* at 29.

[17] *Id.* at 32.

[18] This includes but is not limited to cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders. *Id.* at 35.

[19] The CalFresh Program, federally known as the Supplemental Nutrition Assistance Program (SNAP), issues monthly electronic benefits that can be used to buy most foods at many markets and food stores. *See* Cal. Dep't Soc. Servs., CalFresh Program, https://www.cdss.ca.gov/calfresh (last visited Dec. 11, 2025). WIC provides nutritional support to women, infants, and children. *See* Cal. Dept Pub. Health, WIC Program Overview, https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/AboutWIC/ProgramOverview.aspx (last visited Dec. 11, 2025).

[20] *Community Supports Policy Guide Vol.1*, *supra* note 2, at 39.

[21] *Id.* at 42. Asthma Preventive Services (APS) became a state plan benefit in July 2022, six months after Asthma Remediation Services were added as a community support. *See* Cal. Dep't Health Care Servs., *Allied Health Provider Manual, Asthma Preventive Services (APS)* (2022) https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/B30BA13C-7A4F-47B9-9403-760091E44ADC/asthprev.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYyIPyP5ULO. Because Community Supports must not supplant state plan services, asthma self-management education and in-home environmental trigger assessments must be covered as a state plan service, not through Asthma Remediation Services.

[22] *Community Supports Policy Guide Vol.1*, *supra* note 2, at 46.

[23] *Community Supports Policy Guide Vol.2*, *supra* note 2.

[24] *Id.* at 17–19.

[25] A "Flex Pool is a vehicle to organize rental assistance that (1) coordinates and braids funding streams, facilitating compliance and required reporting; (2) acts as a single fiscal intermediary between funders and landlords; (3) identifies, secures, and supports a portfolio of units; and (4) coordinates with providers of housing supportive services." Cal. Dep't Health Care Servs., *Flexible Housing Subsidy Pools Technical Assistance Resource* 5 (Feb. 10, 2025), https://www.dhcs.ca.gov/Documents/MCQMD/Flexible-Housing-Subsidy-Pools-TA-Resource.pdf.

[26] *Community Supports Policy Guide Vol.2*, *supra* note 2, at 25–30. Along with Housing Deposits and Housing Tenancy and Sustaining Services (HTSS), HTNS make up the "Housing Trio." *See* Cal. Health Care Found., *CalAIM's Trio of Housing Community Supports – Policy at a Glance* (Mar. 20, 2025), https://www.chcf.org/resource/calaim-housing-community-supports-policy-at-a-glance/.

[27] Individuals must meet the U.S. Department of Housing and Urban Development's (HUD's) current definition of homeless or at risk of homelessness as codified at 24 C.F.R. part 91.5, with three modifications: 1) If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and 2) The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days; and 3) For the at risk of homelessness definition at 24 C.F.R. § 91.5, the requirement to have an annual income below 30 percent of median family income for the area, as determined by HUD, will not apply. CES standardizes the way individuals and families at risk of homelessness or experiencing homelessness access are assessed for and referred to the housing and services that they need for housing stability. *See* U.S. Department of Housing and Urban Development (HUD), *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (Notice CPD-17-01)* (Jan. 23, 2017), https://www.hud.gov/sites/documents/17-01cpdn.pdf. *See Community Supports Policy Guide Vol.2*, *supra* note 2, at 27.

[28] *Id.* at 31–36.

[29] *Id.* at 37–42.

[30] Note that individuals cannot receive HTNS and HTSS at the same time; HTSS is designed to serve individuals who are maintaining, not obtaining housing. *See Community Supports Policy Guide Vol.2*, *supra* note 2, at Appendix B: Summary of Interaction Between Community Supports and ECM 110.

[31] *Id.* at 43–47.

[32] For a description of Additional Day Habilitation Program services, *see Community Supports Policy Guide Vol.2*, *supra* note 2, at 42.

[33] *Community Supports Policy Guide Vol.2*, *supra* note 2, at 47–51. Note that Under the CalAIM waiver, CMS refers to this service as Short-Term Recuperative Care.

[34] *See CalAIM Demonstration Approval Technical Correction Attachment, supra* note 5. Note that the term of the 1115 Waiver is through December 31, 2026, so this service may end if the waiver is not renewed, or the benefit is not otherwise offered.

[35] The two Section 1115 waivers authorizing Short-Term Post Hospitalization Housing, Recuperative Care, and Transitional Rent, all three of which are referred to in the waivers as "Room and Board" services, establish a "global cap" on coverage of these three Community Supports. Under the cap, coverage is limited to six months of Room and Board services per enrollee within a rolling 12-month period. This means that an individual may not receive more than a combined six months of Short-Term Post-Hospitalization Housing, Recuperative Care, and Transitional Rent during any rolling 12-month period. This limitation applies even if an individual changes Medi-Cal Managed Care Plans. *See CalAIM Demonstration Approval Technical Correction Attachment, supra* note 5, at 67 and *BH-Connect Waiver, supra* note 5, at 44.

[36] *Community Supports Policy Guide Vol.2*, *supra* note 2, at 52–56.

[37] *See CalAIM Demonstration Approval Technical Correction Attachment, supra* note 5. Note that the term of the Section 1115 Waiver is through December 31, 2026, so this service may end if the waiver is not renewed, or the benefit is not otherwise offered.

[38] *Community Supports Policy Guide Vol.2*, *supra* note 2, at 13.

[39] Transitional Rent is mandatory for MCP enrollees meeting the Behavioral Health Population of Focus as of January 1, 2026 and mandatory for all populations who meet the eligibility criteria for Transitional Rent as of January 1, 2027. *See* BH-Connect Waiver, *supra* note 5, at 221.

[40] Individuals must meet the U.S. Department of Housing and Urban Development's (HUD's) current definition of homeless or at risk of homelessness as codified at 24 C.F.R. part 91.5, with three modifications: 1) If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay or become homeless during that stay, regardless of the length of the institutionalization; and 2) The timeframe for an individual or family who will imminently lose housing is extended from 14 days for individuals considered homeless and 21 days for individuals considered at risk of homelessness under the current HUD definition to 30 days; and 3) For the at risk of homelessness definition at 24 C.F.R. § 91.5, the requirement to have an annual income below 30% of median family income for the area, as determined by HUD, will not apply. *See BH-Connect Waiver, supra* note 5, at 227. *See also* Cal. Dep't Health Care Servs., *Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion, and Development (CITED) Round 4: Transitional Rent* (Jan. 27, 2025), https://tpa-reference-material-prod.s3.us-west-2.amazonaws.com/2025-01-28T10%3A14%3A31.443087685_2025-01-27%20CITED%20Round%204%20Transitional%20Rent%20Webinar.pdf.

[41] Cal. Welf. & Inst. Code § 8526.

[42] For a full description of eligibility criteria, *see Community Supports Policy Guide Vol.2*, *supra* note 2, at 58–62.

[43] For individuals in 3(a)(i)–(iv), they must receive authorization for Transitional Rent within six months (i.e., within 182 days) of the transition event (e.g., date of discharge, date of release). Additionally, the individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization.

[44] Individuals transitioning out of foster care on or after their 18th birthday are eligible to receive Transitional Rent until their 26th birthday and may be authorized at any time during this window. The individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization.

[45] Individuals who are experiencing unsheltered homelessness, assuming satisfaction of the clinical risk factor eligibility requirement, may be authorized at any time. The individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization.

[46] Full Service Partnerships (FSP) are "are recovery-oriented, comprehensive services targeted to individuals who are unhoused, or at risk of becoming unhoused, and who have a severe mental illness often with a history of criminal justice involvement, and repeat hospitalizations." Cal. Comm'n Behav. Health, Full Service Partnerships, https://bhsoac.ca.gov/initiatives/full-service-partnerships/ (last visited Dec. 11, 2025); Cal. Code Regs. Tit. 9, § 3620.

[47] Individuals eligible for FSP, assuming satisfaction of the social risk factor eligibility requirement (experiencing or at risk of homelessness), may be authorized at any time. The individual can use the Transitional Rent Benefit without a redetermination of eligibility for six months from the date of authorization. *Community Supports Policy Guide Vol.2*, *supra* note 2, at 60.

[48] SB 326, The Behavioral Health Services Act, 2023-2024, available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB326 (last visited Dec. 11, 2025). For information on the passage of Proposition 1 and BHSA, *see* Dep't Health Care Servs., Behavioral Health Transformation, https://www.dhcs.ca.gov/BHT/Pages/home.aspx (last visited Dec. 11, 2025). Cal. Dep't Health Care Servs., *Community Supports Policy Guide Vol.2*, *supra* note 2, at 74.

[49] Cal. Dep't Health Care Servs., *Transitional Rent Payment Methodology 2* (Oct. 3, 2025), https://www.dhcs.ca.gov/services/Documents/DirectedPymts/Transitional-Rent-Payment-Methodology.pdf.

[50] *Id.* at 6.

[51] *Id.* at 8.

[52] *Community Supports Policy Guide Vol.1*, *supra* note 2, at 48.

[53] Cal. Dep't Health Care Servs., *Addendum to the PHM Policy Guide: Closed-Loop Referral Implementation Guidance* (Updated May 2025), https://www.dhcs.ca.gov/CalAIM/Documents/WIP-CLR-Implementation-Guidance.pdf.

[54] *Id.* at 4.

[55] AB 133, Cal. Assembly 2021 Reg. Sess., https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133 (last visited Dec. 11, 2025). *See also Community Supports MCP Elections, supra* note 4. ECM and Community Support Contacts for each MCP are available at Cal. Dep't Soc. Servs., Managed Care Plan Enhanced Care Management and Community Supports Referral Pathways, https://www.cdss.ca.gov/inforesources/cdss-programs/enhanced-care-management-and-community-supports-referral-pathways (last visited Dec. 11, 2025).

[56] *Community Supports Policy Guide Vol.1*, *supra* note 2, at 50.

[57] *Id.* at 51.

[58] *Id.* at 52; Cal. Welf. & Inst. Code § 14197.3.

[59] *See* Cal. Dep't Health Care Servs., All Plan Letter 21-011 (Aug. 31, 2022) https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf; *see also* Cal. Dep't Health Care Servs., *Community Supports, or In Lieu of Services (ILOS), Annual Report: Department of Health Care Services (DHCS) 1915(b) Waiver Report to the Centers for Medicare & Medicaid Services (CMS) for Calendar Year (CY) 2024,* at 57–58 (Apr. 2025) https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-1915b-Annual-Report-on-ILOS-STC-B20-2025.pdf; CMS, *California Advancing & Innovating Medi-Cal (CalAIM) Waiver Revised Special Terms and Conditions via CA-0017.R10.01 Amendment Waiver Control # CA 17.R10 January 1, 2022 through December 31, 2026,* at 9 (2023) https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-Approval-Letter-Revised-STCs.pdf.

NATIONAL HEALTH LAW PROGRAM

An Advocate's Guide to Medi-Cal Services

Updated December 2025

Chapter XIV: Ancillary Services

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Outline of Medi-Cal Ancillary Services Covered in this Chapter
A. Therapies and Other Professional Services 1. Physical Therapy 2. Occupational Therapy 3. Respiratory Therapy 4. Audiology 5. Speech Therapy 6. Vision Services 7. Acupuncture 8. Chiropractic Services B. Transportation 1. Emergency medical transportation 2. Nonemergency medical transportation 3. Nonmedical transportation 4. Air transportation (under certain circumstances) C. Diagnostic Tests 1. Laboratory services 2. Imaging services D. Other Specialized Services 1. Dialysis 2. Transplants

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. For beneficiaries under age 21, however, services are required to be provided when they are necessary to correct or ameliorate an identified condition, pursuant to the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards, even if optional for adults.[1] 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."[2] 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."[3] 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.[4]

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.[5] For respiratory care services, the prescription must be from a physician or surgeon.[6] All prescriptions must specifically describe the services and include the frequency, duration, and therapeutic goal of the therapy prescribed, among other requirements.[7]

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.[8] 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.

For occupational therapy, initial and six-month evaluations do not require prior authorization, but all other coverage requests do.[9] 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.[10] 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.[11]

2. Audiology, Speech Therapy, and Podiatry

Medi-Cal covers audiology services, speech therapy services, and podiatry services as outpatient services.[12] 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.[13] Rehabilitation centers are facilities that "provide an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients."[14]

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."[15] 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.[16]

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.[17] 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.[18] 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.[19] Medi-Cal coverage, however, does not extend to routine nail trimming.[20]

Prior authorization of podiatry services is required if the service involves anything other than an evaluative office visit.[21]

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.[22] 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:[23]

- 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.[24] 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.[25] 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.[26] By law, the vendor cannot bill a beneficiary if it accepts Medi-Cal payment for the service.[27]

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.[28]

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).[29] 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.[30]

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 (AOD), and external speech processor and controller.[31] 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.[32] 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.[33] Medi-Cal must also cover all treatments necessary to address conditions discovered during hearing screenings, including hearing aids and cochlear implants.[34] 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 under age 21. In addition, children can obtain coverage of replacement hearing aid batteries on a quarterly basis without prior authorization.[35]

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.[36] 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.[37] 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.[38] 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.[39]

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.[40] Replacement for frames for other reasons may be covered if the provider submits a statement explaining why the prior frame should be replaced.[41] Replacement of frames within two years is always limited to the same frame model whenever feasible.[42]

In general, Medi-Cal covers contact lenses with a prescription only if the use of eyeglasses is not an option.[43] 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

chart continued

Prior Authorization Required	No Prior Authorization Required
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.[44] In addition, when the amount claimed for payment of a low vision optical aid is $100 or more, prior authorization is required.[45] 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.[46] 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.[47]

Vision coverage is more robust for children under age 21 than it is for adults due to the EPSDT mandate. 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.[48] 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.[49] 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 does not limit the ability of children to receive this service.[50]

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.[51] 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.[52] Acupuncture can be provided by an acupuncturist or a physician, dentist, or podiatrist.[53] Medi-Cal covers acupuncture either with or without electrical stimulations of the needles.[54] 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.[55]

A beneficiary does not need a prescription for acupuncture, nor does a beneficiary typically need to obtain prior authorization.[56] 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.[57] However, for managed care beneficiaries, additional services can be provided based upon medical necessity subject to the Managed Care Plan (MCP) prior authorization process.[58]

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.[59] However, this coverage exclusion does not apply in the following situations:

- Services are provided as emergency procedures.[60]
- The beneficiary is pregnant, and the services relate to the pregnancy.[61]
- The beneficiary is a minor under 21 and covered under the EPSDT benefit.[62]
- The beneficiary resides in a skilled nursing facility or an intermediate care facility.[63]
- 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).[64]

In addition, Medi-Cal coverage of chiropractic services extends only to treatment of the spine by means of manual manipulation.[65] 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.[66] 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.[67]

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 age 21 are entitled to all EPSDT-covered treatment or services necessary to correct or ameliorate their illness or condition.

B. Transportation

Federal Medicaid law requires state Medicaid programs to ensure that beneficiaries have sufficient transportation to access medical care.[68] 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 nonmedical transportation (NMT). On a limited basis, Medi-Cal covers transportation via air, which can be provided on an emergency or nonemergency basis.

1. Emergency Medical Transportation

Medi-Cal covers emergency medical transportation in medical emergencies. Coverage for emergency medical transportation extends to transportation to the nearest hospital or acute care facility that meets the beneficiary's medical needs.[69] 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.[70] Medi-Cal will also only cover the lowest-cost type of medical transportation that meets the individual's medical needs.[71]

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.[72] 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.[73]

Physician decisions regarding NEMT must be unhindered by fiscal and administrative management.[74] 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.[75] The transportation provider must ensure door-to-door assistance from the point of departure to the destination.[76] 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.[77]

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.[78]

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.[79] 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.[80] 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.[81]

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.[82] NMT also covers mileage reimbursement.[83] 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.[84]

NMT has long been a benefit when provided as an EPSDT service.[85] 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.[86] Further, effective October 1, 2017, Medi-Cal MCPs must also provide NMT for members who seek 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.[87]

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.[88] For beneficiaries in managed care, NMT is covered if the member 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).[89]
- In the case of minors, NMT can include transportation of the minor's parent or guardian.[90]
- 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.[91] However, beneficiaries using NMT must attest that other available transportation resources have been reasonably exhausted.[92] 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 members, so MCP enrollees should contact their MCP to access this benefit.[93] 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.[94] As with NEMT, beneficiaries in FFS Medi-Cal must request NMT directly from DHCS.[95]

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.[96] 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.[97]

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.[98]

C. Diagnostic Tests

Laboratory and imaging services are mandatory Medicaid services and, therefore, are covered services under Medi-Cal.[99]

Covered laboratory tests include, but are not limited to:[100]

- 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, RNA, COVID-19)
- Oncology screenings
- Pregnancy tests
- Uric acid tests

Covered imaging includes, but is not limited to:[101]

- 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.[102]

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.[103] 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.[104]

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.[105] 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.[106] If a beneficiary seeks to receive home dialysis, the beneficiary's providers must submit evidence of the following:[107]

- 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.

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.[108] Covered transplants include:[109]

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

Authorization is required for major solid organ, autologous islet cell, and bone marrow transplants.[110] Finally, with the exception of corneal, autologous islet cell or kidney transplants, Medi-Cal only covers transplants if the surgeries are performed at hospitals that are approved by Medi-Cal as Centers of Excellence (COE) for the specific organ transplant involved.[111]

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.[112] 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

[1] 42 U.S.C. §§ 1396a(a)(10)A, 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); Cal. Welf. & Inst Code § 14132(v); *see* Cal. Code Regs., tit. 22, §§ 51184, 51340, 51340.1

[2] Cal. Code Regs. tit. 22, § 51309(b).

[3] Cal. Code Regs. tit. 22, § 51085.

[4] Cal. Code Regs. tit. 22, § 51082.1.

[5] Cal. Code Regs. tit. 22, §§ 51081, 51085, 51309(a).

[6] Cal. Code Regs. tit. 22, § 51316(a).

[7] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Physical Therapy* 1 (2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/F6892884-339B-41B9-BAA5-3835F09E2604/phys.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Physical Therapy*]. Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Occupational Therapy* 1 (2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/C41842BA-B1E9-456C-A6D8-B8AADF17A0C6/occu.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Occupational Therapy*]. Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care* 1 (2020) https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/9149A0E0-E994-4AEF-A40E-0048AD9E6241/respir.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Respiratory Care*].

[8] Cal. Code Regs. tit. 22, § 51309(d); *Medi-Cal Provider Manual, Physical Therapy, supra* note 7, at 2.

[9] *Medi-Cal Provider Manual, Occupational Therapy, supra* note 7, at 4.

[10] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Respiratory Care, supra* note 7, at 2.

[11] Cal. Code Regs. tit. 22, § 51304(a).

[12] 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)(B), (E). 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), (2). 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)(3).

[13] Cal. Code Regs. tit. 22, § 51305(f); Cal. Code Regs. tit. 22, § 51314(a).

[14] Cal. Code Regs. tit. 22, § 51117.

[15] Cal. Code Regs. tit. 22, § 51098.

[16] 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* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D935351C-3069-4C4B-A1CC-A0280ABE96B4/audio.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Audiological Services*].

[17] 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://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/686001F1-D83B-441B-989D-693E1FFB7EA0/speech.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[18] 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://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/331928A6-2936-449E-86D5-11B7DC2AC2F2/podi.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Podiatry Services*].

[19] Cal. Code Regs. tit. 22, § 51310(a)(1). *See also Medi-Cal Provider Manual, Podiatry Services, supra* note 17, at 1.

[20] Cal. Code Regs. tit. 22, § 51310(b); *Medi-Cal Provider Manual, Podiatry Services, supra* note 17, at 1.

[21] Cal. Code Regs. tit. 22, § 51310(a).

[22] Cal. Code Regs. tit. 22, § 51304(a).

[23] Cal. Welf. & Inst Code § 14133.16.

[24] Cal. Welf. & Inst Code § 14131.05(c); *see* Cal. Dep't Health Care Servs., *Hearing Aid Benefit Cap & Benefits Frequently Asked Questions for Members,* https://www.dhcs.ca.gov/services/Pages/HearingAidCapFAQ.aspx#:~:text=The%20%241%2C510%20cap%20will%20allow,you%20receive%20your%20hearing%20aids (last visited Dec. 16, 2025) [hereinafter *Hearing Aid Benefit Cap & Benefit FAQs*]. *See also* Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Hearing Aids* 1 (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/383085AB-A904-471E-9230-DB71771C3961/hearaid.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Hearing Aids*].

[25] Cal. Welf. & Inst Code § 14131.05(d), (e); *Medi-Cal Provider Manual, Hearing Aids, supra* note 24, at 1.

[26] *Hearing Aid Benefit Cap & Benefit FAQs, supra* note 24.

[27] 42 C.F.R. § 447.15; Cal. Welf. & Inst Code §§ 14019.3(d), 14019.4(a).

[28] *Medi-Cal Provider Manual, Audiological Services, supra* note 16, at 8.

[29] Cal. Code Regs. tit. 22, § 51517(b)(1).

[30] *Hearing Aid Benefit Cap & Benefit FAQs, supra* note 24.

[31] *Medi-Cal Provider Manual, Audiological Services, supra* note 16, at 8.

[32] 42 U.S.C. § 1396d(r)(4).

[33] Cal. Code Regs. tit. 22, § 51184(a)(1); Cal. Dep't Health Care Servs., *Periodicity Schedules* (updated Mar. 8, 2022), https://www.dhcs.ca.gov/services/chdp/Pages/Periodicity.aspx [hereinafter *Periodicity Schedules*].

[34] CMS, *EPSDT–A Guide for States: Coverage in the Medical Benefit for Children and Adolescents* 15 (2014), https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf.

[35] Cal. Code Regs. tit. 22, § 51340.1(c)(2).

[36] Cal. Code Regs. tit. 22, § 51305(j).

[37] 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. 16, 2025) [hereinafter Medi-Cal Vision Benefits].

[38] Cal. Code Regs. tit. 22, § 51306(a). *See also* Medi-Cal Vision Benefits, *supra* note 37.

[39] Cal. Code Regs. tit. 22, § 51306(c).

[40] Cal. Code Regs. tit. 22, § 51317(d).

[41] Cal. Code Regs. tit. 22, § 51317(d)(1).

[42] Cal. Code Regs. tit. 22, § 51317(d)(2).

[43] Cal. Code Regs. tit. 22, § 51317(e).

[44] Cal. Code Regs. tit. 22, § 51317(f).

[45] Cal. Code Regs. tit. 22, § 51317(f)(5).

[46] Cal. Code Regs. tit. 22, § 51317(g); Medi-Cal Vision Benefits, *supra* note 37.

[47] Cal. Code Regs. tit. 22, § 51317(g)(2).

[48] Cal. Code Regs. tit. 22, § 51184(a); *Periodicity Schedules, supra* note 33. *See also* Cal. Dep't Health Care Servs., *Health Assessment Guidelines - Chapter 27: Vision* (2017), https://hhsa.cosb.us/wp-content/uploads/2022/06/Step-5-State-Vision-Screening-Guidelines.pdf.

[49] 42 U.S.C. § 1396d(r)(2).

[50] 42 U.S.C. § 1396d(r)(2)(B).

[51] *See* 2016 Cal. Stat. ch. 30 (S.B. 833), §§ 28, 36.

[52] Cal. Code Regs. tit. 22, § 51074.5.

[53] Cal. Code Regs. tit. 22, § 51308.5(a).

[54] Cal. Code Regs. tit. 22, § 51308.5(c).

[55] 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://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/50FE1D59-6E0C-4741-8AA7-06000541C69D/acu.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Acupuncture Services*].

[56] *Medi-Cal Provider Manual, Acupuncture Services, supra* note 55, at 2.

[57] Cal. Code Regs. tit. 22, §§ 51304(a), 51308.5(a). *See also Medi-Cal Provider Manual, Acupuncture Services, supra* note 55.

[58] *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.

[59] Cal. Welf. & Inst Code § 14131.10(b)(1)(C).

[60] Cal. Welf. & Inst Code § 14131.10(b)(2)(B).

[61] Cal. Welf. & Inst Code § 14131.10(b)(3).

[62] Cal. Welf. & Inst Code § 14131.10(c)(1).

[63] Cal. Welf. & Inst Code § 14131.10(c)(2).

[64] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Chiropractic Services* 6 (2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/63F2D3B4-0FEF-47D3-B3F0-9D1AA2AC8C8E/chiro.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Chiropractic Services*].

[65] Cal. Code Regs. tit. 22, § 51308. *See also Medi-Cal Provider Manual, Chiropractic Services, supra* note 64, at 1.

[66] *Medi-Cal Provider Manual, Chiropractic Services, supra* note 64.

[67] Cal. Code Regs. tit. 22, § 51304(a); *Medi-Cal Provider Manual, Chiropractic Services, supra* note 64, at 6.

[68] 42 C.F.R. § 431.53.

[69] Cal. Code Regs. tit. 22, § 51323(b)(1).

[70] *Id.*

[71] Cal. Code Regs. tit. 22, § 51323(b).

[72] Cal. Code Regs. tit. 22, § 51323(a); Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Medical Transportation - Ground* (2023), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7DD185A7-526A-41B3-AF42-37ED652648B0/mctrangnd.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Medical Transportation - Air* (2020), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/D20DC9E4-1BFC-4C9D-9E6A-1F87691FF0B9/mctranair.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO. [hereinafter called *Medi-Cal Provider Manual, NEMT Transportation Services*].

[73] Cal. Code Regs. tit. 22, § 51323(b).

[74] 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].

[75] *Id.*

[76] *Id.*

[77] *Id.* at 10.

[78] Cal. Welf. & Inst Code § 14136.3; Cal. Code. Regs. tit. 22, § 51323(b)(2)(C).

[79] Cal. Dep't Health Care Servs., DHCS Transportation Services, https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx (last visited Dec. 16, 2025). FFS beneficiaries can access NMT and NEMT by emailing DHCSNMT@dhcs.ca.gov or going to the DHCS Transportation webpage to learn how to find available NMT and NEMT providers.

[80] All Plan Letter 22-008, *supra* note 74, at 3, 7.

[81] *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*].

[82] Cal. Welf. & Inst Code § 14132(ad)(2)(A)(i); All Plan Letter 22-008, *supra* note 74, at 8.; Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual - Non-Medical Transportation* (2022), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/206EE477-ACE3-447C-BFA2-1864C28E6196/ped_updated_non-medical_transportation_31767.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, NMT Transportation Services*].

[83] All Plan Letter 22-008, *supra* note 74, at 8.

[84] *Id.*

[85] *Id.* at 1.

[86] Cal. Welf. & Inst Code § 14132(ad)(9).

[87] All Plan Letter 22-008, *supra* note 74, at 2.

[88] *Id.* at 8.

[89] *Id.* at 2.

[90] *Id.* at 9.

[91] *See* generally *Id.*

[92] Cal. Welf. & Inst Code § 14132(ad)(2)(B); All Plan Letter 22-008, *supra* note 74, at 9. *See also* NEMT and NMT FAQs, *supra* note 81, at 4.

[93] All Plan Letter 22-008, *supra* note 74, at 9–10.

[94] *Id.* at 9. *See also* NEMT and NMT FAQs, *supra* note 81, at 6.

[95] Cal. Dep't Health Care Servs., DHCS Transportation Services, https://www.dhcs.ca.gov/services/medi-cal/Pages/Transportation.aspx (last visited Dec. 16, 2025). FFS beneficiaries can access NMT and NEMT by emailing DHCSNMT@dhcs.ca.gov or going to the DHCS Transportation webpage to learn how to find available NMT and NEMT providers.

[96] Cal. Code Regs. tit. 22, §, 51323(c)(1).

[97] *Medi-Cal Provider Manual, Medical Transportation Services, supra* note 72.

[98] Cal. Code Regs. tit. 22, § 51323(c)(2).

[99] Cal. Code Regs. tit. 22, § 51311(a).

[100] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Pathology: Billing and Modifiers* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/6111CBD6-6671-41AF-921F-3EB993362756/pathbil.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[101] Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Radiology: Diagnostic* (2025), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/7A39FBAE-FEC6-4C26-974E-DA1147B2B0B5/radidia.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO.

[102] 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 Dec. 16, 2025).

[103] Cal. Code Regs. tit. 22, § 51311(c).

[104] Cal. Code Regs. tit. 22, § 51311(d)(1).

[105] Cal. Code Regs. tit. 22, § 51157(a).

[106] Cal. Code Regs. tit. 22, § 51330(b).

[107] Cal. Code Regs. tit. 22, § 51330(c).

[108] Cal. Welf. & Inst Code § 14132.69(a); Cal. Dep't Health Care Servs., *Medi-Cal Provider Manual, Transplants* 1 (2021), https://mcweb.apps.prd.cammis.medi-cal.ca.gov/assets/8B313A4A-3B84-49DB-B98B-6A51BECCF01C/transplant.pdf?access_token=6UyVkRRfByXTZEWIh8j8QaYylPyP5ULO [hereinafter *Medi-Cal Provider Manual, Transplants*].; Cal. Dep't Health Care Servs, All Plan Letter 21-015 (Rev. Oct. 14, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015.pdf.

[109] *Medi-Cal Provider Manual, Transplants, supra* note 108, at 1.; *See* All Plan Letter 21-015, *supra* note 108, at 4.

[110] *Medi-Cal Provider Manual, Transplants, supra* note 108, at 1.; *See* All Plan Letter 21-015, *supra* note 108, at 4.

[111] *Medi-Cal Provider Manual, Transplants, supra* note 107, at 1.; *See* All Plan Letter 21-015, *supra* note 108, at 4.; Cal. Dep't Health Care Srvcs., All Plan Letter 21-015, Attachment 2 (2023), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-015-Attachment-2-MOT.pdf.; *See also* Cal. Welf. & Inst Code § 14132.71(a) (requiring DHCS to establish standards for facilities that provide transplants).

[112] Cal. Welf. & Inst Code § 14132.70.

Appendix A: Commonly Referenced Laws and Commonly Used Terms

AAP	American Academy of Pediatrics
ABP	Alternative Benefit Plan
ACA	Patient Protection and Affordable Care Act
ACIP	Advisory Committee on Immunization Practices
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
BH-CONNECT	Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment
BHIN	Behavioral Health Information Notice (formerly known as Mental Health and Substance Use Disorder Services (MHSUDS) Information Notice
BHP	County Behavioral Health Plan (also sometimes referred to as Mental Health Plan)
CalAIM	California Advancing and Innovating Medicaid
CalHHS	California Health and Human Services Agency
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
CDPH	California Department of Public Health
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
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
OUD	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

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 (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

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative Website
https://www.dhcs.ca.gov/CalAIM/Pages/BH-CONNECT.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

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)