California Children's Services Due Process Toolkit

By Alicia Emanuel, Anuja Kumaria, Anna Leach-Proffer, Sydney Louie, Alexis Robles-Fradet, and Skyler Rosellini

Support for this work was provided by the Lucile Packard Foundation for Children's Health, Palo Alto, CA.
The views presented here are those of the authors and do not reflect the views of the Foundation or its staff.

Learn more at **LPFCH.org/CYSHCN.**

California Children's Services Due Process Toolkit

Table of Contents

This toolkit is intended to help California Children's Services (CCS) beneficiaries and their families navigate CCS program grievances and appeals. The toolkit provides guidance and best practices on the grievance and appeals process so that readers can understand how to get care through the CCS program. The guide includes the applicable laws, regulations, and policy guidance as well as flowcharts to help explain the process and an index of acronyms referenced in the guide in Addendum A.

I. Background

A. Introduction on Medicaid Due Process

CCS can be a complex program to understand because the rules often depend on how the beneficiary gets CCS services and the county that the CCS beneficiary lives in. Approximately 90% of children in the CCS program also have Medi-Cal, which is California's Medicaid program. Therefore, CCS beneficiaries need to understand how CCS and Medi-Cal rules overlap. This toolkit will explain more about which rules apply to CCS-only beneficiaries and which apply to CCS beneficiaries with Medi-Cal.[1]

Children enrolled in CCS have many legal rights including the right to appeal a decision. Specifically, if a CCS beneficiary experiences a delay, denial, reduction, or discontinuation of services, or other issues with their CCS eligibility and benefits, CCS beneficiaries must receive a written notice before experiencing a delay, denial, reduction, or discontinuation of services, or other issues with their CCS eligibility and benefits.[2]

Since most children in the CCS program also have Medi-Cal coverage, they are also protected by Medi-Cal appeal rights, or Medi-Cal "due process" rights. Medi-Cal appeal rights are separate from CCS appeal rights. Some of the most important Medi-Cal protections are the right to receive a written notice before benefits are denied, stopped, or reduced and the right to request an appeal for a State Fair Hearing.[3] Medi-Cal members' right to benefits are protected by the Due Process Clause of the U.S. Constitution.

B. CCS Program

CCS is a state program for children and youth with special health care needs. In the CCS program, children and youth up to the age of 21 years old with certain health conditions can get diagnostic and treatment services, medical case management, and physical and occupational therapy services.[4] They can also receive

[1] Dep't of Health Care Srvs, California Children's Services Program Enrollment Data, https://www.dhcs.ca.gov/services/ccs/Pages/EnrollmentData.aspx.

[2] 22 CCR § 42132, 22 CCR § 42140, 42160, 42180; Dep't of Health Care Srvs, CCS Numbered Letter 04-0424, CCS Program Appeals and State Hearing Process (June 3, 2024), https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-04-0424.pdf.

[3] U.S. Const. amend. XIV, § 1; *see Goldberg v. Kelly*, 397 U.S. 254, 266 (1970) explaining that Medicaid members' rights to benefits are protected by the Due Process Clause of the U.S. Constitution.; *see also* 42 C.F.R. §§ 431.200-431.250; 42 C.F.R. §§ 438.400-438.424.

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

medical therapy services that are delivered at public schools through the Medical Therapy Program (MTP). Examples of CCS-eligible conditions are cystic fibrosis, hemophilia, cerebral palsy, health disease, cancer, traumatic injuries, and more.[5] The CCS program covers:

- Doctor visits
- Hospital stays
- Surgery
- Physical and occupational therapy
- Lab tests
- X-rays
- Durable Medical Equipment (DME) and orthopedic appliances

Eligibility for the CCS program depends primarily on having a diagnosis of a CCS-eligible condition(s). Children must also be California residents, their family's annual income must be less than $40,000. If a family's income is over $40,000, their child may still be eligible for the CCS program if any of the following apply:

- The child has full-scope Medi-Cal
- The family's out-of-pocket medical expenses for the child are more than 20% of the family's adjusted gross income
- The family only wants MTP services for their child
- The child needs to see a doctor to determine if their condition is eligible for CCS
- The family adopted the child with a known medical condition that made them eligible for CCS

Once enrolled, how a child gets services through CCS depends on whether they live in a Whole Child Model (WCM) county or not.[6] If the child lives in a WCM county and has Medi-Cal, a health plan called the Medi-Cal Managed Care Plan (MCP) is responsible for authorizing CCS eligible services, case management, and more.[7] In non-WCM counties, or "classic counties," the county CCS program is responsible for these duties. The CCS beneficiary will have a case manager through either the county CCS program or the Medi-Cal MCP.[8]

[5] Dep't of Health Care Srvs, California Children's Services Brochure, https://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/pub4.pdf; *see also* Cal. Health & Safety Code § 123870.

[6] DME services and supplies must be determined to be "medically necessary" and prescribed by a CCS-paneled physician who specializes in the care a CCS beneficiary needs. The need for DME services and supplies may be identified by other providers like school providers, regional centers, or Medical Therapy Program (MTP) providers. If these providers are not CCS-paneled physicians, they must submit a referral to the beneficiary's CCS program before they submit a Service Authorization Request (SAR).

[7] Dep't of Health Care Srvs, CCS NL 12-1223, California Children's Services Program Whole Child Model (Revised) (Dec. 27, 2023), https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-12-1223.pdf.

[8] Dep't of Health Care Srvs, California Children's Services Brochure, https://www.dhcs.ca.gov/formsandpubs/publications/Documents/CMS/pub4.pdf.

Within CCS, MTP is a special program that provides physical therapy (PT), occupational therapy (OT), and Medical Therapy Conference (MTC) services for children with disabling conditions like neurological or musculoskeletal disorders. MTPs can also provide PT and OT services through telehealth as an alternative to in-person visits as appropriate and directed by the MTCs. If a child is getting services from an MTP, they must have an annual in-person evaluation by a CCS-paneled physician. A current medical report is required to be on file to receive MTP services. MTP is provided in partnership between county health departments, the Department of Health Care Services (DHCS), and local education partners.[9]

In order for CCS-eligible services to be covered by CCS, they must be approved through a service or treatment authorization. A Service Authorization Request (SAR) is a request a provider submits to the CCS program to get services approved and paid for. Once submitted, the SAR goes through the CCS approval process. This SAR process applies to CCS beneficiaries without Medi-Cal, as well as CCS beneficiaries with Medi-Cal who live in non-WCM counties. Conversely, if the beneficiary lives in a WCM county, the CCS-paneled provider must submit a Treatment Authorization Request (TAR) to the MCP. The only difference between a SAR and a TAR is that a SAR applies to the CCS program and a TAR applies to the Medi-Cal program. The MCP is then required to approve services that are medically necessary and meet the CCS program's standards.

i. Service Authorizations

a. Durable Medical Equipment (DME)

DME services and supplies must be determined to be "medically necessary" and prescribed by a CCS-paneled physician who specializes in the care a CCS beneficiary needs. The need for DME services and supplies may be identified by other providers such as school providers, regional centers, or MTP providers. If these providers are not CCS-paneled physicians, they must submit a referral to the beneficiary's CCS program before they submit a SAR.[10]

b. Private Duty Nursing

Private Duty Nursing (PDN) is covered when necessary to treat a beneficiary's CCS-eligible condition. Home Health Agencies develop a plan of care that must be signed by a CCS-paneled physician. They then submit that plan of care to the county or to the Medi-Cal MCP for approval of a SAR.

[9] Dep't of Health Care Srvs, Medical Therapy Program, https://www.dhcs.ca.gov/services/ccs/Pages/MTP.aspx.

[10] National Health Law Program, Helping Families Obtain Durable Medical Equipment and Supplies through The California Children's Services (CCS) Program (2021), https://healthlaw.org/wp-content/uploads/2021/08/2021-CCS-DME-Issue-Brief_8.6.2021-updated.pdf.

II. CCS Program Rules for Notices

Children enrolled in the CCS program are entitled to a written notice, called a Notice of Action (NOA), when the CCS program takes certain actions on their eligibility, services, or supplies. An NOA must be in writing, explain why the CCS program is taking the action, indicate the rule or law that supports the action they are taking, and provide information about the CCS beneficiary's right to appeal.[11] The rules regarding notices differ depending on how the beneficiary gets CCS services and the type of action taken, so it is important to be aware of these complicated rules.

A. Eligibility

If a CCS beneficiary is denied or discontinued from the CCS program, CCS is required to send the beneficiary and their family a written notice **at least seven (7) days** before the action takes place.[12] However, for CCS beneficiaries with Medi-Cal, CCS must send a written notice **at least ten (10) days** before the action takes place. A written notice is also required when the amount of a family's annual enrollment fee is increased. (**Note:** Beneficiaries with full-scope Medi-Cal are not charged an enrollment fee, regardless of family income).

B. Services

CCS beneficiaries also have notice and appeal rights when negative actions are taken with respect to their CCS benefits, such as treatment, services, or supplies. A "negative action" can include stopping or reducing a beneficiary's CCS-related services or supplies that CCS already approved, denying a new request for CCS-related services, or denying a request for a CCS benefit that is not currently provided in the program.[13] The CCS program must send written notice when CCS services are denied, stopped, changed, or reduced.[14] Again, written notice is required **at least seven (7) days** in advance for CCS-only beneficiaries and **at least ten (10) days** in advance for CCS beneficiaries with Medi-Cal. *(See below in Section II(D) for more information for CCS children with Medi-Cal coverage.)*

C. Notices Are Not Required in All Situations in the CCS Program

In the CCS program, a written notice is not required in all situations. For example, the CCS program does not have to send a written notice when a beneficiary's CCS-paneled provider does not think the CCS beneficiary needs the CCS services or supplies anymore.[15] The CCS program also does not have to send a written notice if a CCS beneficiary or their family voluntarily cancels their CCS enrollment or stops CCS services, if the CCS treatment was allowed for a limited time, or if the CCS beneficiary is in a licensed acute care or sub-acute care medical facility.[16] However, if the CCS beneficiary also has Medi-Cal, these exceptions should not apply because a Medi-Cal beneficiary is entitled to a written notice for any negative action regardless of the reason.

[11] 22 CCR § 42131(b).

[12] 22 CCR § 42132(a).

[13] 22 CCR § 42132(a).

[14] 22 CCR § 42132(a).

[15] 22 CCR § 42132(b).

[16] 22 CCR § 42132(b).

D. Notice Requirements for CCS Beneficiaries with Medi-Cal

A CCS beneficiary who has Medi-Cal coverage has additional rights to written notice. If a CCS beneficiary has Medi-Cal, the CCS program must send a written notice **at least ten (10) days** before the negative action on their CCS benefits begins. As explained in the beginning of this section, a proper notice must be in writing, and the notice must give a reason for the action that CCS is taking, the date the action will start, the rule or law that supports the action being taken, and information about the CCS beneficiary's right to appeal.[17]

A CCS beneficiary with Medi-Cal also has the right to request a hearing (called an "appeal") when eligibility is denied, a service request is denied or reduced, or a decision on whether services are approved is delayed. When a beneficiary's eligibility or services that were previously approved are later denied, terminated, or reduced, CCS beneficiaries on Medi-Cal have the right to keep their benefits while they go through the appeals process. This is called "Aid Paid Pending" (APP) or also referred to as "Continuing Benefits." This is a critical right for CCS beneficiaries and their families to avoid gaps in coverage or services when they appeal. *Read more about the CCS and Medi-Cal appeals processes in Section IV of this toolkit.*

Advocacy Tip: Always check the date on the notice. CCS beneficiaries with Medi-Cal must receive notice **at least ten (10) calendar days** before benefits are stopped or changed. If the CCS beneficiary does not receive the notice at least 10 days before the action date, the CCS beneficiary can ask for an appeal using the contact information in the notice and tell the appeals office or the Administrative Law Judge (ALJ) that the notice was not sent on time or is missing information. This is important because if a notice does not include all of the information described above, or if the program sent it late or did not send a required notice at all, then the CCS program must take back any negative action that may already have happened and/or restart the notice process.

[17] 42 CFR § 435.919; 22 CCR § 50179; 42 CFR 438.404(b); Cal. Health & Safety Code § 1367.01; 22 CCR §§ 51014.1, 51014.2, and 53894.

III. Right to File a Grievance with the CCS Program

If a CCS beneficiary (with or without Medi-Cal) is dissatisfied with an action or inaction taken by the CCS program, they can file a grievance. A grievance is similar to a complaint. Filing a grievance helps to ensure that the CCS beneficiary has their concerns resolved. A CCS grievance can be either informal or formal.[18]

A CCS beneficiary can file a grievance for any concern, including:[19]

- Concerns with coordination of care, services, equipment, or appointments
- Poor customer service
- Discrimination against the CCS beneficiary or their family
- Health information privacy concerns
- Quality of care concerns
- Issues with referrals for services
- Issues with scheduling appointments
- Concerns with timeliness of service authorizations or CCS Program eligibility decisions

To file a formal grievance, a CCS beneficiary must complete a CCS Grievance Form. CCS families can ask DHCS or their county CCS program for assistance with filling out the form. This includes the right to receive translation assistance. Grievances can be submitted verbally, in-person, via telephone, by mail or email. Once the form is submitted, the formal grievance process begins.[20]

Advocacy Tip: Whenever possible, CCS beneficiaries should request a formal CCS grievance instead of an informal one. Formal grievances require DHCS or the county CCS office to respond to a CCS beneficiary within a specific timeline and to include a grievance form and log. Informal CCS grievances do not have to follow these same standards, which means that an informal grievance can be easily forgotten or delayed. However, if a CCS beneficiary has an emergency, then an informal grievance can be filed if the beneficiary is unable to send a formal grievance.

CCS grievances must be addressed by the CCS program **within thirty (30) days**, but must also be expedited if the issue is urgent for a CCS beneficiary. For a standard grievance, the CCS program has **five (5) business days** to acknowledge receipt of the grievance and coordinate with the county CCS program if needed.

[18] Dep't of Health Care Srvs, CCS Numbered Letter 06-1023, California Children's Services Program Grievances Process (April 12, 2024), https://www.dhcs.ca.gov/services/ccs/Documents/20240308-CCSNL-Grievance-Process.pdf. In an informal grievance, a CCS beneficiary can send a complaint in person, by phone, or by email. Depending on the county, either DHCS or the county CCS program decides if the issue can be resolved immediately. If they can resolve the complaint promptly then no formal grievance is filed. Informal grievances are not formally tracked.

[19] Dep't of Health Care Srvs, CCS Grievance, Appeal, and State Fair Hearing Fact Sheet, https://www.dhcs.ca.gov/services/ccs/Documents/20240202-CCS-Grievance-Appeal-SH-Factsheet-Independent.pdf.

[20] Dep't of Health Care Srvs, CCS Numbered Letter 06-1023 Attachment A, https://www.dhcs.ca.gov/services/ccs/Documents/20230328-CCSNL-Grievance-Flowchart.pdf.

Standard grievances must be resolved within **thirty (30) calendar days** from when the grievance was received. DHCS or the county CCS program must notify the CCS beneficiary in writing about the outcome and status of the grievance within **five (5) business days** of when the grievance is resolved.[21]

However, if an action taken by the CCS program would cause serious harm to a CCS beneficiary, then the beneficiary can file an urgent or "expedited grievance." Expedited grievances are appropriate when a CCS beneficiary faces threats to their health including severe pain or potential loss of life, limb, or major bodily function. When an expedited grievance is filed, DHCS or the county CCS program must direct the CCS beneficiary to the appropriate entity and make a reasonable effort to confirm they received the grievance through a phone call **within one (1) business day** of receipt. Expedited grievances must also be resolved **within three (3) business days**. They must make a reasonable effort to verbally notify the CCS beneficiary about the status and follow up on the grievance in writing.[22]

How to file a grievance depends on which county the CCS beneficiary lives in. Below are the steps to take for each county:[23]

Counties	Phone	Email Contact	County CCS Office
Independent Counties: County CCS programs are responsible for receiving, acknowledging, and resolving grievances[24]	(916) 713-8300	CCSMonitoring@DHCS.ca.gov	The addresses, emails, and phone numbers for all county offices are listed on the DHCS Webpage at: **County Offices (ca.gov)**
Dependent Counties: DHCS is responsible for receiving, acknowledging, and resolving grievances[25]	(916) 713-8300	CCSMonitoring@DHCS.ca.gov	**Mail Address:** DHCS Integrated Systems of Care Division Attn: County Compliance Unit, 1501 Capitol Ave, MS 4502, PO Box 997437, Sacramento, CA 95899-7437 **In Person, at the County Office:** The addresses for all county offices are listed on the DHCS website: **County Offices (ca.gov)**

[21] Dep't of Health Care Srvs, CCS Numbered Letter 06-1023, https://www.dhcs.ca.gov/services/ccs/Documents/20240308-CCSNL-Grievance-Process.pdf.

[22] Dep't of Health Care Srvs, CCS Numbered Letter 06-1023, https://www.dhcs.ca.gov/services/ccs/Documents/20240308-CCSNL-Grievance-Process.pdf.

[23] Dep't of Health Care Srvs, California Children's Services Program Grievance Intake, https://www.dhcs.ca.gov/services/ccs/Documents/20240328-CCSNL-Grievance-Form.pdf.

[24] Independent Counties include: Alameda, Butte, Contra Costa, Fresno, Humboldt, Kern, Los Angeles, Marin, Mendocino, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo.

[25] Dependent Counties include: Alpine, Amador, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Imperial, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Modoc, Mono, Nevada, Plumas, San Benito, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba.

IV. Appeals & Hearings

A CCS beneficiary should consider filing an appeal when they receive a denial of a request for a new CCS service or supply, a denial or reduction in CCS services or supplies they are currently receiving, or a delay in processing an approved service.[26] A CCS beneficiary can also appeal a denial of a CCS application or a termination from the CCS program if they think the decision is incorrect.

The CCS appeal process is different for CCS beneficiaries *without* Medi-Cal and CCS beneficiaries *with* Medi-Cal. As previously mentioned, federal Medicaid rules provide stronger protections to CCS beneficiaries *with* Medi-Cal. So, if a CCS beneficiary has both CCS and Medi-Cal, then Medi-Cal rules must apply instead of CCS rules. For example, if there is a longer appeal timeline under Medi-Cal, the CCS beneficiary with Medi-Cal is entitled to the longer Medi-Cal timeline instead of the shorter CCS timeline.

Generally, CCS beneficiaries *without* Medi-Cal follow the CCS appeal process in Section IV(B) below. CCS beneficiaries with Medi-Cal have all the appeal rights in Section IV(B), as well as all of the Medi-Cal appeal rights in Section IV(C).

A. Should a CCS Beneficiary Without Medi-Cal File an Appeal?

A CCS beneficiary without Medi-Cal should consider filing an appeal when the CCS program terminates or changes their enrollment in the program or takes a negative action against certain CCS services or supplies.

There are limited situations when a CCS beneficiary *cannot* file a CCS appeal.[27] If the beneficiary's CCS physician decides that in their professional judgment the CCS beneficiary's treatment should end or change, the CCS beneficiary cannot file an appeal through the CCS program. In this situation, CCS must provide the beneficiary and their family with an independent evaluation at no cost to them. The CCS program must send the beneficiary a list of three expert physicians to choose from to evaluate the beneficiary. The decision of the independent evaluation is final.[28] This does not apply if a CCS beneficiary is also enrolled in Medi-Cal.

Advocacy Tip: If you receive a written notice that the CCS program is taking an action that you disagree with, keep it for your records. The information in the notice will help you with your appeal, even if the information in the notice is incorrect. If the CCS program fails to send a notice, you can still file an appeal.

B. CCS Appeal Process for Beneficiaries Without Medi-Cal

CCS beneficiaries should be aware of the different stages of the CCS appeals process. The appeal rights discussed in this section apply to CCS beneficiaries without Medi-Cal. The first level appeal is an optional step for beneficiaries who elect to use it, but it is not required. **Note:** CCS beneficiaries with Medi-Cal who are not in a Whole Child Model county can also use this appeals process or can go directly to the State Fair Hearing process described in Section IV(C) below.

[26] 22 CCR § 42140.

[27] 22 CCR § 42140(b) explaining that the CCS program does not need to grant an appeal if the sole issue is one of federal or state law requiring an automatic change that impacts all, or some, CCS beneficiaries.

[28] 22 CCR § 42140(a).

i. First Level Appeal

Once the CCS beneficiary receives a written notice that denies a CCS application, denies or reduces a CCS service, or delays access to a CCS service or supply, the CCS beneficiary has **thirty (30) calendar days** from the date of the Notice of Action (NOA) to request an appeal. This is called the First Level Appeal.[29] This provides an opportunity for the CCS beneficiary to share additional information to the county CCS program so that the county may reconsider its decision before moving forward with a State Fair Hearing. The CCS program must send a written First Level Appeal decision **within twenty-one (21) days** of receiving the First Level Appeal.[30] The appeal decision must include the reason for the decision, the facts the decision was based on, and supporting laws and rules.[31]

Advocacy Tip: A First Level Appeal does not need to be filed before requesting a State Fair Hearing. CCS beneficiaries can skip the First Level Appeal and file a State Fair Hearing if they prefer.[32] Some families may try to resolve a CCS issue informally before going to a hearing. Other families may want to request a State Fair Hearing before an Administrative Law Judge (ALJ) instead.

ii. How to Ask for a First Level Appeal

To ask for a First Level Appeal, the CCS beneficiary must send a written appeal to the CCS office. If the CCS beneficiary is in an independent county, the First Level Appeal goes to the local CCS office. If the CCS beneficiary is in a dependent county, the First Level Appeal goes to the State CCS Regional office. The written appeal should include the reason the CCS beneficiary is appealing, information that supports the reason for the appeal, and what result the CCS beneficiary is seeking.[33] The First Level Appeal should include all relevant documents that support the appeal, such as letters of support from treating doctors, medical records, and nursing notes. If a CCS beneficiary asks the CCS agency for help with an appeal, the CCS agency is required to provide assistance to complete the request.[34]

Advocacy Tip: Although the regulations require that a CCS beneficiary receives a First Level Appeal decision **within twenty-one (21) days**, this does not always happen on time. If the CCS beneficiary does not receive a response **within twenty-one (21) days**, they do not have to wait for the decision and can file a State Fair Hearing. (*See **Section IV(C)(iv)** below on CCS State Fair Hearings).*

[29] 22 CCR § 42160(a).

[30] 22 CCR § 42160(e).

[31] 22 CCR § 42160(e).

[32] 42 CFR § 431.220; Cal. Welf. & Inst. Code § 10950; See also Dep't of Health Care Srvs, CCS Numbered Letter 04-0424, CCS Program Appeals and State Hearing Process (June 3, 2024), https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-04-0424.pdf p.4.

[33] 22 CCR § 42160(a), (b) & (c); see also Dep't of Health Care Services, CCS Numbered Letter 04-0424, (June 3, 2024), https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-04-0424.pdf.

[34] 22 CCR § 42160(d).

iii. Requesting Aid Paid Pending

A CCS beneficiary can ask for CCS services to continue while the appeal is ongoing. This is called Aid Paid Pending (APP) and ensures that CCS beneficiaries can keep their CCS benefits and services while they go through the appeals process. In order to request APP, the CCS beneficiary must send an email to the Department of Health Care Services' (DHCS) Integrated Systems of Care Division (ISCD), Hearing and Appeals Unit (HAU) at ISCDHAU@dhcs.ca.gov and request "aid paid pending" or "continuation of services" and provide the beneficiary's name and CCS case number.

Advocacy Tip: If APP is granted during the First Level Appeal but the issue is not resolved during the First Level Appeal, the CCS beneficiary does not have to ask for APP a second time while they prepare for a State Fair Hearing. However, it is advisable to reach out to DHCS to confirm the request for APP.

iv. CCS State Fair Hearing

A CCS beneficiary has a right to request a State Fair Hearing if the First Level Appeal is denied or they do not agree with the First Level Appeal decision.[35] A State Fair Hearing is an informal hearing in front of an ALJ. At the hearing, a CCS beneficiary can explain why they disagree with a decision that the CCS program made and provide evidence to support their position. State Fair Hearings are administered by the California Department of Social Services (CDSS) State Hearings Division (SHD). A CCS beneficiary who does not have Medi-Cal has **fourteen (14) calendar days** from the date of the written First Level Appeal decision to request a State Fair Hearing.[36] The request must be submitted with a copy of the First Level Appeal decision.[37] A late request for a State Fair Hearing may be denied. If a CCS beneficiary misses the deadline to request a State Fair Hearing, they can still file for the hearing if they can show that there is good cause for late filing, such as because of severe illness or disability.[38]

Advocacy Tip: The CCS appeals timeline for beneficiaries who do not have Medi-Cal is very fast. It is very important to pay attention to the deadline to request a State Fair Hearing and request it immediately; otherwise a late request may be denied. If a CCS beneficiary misses the deadline to request a CCS State Fair Hearing, they should argue that there is good cause for late filing. Examples of situations that may be considered good cause include hospitalization of the CCS beneficiary or a family member, a family emergency, or that CCS failed to send a written notice prior to the effective date of the negative action.

[35] 22 CCR § 42180.

[36] 22 CCR § 42180(a)(1).

[37] 22 CCR § 42180(a)(1).

[38] 22 CCR § 42180(b).

After the CCS program may still require more information. If this is the case, the CCS program must notify the CCS beneficiary **within fourteen (14) calendar days** from the date of the request. The CCS beneficiary will be given **fourteen (14) calendar days** after the date of the request to submit the additional information for the hearing.[39] If a State Fair Hearing request is accepted, State Hearings Division (SHD) must send written notice of the time and place of the hearing to each party **at least thirty (30) calendar days** before the hearing.[40]

Advocacy Tip: If the CCS beneficiary did not receive a written notice or they receive it in less than ten (10) days when the change to their CCS benefits begins, the CCS beneficiary can still ask for an appeal and Aid Paid Pending (APP). Also, an appeal can still be requested if a notice was late, never sent, or the notice was faulty, for example, if it was missing required information. When the CCS beneficiary asks for the appeal, they will need to explain that they did not receive a written notice or that they received the written notice late.[41]

Advocacy Tip: *All* CCS beneficiaries currently have a temporary extension to request a State Fair Hearing within 120 days. DHCS has not set a date when this temporary extension will end. Check any written notices for specific details on when the CCS beneficiary need to request an appeal.

v. How to Ask for a State Fair Hearing

As mentioned above, all CCS appeals are handled by the CDSS SHD. An appeal can be requested online, by phone, FAX, or in writing through the mail.[42] As mentioned in Section IV(B)(i), CCS beneficiaries have the option to either file a CCS First Level Appeal or immediately file a request for a State Fair Hearing with the State Hearings Division.

Below are the different ways to file a State Fair Hearing:

Online: Create an ACMS account or submit an appeal without an account at https://acms.dss.ca.gov/acms/login.request.do or go to https://www.cdss.ca.gov/hearing-requests

By phone: Call State Hearings Division at 1-800-743-8525 or TDD 1-800-952-8349

By FAX: (833) 281-0905

By mail: California Department of Social Services

State Hearings Division
P.O. Box 944243, Mail Station 9-17-442
Sacramento, CA 94244-2430

[39] 22 CCR § 42180(a)(2).

[40] 22 CCR § 42305.

[41] 22 CCR § 42321.

[42] *See also* cdss.ca.gov/hearing-requests.

Once the State Fair Hearing request is received, the CCS beneficiary has the right to request a telephone hearing, video hearing, or in-person hearing.[43] For more information about the CCS appeals process, see NHeLP's publication, *Helping Families Obtain Durable Medical Equipment and Supplies Through the California Children's Services (CCS) Program* and NHeLP's *Know Your Appeal Rights for the California Children's Services Program* fact sheet.

C. Appeal Process for CCS Beneficiaries *with* Medi-Cal

As mentioned in Section I(A), roughly ninety (90) percent of CCS beneficiaries are also enrolled in Medi-Cal. A CCS beneficiary with Medi-Cal has the right to file a Medi-Cal State Fair Hearing in addition to, or instead of, a CCS appeal. So, a CCS beneficiary with Medi-Cal has all the appeal rights in Section IV(B) available to them, in addition to all the appeal rights here in Section IV(C). However, the time frames for an appeal are more generous under Medi-Cal.

Advocacy Tip: The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is a Medi-Cal benefit that applies to the Medi-Cal State Fair Hearing process for CCS beneficiaries with Medi-Cal. The CCS "medical necessity" definition may be too limiting to effectively treat certain CCS conditions. Under EPSDT, benefits and services necessary to "correct or ameliorate defects and physical and mental illnesses and conditions" are required to be covered. For CCS beneficiaries with Medi-Cal, the EPSDT medical necessity standard must apply.[44]

Advocacy Tip: A CCS beneficiary with Medi-Cal is entitled to the longer Medi-Cal appeal timelines when filing a CCS appeal or State Fair Hearing. For example, a CCS beneficiary with Medi-Cal should get **ninety (90) calendar days** to file a CCS State Fair Hearing even though the timeline to file a CCS hearing is **fourteen (14) calendar days** because the beneficiary also has Medi-Cal coverage.

Medi-Cal appeal rights depend on how the CCS beneficiary gets Medi-Cal services. Some beneficiaries have Medi-Cal through a Medi-Cal MCP, while other beneficiaries have fee-for-service, or "regular" Medi-Cal.

Advocacy Tip: A CCS beneficiary is enrolled in a Medi-Cal MCP if they have two Medi-Cal insurance cards: a Benefits Identification Card with a yellow poppy flower on it and a second, separate card with an insurance plan name on it.

[43] Cal. Gov't. Code § 100506.4(h)(2); Cal. Dep't of Social Srvs, Manual of Policies and Procedures 22-045.1.

[44] 42 USC § 1396d(r)(5).

i. CCS Beneficiary with Fee For Service Medi-Cal

If a CCS beneficiary with Medi-Cal is not enrolled in a Medi-Cal MCP, the CCS beneficiary may submit an authorization request to Medi-Cal for services denied by CCS. If Medi-Cal also denies the authorization, then the CCS beneficiary may request a Medi-Cal State Fair Hearing in addition to a CCS State Fair Hearing. A Medi-Cal State Fair Hearing must be filed within **ninety (90) calendar days** of the written notice or, if they did not receive a written notice, before the action they disagreed with took place.[45] Again, CCS beneficiaries do not need to pursue the CCS First Level Appeal before filing a CCS State Fair Hearing. **Note:** A State Fair Hearing about the CCS beneficiary's eligibility and enrollment will go through the CCS State Fair Hearing process.

ii. CCS Beneficiary with Medi-Cal Managed Care in a Whole Child Model County

If a CCS beneficiary has Medi-Cal lives in a Whole Child Model county, the CCS beneficiary accesses CCS services and supplies through the Medi-Cal MCP. The CCS beneficiary has the option to pursue the Medi-Cal MCP appeals process in addition to the CCS program's appeal process.

A CCS beneficiary who is enrolled in a Medi-Cal MCP can file an appeal with the MCP if they disagree with the CCS program's decision concerning the beneficiary's CCS services. This plan appeal is required before requesting a Medi-Cal State Fair Hearing. A plan appeal can be filed with the MCP by telephone, online, or via mail. A CCS beneficiary must file an appeal **within sixty (60) calendar days** of the notice date. A CCS Medi-Cal beneficiary can ask for an expedited plan appeal if their life or health is at risk. With an expedited appeal, the plan must send the CCS beneficiary written notice **within seventy-two (72) hours**. For more information on Medi-Cal MCP appeals, see *Disability Rights California's Medi-Cal Managed Care Appeals and Grievances* publication.[46] **Note:** Appeals related to CCS eligibility in Whole Child Model counties still go to the CCS program. *(See the table in Section III. above for information about specific counties)*.

iii. CCS Beneficiary with Medi-Cal Managed Care in a Classic County

If a CCS beneficiary has Medi-Cal managed care but is not in a Whole Child Model county and is instead in a "classic county", CCS appeals should still go through the county CCS program. The CCS beneficiary may submit an authorization request to the Medi-Cal for the services denied by CCS. If the MCP also denies authorization for the services requested, the CCS beneficiary has a right to file a Medi-Cal appeal with the Medi-Cal MCP. If a CCS beneficiary requests a Medi-Cal State Fair Hearing regarding a denial of services by the MCP in addition to a CCS State Fair Hearing regarding a denial of services by CCS, the two hearings will operate separately. **Note:** A State Fair Hearing about the CCS beneficiary's eligibility and enrollment will go through the CCS State Fair Hearing process.

iv. Aid Paid Pending

A CCS beneficiary with Medi-Cal has the right to request Aid Paid Pending (APP). More specifically, if there is a termination or reduction in Medi-Cal services, the beneficiary has the right to keep their services while going through the appeals process, and the services will not change until they receive a State Fair

[45] *See* Dep't of Health Care Srvs, CCS Numbered Letter 04-0424, CCS Program Appeals and State Hearing Process (June 3, 2024), https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-04-0424.pdf. Due to a current waiver, the timeline to request a hearing has currently been extended to 120 days (not 90 days) through June 2025.

[46] Disability Rights California, Medi-Cal Managed Care Appeals and Grievances (July 1, 2018), https://www.disability-rightsca.org/publications/medi-cal-managed-care-appeals-and-grievances.

Hearing decision. Generally, the Medi-Cal beneficiary must make the APP request before the date of the change listed on the notice, or **within ten (10) days** of the date they receive the notice. APP should be requested when filing the appeal. As of this writing, however, right now, Medi-Cal beneficiaries get APP, even if they did not request APP, as long as they file a State Fair Hearing **within 120 days** of the written notice.

Advocacy Tip: The right to APP without needing to request it within the normal 10 days from receiving notice automatically will apply to both the Medi-Cal and CCS population through June 2025. After that time, APP must be requested within the 10 days from receiving the written notice or before the negative action takes effect.

D. Preparing for a State Fair Hearing:

After the CCS beneficiary requests either a CCS State Fair Hearing or a Medi-Cal State Fair Hearing, they will receive two notices from CDSS State Hearings Division. The first notice is to confirm the request for a hearing. The second notice has the date, time, and place of the hearing.

Soon after sending the first notice, the county will assign a hearing representative who represents the county at the hearing. They are responsible for contacting the CCS beneficiary prior to the hearing to provide information about the case. The hearing representative must assist with trying to resolve the case prior to the State Fair Hearing. The CCS beneficiary is not required to resolve the matter prior to the hearing if they still do not agree with the hearing representative.

Advocacy Tip: The CCS beneficiary can contact the hearing representative to discuss the case, and the parties may be able to resolve the issue without going to a hearing. However, the CCS beneficiary should not withdraw the hearing request until receiving written confirmation that the issue has been fixed. Keeping the hearing request ensures the CCS program will address the issue before or after the hearing. If the hearing representative cannot fix the issue before the hearing, then the CCS beneficiary's right to continue with the hearing is preserved.

i. How to Prepare for the State Fair Hearing

Step 1: Review the Case Records

The CCS beneficiary should gather and review all the notices and other documents related to the hearing request.

Step 2: Gather Information

The CCS beneficiary should collect relevant medical records and letters of support from treating doctors. Ideally, these letters will be from a CCS-paneled doctor. To find out if a doctor is CCS paneled, use this website: https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx. It is important to have a letter of support from the treating doctor explaining why the CCS beneficiary needs the service that was denied, reduced, or terminated.

Advocacy Tip: The CCS beneficiary should reach out to the treating doctor and explain that a service the beneficiary needs has been denied by CCS. The CCS beneficiary should request that the doctor draft a letter explaining why the service that has been denied is medically necessary. It is helpful if the letter provides specific examples and is supported with relevant medical records.

Contact DRC at 1-800-776-5746 or visit https://www.disabilityrightsca.org/get-help for a sample letter of support from a doctor.

Advocacy Tip: Upload documents online through the ACMS portal. ACMS is the Appeals Case Management System that is used by CDSS for all hearings. It is the easiest way to track the progress of the appeal and view documents. If the CCS beneficiary is not able to use ACMS, they can contact the assigned hearing representative to ask if the documents can be submitted via email, mail, or FAX.

Step 3: Review the CCS Program's Position Statement

The CCS program will provide an explanation for why they denied or reduced the CCS beneficiary's benefits or services in a written position statement. The CCS program must send the written position statement to CCS beneficiaries, and any advocate working on their behalf, **at least two (2) business days** before the hearing.

This statement will be either mailed or available on the ACMS portal to download. The CCS beneficiary has the right to have the position statement sent in their preferred language. If they don't receive the position statement in their preferred language, the CCS beneficiary has the right to have it read by a translator in their preferred language. The CCS beneficiary may request a translator by contacting the hearing representative who must provide translation at no cost to the CCS beneficiary.

The position statement will explain the CCS program's reasons for taking action against the CCS beneficiary's eligibility or CCS services (even if the CCS beneficiary disagrees with the reasons). The position statement will also help the CCS beneficiary identify other evidence and witnesses they may need. If the CCS beneficiary does not get a copy **within two (2) business days** prior to the hearing, the CCS beneficiary has a couple of options. First, they can proceed with the hearing and ask the ALJ to "have the record left open" so they can submit additional information to respond to anything in the county's position statement. Even if the CCS beneficiary can get the CCS program's position statement on time, they can still ask to have the hearing record left open to submit more evidence. Second, if the CCS beneficiary receives a late position statement, they have the right to postpone the hearing if they need more time to prepare for it.

A CCS beneficiary can provide their own position statement in response to the county's statement. This is optional. However, a written summary of the CCS beneficiary's position may help to simplify the hearing and may help the beneficiary feel more prepared at the hearing. It is important that the statement explain why the CCS beneficiary believes the action taken by the CCS program is wrong.

Contact DRC at 1-800-776-5746 or visit https://www.disabilityrightsca.org/get-help for a sample position statement.

Step 4: Postponements

A CCS beneficiary can ask to postpone their hearing at any time prior to the actual hearing if they cannot make the scheduled date and time of the hearing or if they need more time to prepare. The first request for postponement is generally granted without the need to provide a reason, but any additional postponements will require an explanation.[47] Aid Paid Pending will continue if a postponement is granted.

Advocacy Tip: Once the CCS beneficiary receives the CCS program's position statement, they may want to request a postponement of their hearing to be able to better prepare for their case. This will allow time to negotiate with the hearing representative as well as to gather any updated records.

ii. What to Expect at the State Fair Hearing

CCS State Fair Hearings are more informal than other legal proceedings. Most hearings are done over the phone or by video conference, with the option to have an in-person hearing at the county CCS office. Each side will have the opportunity to present information to support their position. The CCS beneficiary should present information (testimony by witnesses, doctors' letters, diary log, and medical records) to show their needs for the benefits or services that were denied.

The evidence must show:

1) That the CCS services or supplies requested are medically necessary. The CCS beneficiary can discuss this with the CCS panelled provider involved in the case.

2) The services must be related to the CCS-eligible condition.

Advocacy Tip: The CCS beneficiary is permitted to bring witnesses to provide testimony. Witnesses may include the beneficiary's family members, the beneficiary's treating doctors, or current CCS service providers. The witnesses should be prepared to explain why the decision made by CCS was incorrect as well as their qualifications for determining what is medically necessary.

iii. What to Expect After the State Fair Hearing

The State Fair Hearing decision must be mailed to the CCS beneficiary. If the CCS beneficiary registered their hearing online through ACMS, the decision will also be available to view and download from their ACMS case account.

However, if the CCS beneficiary still does not agree with the ALJ's hearing decision, they can request a rehearing. The beneficiary may also file a lawsuit in California Superior Court.

1. **Request for Rehearing**

   CCS beneficiaries have the right to request a rehearing **within thirty (30) days** after receiving the hearing decision. To have a rehearing granted, the CCS beneficiary must explain why the ALJ did not properly consider the information presented at the hearing or did not apply the correct rules when making the decision.

[47] 7 CFR § 273.15(c)(4); Cal. Welf. & Inst. Code § 10952.5; Cal. Dep't of Social Srvs, Manual of Policies and Procedures, 22-053.

[48] Cal. Code Civ. Proc. § 10952.5.

2. **Petition for Writ of Administrative Mandamus**
   If the CCS beneficiary disagrees with the hearing decision, they also have the option to file a Writ of Administrative Mandate in California Superior Court.[48] The writ must be filed **within 1 year of the date of the hearing** decision and is a formal legal proceeding. The beneficiary should seek legal advice before doing this.

iv. How to Get Help with the Appeals Process

If a CCS beneficiary and their family have questions or need help, the following resources are available:

1. The CCS beneficiary's county CCS office.
2. Health Consumer Alliance for free legal help, call 888-804-3536/TTY 877-735-2929 or visit healthconsumer.org.
3. Disability Rights California (DRC) — 1-800-776-5746 or visit https://www.disabilityrightsca.org/get-help.
4. Local Family Resource Centers can also provide information and support regarding the CCS appeal process. For information on how to contact the nearest Family Resource Center, call 1-800-515-BABY or go to the Family Voices of California website at www.familyvoicesofca.org.
5. Parent Training and Information Centers may also be able to provide support (www.cde.ca.gov/sp/se/qa/caprntorg.asp).
6. Family Voices of California — call 415-282-7494 or visit familyvoicesofca.org.

Addendum A

Acronym list:

ACMS – Appeals Case Management System

ALJ – Administrative Law Judge

APP – Aid Paid Pending

CCS – California Children's Services

CDSS – California Department of Social Services

DHCS – Department of Health Care Services

DME – Durable Medical Equipment

ISCD – Integrated Systems of Care Division

MCP - Managed Care Plan

MTP – Medical Therapy Program

NOA – Notice of Action

PDN - Private Duty Nursing

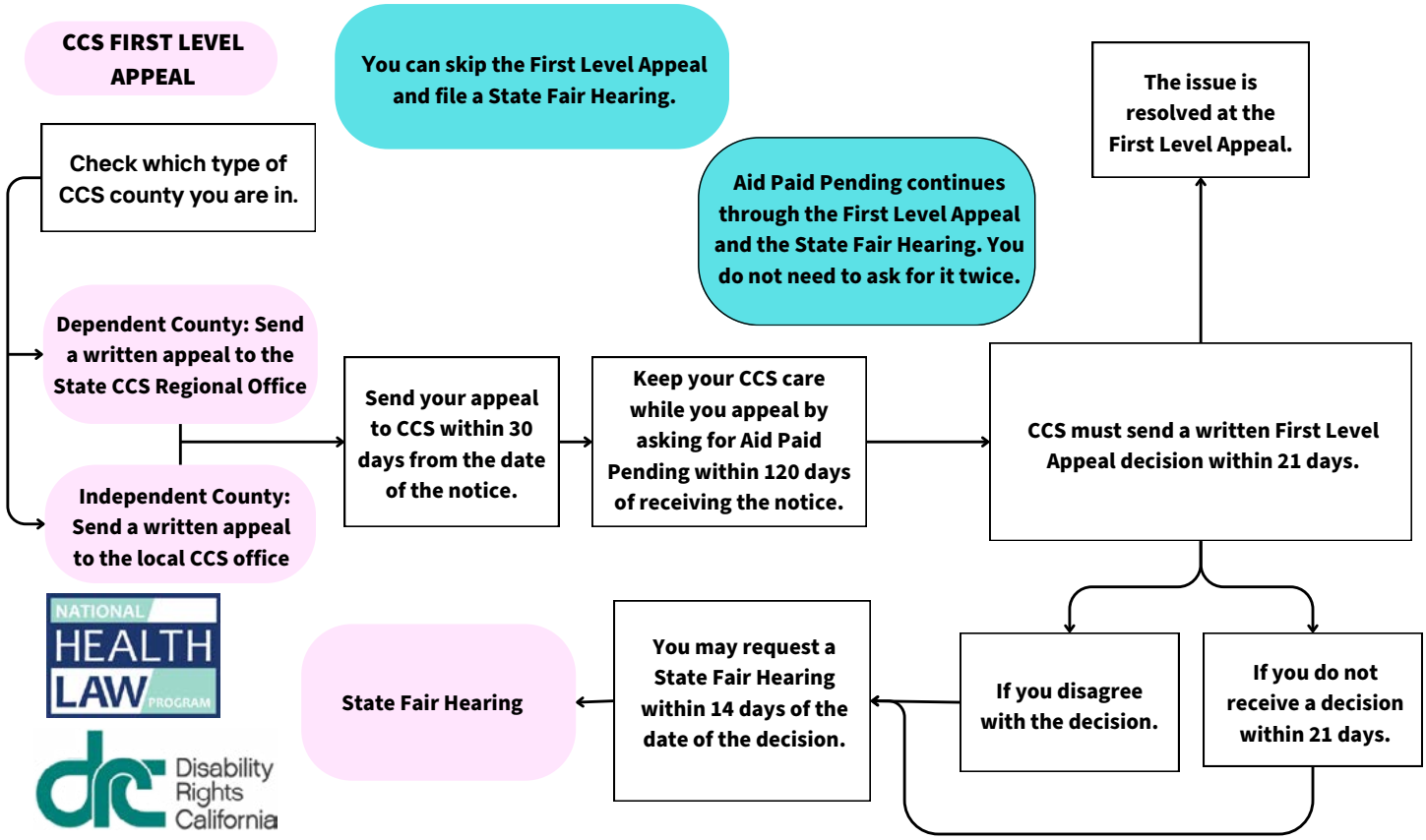
SAR - Service Authorization Request

TAR – Treatment Authorization Request

WCM – Whole Child Model

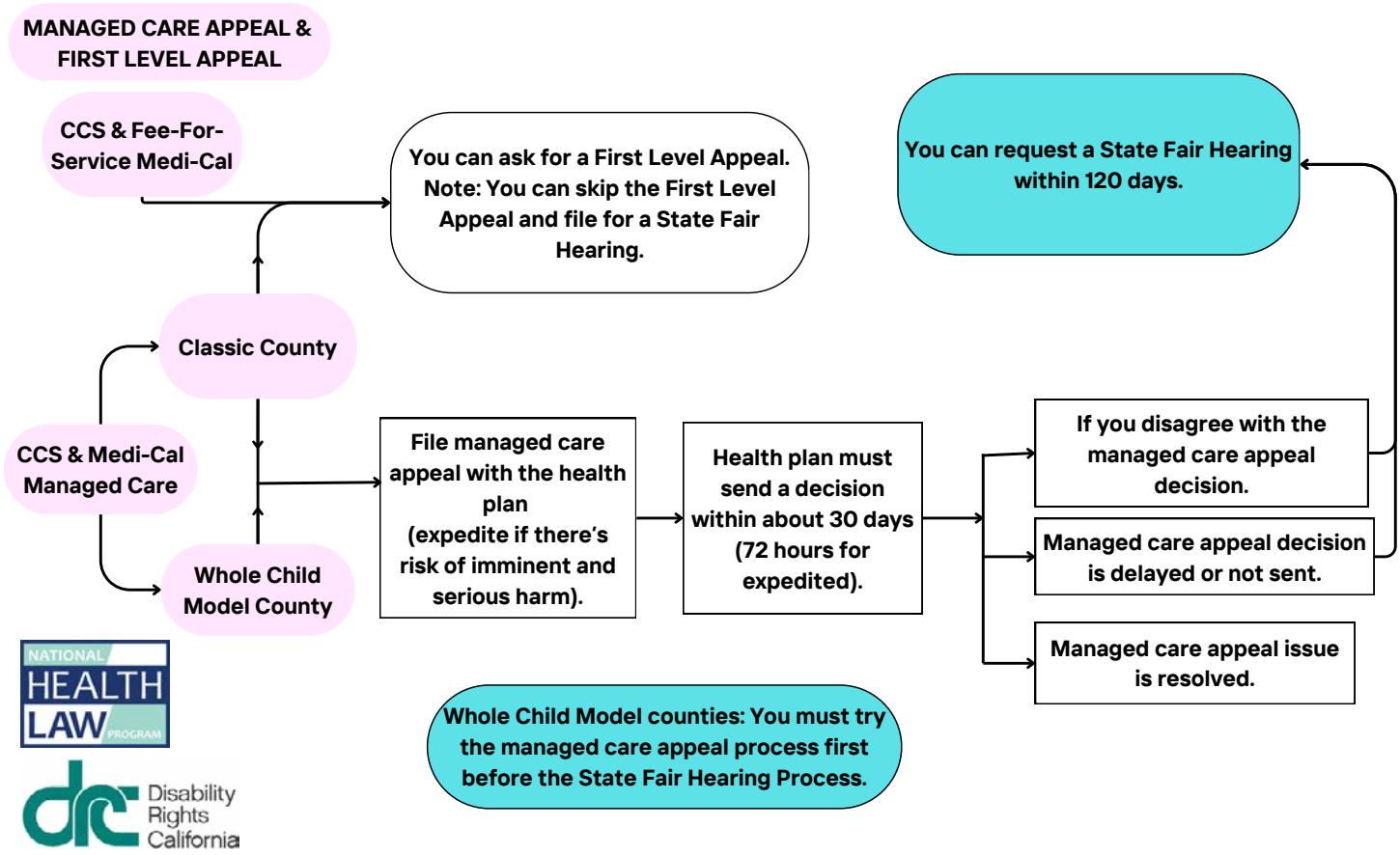
CCS FIRST LEVEL APPEAL: ALL CCS BENEFICIARIES*

Follow the appeals process when new or existing CCS services or supplies are reduced or denied, when approved services are delayed, when CCS applications are denied, or when enrollment in the CCS program is terminated. ***Note:** CCS beneficiaries with Medi-Cal in Whole Child Model counties do not go through the First Level Appeal.



APPEALS FOR CCS BENEFICIARIES WITH MEDI-CAL

Follow the appeals process when new or existing CCS services or supplies are reduced or denied, when approved services are delayed, when CCS applications are denied, or when enrollment in the CCS program is terminated. **Note**: See the First Level Appeal flow chart and the Appeals & Hearings Section in the toolkit to learn more about the process.



STATE FAIR HEARINGS: CCS & MEDI-CAL

You have the right to a State Fair Hearing if you disagree with a decision by CCS and/or by Medi-Cal.
Note: All State Fair Hearings are requested through the CA Department of Social Services (CDSS) State Hearings Division (SHD).