Programs Overview

Page updated: January 2024

This section explains basic qualifying information about health care services administered to eligible California residents by the Department of Health Care Services (DHCS). Programs that are offered through Medi-Cal are identified in the description. Refer to eligibility sections in the Part 1 manual or policy and billing sections in the appropriate Part 2 manual for additional program information. An asterisk (*) indicates programs that have no correlating Part 1 or Part 2 manual section with additional information.

Adult Day Health Care (ADHC) Centers

State law eliminated Adult Day Health Care (ADHC) as a Medi-Cal benefit effective April 1, 2012. ADHC providers were given the option to transition, as appropriate, to the Community-Based Adult Services (CBAS) program, or other programs that met participants' needs.

For CBAS information, refer to the Part 2 manual *Community-Based Adult Services (CBAS)* sections.

‹‹Medi-Cal Waiver Program

The Department of Health Care Services Office of AIDS (OA) has received a federal waiver of certain Medicaid requirements, enabling the Medi-Cal program to provide home and community-based services to persons with a written diagnosis from his/her attending physician of HIV Disease or AIDS with current symptoms related to HIV Disease, AIDS or HIV Disease/AIDS treatment in lieu of placement in a nursing facility or hospital. The Medi-Cal Waiver Program is approved by the Centers for Medicare & Medicaid Services (CMS) and must continue to be cost effective for the state to receive federal matching funds.

The OA enters into agreements with agencies throughout California to administer the waiver program and provide case management services. These waiver agencies subcontract with or employ (requires prior written authorization by the OA), appropriately licensed providers to render direct care services.››

To participate in the waiver program, a waiver agency must be one of the following:

- A Home and Health Agency licensed and certified by DHCS
- The outpatient department of a hospital licensed and certified by DHCS
- A county health department
- ‹‹A community-based organization that meets certain DHCS OA standards and requirements››

Agencies that have demonstrated organizational, administrative and financial capabilities through the AIDS Case Management Program (CMP) are eligible to become a waiver agency.

Enrollment Procedures

‹‹Providers submit a letter to the OA that includes a request to become a waiver agency, the counties to be served and a statement that becoming a waiver agency will be cost and administratively feasible.››

DHCS Office of AIDS: Address/Telephone Number

Agencies interested in becoming waiver agencies or persons interested in learning more about the waiver program should contact the OA at (916) 449-5900 or write to:

Department of Health Care Services
Office of AIDS
Community-Based Care Section
MS 7700
P.O. Box 997426
Sacramento, CA 95899-7426

Additional information about the waiver program can be found on the Office of AIDS Web site: *www.cdph.ca.gov/programs/aids*. ‹‹For policy information, refer to the Part 2 manual, *Outpatient Services for Medi-Cal Waiver Program.*››

Breast and Cervical Cancer Treatment Program (BCCTP)

The Department of Health Care Services (DHCS) implemented the BCCTP on January 1, 2002. BCCTP provides urgently needed cancer treatment coverage to individuals with breast and/or cervical cancer who require treatment and have met the Centers for Disease Control (CDC) screening criteria, or were screened by a CDC provider.

The BCCTP is the first program in the nation with the capability to grant same day, temporary, full-scope Medicaid (accelerated eligibility [AE]) from the doctor's office through an Internet-based application for those women who appear, by the information on the application, to meet the federal eligibility requirements. Applicants receiving AE then undergo a final eligibility determination completed by an eligibility specialist (ES).

Those applicants who do not qualify for AE must have their BCCTP eligibility determined by an Eligibility Specialist (ES) before eligibility can be established in the Medi-Cal Eligibility Data System (MEDS).

California Alternative Assistance Program (CAAP)*

The Medi-Cal program includes Aid to Families With Dependent Children (AFDC) recipients under the California Alternative Assistance Program (CAAP), effective May 1, 1994. CAAP-AFDC recipients are identified by aid codes 3A (Family Group) and 3C (Unemployed Parent Group).

CAAP-AFDC recipients receive Medi-Cal and child care assistance instead of a federal cash grant. The CAAP-AFDC program provides full-scope Medi-Cal coverage with no Share of Cost until the recipients' county changes the status or removes them from the Medi-Cal Eligibility Data System (MEDS).

California Children's Services (CCS)

The California Children's Services (CCS) Program provides diagnostic, treatment, physical and occupational therapy services and case management to children under 21 years of age with CCS eligible medical conditions. The CCS Program is administered as a partnership between county health departments, known as CCS counties, and DHCS. In 2018, DHCS established the Whole Child Model (WCM) Program in designated County Organized Health System (COHS) or Regional Health Authority counties to incorporate CCS covered services for Medi-Cal eligible CCS children and youth into a Medi-Cal Managed Care Plan (MCP) contract.

Community-Based Adult Services Program (CBAS)

Community-Based Adult Services (CBAS) centers offer a package of health, therapeutic and social services in a community-based day health care program. Services are provided according to a six-month plan of care developed by the CBAS center's multidisciplinary team. The services are designed to prevent premature and unnecessary institutionalization and to keep participants as independent as possible in the community.

Comprehensive Perinatal Services Program (CPSP)

The Comprehensive Perinatal Services Program (CPSP) is within the scope of the benefits of the Medi-Cal program. Participation by Medi-Cal recipients is voluntary.

In addition to the "traditional" maternity services, CPSP allows qualified providers to be reimbursed for nutrition, psychosocial and health education services, and related case coordination. Reimbursement is also provided for prenatal vitamin and mineral supplements. Hospital outpatient departments, community clinics, county clinics, individual physicians, physician groups and certified nurse midwives are eligible to provide these services. Providers must have a current provider number and complete an application to participate as a CPSP provider.

Diabetes Prevention Program

State law requires DHCS to establish the Diabetes Prevention Program (DPP) as a Medi-Cal covered benefit. Medi-Cal's DPP benefit will be consistent with the federal Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program, a public-private partnership to offer evidence-based, low-cost interventions in communities across the nation to prevent type 2 diabetes. Using CDC-approved lifestyle change curriculum, DPP organizations help individuals learn healthy practices and self-monitoring techniques that reduce their risk of developing diabetes.

Drug Use Review (DUR)

Federal law requires that, effective January 1, 1993, California pharmacies participating in the Medi-Cal program must provide prospective Drug Use Review (prospective DUR). The Federal Department of Health and Human Services (DHHS) has issued guidelines to assist pharmacies in implementing the prospective DUR process.

Emergency Assistance (EA) Program

Emergency Assistance (EA) is a federally funded program under Title IV-A of the Social Security Act. It provides services to families in emergency situations. EA services are available to eligible families for up to six months or until the emergency is over, whichever is less. The EA program allows for 50 percent federal financial participation for probation and child welfare services.

Every Woman Counts

Every Woman Counts provides selected benefits to uninsured and underinsured women whose household income is at or below 200 percent of the Federal poverty level. The goal of the program is to reduce breast and cervical cancer mortality rates in this population of California women. In addition to offering screening and diagnostic services, Every Woman Counts is designed to facilitate annual rescreening of women with normal or benign breast and/or cervical conditions and to provide follow-up services for women with possible diagnoses of breast and/or cervical cancer, including referral for treatment when necessary. Only specified providers are able to offer cervical services at this time.

Family PACT

The Family PACT (Planning, Access, Care and Treatment) program is under joint administration of the Office of Family Planning (OFP) and Medi-Cal. The OFP is responsible for program policy, program monitoring, quality improvement and evaluation. The California MMIS Fiscal Intermediary is responsible for client and provider enrollment, claims processing and providing public response regarding these issues.

One of the goals of the Family PACT program is to expand access to family planning services. Expanded access is achieved through the expansion of the provider community. Under Family PACT, any Medi-Cal provider who elects to provide the full scope of comprehensive family planning services consistent with Family PACT standards of care can enroll and be reimbursed at Medi-Cal rates.

Under this model program, all women and men in California with incomes at or below 200 percent of the federal poverty level with no other source of family planning health care coverage have access to comprehensive family planning services, including contraception, pregnancy testing, female and male sterilization, limited infertility services, reproductive health counseling and education related to contraceptive methods, as well as screening for sexually transmitted infections and breast and cervical cancer.

Note: Pregnancy care other than the diagnosis of pregnancy is not funded under the Family PACT program. Abortions and services ancillary to abortions are not funded under Family PACT.

Genetically Handicapped Persons Program (GHPP)

The Genetically Handicapped Persons Program (GHPP) is a health care program for adults, 21 years of age and older, with specific genetic diseases including, but not limited to:

- Hemophilia
- Cystic Fibrosis
- Hemoglobinopathies, including sickle cell disease, thalassemia
- Huntington's Disease, Joseph's Disease, Friedreich's Ataxia
- Metabolic diseases (PKU, Wilson's Disease, galactosemia)
- Von Hippel-Lindau syndrome

GHPP provides complete medical services, social support services, nutrition products and medical food, Durable Medical Equipment (DME), medical supplies, home health services, mental health services and psychotherapy counseling. All GHPP authorizations are adjudicated by DHCS GHPP staff.

Heroin Detoxification

All heroin detoxification services must be performed by or under the supervision and orders of a licensed physician. Ancillary personnel actually preparing and administering medications must be acting within the limits of their licenses or certificates.

For policy information, refer to the Part 2 manual, *Outpatient Services for Heroin Detoxification*.

Home and Community-Based Services (HCBS)

Home and Community-Based Services (HCBS) are designed to provide safe and appropriate home and community care to recipients who would otherwise require long term placement.

The Department of Health Care Services (DHCS), Long-Term Care Division, In-Home Operations (IHO) Branch administers two 1915 (c) HCBS waivers: the In-Home Operations (IHO) Waiver and the Nursing Facility/Acute Hospital (NF/AH) Waiver.

To be eligible to receive waiver services, an individual must meet Medi-Cal financial eligibility requirements. The appropriate county welfare department is responsible for making this Medi-Cal eligibility determination. All services must be cost-neutral to the Medi-Cal program. The total cost of providing waiver services and all other medically necessary State Plan services must be less than the total cost incurred for providing care to the recipient at the otherwise appropriate nursing facility. A recipient may be enrolled in only one 1915 (c) waiver at a time. If a recipient is eligible for services from two waivers, the recipient may choose the waiver that is best suited to their needs.

Services offered under these waivers include, but are not limited to, private duty nursing case management and waiver personal care services.

For policy information, refer to the Part 2 manual, Outpatient Services for *HHA and HCBS (Home Health Agencies and Home and Community-Based Services).*

Home Health Agencies

Home Health services are reimbursable as an outpatient benefit when prescribed by a physician and provided at the patient's home in accordance with a written treatment plan reviewed by a physician every 60 days.

For policy information, refer to the Part 2 manual, HHA and HCBS *(Home Health Agencies and Home and Community-Based Services).*

Hospice Care

Hospice care is medical multidisciplinary care designed to meet the unique needs of terminally ill individuals. Any Medi-Cal eligible recipient certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Election of hospice care occurs when the patient (or representative) voluntarily files an election statement with the hospice provider. This statement acknowledges that the patient understands that the hospice care relating to the illness is intended to alleviate pain and suffering rather than to cure, and that certain Medi-Cal benefits are waived by this election.

Note: Any Medi-Cal eligible recipient younger than 21 years of age and certified by a physician as having a life expectancy of six months or less may elect to receive hospice care and curative treatment associated with the hospice-related diagnosis in addition to all other medically necessary Medi-Cal benefits to which the recipient is entitled.

For policy information, refer to the Part 2 manual, *Outpatient Services for Hospice Care Program*.

Indian Health Services Memorandum of Agreement (IHS-MOA)

On April 21, 1998, the Department of Health Care Services (DHCS) implemented the Indian Health Services Memorandum of Agreement (IHS-MOA) between the federal IHS and the Centers for Medicare & Medicaid Services (CMS). The IHS-MOA changed the reimbursement policy for services provided to Medi-Cal recipients within American Indian or Alaskan native health care facilities identified as federal "638" facilities. Providers electing to participate under the IHS-MOA must enroll with the Provider Enrollment Division (PED) via the Provider Application and Validation for Enrollment (PAVE) portal on the DHCS website *(www.dhcs.ca.gov)*. Providers are asked to upload a completed copy of the *'Elect to Participate' IHS/MOA Application* (DHCS 7108), which can be retrieved from the "Forms" page of the Medi-Cal website *(www.medi-cal.ca.gov)*. Refer to the *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics* section in the appropriate Part 2 manual for the complete list of services provided.

In-Home Medical Care (IHMC) Waiver Program

The In-Home Medical Care (IHMC) Waiver program serves Medi-Cal recipients who, in the absence of waiver services, would otherwise require acute hospital care for at least 90 consecutive days.

In-Home Operations Waiver

The In-Home Operations (IHO) Waiver serves either 1) participants who have continuously been enrolled in a DHCS In-Home Operations administered Home and Community-Based (HCBS) waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse; or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Nursing Facility/Acute Hospital (NF/AH) Waiver for the participant's assessed level of care.

Local Educational Agency (LEA)

The Local Educational Agency (LEA) Medi-Cal Billing Option Program offers health assessment and treatment for Medi-Cal-eligible children and Medi-Cal-eligible family members within the school environment. Local Educational Agencies (LEAs), as defined under *California Education Code*, Section 33509(e), may apply to participate in this program.

LEA benefits include Targeted Case Management (TCM) services that assist eligible students and eligible family members to access needed medical, social, educational and other services.

For policy information, refer to the *Local Educational Agency* (LEA) sections in the appropriate Part 2 Medi-Cal manual.

Medi-Cal Dental

The fee-for-service dental portion of the Medi-Cal program is known as Medi-Cal Dental. The Medi-Cal Dental program has been administered by Delta Dental since 1974. Medi-Cal recipients are eligible for dental services rendered under the Medi-Cal Dental program. Providers should refer to the *Medi-Cal Dental Provider Handbook* for limitations or restrictions.

Minor Consent Program

The Minor Consent Program offers eligible minors the opportunity to receive confidential care for specific services. *California Code of Regulations*, Title 22, Section 51473.2, states that providers may render services to minors without parental consent only if the services are related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse treatment and counseling, and outpatient mental health treatment and counseling. If a public agency has legal responsibility for a minor, the minor is not eligible for Minor Consent Program services. The minor must apply for the regular Medi-Cal program.

Multipurpose Senior Services Program (MSSP)

The California Department of Aging (CDA), Medi-Cal Services Branch, has received a waiver of certain Medi-Cal state plan requirements, enabling the Medi-Cal program to offer home and community-based services to enable frail, elderly clients to remain at home as an alternative to institutionalized care. The MSSP waiver program allows agencies (MSSP providers) that contract with the Department of Health Care Services (DHCS) to provide comprehensive social and health case management.

For policy information, refer to the Part 2 manual, *Outpatient Services for Multipurpose Senior Services Program*.

Nursing Facility/Acute Hospital (NF/AH) Waiver Program

The NF/AH Waiver provides services in the home to Medi-Cal recipients who would otherwise receive care in an intermediate care facility, a skilled nursing facility, a subacute nursing facility, or an acute care hospital. Services include private duty nursing, case management, waiver personal care services and other home and community-based services.

OBRA and IRCA

‹‹Restricted or full-scope Medi-Cal benefits are extended to previously ineligible non-citizens, effective on or after October 1, 1988. This program was mandated by the *Federal Omnibus Budget Reconciliation Act of 1986* (OBRA) and *the Immigration Reform and Control Act of 1986* (IRCA). IRCA created a legalization program under which the status of certain non-citizens unlawfully residing in the United States may be adjusted over time to permanent resident status. In granting these non-citizens amnesty, the law specifies that their participation in certain assistance programs be restricted to five years. OBRA applies to other non-citizens such as those who are undocumented and temporary visitors.››

Prenatal Care Guidance Program

The Prenatal Care Guidance (PCG) program is integrated into the existing Maternal and Child Health (MCH) programs in local health departments. The PCG seeks to educate Medi-Cal-eligible women about the importance of prenatal care as well as assist them in obtaining and continuing prenatal care.

Welfare departments are responsible for informing all mothers who apply for and are currently eligible for welfare that publicly funded medical care is available for their children. The integration of MCH and PCG activities will avoid duplicate effort and cost because information about prenatal and well-baby care is usually given to the same people.

Individual PCG programs have been developed at the county level and therefore differ among counties. For further information, contact the local MCH program through the local county health department.

Presumptive Eligibility for Pregnant Women

The Presumptive Eligibility for Pregnant Women (PE4PW) program allows Qualified Providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for conditions related to pregnancy to low-income, pregnant patients, pending their formal Medi-Cal application. The PE program is designed for California residents who believe they are pregnant and who do not have Medi-Cal coverage for prenatal care.

Rehabilitation Clinics

Physical therapy, occupational therapy, speech pathology and audiology evaluations and services are performed in outpatient rehabilitation clinics.

For policy information, refer to the Part 2 manual, *Outpatient Services for Rehabilitation Clinics*.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) provide ambulatory health care services to recipients in rural and non-rural areas.

Rural Health Clinics (RHCs) extend Medicare and Medi-Cal benefits to cover health care services provided by clinics operating in rural areas. Specifically trained primary care practitioners administer the health care services needed by the community when access to traditional physician care is difficult.

Federally Qualified Health Centers (FQHCs) were added as a Medi-Cal provider type in response to the Federal Omnibus Budget Reconciliation Act (OBRA) of 1989. Federal law generally defines FQHC services the same as those offered by Rural Health Clinics.

Rural Hospital Swing Bed Program

The rural hospital swing bed program offers long term care services in areas where there is a shortage of Nursing Facility Level B (NF-B) beds. To be eligible for the rural hospital swing bed program, hospitals must:

- Meet the standards for hospitals specified in *California Code of Regulations*, Title 22, Section 51207.
- Be certified as a special hospital provider of long term care services under Title XVIII of the federal Social Security Act.
- Be approved by DHCS as a primary health services hospital in accordance with Division 2, Article 10, of the *Health and Safety Code* commencing with Section 1339.

Under the program, rural hospitals may designate some beds for use interchangeably as acute beds or nursing facility beds.

Specialty Mental Health Services

The State Department of Mental Health (DMH) implemented the Specialty Mental Health Services Consolidation Program for Medi-Cal recipients currently receiving or in need of outpatient or medical professional mental health services. This program expands the Psychiatric Inpatient Hospital Services Consolidation Program that has been in existence since January 1995.

Under the consolidation program, coverage for specialty mental health services will be provided through Mental Health Plans (MHPs) in California's 58 counties. In most cases, the MHP will be the county mental health department. MHPs render, or authorize and pay for specialty mental health services.

Subacute Care Programs

Adult and pediatric subacute level of care refers to very intensive, licensed, skilled nursing care provided in Distinct-Part/Nursing Facilities Level B (DP/NF-B) in acute care hospitals, or in Free-Standing Nursing Facilities Level B (FS/NF-B) to patients who have a fragile medical condition. Beds designated for either adult or pediatric subacute care cannot be used for swing beds.

Tribal Federally Qualified Health Centers (Tribal FQHCs)

Tribal FQHCs provide covered primary care clinic services to Medi-Cal patients. Tribal FQHC services may be provided in the clinic or offsite by tribal providers and non-tribal providers who are contractors of the Tribal FQHC.

Tribal FQHCs were added as a provider type per Section 1905(l)(2)(B) of the Social Security Act, which denotes that outpatient health care programs operated by a tribe or tribal organization under the Indian Self-Determination and Education Assistant Act (ISDEAA), Public Law 93-638, are eligible to enroll as a Tribal FQHC in Medi-Cal.

Tuberculosis Program

The Medi-Cal Tuberculosis (TB) Program is funded under Title XIX of the Social Security Act to treat individuals who have been infected with TB. This program covers outpatient TB related services for people who are TB-infected and eligible under aid code 7H. Recipients with aid code 7H will receive TB-related services at a zero Share of Cost.

Vaccines For Children (VFC)

The federal Vaccines For Children (VFC) program supplies vaccines free-of-charge to enrolled physicians for Medi-Cal-eligible children. Every Medi-Cal-eligible child younger than 19 years of age may receive vaccines supplied by the VFC program. ‹‹To participate, providers must enroll in VFC even if already enrolled with Medi-Cal.››

Special Group Information

Eligibility information for individuals identified as members of special groups is found in the eligibility sections of the Part 1 manual.

Managed Care Information

Eligibility information about Managed Care Plans (MCPs) is found in the managed care sections of the Part 1 manual.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	This program has no correlating Part 1 or Part 2 manual section.