



California's Protection & Advocacy System  
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# Using Your Medi-Cal Share of Cost If You Are a Nursing Facility Resident

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*April 2017, Pub. #5597.01*

## OVERVIEW

If the Medi-Cal program is paying for your nursing facility care and if you also have income – such as from Social Security benefits – you will have a Medi-Cal share of cost equal to all of your income above \$35 a month. “Nursing facility” includes a subacute facility and a hospital “distinct part unit” with step-down beds. Thus if your Social Security benefits were \$835 a month, your share of cost would be \$800 a month. A share of cost is the monthly amount Medi-Cal requires you to pay (or incur an obligation to pay) for medical and remedial goods and services before Medi-Cal begins to pay. Most people use their share of cost to pay for nursing facility care. However, under State and [Federal](#)<sup>1</sup> law, you can use your share of cost to pay for other services and equipment you need. To use your share you must ensure the use is supported by your plan of care or a doctor’s prescription. The amount the facility receives from Medi-Cal for your care will remain the same. This is because Medi-Cal will increase the amount it pays the facility by the amount of your share of cost used to pay for other services and equipment.

Because you are a nursing facility resident, federal law – The Nursing Home Reform Act - says that you are entitled to services that maximize your mental, physical and psycho-social [wellbeing](#).<sup>2</sup> You can use your share of cost – i.e., the \$800 in the example above - to supplement the services you receive in the nursing facility when necessary to maximize your mental, physical and psycho-social wellbeing because that is the medical necessity standard that applies when you are in a nursing facility. The settlement in an old case – *Johnson v. Rank*<sup>3</sup> - established that nursing facility residents may meet their share of cost by paying for

“medically necessary medical or remedial care, supplies or equipment not paid for by the Medi-Cal program and which are consistent with the plan of care ordered by the [physician.](#)”<sup>4</sup> As explained below, all you need to do is have the supplemental service or equipment written into your plan of care or prescribed by your doctor.

### **What can my share of cost pay for?**

Here are some examples:

- Help in returning [home.](#)<sup>5</sup> for instance, using your share of cost to pay a home health agency or occupational therapist to do a home assessment to identify what changes and equipment are needed so that you may live safely in your [home.](#)<sup>6</sup> Some of the things you may need to live safely in your home include a stairway [chairlift](#)<sup>7</sup> so you can get into your home or up and down your internal stairs; A ceiling track Hoyer lift so that it is easier to get from your bed to your bathroom and back. Paying for a lift to get you in and out of your bathtub. Paying for a case manager to help you return to the community. If you do not have a home to return to, the case manager could help you find a place to live.
- Getting an assessment from a specialist: Your share of cost can pay for the transportation from the nursing facility to the specialist and back and can pay for the specialist. The assessment could be by a program – like an outpatient clinic at an acute rehabilitation hospital – that can evaluate your rehabilitation potential such as whether with treatment and therapy you might be able to walk with a walker.
- If you cannot talk or your speech is difficult to understand because of a disability, you can use your share of cost to pay for an assessment from a speech pathologist with experience and expertise about communication devices. The assessment would be to determine if you would benefit from having a communication device (ACD) or a speech generating device (SGD) such as that used by Stephen Hawking. And you can use your share of cost to pay for the device, for the training on how to use it and for updates as your needs change and technology improves.
- When the wheelchairs available through the nursing facility do not meet your needs because you need and can operate a power chair or you need custom features (like a specialized seating system and/or tilt-in-space features to prevent bedsores, deep vein thrombosis,

facilitate communication), you can use your share of cost to pay for an assessment to determine what you need and for the wheelchair itself.

- Individual counseling services from a psychiatrist or psychologist or therapist if you are feeling very sad or depressed.
- Physical and/or occupational therapy and/or speech therapy beyond what would be available through the nursing facility. You can use your share of cost to pay for therapy services provided at a hospital or rehabilitation hospital outpatient clinic. Our experience is that such outpatient clinics provide intensive therapy designed to improve function as quickly as possible. Your share of cost can pay for the cost of transportation to and from the clinic. Extra therapy may help you regain or improve your speech, your ability to get around, your ability to care for yourself – such as dressing yourself, feeding yourself, using the bathroom on your own, transferring from a wheelchair to a bed or chair and back.
- Behavioral assessment to evaluate problem behaviors and the development of a plan to reduce the problem behaviors; training of nursing facility staff and other services to implement a behavior plan.

**What if the doctor that comes in to see me and other nursing facility residents does not support my using my share of cost to get needed extra equipment and services?**

Try to educate your doctor about your *Johnson v. Rank* and Nursing Home Reform Act rights by showing him or her this publication and its attachments. Ask a friend or a family member if available to support you in a meeting to amend your plan of care to include the services and equipment you need. You can also ask the Ombudsman Program for help. Information about the program should be posted in the nursing facility. Or call [1-800-510-2020](tel:1-800-510-2020).<sup>8</sup>

If education or asking for a meeting to change your plan of care does not work, use your share of cost to pay a doctor that will support you such as the doctor who cared for you before you went into the nursing facility. You have a right to choose your own doctor. You have a right not to use the doctor the nursing facility arranged to treat the other nursing facility residents.

**What if I am in a county where the managed care plan pays for the nursing facility care and the doctor assigned does not support me?**

If you are in a county where the managed care plan pays for the nursing facility care and you do not also have Medicare, you can tell the managed care plan you want another doctor assigned to you. Or you can use your share of cost to pay for a second opinion. You may have to file a grievance and request a fair hearing. It will be more difficult for you but it is important to remember that as a nursing facility resident you have the right to services and equipment you need to maximize your mental, physical and psycho-social wellbeing.

If you also have Medicare, the next question is whether or not you assigned your Medicare to the same Medi-Cal managed care plan. If no, then you can use the share of cost to pay the doctor's copay to visit you in the nursing facility. If yes, then you are in the situation explained in the prior paragraph.

**When I use my share of cost, am I able to pay more than what Medi-Cal would pay?**

Yes. You can pay more than what Medi-Cal would pay. You can pay up to the market or regular rates. Look to what private health plans pay providers. For instance, you can use your share of cost to supplement the part Medicare pays your doctor up to his or her regular full Medicare rate.

**What is the procedure for using your share of cost for something other than nursing facility care?**

The procedures laid out in the Department of Health Care Services (DHCS) All-County Welfare Director's Letter No. 89-54 (accessible excerpt at the end of this publication, and available here:

<http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c89-54.pdf>)

give the nursing facility responsibility for seeing that bills and payments are counted against the share of [cost](#).<sup>9</sup> Also attached is an excerpt from the Long-Term Care section of the Medi-Cal provider Manual explaining to facilities the general and *Johnson v. Rank* share of cost procedures.

The resident or resident's family member gives the bills or receipts to the nursing facility along with the physician's order if not already in the file or if not already made a part of the plan of care. If the bills or receipts are given to the nursing facility before or at the time the nursing facility share of cost is paid, the amount of the share of cost will be reduced by the amount of

the bills or receipts. If the bills or receipts are given to the nursing facility after the share of cost is paid, the bills or receipts will be held to the next month.

**What if the bills or receipts are for more than that month's share of cost?**

The amount by which the bills or receipts exceed this month's share of cost will be carried over to the next month.

**How long do I have to deduct bills or receipts from the share of cost I would otherwise pay to the nursing facility?**

The two-month limitation in the *Johnson v. Rank* All-County Welfare Directors Letter no longer applies. This is because the court injunction in *Hunt v. Kizer*, which was implemented by DHCS All-County Welfare Directors Letter No. 90-11 (January 19, 1990), requires "that the Department of Health Services no longer impose any time limitation on medical expenses which Medi-Cal applicants or beneficiaries may use to meet their share of [cost.](#)"<sup>10</sup> There is no time limitation in the *Johnson v. Rank* Provider Manual instructions attached. We advise, however, that any bills or receipts for care, supplies or equipment be submitted promptly for credit.

**Will I be able to use my share of cost to help me go out into the community?**

Yes provided going out into the community is written into your plan of care but only with respect to medical or remedial care, supplies or equipment to help you do that. For instance, your plan of care may say that you will attend the monthly Audubon Society meetings to maintain your community connections and for your psycho-social wellbeing. If you need someone to go with you to provide personal care services while you travel there on paratransit and while at the meeting, you could use your share of cost to pay an attendant. If you need a portable oxygen system and one is not available through the nursing facility or what is available will not last long enough, you could pay for that – such as via a rental - out of your share of cost. Ask your doctor to write a specific order for the attendant and if necessary the rental of a portable oxygen tank or concentrator.

**Will I be able to use my share of cost to buy a power wheelchair to get to a church three blocks away? I would like to visit the church for services and for its bingo games and other senior and disabled**

**programs but I can't get there without a power wheelchair. A power wheelchair would also help me get around the facility because my manual chair is now too hard for me to use.**

Probably yes provided that your doctor writes independent community and facility mobility into your plan of care and first orders an assessment and transportation to get to the assessment and then writes an order for the wheelchair prescribed by the assessment. As a first step you would need to use your share of cost to pay for an assessment including the transportation. The assessment would look to see if you could get around in the community and the facility with the right manual wheelchair and if not, whether you are able to safely use a power chair and if so, what kind of wheelchair and features would meet your needs.

**Will I be able to use my share of cost to help me spend the day at my family's holiday gathering?**

Yes, but only with respect to medical or remedial care, supplies or equipment to help you do that. For instance, if you may need suctioning while at the gathering or traveling to and from a gathering, you can use your share of cost to pay an LVN to go with you and to pay for equipment rental and supplies that you are not able to borrow from the nursing facility. Medi-Cal regulations authorize up to 18 overnight visits and 12 more with your doctor's [approval](#).<sup>11</sup> You can also ask that your plan of care include training for family members or others who will be with you in the community or at gatherings.

**If I do not have a share of cost, am I out of luck in terms of getting supplemental services?**

No, but it is harder to get the services. A treatment authorization request or TAR can be submitted by a provider to Medi-Cal to get approval for the supplemental services or equipment you need. With the TAR must be a detailed explanation about why you need the services to maximize your mental, physical or psycho-social wellbeing as well as why the services you need are not available within the nursing facility's per diem rate. With the TAR justification should be a copy of the plan of care including the requested service, equipment or supplies. The Fee-for-Service Medi-Cal TAR or managed care service authorization request should have "[Valdivia](#)"<sup>12</sup> written on it so that it alerts the Medi-Cal field office or the managed care plan that the Nursing Home Reform Act nursing facility medical necessity standards apply. If the nursing facility services are paid by Medi-Cal through a managed care plan, then it would be the managed

care plan that would be the entity to approve the service authorization request.

**Where can I get more information or assistance if I need help?**

**Disability Rights California [www.disabilityrightsca.org](http://www.disabilityrightsca.org) –  
1-800-776-5746**

**Disability Rights California is funded by a variety of sources, for a complete list of funders, go to <http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html>.**

**Jackson v. Rank Accessible Excerpt**

To: All County Welfare Directors  
July 24, 1989  
All County Administrative Officers  
Letter No: 89-54

**SUBJECT: JOHNSON V. RANK FINAL SETTLEMENT**

This is to provide you with information concerning the final settlement in the Johnson V. Rank lawsuit. Counties do not need to take any new actions pursuant to this case.

As a result of the final settlement in the Johnson V. Rank lawsuit, effective October 1, 1989 all Medi-Cal beneficiaries in long-term care (LTC) facilities must obtain a physician's prescription or order for any non-covered medical or remedial drug or service the cost of which is to be applied towards his/her share of cost.

Under the Johnson V. Rank judgement by consent, Medi-Cal beneficiaries must have the opportunity to use their shares of cost to purchase medically necessary or medical or remedial care, supplies and/or equipment not paid for by the Medi-Cal program and which are consistent with the plan of care ordered by their physician. This judgement has now been further clarified to specify that a physician's prescription or order (or its copy) is necessary and must be in the beneficiary's medical records at the facility in order for a beneficiary to apply the cost of a non-covered drug or service against his/her share of cost.

A Medi-Cal Provider Bulletin (enclosure A) outlining the above provision is being sent to all Medi-Cal providers. Additionally, a stuffer (enclosure B) is being sent to all Medi-Cal beneficiaries currently in long-term care.

All other procedures for processing Medi-Cal applications and claims for beneficiaries affected by the Johnson v. Rank court order remain the same as those previously issued in All County Welfare Directors Letters (ACWDL). Consistent with the provisions described in ACWDL 85-28, counties will issue the revised ID 104 (enclosure C) information notice to each new LTC/SOC beneficiary. Please reproduce this revised form until it is available from the DHS warehouse. Additionally, at the time of application, counties are required to fully explain this process to all new LTC beneficiaries, or the person acting on their behalf. The information notice should also be forwarded to LTC beneficiaries as part of the annual redetermination process.

Thank you for your continued assistance and support in complying with the terms and conditions of the Johnson v. Rank judgement. If you need additional information, contact Sandy Poindexter at (916) 324-4953.

Sincerely,

Original signed by  
Frank S. Martucci, Chief  
Medi-Cal Eligibility Branch

Enclosures

Cc: Medi-Cal Liasons  
Medi-Cal Program Consultants  
Expiration Date: July 24, 1990

#### PROVIDER BULLETIN

As a result of the final settlement in the Johnson v. Rank lawsuit, effective October 1, 1989 all Medi-Cal beneficiaries in long-term care (LTC) facilities must obtain a physician's prescription or order for any non-covered medical or remedial drug or service the cost of which is to be applied towards his/her share of cost.

Under the Johnson v. Rank judgement by consent, Medi-Cal beneficiaries must have the opportunity to use their shares of cost to purchase medically necessary medical or remedial care, supplies and/or equipment not paid for by the Medi-Cal program and which are consistent with the plan of care



ordered by their physician. This judgement has now been further clarified to specify that a current physician's prescription or order (or its copy) is necessary and must be in the beneficiary's medical records at the facility in order for a beneficiary to apply the cost of a non-covered drug or service against his/her share of cost.

Long-term care facilities have the obligation to ensure that this prescription order (or its copy) is in the beneficiary's medical record. All records are subject to audit by the Department of Health Services (DHS) to verify: 1- that the prescription or order is on file: 2- that the services used to meet the share of cost are not included in the Medi-Cal per diem rate paid to the LTC facilities and 3- the accuracy of the facility's accounting procedures.

Beneficiaries will be contacting either the business office or the Patient Coordinator if they have questions – If you are unable to answer these questions, please contact Provider Relations at (916) 323-1945.

**IF YOU ARE A BENEFICIARY IN LONG-TERM CARE (LTC), READ THIS IMPORTANT NOTICE.**

#### **MEDI-CAL STUFFER**

Under a lawsuit entitled Johnson V. Rank you are allowed to deduct the cost of necessary medical or remedial drugs or services not covered by Medi-Cal from your share of cost. This lawsuit has just been finalized. The rules for using the cost of medical or remedial drugs or serviced not paid for by Medi-Cal to meet your share of cost has changed. Beginning the first of October 1989 all Medi-Cal persons in long-term care facilities must have a current physician's prescription or order for any medical or remedial drug or service that is to be used to meet the share of cost.

This physician's prescription or order (or its copy) must be kept on file in your medical record at the nursing home. Without this prescription or order the drugs or services will not be allowed as a deduction from your share of cost. If you or your relatives purchase any non-covered drugs or services you must submit a prescription (or its copy) from your physician for the drug or service to the facility along with your bill or be certain that the facility's records contain a written order by your physician for the drug or service. If you deduct expenses for non-covered drugs or services from your share of cost and the nursing home finds that there is no valid prescription or order (or its copy), they will require you to pay an additional amount toward your share of cost.

Any questions concerning this change should be directed to the patient coordinator at the nursing home or to your county welfare department eligibility worker.

DEPARTMENT OF HEALTH SERVICES  
IMPORTANT NOTICE ABOUT YOUR MEDI-CAL BENEFITS

THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES MUST ALLOW MEDI-CAL BENEFICIARIES WHO HAVE A SHARE OF COST AND ARE IN A NURSING HOME TO USE THEIR SHARE OF COST TO PAY FOR NECESSARY MEDICAL OR REMEDIAL DRUGS, SERVICES, AND OTHER ITEMS WHICH ARE NOT PAID BY MEDI-CAL. HOWEVER, A DOCTOR'S PRESCRIPTION OR ORDER IS REQUIRED TO INDICATE THE ITEM IS NECESSARY.

IF YOU OR YOUR RELATIVES HAVE TO PAY FOR ANY NECESSARY MEDICAL SERVICES, SUPPLIES, OR DRUGS, YOU SHOULD BE SURE TO SUBMIT THE BILLS OR RECEIPTS TO THE NURSING HOME NO LATER THAN TWO MONTHS AFTER YOU RECEIVE THE SERVICE, SUPPLIES, OR DRUGS.

YOU HAVE THE FOLLOWING CHOICES IN SUBMITTING YOUR BILLS/RECEIPTS TO THE NURSING HOME FOR PAYMENT.

1. IF YOU PRESENT YOUR BILLS/RECIPTS TO THE NURSING HOME AT THE BEGINNING OF THE MONTH, WHEN YOU NORMALLY PAY YOUR SHARE OF COST, YOU MAY DEDUCT THE COST OF THE DRUGS/SERVICES/REMEDIAL ITEMS FROM YOUR CURRENT MONTH'S SHARE OF COST BEFORE PAYING THE REMAINING SHARE OF COST TO THE NURSING HOME.
2. IF YOU RECEIVE A BILL/RECEIPT AFTER THE DATE YOU PAY YOUR SHARE OF COST, YOU MAY HOLD THE BILL/RECIPT UNTIL THE FOLLOWING MONTH, AND THEN DEDUCT IT FROM YOUR SHARE OF COST. YOU MUST SUBMIT THE BILLS AND RECEIPTS NO LATER THAT TWO MONTHS AFTER YOU RECEIVE THE SERVICES, SUPPLIES OR DRUGS.

EXAMPLES:

- IF YOU HAD A \$200 SHARE OF COST IN APRIL, AND YOU SPENT \$50 FOR DRUGS, SERVICES, OR REMEDIAL ITEMS IN MARCH,

YOU MAY PAY THE NURSING HOME \$150 FOR YOUR APRIL SHARE OF COST ( $\$200 - \%50 = 150$ ). YOU MUST SUBMIT THE BILLS/RECEIPTS TO THE NURSING HOME AT THE SAME TIME YOU NORMALLY PAY YOUR SHARE OF COST

- IF YOU HAD A \$200 SHARE OF COST IN MAY, AND YOU PAID \$75 FOR DRUGS, SERVICES, OR REMEDIAL ITEMS IN APRIL BUT DID NOT RECEIVE YOUR BILL/RECEIPT UNTIL AFTER YOU PAID YOUR MAY SHARE OF COST, THEN YOU MAY PAY THE NURSING HOME \$125 ( $\$200 - \$75 = \$125$ ) FOR YOUR JUNE SHARE OF COST. YOU MUST SUBMIT THE BILL/RECEIPT TO JUSTIFY THE DEDUCTION OF THE \$75.

NOTE: YOU CANNOT DEDUCT THE APRIL EXPENSES AFTER JUNE.

DRUGS AND SERVICES, THE COST OF WHICH HAVE BEEN DEDUCTED FROM YOUR SHARE OF COST MUST HAVE BEEN PRESCRIBED OR ORDERED BY A DOCTOR. THE NURSING HOME MUST VERIFY THAT THIS REQUIREMENT IS MET BEFORE YOU CAN DEDUCT BILLS/RECEIPTS FROM YOUR SHARE OF COST. IF YOU OR YOUR RELATIVES HAVE TO PAY FOR ANY NECESSARY DRUGS OR SERVICES YOU MUST SUBMIT A PRESCRIPTION OR ORDER (OR A COPY) FROM YOUR DOCTOR TO THE NURSING HOME ALONG WITH YOUR BILL. YOU DO NOT NEED TO SUBMIT THE DOCTOR'S ORDER IF YOU ARE SURE THAT THE NURSING HOME'S RECORDS CONTAIN A WRITTEN ORDER BY YOUR DOCTOR FOR THE DRUG OR SERVICE. IF YOU DEDUCT EXPENSES FOR DRUGS OR SERVICES FROM YOUR SHARE OF COST AND THEN THE NURSING HOME DETERMINES THAT THE SERVICES WERE NOT PRESCRIBED OR ORDERED BY YOUR DOCTOR, THE NURSING HOME WILL REQUIRE YOU TO PAY AN ADDITIONAL AMOUNT TOWARD YOUR SHARE OF COST.

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<https://docs.google.com/forms/d/1d6ezTI2M5UMAWU66exLbc1SQ9wDPzvtuS3AGR4-cgwE/viewform?c=0&w=1>

For legal assistance call 800-776-5746 or complete a [request for assistance form](#). For all other purposes call 916-504-5800 (Northern CA); 213-213-8000 (Southern CA).

*Disability Rights California is funded by a variety of sources, for a complete list of funders, go to <http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html>.*

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<sup>1</sup> Federal regulations at 42 C.F.R. § 435.831(e) sets out the order of priority for using a share of cost for persons in the community and in a medical facility: First, any health benefit premium; second, any medical or remedial goods or services recognized under state law but not included as a benefit under the state’s Medicaid program (called Medi-Cal in California); third, goods and services covered under the state Medicaid program. See, also, 42 C.F.R. § 435.832(c)(4)(ii). [“Return to Main Document”](#)

<sup>2</sup>The “maximize” standard under the Nursing Home Reform Act is set out at 42 U.S.C. § 1396r(b)(4) and in the implementing regulations at 42 C.F.R. § 483.25. [“Return to Main Document”](#)

<sup>3</sup> Case No. 84-5979-SC, Consent Decree 11/23/85, modified effective 10/1/89, E.D. Calif., CCH MEDICARE AND MEDICAID GUIDE New Dev. 35,026. [“Return to Main Document”](#)

<sup>4</sup> Department of Health Services (DHS) All-County Letter Welfare Directors Letter No. 89-54 (July 29, 1989) enclosed; 42 C.F.R. § 435.832(c)(4)(ii). [“Return to Main Document”](#)

<sup>5</sup> Nursing Facilities are required to link residents who indicate they want to live in the community to community programs – called “Local Contact Agencies” or LCAs – that can assist them in doing that. See this DRC publication that explains the extra help nursing facility residents are entitled to receive to return to the community. <http://www.disabilityrightsca.org/pubs/549601.pdf>. Go here for the list of

LCAs: <http://www.dhcs.ca.gov/services/ltc/Pages/MDS3,SectionQ.aspx>.

For the programs with a responsibility for helping Medi-Cal beneficiaries who want to move from a nursing facility into the community, contact one of these California Community Transitions (CCT) programs:

[http://www.dhcs.ca.gov/services/ltc/Documents/CCT\\_LO\\_ContactInfo\\_10-10-16.pdf](http://www.dhcs.ca.gov/services/ltc/Documents/CCT_LO_ContactInfo_10-10-16.pdf). [“Return to Main Document”](#)

<sup>6</sup> If the changes you need to go home involve structural changes to your home such as widening a bathroom door, installing grab bars, or putting in a ramp to get into the front door, such expenses cannot be covered by your share of cost but can be paid for through a CMT (see prior end note) and/or through a home and community-based services waiver through Medi-Cal. [“Return to Main Document”](#)

<sup>7</sup> Stairway chairlifts are durable medical equipment covered by the Medi-Cal program. *Blue v. Bonta* (2002) 99 Cal.App.4<sup>th</sup> 980. By extension, Medi-Cal durable medical equipment should also include ceiling track Hoyer lifts. [“Return to Main Document”](#)

<sup>8</sup> <http://www.aging.ca.gov/programs/ltcop/> [“Return to Main Document”](#)

<sup>9</sup> <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c89-54.pdf> [“Return to Main Document”](#)

<sup>10</sup> <http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c90-11.pdf> [“Return to Main Document”](#)

<sup>11</sup> See State Medi-Cal regulation at 22 CCR § 51535. [“Return to Main Document”](#)

<sup>12</sup> “Valdivia” refers to the settlement in *Valdivia v. Coye*, Class Action Stipulation & Order filed April 13, 1993, E.D. Cal. Case No. S-90-1226 EJG/PAN, CCH MEDICARE & MEDICAID GUIDE NEW DEV. 41,959. For information on how Valdivia TARs are processed and the problems in getting one approved, you can visit: [http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp) and search for “valdivia.” [“Return to Main Document”](#)