



Helping Families Obtain Durable Medical Equipment and Supplies Through The California Children's Services (CCS) Program

By Alicia Emanuel and Michelle Lilienfeld

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I. Introduction

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 a CCS eligible condition.¹ There are approximately 200,000 children on CCS, and many of them require access to medically necessary Durable Medical Equipment (DME) and medical supplies.² CCS is difficult to navigate because there are significant gaps in the program structure and insufficient state policies and procedures to guide CCS beneficiaries and their families, advocates, counties, health plans, and providers. Another complexity is that approximately ninety percent of children in the CCS program are Medi-Cal eligible.³ Therefore, advocates helping CCS beneficiaries need to understand the interplay between CCS and Medi-Cal. This advocates issue brief provides the framework for accessing DME and supplies through CCS, including: a program overview, existing guidance on how to access services in Whole Child Model and non-Whole Child Model counties, considerations when children have Medi-Cal and/or other health coverage, and consumer rights.

II. CCS Program Overview

To be eligible for CCS, children must meet the age, income, and residence requirements and have a qualifying medical condition.⁴ Qualifying medical conditions are serious and severe

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¹ Cal. Health & Safety Code § 123800 *et seq.* (enabling legislation); Cal. Welf. & Inst. Code § 14094 *et seq.*; 22 CCR § 51013.

² *Active California Children's Services (CCS) Enrollees, by Age Group*, <http://www.kidsdata.org/topic/600/special-needs-ccs/table>.

³ DHCS Medi-Cal Children's Health Dashboard (March 2019), <https://www.dhcs.ca.gov/services/Documents/Mar2019PedDashboard.pdf>.

⁴ CCS Numbered Letter 11-1500, Verifying Residential Eligibility For Children Who Are Medi-Cal Full-Scope Or Healthy Families Eligible (Nov. 27, 2000) states that the address found in MEDS may be used for the CCS eligible child, <https://www.dhcs.ca.gov/services/ccs/Documents/ccsn111500.pdf>.

physical disabilities or illnesses.⁵ Mental disorders, developmental disabilities, or learning disabilities alone do not meet CCS medical eligibility requirements.⁶

Traditionally, the Department of Health Care Services (DHCS) and county health departments have administered the CCS program. This structure was established to fulfill the original intent of the program to provide necessary medical care for children with CCS eligible conditions whose parents could not afford to pay for the care, wholly or in part.⁷ Approximately ninety percent of children in the CCS program are Medi-Cal eligible.⁸ Therefore, Medi-Cal pays for the cost of CCS care for these children. The remaining ten percent of CCS beneficiaries are enrolled in CCS only, and those services are funded equally by county and state funds.⁹

Responsibility for CCS program administration has changed and now depends on the county the child lives in. Implemented in 2018, the Whole Child Model (WCM) program authorizes Medi-Cal Managed Care Plans (MCPs) to administer the CCS program in 21 County Organized Health System (COHS) counties.¹⁰ In WCM counties, the MCP integrates Medi-Cal managed care and CCS program administrative functions to provide comprehensive care coordination and integrated services to Medi-Cal eligible children on CCS for both their CCS eligible and non-CCS eligible medical conditions. As a result, the MCP assumes full financial

⁵ *Overview of CCS Medical Eligibility*, DHCS (Jan. 2016), <http://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx>; K. Smith et al., *California's Service System for Children and Youth with Special Health Care Needs: Analysis and Recommendations for A Service System That Works for Children and Families* 35-36 (Dec. 2009), <http://www.lpfch.org/sites/default/files/field/publications/servicesystemreport.pdf>. The broad categories of covered diagnoses include: certain infectious diseases; leukemia (and other malignant neoplasms); endocrine, nutritional and metabolic diseases, and immune disorders; blood diseases and diseases of blood-forming organs, such as sickle cell anemia and hemophilia; nervous system diseases, such as spina bifida and muscular dystrophy; certain eye diseases, such as optic neuritis, cataract, glaucoma; diseases of the ear and mastoid processes, such as those resulting in hearing loss or mastoiditis; circulatory system diseases, such as aortic aneurysm and congenital heart abnormalities; respiratory system diseases, such as chronic fibrosis and respiratory failure; digestive system diseases, such as Crohn's diseases, chronic diverticulitis, and chronic peptic ulcers; genitourinary system diseases, such as chronic nephrosis and kidney stones; skin and subcutaneous tissue diseases, such as pemphigus and disfiguring and joint limiting scars; musculoskeletal system and connective tissue diseases, such as osteomyelitis and severe scoliosis (20 degree or greater); congenital abnormalities, such as hydrocephalus or cleft lip; and severe conditions resulting from accidents, poisonings, violence, and immunization reactions. 22 CCR §§ 41515-41518.

⁶ 22 CCR § 41517. While the CCR uses the term "mental retardation," this has been replaced in more recent DHCS literature with "intellectual disability." See DHCS Medical Eligibility Guidelines Workgroup, *CCS Medical Eligibility Guide*, DEP'T HEALTH CARE SERVS. (Mar. 15, 2017), <https://www.dhcs.ca.gov/services/ccs/Documents/CCSMedicalEligibility.pdf>, at 12.

⁷ Cal. Health & Safety Code § 123825.

⁸ DHCS Medi-Cal Provider Manual, California Children's Services (CCS) Program, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchild_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc.

⁹ *Id.*; Cal. Health & Safety Code § 123905.

¹⁰ SB 586, (Hernandez, Chapter 625, Statute of 2016); See also DHCS California Children's Services (CCS) Program Whole Child Model Frequently Asked Questions (Jan. 2019), <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-WCM-FAQ-19.01.pdf>. Please note that of the 21 counties in the WCM program, only San Mateo County is regulated by the Department of Managed Health Care.

responsibility for authorization and payment of CCS eligible medical services, including service authorizations, claim processing and payment, case management, and quality oversight.¹¹ As of this publication, the WCM program has been implemented in all 21 counties. See *Figure 1 below*.

Figure 1: Roll-out of Whole Child Model Program*

Health Plan	Counties
Phase 1 – Implemented July 1, 2018	
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Merced, Monterey, Santa Cruz
Health Plan of San Mateo	San Mateo
Phase 2 – January 1, 2019	
Partnership Health Plan of California	Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo
Phase 3 – July 1, 2019	
CalOptima	Orange

*Chart from DHCS FAQ July 2019

In non-WCM counties, CCS beneficiaries continue to access services as they did before the implementation of the WCM program, and county size determines who administers the program. In non-WCM counties with populations **greater than** 200,000 people, the county is responsible for administering the CCS program independently.¹² This means that county staff perform case management activities for CCS eligible children living in the county. In non-WCM counties with populations **less than** 200,000, the Children’s Medical Services (CMS), a subset of DHCS, with two regional branch locations in Sacramento and Los Angeles, provides medical case management, eligibility, and benefit determinations. Even if a child in a non-WCM county is enrolled in a Medi-Cal MCP, CCS services are “carved out” of the MCP—so the child must obtain CCS services, and authorization for services, from the CCS program, not their Medi-Cal MCP.

¹¹ CCS Numbered Letter 04-0618, California Children’s Services Program Whole Child Model (June 7, 2018), https://www.dhcs.ca.gov/services/ccs/Documents/04-0618_WCM.pdf.

¹² Cal. Health & Safety Code § 123850(a).

III. Accessing DME Services and Supplies Through CCS

A. General Requirements and How to Avoid DME and Medical Supply Denials

The CCS program only authorizes DME for the purpose of improving mobility and self-care activities, including communication, when limited by the child's CCS eligible medical condition.¹³ The DME must be medically necessary to treat a CCS eligible condition.¹⁴ Medical necessity is defined as a "limitation of a mobility or a self-care skill related to a CCS eligible medical condition which is verified by physical findings and which justifies authorizing DME."¹⁵ For example, the CCS program may approve a wheelchair for a child to ambulate at home and school if the limitation of mobility is related to the CCS eligible condition.

- **Advocacy tip:** Please note that the CCS "medical necessity" definition may be too limiting to effectively treat certain CCS conditions. For example, this standard may not account for a child's need for an elevating wheelchair to reach their bed, or specific features on a bed to prevent risk of decubitus ulcers. Advocates should be aware that for CCS beneficiaries that have Medi-Cal, the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) medical necessity standard must apply. Under EPSDT, benefits and services necessary to "correct or ameliorate defects and physical and mental illnesses and conditions" are required to be covered.¹⁶

There are specific requirements for accessing DME through CCS that advocates should keep in mind to avoid DME denials. DME requests require prior authorization and using the lowest cost DME available that meets the beneficiary's medical needs.¹⁷ DME must also be prescribed by a CCS-paneled physician within the scope of their practice, as defined by California law.¹⁸ DME prescribed by a non-physician provider will not be reimbursable. Additionally, a provider (physician, nurse practitioner, clinical nurse specialist, or physician assistant) seeing the child for the primary reason the DME is required, must have a face-to-face encounter with the beneficiary before the provider can prescribe the DME.¹⁹ If the face-to-

¹³ See CCS Numbered Letter 09-0703, Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (Aug. 8, 2003), <https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl090703.pdf>.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ 42 USC § 1396d(r)(5).

¹⁷ See CCS Numbered Letter 07-1004, Health Care Financing Administration Common Procedural Coding System (HCPCS) Code Changes Effective November 1, 2004 for Durable Medical Equipment (DME) and Diabetic Supplies (Oct. 28, 2004), <https://www.dhcs.ca.gov/services/ccs/documents/ccsnl071004.pdf>.

¹⁸ See CCS Information Notice 17-06, Revised Medical Supplies, Incontinence Supplies, Durable Medical Equipment (DME), and Enteral Nutrition Products, Covered When Ordered by a Physician (Jan. 8, 2018), <https://www.dhcs.ca.gov/services/ccs/Documents/ccsin1706.pdf>; See also 42 CFR 440.70.

¹⁹ *Id.*

Figure 2: CCS DME Requirements

- Prior authorization
- Use lowest cost DME to meet the need
- Prescription by a CCS physician
- Must have face to face contact
- DME must be portable

NOTE: For Medi-Cal beneficiaries, EPSDT applies.

face encounter is done by a non-physician, that provider must communicate the clinical findings to the ordering physician. All claims for DME and DME accessories must include modifiers designating whether it is a (1) new equipment purchase; (2) equipment rental; or (3) repair and replacement parts for beneficiary owned equipment.²⁰ Additionally, DME must be portable “to allow it to regularly accompany the child to multiple

activity locations or change of residence without requiring installation or alteration beyond that which the family/care provider can practically and safely perform without outside assistance.”²¹

- **Advocacy tip:** If CCS denies medically necessary DME and supplies, there are appeal rights through CCS. For children on Medi-Cal, there are Medi-Cal appeal rights as well. For more information about appeals, see Section IV of this issue brief.

B. Identifying the Need for DME and Supplies

DME must be prescribed by the physician who is approved to treat the child’s CCS eligible medical condition, i.e. a CCS-paneled provider within their scope of practice. However, the need for DME and supplies may be identified by various providers in several different entities, as described below. The types of providers who may identify the need for DME and supplies include but are not limited to the child’s: (1) primary care physician or pediatric specialist (as well as hospital physicians), (2) school providers, or (3) regional center providers. Below is information about how each of these providers may go about identifying the need for DME or supplies.

- **Advocacy tip:** Keep in mind that the child’s specific DME and medical supply needs must be identified by an occupational therapy assessment, and the DME ultimately must be prescribed by the physician who is approved to treat the child’s CCS eligible medical condition.

i. Physician Identifies Need for DME

A physician identifying the child’s need for DME or supplies is the most direct pathway to accessing DME and supplies through CCS. Often, the child’s primary care physician or pediatric specialist identifies the need for DME. However, the CCS program only covers medically necessary DME and supplies prescribed by a CCS-paneled physician or a physician

²⁰ CCS Numbered Letter 07-1004, *supra*, note 17.

²¹ CCS Numbered Letter 09-0703, *supra*, note 13.

working with a CCS-paneled physician at a CCS approved facility.²² Therefore, if a non-CCS physician identifies the child’s need for DME, the child will need a referral to a CCS-paneled physician to submit the Service Authorization Request (SAR), unless they work in a CCS approved facility. Figure 2 below explains how CCS beneficiaries can access CCS-paneled providers, depending on whether they are in a WCM or non-WCM county.

Figure 3: CCS-paneled physicians

Non-WCM Counties	WCM Counties
<p>In non-WCM counties, each county has a panel of doctors, clinics or specialty care centers, hospitals, and therapists that are approved to provide CCS services, including DME. Families can obtain a list of approved providers from the county (large/independent counties [with populations > 200,000]) or regional CCS office (small/dependent counties [with populations < 200,000]).</p>	<p>In WCM counties, Medi-Cal eligible CCS beneficiaries access DME through CCS-paneled providers in the MCP’s network. The MCP is required to demonstrate an adequate network of pediatricians, pediatric specialists, and pediatric subspecialists, as well as show that the MCP’s network contains adequate provider overlap with the CCS-paneled providers.²³ If a child needs to see a specialist that is not in the plan’s network, the MCP must coordinate and approve these services.²⁴</p>

ii. School Identifies Need for DME

A provider in the child’s school may identify the need for DME and supplies. Often this occurs through the Medical Therapy Program (MTP). The MTP is a part of the CCS program that provides physical therapy, occupational therapy, and physician consultation to children with specifically defined medical conditions, generally due to neurological or musculoskeletal disorders.²⁵ Within the MTP, the Medical Therapy Units (MTUs), which are outpatient clinics located in designated public schools, perform a therapy evaluation to ensure the child has

²² CCS Information Notice 17-06, *supra*, note 18.

²³ DHCS All Plan Letter 18-005, Network Certification Requirements (Feb. 16, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-005.pdf>, at 6, Attachment D-E.

²⁴ DHCS California Children’s Services (CCS) Program Frequently Asked Questions 2 (Jan. 2019), <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-WCM-FAQ-19.01.pdf>.

²⁵ 22 CCR § 41450; See also CCS Information Notice 18-05, Fiscal Year (FY) 2018-2019 County Allocations for CCS County Administration and the CCS Medical Therapy Program (MTP) (Aug. 6, 2018) <https://www.dhcs.ca.gov/services/ccs/Documents/CCS%20Allocation%20Information%20Notice%202018-05.pdf>; 22 CCR § 41450.

access at home, in the classroom, and out in the community. The MTU therapist may recommend DME, such as orthotics/braces, wheelchairs, or other assistive devices—like a device to help with communication—based on the MTU’s assessment or the therapist’s evaluation of a request coming from outside the MTU.²⁶

The MTU therapist (along with the DME provider who evaluated the child) then submits the DME request to the appropriate entity based on who administers the CCS program in that given county. In WCM counties, the managed care plan will authorize the DME request for Medi-Cal eligible children, and the county or regional CCS office will authorize it for non-Medi-Cal eligible children. In non-WCM counties, the DME request continues to be submitted to the county or regional CCS office. The process of seeking DME authorization can be delayed and/or become convoluted when different care providers have different perspectives on the type of DME the child needs.

Advocates working on DME approvals that originate in a school must be mindful of the interplay between school districts or local education agencies (LEAs) and CCS. The Individuals with Disabilities Education Act provides grants to local educational agencies that can be used to pay for equipment and other services that children with special needs require as part of their individual education plans (IEP).²⁷ In some cases, the services required to facilitate an IEP can overlap with those required to treat a child’s CCS eligible condition. If a child is served by CCS and a LEA/special education local plan area (SELPA), any DME predominantly for school use (including equipment the child’s IEP program team deems necessary for the child to benefit educationally), is the LEA’s responsibility to provide and pay for.²⁸ As mentioned before, CCS will only cover DME that is medically necessary for the CCS eligible condition.²⁹ The LEA and CCS are required to have a memorandum of understanding (MOU) that includes reimbursement procedures for DME paid for by the LEA.³⁰

²⁶ CCS Numbered Letter 09-0703, *supra*, note 13.

²⁷ Advocates should be aware that school districts also function as Medi-Cal providers. See 42 U.S.C. §1396b(c), which says that Medicaid payments are permitted for medical services provided to Medicaid eligible children under IDEA and included in the child’s IEP.

²⁸ CCS Numbered Letter 09-0703, *supra*, note 13.

²⁹ *Id.*

³⁰ CCS Information Notice 07-01, Subject, Revised Interagency Agreement (IA) between California Department of Health Services, CMS Branch and California Department of Education (CDE), Special Education Interagency Cooperative Agreement 5-6 (Jan. 4, 2007), <http://www.dhcs.ca.gov/services/ccs/Documents/ccsin0701.pdf>.

- **Advocacy Tip:** If educational need and medical need overlap, LEA and CCS may each be responsible for a share of the costs.³¹ The MTP is required to coordinate with the LEA who administers a child's IEP. MTP staff can attend IEP meetings, when requested, to make sure school staff are aware of any access to DME the child has through the MTP.

Advocates should be aware that the implementation of the WCM program does not impact MTPs, which continue to be administered by the counties.³² The only distinction is that in non-WCM counties, the DME authorizations continue to go to the county CCS office whereas authorization requests for DME for Medi-Cal eligible children in WCM counties must now be submitted to the MCP for review and approval. Ultimately, the managed care plan has an obligation to coordinate with the local CCS MTU to ensure CCS eligible children can access appropriate MTP services.³³

- **Advocacy Tip:** Implementation of the WCM program does not impact how the Medical Therapy Program is administered, but it does change how to seek approval for DME and supplies in WCM counties, as described above.

iii. Regional Center Provider Identifies Need for DME

A CCS beneficiary's need for DME and supplies may also be identified through a Regional Center provider. Twenty-one Regional Centers across the state, under contract with the Department of Developmental Services, provide DME and supplies to children with developmental disabilities without regard to the family's income level.³⁴ The medical necessity of the DME is based on the developmental disability that makes the child eligible for Regional Center services. Regional Centers are the payer of last resort.³⁵ This means that CCS beneficiaries must exhaust coverage of DME in private insurance, Medi-Cal, CCS, and the school district before Regional Centers are obligated to provide or pay for the DME.

³¹ CCS Information Notice 14-05, Subject: Impact of Special Education Due Process Hearings on the CCS Program and the Medical Therapy Program (MTP) 3 (May 2, 2014), <http://www.dhcs.ca.gov/services/ccs/Documents/ccsin1405.pdf>.

³² CCS Whole Child Model FAQ (Updated Nov. 2018), <https://www.dhcs.ca.gov/services/ccs/Documents/CCS-WCM-FAQ-11.2018.pdf>.

³³ See CCS MOU Template 6.

³⁴ State of California Department of Developmental Services, DDS Transparency Portal, <https://www.dds.ca.gov/Transparency/>.

³⁵ CA Welf. & Inst. Code § 4659.10.

- **Advocacy Tip:** As described in the section above, a child’s need for DME and supplies through the CCS program can be identified in many venues. Advocates should be prepared to navigate the complexities of CCS DME approval, especially when there are potentially multiple providers identifying the need for DME.

C. Prior Authorization

Once the child’s need for DME and supplies is identified, a request for those services goes through the CCS approval process.

i. General

Only DME and supplies related to a CCS eligible medical condition may be authorized and reimbursed by the CCS program. CCS requires prior authorization for DME and supplies through SARs.³⁶ CCS prior authorization requirements apply to both CCS only beneficiaries and non-WCM county Medi-Cal beneficiaries in the CCS program. CCS beneficiaries with full-scope Medi-Cal in WCM counties will seek CCS DME approval through their MCP. There are coverage limitations imposed on CCS DME, including the following: DME approvals “shall be limited to the lowest cost item that meets the patient’s medical needs”; CCS imposes maximum allowances and frequency limits to access DME; and some DME may require a home, school, or community assessment prior to submission of the request for authorization.³⁷ Notwithstanding these limitations, Medi-Cal eligible children are entitled to DME services that are medically necessary under the EPSDT mandate. If DME is approved, a record of the authorization is retained as part of the individual’s case record in the administering agency.³⁸ In WCM counties, the administering agency is the MCP and in non-WCM counties and WCM counties with CCS-only beneficiaries, the administering agency is the county CCS office or Regional Office.

Advocates should be aware of situations when providers must submit a product-specific SAR for CCS DME approval. A SAR is required for DME and supplies if: (1) the billing limits of the product (e.g. quantity) exceed what Medi-Cal will cover, (2) there is no specific Healthcare Common Procedure Coding System (HCPCS) code for the medical supply, or (3) Medi-Cal

³⁶ See CCS SAR Provider Bulletin (August 2017), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchilidsar_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc; CCS Numbered Letters 07-1004, *supra*, note 17; 22 CCR § 41770(b).

³⁷ 22 CCR § 51321(g); DHCS Medi-Cal Provider Manual, DME: Billing Codes for California Children’s Services (CCS) (Aug. 2016), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/duracdccs_a04a06a08p00.doc.

³⁸ 22 CCR § 41770.

requires a Treatment Authorization Request (TAR) for the medical supply.³⁹ For **DME**, the provider must submit a product-specific SAR that includes the following information, in addition to what is required by Medi-Cal:

- a signed prescription by a CCS provider,
- HCPCS code,
- detailed description of the DME item,
- if using an unlisted or miscellaneous code—an explanation of why the code is being used rather than an HCPCS code,
- model number,
- manufacturer,
- whether the item will be rented or purchased and associated charges,
- estimated length of need for the DME, and
- any special features of the DME.⁴⁰

For **medical supplies**, in addition to what is required by Medi-Cal, the provider must submit the following information:

- a signed prescription by a CCS provider, and
 - HCPCS code.⁴¹
- **Advocacy tip:** As noted above (and in prior sections), advocates should be aware that these additional CCS DME authorization limitations may not be consistent with the EPSDT medical necessity standard that applies to Medi-Cal beneficiaries under age 21, and advocates can appeal these limitations or denials. These appeal rights are discussed in Section IV of this issue brief.

ii. Specific Prior Authorization Requirements for Non-WCM Counties and WCM Counties

If a child is enrolled in CCS in a non-WCM county, the prior authorization process has not changed. The child's provider submits the SAR for DME to the county office or regional CCS office, depending on whether the child lives in a dependent or independent county. (See *Figure 3, page 6.*) If a Medi-Cal eligible child is enrolled in CCS in a WCM county, the CCS-paneled

³⁹ DHCS Medi-Cal Provider Manual, CCS Program Service Authorization Request (SAR), p.9 http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildsar_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc.

⁴⁰ CCS SAR Provider Bulletin (August 2017), https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchildsar_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc.

⁴¹ *Id.*

provider must submit a TAR for DME to the Medi-Cal MCP.⁴² The MCP is required to authorize services based on medical necessity and consistent with CCS program standards, including CCS statutes and regulations, regulations related to the WCM program, CCS Numbered Letters, and county CCS Information Notices.⁴³ In order to make these determinations, the county CCS programs are required to regularly communicate and share information (written or electronic) with the MCP to facilitate access to DME for CCS eligible children.⁴⁴ Note that CCS-only children who are in WCM counties and are not Medi-Cal eligible will continue to get CCS services as they did before the WCM program, on a fee-for-service (FFS) basis.⁴⁵

CCS beneficiaries in WCM counties who are Medi-Cal eligible will receive all of their services, including those for their CCS eligible condition, through their Medi-Cal MCP. As a result, each MCP must develop a comprehensive plan detailing the transition of existing CCS beneficiaries into a MCP for treatment of their CCS eligible condition.⁴⁶ These transition plans are subject to DHCS approval. Specific to DME, if a beneficiary has an established relationship with a specialized or customized DME provider, the MCP must provide access to that provider for up to 12 months after the beneficiary starts accessing CCS services through a MCP to ensure there is adequate continuity of care.⁴⁷ A MCP may extend this period beyond 12 months for specialized or customized DME that is under warranty and determined medically necessary by a treating provider.⁴⁸ MCPs are required to pay the DME provider at rates that are at least equal to the applicable CCS FFS rate, unless the DME provider and MCP mutually agree otherwise.⁴⁹ This continuity of care obligation extends to the MCP's subcontractors. The MCP is also responsible for ensuring that families have ongoing information about how to request continuity of care for specialized DME and how to request DME maintenance.⁵⁰

- **Advocacy tip:** Advocates should encourage beneficiaries to contact the MCP's Member Services to get information on how to request continuity of care requests. If they do not get the information they need, MCP enrollees have the right to file a grievance.

⁴² See DHCS All Plan Letter 18-023, California Children's Services Whole Child Model Program (Dec. 23, 2018), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-023.pdf>.

⁴³ CCS Numbered Letter 04-0618, California Children's Services Whole Child Model (June 7, 2018), https://www.dhcs.ca.gov/services/ccs/Documents/04-0618_WCM.pdf; See also *Id.*, 3.

⁴⁴ CCS Template MOU p. 4.

⁴⁵ CCS Whole Child Model FAQ, *supra*, note 32.

⁴⁶ DHCS All Plan Letter 18-023, *supra*, note 42, at 4.

⁴⁷ CCS Whole Child Model FAQ, *supra*, note 32.

⁴⁸ *Id.*

⁴⁹ DHCS All Plan Letter 18-023, *supra*, note 42, at 11.

⁵⁰ CCS Template MOU p. 5.

iii. Inter-County Transfers

There are unique challenges in accessing continued DME for CCS beneficiaries when they move to a different county. This transition from one county to another is called an inter-county transfer (ICT). Since some counties are WCM counties and some are not, and because county CCS programs use the Children's Medical Services Net (CMS Net) system to house and share data needed for ICTs while MCPs use different data systems, further coordination is required when a CCS beneficiary moves from a WCM to a non-WCM county, or vice versa. Through a MOU, the participating MCP and county CCS program must develop protocols for the exchange of ICT data to ensure seamless continuity of care of already approved DME for CCS members.⁵¹ ICT data includes authorization data, member data, and case management information. When a child moves out of a WCM county, the county CCS program notifies the MCP and initiates the data transfer request and the MCP is responsible for providing the data transfer. Conversely, when a child moves into a WCM county, the county CCS program will provide the transfer data to the MCP. Advocates should be aware that CCS data transfers between counties continues to be a source of confusion and delay in accessing DME through the CCS program.

D. Medi-Cal and Other Health Coverage's Impact on Access to DME and Supplies

i. CCS and Medi-Cal coverage

Since the vast majority of CCS eligible children are also Medi-Cal eligible, it is imperative that advocates for CCS beneficiaries understand the interplay between CCS and Medi-Cal. Of the CCS eligible children enrolled in Medi-Cal, ninety percent are enrolled in Medi-Cal MCPs, but advocates still need to understand the distinction between the Medi-Cal FFS and Medi-Cal MCP approval process, where applicable.⁵²

Generally, children with Medi-Cal and CCS should first seek authorization for services related to a CCS eligible condition through CCS. If a child is in a non-WCM county, and has both CCS and Medi-Cal, the treating provider should first seek authorization for DME related to the CCS eligible condition through CCS. If CCS denies the DME because it is not related to the CCS eligible condition, the provider should then seek authorization through FFS Medi-Cal or the Medi-Cal MCP, whichever is applicable. If the child is enrolled in Medi-Cal managed care, the

⁵¹ Cal. Welfare & Inst. Code § 14094.9; DHCS All Plan Letter 18-023, *supra*, note 42, at 4.

⁵² DHCS Medi-Cal Children's Health Dashboard (March 2019), <https://www.dhcs.ca.gov/services/Documents/Mar2019PedDashboard.pdf>.

MCP has the responsibility to coordinate the beneficiary's care, including but not limited to all medically necessary services delivered both within and outside the MCP's provider network.⁵³

- **Advocacy Tip:** Advocates should be aware of the MCP's ultimate obligation to coordinate care when there are DME coverage disputes between the CCS program and the Medi-Cal MCP.

If a child resides in a WCM county and is enrolled in Medi-Cal and CCS then all CCS DME and supply requests must be authorized by the MCP. If a child is in a WCM county and is CCS-only, then requests for authorization of DME and supplies will continue to go through CCS.⁵⁴

- **Advocacy Tip:** Advocates should refer to CCS Numbered Letters, Medi-Cal All-Plan Letters, and the EPSDT medical necessity requirements in any appeal of an unfavorable decision on DME to ensure that the beneficiary's medically necessary DME is approved without delay. See Section IV of this issue brief for more information about appeal rights.

ii. CCS and OHC/Private Insurance Coverage

When a child is a CCS beneficiary but also has OHC/private insurance, the same general rule applies that a child must see a CCS-paneled provider if they want CCS to cover the DME. When a child has OHC and CCS, the CCS-paneled provider must first seek CCS authorization for the DME before providing it. The provider must then bill the OHC before seeking reimbursement from CCS. In other words, the OHC must be exhausted before CCS will pay for the services. Once the provider has billed the OHC for the covered service, the provider can then bill CCS for the remainder of the cost up to the Medi-Cal rate of payment and/or for services not covered by the OHC.⁵⁵ The provider must submit the OHC's explanation of benefits (EOB) with every claim to CCS.⁵⁶ The process is the same even if the private insurance plan has a high deductible that the beneficiary cannot afford.⁵⁷ After the private insurance pays what it will pay, CCS should pay the balance up to the CCS rate amount.⁵⁸

- **Advocacy tip:** Advocates should be aware that there is no clear CCS guidance about

⁵³ DHCS APL 14-017, Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Beneficiaries Under the Age of Twenty-One 3 (Dec. 12, 2014), <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf>.

⁵⁴ CCS Whole Child Model FAQ, *supra*, note 32.

⁵⁵ CCS Numbered Letter 06-0394, Required Use of Health Insurance 2 (Mar. 10, 1994), <https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl060394.pdf>.

⁵⁶ DHCS Medi-Cal Provider Manual, California Children's Services (CCS) Program, https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/calchild_m00i00o03o04o07o09o11a02a04a05a06a07a08p00v00.doc.

⁵⁷ CCS Numbered Letter 06-0394, *supra*, note 55, at 5.

⁵⁸ *Id.*; CCS Numbered letter 06-0582 (May 15, 1987).

what should transpire when a CCS beneficiary goes to a CCS-paneled provider who is not contracted with their OHC. This is an area where further guidance is needed.

a. Preferred Provider Organization (PPO) Plan

Beneficiaries who have OHC through a Preferred Provider Organization (PPO) plan in addition to CCS should obtain authorization for the covered service from both the PPO and CCS before receiving the service.⁵⁹ Since CCS is the payer of last resort, the child's provider must first bill the PPO for the CCS covered service before seeking payment from CCS.⁶⁰ PPOs allow enrollees to receive services from both preferred and non-preferred providers. If the prescribing provider is a PPO preferred provider, the PPO will pay a larger part of the bill than if the provider is not a preferred provider. However, the provider also has to be a CCS provider for CCS to pick up any remainder of the bill not covered by the PPO. Therefore, it is preferable for the CCS beneficiary to obtain services from a provider that is both a PPO preferred provider and a CCS provider. However, if this is not possible, it is more important that the provider be a CCS provider since CCS will pay the claim at the CCS rate minus any payment the PPO has made.

b. Health Maintenance Organization (HMO) Plan

According to existing DHCS guidance, CCS will generally deny CCS eligibility for children who already have OHC through a Health Maintenance Organization (HMO) plan.⁶¹ However, if the HMO does not cover DME or services that are needed to treat a CCS eligible condition, such as wheelchairs or other equipment, then CCS will approve the application despite the child having comprehensive HMO coverage.⁶² If the HMO does not cover the DME or services needed to treat a CCS eligible condition, CCS requires proof of this before approving an application for the CCS program. The applicant should get a letter from the HMO stating that it does not cover the needed DME or services, signed by the HMO's "authorized membership services representative."⁶³ Once CCS approves the child's application for CCS eligibility, the beneficiary must then go through the normal process to get CCS to approve the specific DME or supplies sought, starting with going to a CCS-paneled provider and having that provider seek authorization for the DME. In a WCM county, the provider will seek authorization from the MCP for Medi-Cal eligible children, or the CCS county or regional office for non-Medi-Cal eligible children. In a non-WCM county the provider will seek authorization from the CCS

⁵⁹ CCS Numbered Letter 06-0394, *supra*, note 55, at 5.

⁶⁰ CCS Numbered Letter 06-0394, Required Use of Health Insurance 3 (Mar. 10, 1994), <https://www.dhcs.ca.gov/services/ccs/Documents/ccsnl060394.pdf>.

⁶¹ *Id.* at 5.

⁶² *Id.*

⁶³ CCS Numbered Letter 06-0394, *supra*, note 55, at 3.

county or regional office. The provider should not need to seek reimbursement from the private HMO first.

If the private HMO covers, as a part of its plan benefit, the DME or supplies needed to treat a CCS eligible condition but refuses to approve it for an enrolled child (i.e. if the HMO provider refuses to provide a referral to a CCS specialist or a special care center, or the HMO will not approve such a referral), the beneficiary must get a written denial from the HMO regarding the referral and take the denial to a CCS provider or special care center and have the provider or center help assist with submitting a request for authorization of the DME to CCS.⁶⁴

iii. CCS, Medi-Cal, and Private Insurance

Children who have CCS, Medi-Cal, and private insurance/OHC will always be required to seek authorization from the OHC plan first because Medi-Cal and CCS are payers of last resort. However, for CCS to cover any of the bill, the DME must be for the CCS eligible condition and the child must see a CCS-paneled provider. If a CCS beneficiary has OHC and Medi-Cal, the provider should bill the private insurance plan before seeking payment from Medi-Cal and/or CCS.⁶⁵ Whether Medi-Cal or CCS is responsible for any remainder of the bill depends on whether the treatment needed is for a CCS eligible condition or another health condition, and whether or not the child is in a WCM county.

- **Advocacy Tip:** Keep in mind that Medi-Cal will only pay for DME for a CCS beneficiary with both OHC and Medi-Cal if CCS determines the DME is not needed to treat the CCS eligible condition, or if the child is in a WCM county.

iv. Medicare

Another type of OHC advocates need to be aware of when assisting CCS beneficiaries is Medicare. Some CCS beneficiaries are eligible for Medicare either because their parent died, or they have a disability or end stage renal disease. These beneficiaries will still generally have to seek approval from CCS first for the DME or supplies if they want CCS to pay for any part of the services.⁶⁶ The beneficiary should, whenever possible, see a CCS-paneled provider that also accepts Medicare; however, it is more important that the provider be a CCS provider so that CCS will pay for the services if Medicare denies coverage or only pays for a portion of the bill.

⁶⁴ “The California Department of Managed Health Care handles complaints against health benefit plans it administers under the Knox-Keene Act. The Department of Managed Health Care requires that the health benefit plans internal grievance procedure be pursued before the Department will process a complaint.” *California Children’s Services: Service Rights and Entitlement Programs Affecting Californians with Disabilities*, DISABILITY RIGHTS CAL. 24-5, <https://www.disabilityrightsca.org/system/files/file-attachments/506001.pdf>.

⁶⁵ DHCS All Plan Letter 18-023, *supra*, note 42, at 3.

⁶⁶ Once CCS has approved the services, the provider will first have to bill Medicare then Medi-Cal before billing CCS for the balance. This is because Medi-Cal is a payer of last resort. If the service is not covered by Medicare or Medi-Cal, the beneficiary will need to get a denial from Medicare and Medi-Cal before billing CCS.

As illustrated, in the section above, the process of securing DME for CCS beneficiaries can be complicated by the different types of insurance the child has and how these forms of insurance interact. Given DHCS has not issued adequate or updated guidance on CCS and OHC so that these processes are more easily understood, advocates are left to navigate these complexities on their own.

IV. Consumers' Right to Appeal Denials for DME and Supplies

CCS is a complicated program that is difficult to navigate, and this can lead to service denials, including denials of medically necessary DME and supplies. Therefore, appeal rights are a critical consumer protection to challenge these denials. However, the CCS program appeal rights are not as robust as those under the Medi-Cal program. This impacts children who have both CCS and Medi-Cal coverage, and is a significant gap in the CCS program structure. In this section we provide an overview of Medi-Cal and CCS appeal rights and highlight some of the problems with the current appeals process for beneficiaries trying to access DME and supplies through CCS.

A. Medi-Cal Appeal Rights

Ninety percent of children on the CCS program are Medi-Cal beneficiaries.⁶⁷ This section provides an overview of the Medi-Cal appeals process. (*For CCS beneficiaries who are not Medi-Cal eligible this section does not apply, please see Section B below*). Medi-Cal eligible children are entitled to specific due process protections under the U.S. Constitution, as well as under federal and state Medicaid laws and regulations.⁶⁸ This includes the right to a notice and hearing when claims are denied or not acted upon with reasonable promptness.⁶⁹ A beneficiary who requests a hearing prior to the effective date of the adverse action has the right to receive continued benefits, known as “aid paid pending” (APP), at the previously authorized level pending the outcome of the hearing.⁷⁰ These due process rights are what make the Medi-Cal program an entitlement and a source of dependable coverage for those enrolled in the program.

The Medi-Cal appeals process varies for beneficiaries who have Medi-Cal FFS and those enrolled in a Medi-Cal managed care plan. Beneficiaries with Medi-Cal FFS have **90 days** from the date on the Notice of Action (NOA) to appeal and ask for a State Fair Hearing, and

⁶⁷ DHCS Medi-Cal Children's Health Dashboard (March 2019), <https://www.dhcs.ca.gov/services/Documents/Mar2019PedDashboard.pdf>.

⁶⁸ 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250. See 42 C.F.R. § 431.205(d); 22 CCR §§ 50179 and 51014.1.

⁶⁹ *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970), see, e.g., 42 U.S.C. § 1396a(a)(3).

⁷⁰ *Goldberg*, 397 U.S. at 267; see also 42 C.F.R. § 431.230; 22 CCR § 51014.2.

can receive APP if the appeal is filed within **10 days** of the date the denial was mailed to the beneficiary.⁷¹

There is a different grievance, appeal, and fair hearing process for beneficiaries in Medi-Cal managed care.⁷² Beneficiaries enrolled in a MCP have **60 calendar days** from the date of the Notice of Adverse Benefit determination to appeal.⁷³ The health plan has **30 calendar days** from the date it received the appeal to make a determination on the beneficiary's appeal.⁷⁴ In situations where a provider indicates, or the managed care plan determines, that the beneficiary's life or health are at risk, the health plan must expedite the decision and has **72 hours** from when it received the appeal to make a decision.⁷⁵ If the decision is not favorable to the beneficiary, the beneficiary has **120 calendar days** from the date of the plan's decision to request a Medi-Cal state fair hearing.⁷⁶

Children in a WCM county with CCS and Medi-Cal coverage, who get denied DME or supplies, have the right to appeal through the MCP grievance and appeal process outlined above.⁷⁷ For children on CCS and Medi-Cal in non-WCM counties, or for children who have CCS only, there is a separate CCS appeals process (*See Section B below*). Yet, it is important to understand that all Medi-Cal beneficiaries have the right to appeal through the Medi-Cal fair hearing process in addition to, or instead of, the CCS Fair hearing process. Currently, there is no coordination between CCS and Medi-Cal appeals and no state guidance on how Medi-Cal due process rights intersect with CCS. This has caused a great deal of confusion for beneficiaries and additional state guidance in this area is needed.

B. CCS Appeals Process

Under the CCS appeals process, the county will send a written NOA within **seven calendar days** of the decision.⁷⁸ A NOA gets triggered in certain circumstances, for example, when there is a denial of: (1) a request for a *new* medical service, (2) a program benefit not currently

⁷¹ Welf. & Inst. Code § 10951(a)(1); 22 CCR § 51014.2.

⁷² 42 CFR § 438.400 *et seq*; Letter from Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans 2 (May 9, 2017) [hereinafter APL 17- 006], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>; Cal. Health & Safety Code §1368.03(a); 28 CCR §1300.68(a)(1); See also National Health Law Program's *Internal Grievances and External Review for Service Denials in Medi-Cal Managed Care Plans (Updated Oct 2019)*, <https://healthlaw.org/resource/internal-and-external-review-medi-cal-managed-care-plans-managed-care-in-california-series-issue-no-4-revised-october-2019/>.

⁷³ 42 CFR § 438.402(c)(2)(ii).

⁷⁴ 42 CFR § 438.408(b)(2); 28 CCR § 1300.68(a); 22 CCR § 53858(g)(1) [2-Plan], § 53914(g)(1) [GMC]; APL 17-006, *supra*, note 72.

⁷⁵ 42 C.F.R. §§.408(b)(3), 438.410(a); Cal. Health & Safety Code § 1368.01(b); Cal. Health & Safety Code §1368.03(a), §1374.30(j)(3); 22 CCR § 53858(e)(7) [2-Plan; no GMC equivalent]; APL 17-006, *supra*, note 72.

⁷⁶ 42 C.F.R. § 438.408(f)(1) and (2); see also APL 17-006, *supra*, note 72.

⁷⁷ Please note that a child in a WCM county that is not Medi-Cal eligible will go through the CCS appeals and hearing process.

⁷⁸ 22 CCR § 42701(a).

provided, or (3) the continuation of a *currently* authorized CCS medical service or benefit.⁷⁹ A NOA is also required if a *new* medical service or program benefit is approved, but the CCS program has modified the approved service or benefit.⁸⁰

The CCS NOA must include:

- a description of the proposed action,
- the basis for that action,
- the effective date,
- the law, regulation, or policy supporting the action, and
- appeal rights.⁸¹

One of the problems with the CCS appeals process is that under certain circumstances, a written NOA is *not* required, for example, when there is a reduction, termination, or modification of *current services or benefits* that are ordered by the CCS physician or when the services or benefits were only authorized for a limited period, which has ended.⁸² Without a NOA beneficiaries may not know of their right to appeal. For Medi-Cal eligible beneficiaries, this also does not comply with the Medi-Cal due process rights under state and federal law. Another issue is that under the CCS program, a beneficiary has the right to appeal a CCS agency decision, *except* when the CCS physician responsible for the beneficiary's medical supervision ordered or terminated the service under dispute.⁸³ If a beneficiary disagrees with the CCS physician, they are provided with the names of three expert physicians from which to pick one to evaluate the beneficiary.⁸⁴ CCS will pay the cost of the evaluation, and the expert physician's opinion is considered final.⁸⁵ This process is also contrary to Medi-Cal appeal rights.

- **Advocacy Tip:** Beneficiaries who have both CCS and Medi-Cal coverage have the right to the Medi-Cal notice and appeals process as well. Advocates should make sure such Medi-Cal protections and appeal rights are provided in particular where inadequate notices are issued or no notice is provided as required in Medi-Cal.

i. First Level Appeals

Through the CCS appeals process, beneficiaries who are not satisfied with a decision can submit a written appeal postmarked within **30 calendar days** from the date of the NOA.⁸⁶ The

⁷⁹ 22 CCR § 42701(a)(2).

⁸⁰ 22 CCR § 42701(a)(5).

⁸¹ 22 CCR § 42131(b).

⁸² 22 CCR § 42132(b)(1) and (3).

⁸³ 22 CCR § 42140.

⁸⁴ *Id.*

⁸⁵ *Id.*

⁸⁶ 22 CCR § 42160(a).

written appeal should: (1) include the reason for the appeal, (2) provide available information to support the request, and (3) state the action, decision, or relief sought.⁸⁷ If there is a need for continued services during the appeal process, the written appeal must include that request.⁸⁸ If the beneficiary lives in a county that administers CCS services “independently,” the appeal gets sent to the program director or county CCS agency designee.⁸⁹ For all other counties, the appeal is sent to the State CCS Regional Office for that county.⁹⁰ The local CCS agency must upon request assist applicants or beneficiaries to complete the request for an appeal.⁹¹ Once CCS receives the written appeal, if sufficient information is available, it has **21 calendar days** to send the beneficiary a written response that includes a decision, the basis for it, and pertinent facts and supporting statutes or regulations.⁹² If additional information is required to make a decision, CCS must mail the decision within 21 calendar days of receiving the information.⁹³

ii. Request for CCS State Fair Hearing

If the beneficiary’s first level appeal is denied, the beneficiary may request a CCS State Fair Hearing.⁹⁴ The beneficiary must file the request within **14 calendar days** of the date of the written appeal decision.⁹⁵ The CCS Fair Hearing request must be signed by the beneficiary or legal guardian and include the written decision from the First Level Appeal.⁹⁶ If DHCS determines that the CCS State Fair Hearing request is not specific enough or that necessary information is missing, it will notify the beneficiary within 14 calendar days, and the beneficiary will have 14 calendar days from the date of the request for information to submit the additional information.⁹⁷ If the beneficiary does not submit the additional information within the 14 calendar day period, the hearing officer may defer or deny the Fair Hearing request.⁹⁸ Late requests for a CCS Fair Hearing will be denied unless the beneficiary is able to establish good cause for the late filing.⁹⁹ Late cause requests must be made in writing, and the hearing officer will make good cause determinations based on these requests.¹⁰⁰

iii. Request for Continued Services During CCS Appeal

If the first level appeal or CCS Fair Hearing request includes a request to continue or resume services (previously authorized by CCS) during the appeal process, the beneficiary will need a

⁸⁷ 22 CCR § 42160(b).

⁸⁸ *Id.*

⁸⁹ 22 CCR § 42160(c)(1).

⁹⁰ 22 CCR § 42160(c)(2).

⁹¹ 22 CCR § 42160(d).

⁹² 22 CCR § 42160(e).

⁹³ *Id.*

⁹⁴ 22 CCR § 42160(f).

⁹⁵ 22 CCR § 42180(a)(1).

⁹⁶ *Id.*

⁹⁷ 22 CCR § 42180(a)(2).

⁹⁸ 22 CCR § 42180(a)(3).

⁹⁹ 22 CCR § 42180(b).

¹⁰⁰ *Id.*

medical decision that the continued services are medically necessary. The medical decision regarding the need for continued services occurs as follows:

- CCS authorizes that the beneficiary get evaluated by a non-CCS expert physician,
- Within five days of receipt of the request for evaluation, the CCS agency must provide the beneficiary with the names of three non-CCS expert physicians,
- Within five days of the receipt of the names of the three physicians, the beneficiary must select a physician from the list to perform an evaluation,
- Within five days of notification to CCS of the choice of physician, the CCS agency must set up an appointment for the evaluation at a time mutually acceptable to all, and
- Medically necessary benefits will continue until the evaluation is completed and received by CCS.¹⁰¹

Benefits and services will continue or resume pending the appeal if:¹⁰²

- The non-CCS expert physician finds that terminating or changing the beneficiary's current medical services will result in:
 - potential injury or loss of life,
 - measurable, significant loss of physical functioning, or
 - significant risk of deterioration.
- There is no reasonable alternative for the provision of such services.
- The service or benefit being appealed is an approved CCS program benefit.

Note for Advocates

As explained in this section, there is no coordination between CCS and Medi-Cal appeals, and the CCS appeals process is not consistent with Medi-Cal due process rights. This is an area where additional state guidance is needed to address these discrepancies for Medi-Cal eligible children in the CCS program. In addition, there is a different appeals process for children in WCM and non-WCM counties, which also means appeal rights vary depending on the county the child lives in.

¹⁰¹ 22 CCR § 42321(a).

¹⁰² 22 CCR § 42321(b).

V. Conclusion

This issue brief provides an overview of access to DME and supplies under the CCS program. Accessing DME through the CCS program can be challenging for beneficiaries and advocates, in particular because of the structural complications and complex rules. There is also a lack sufficient guidance by the state in numerous areas, such as care coordination and due process rights for beneficiaries with CCS and Medi-Cal coverage. Please visit the National Health Law Program’s website regularly for more information about access to DME and supplies through the CCS program.