Navigating Due Process Rights in the CA Children's Services (CCS) Program

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Disability Rights California

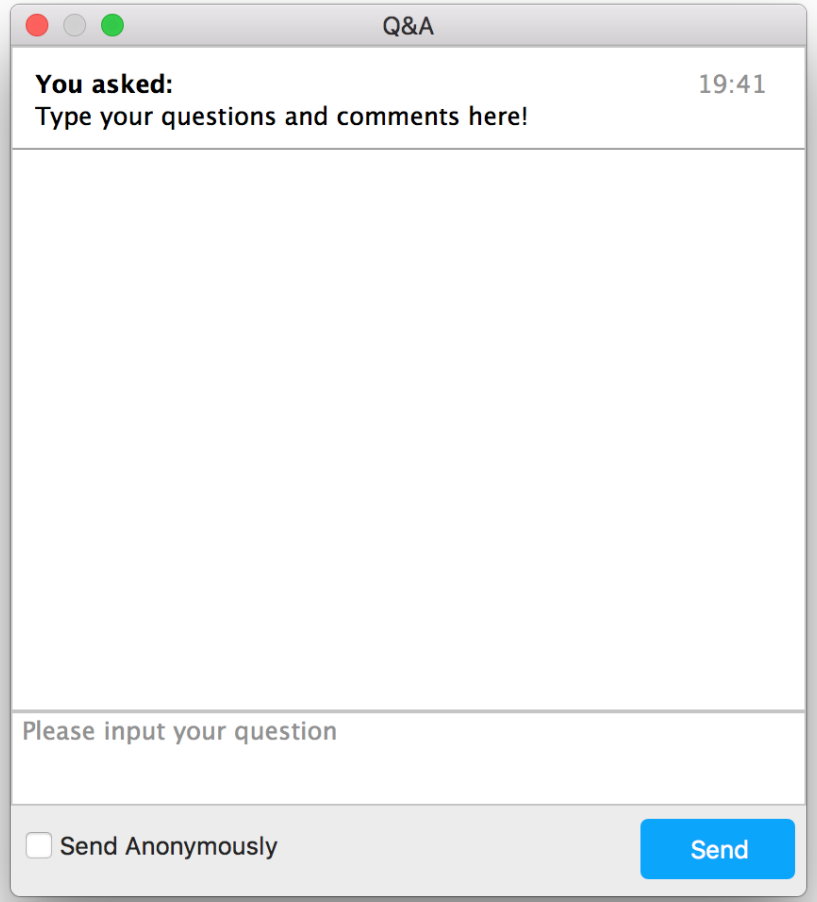
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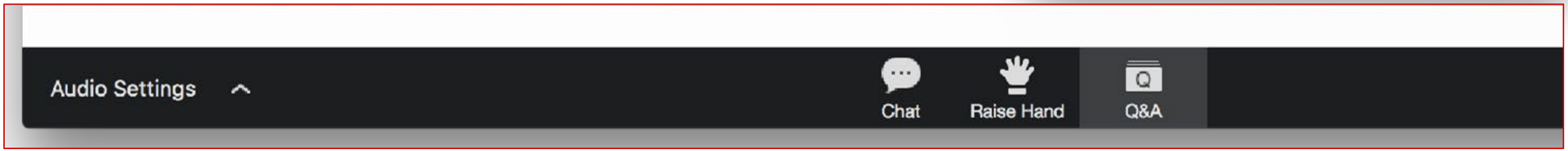
Housekeeping

- All attendees are in listen-only mode
- Webinar is being recorded
- Slides were sent out in advance to those registered
  - Slides will also be available with the recording and sent in follow-up email
- Webinar is being closed captioned

Housekeeping – Q&A and Chat

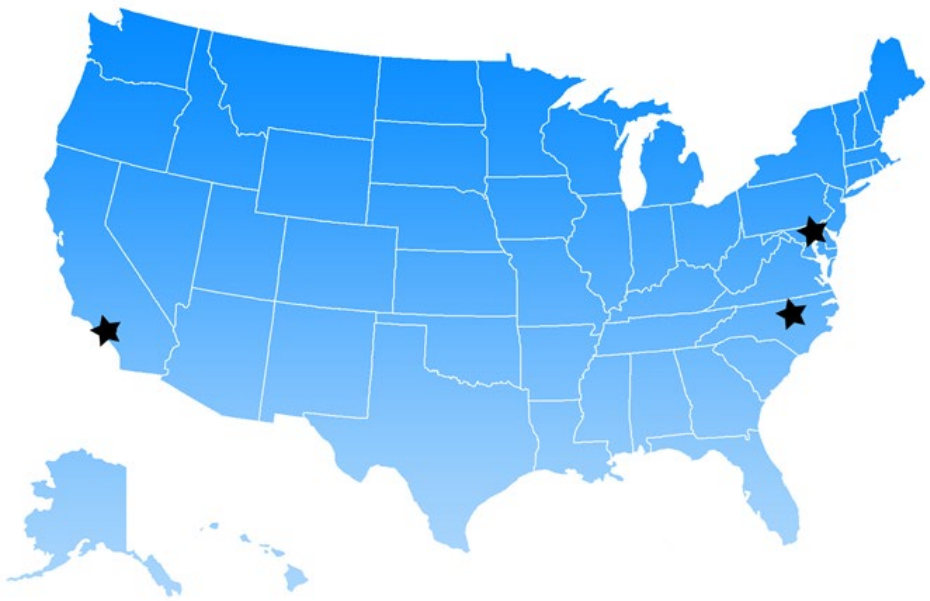
- Please use the Q&A box for all **questions** to the panelists
  - Click on the Q&A icon at the bottom of the screen
  - We encourage questions!
- We will answers questions at each section break and at the end
- If you have a **technical issue**, please use the chat function or send a direct chat message to Alexis Robles-Fradet





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Source: https://healthlaw.org/equity-stance/

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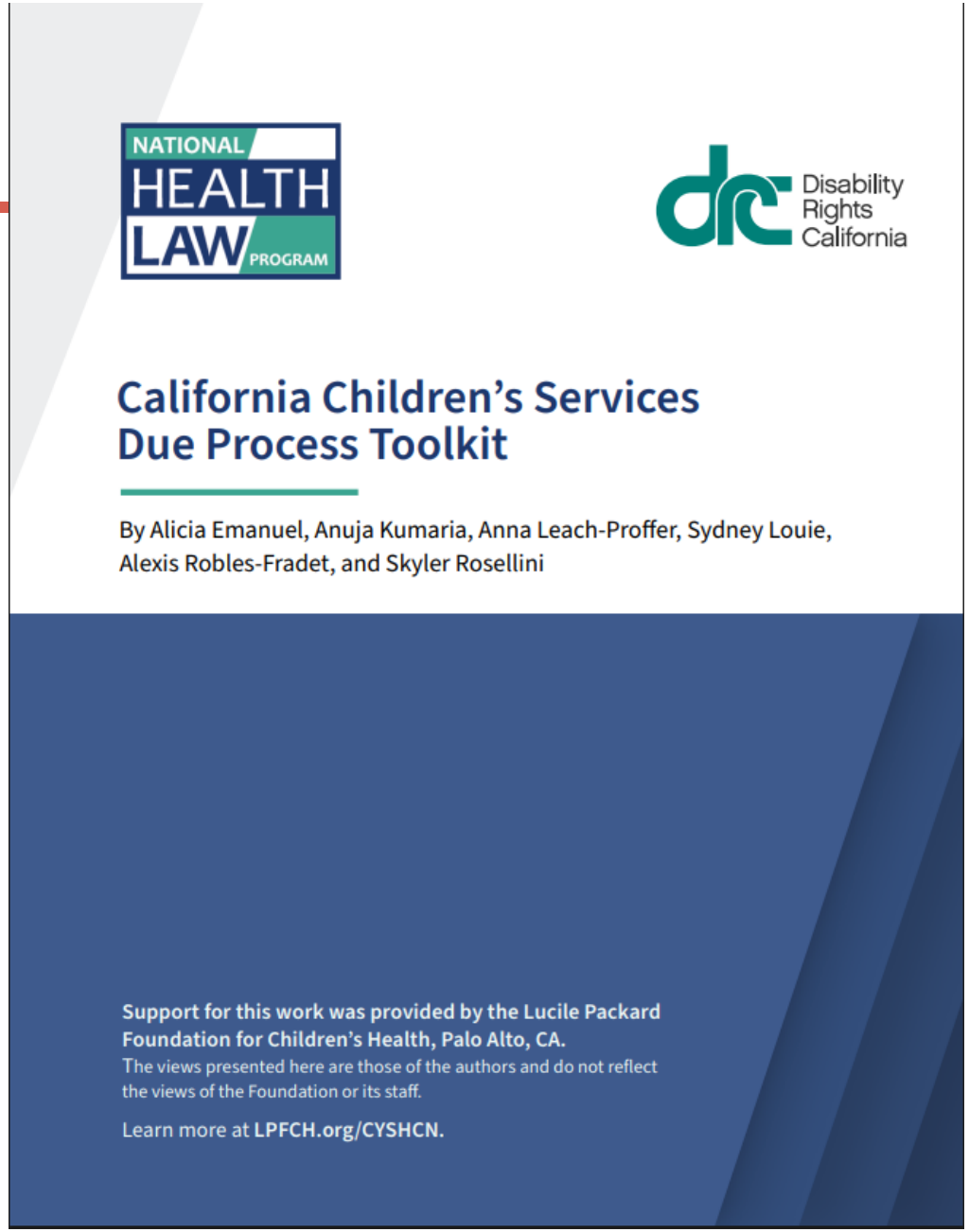
- **DRC** is a nonprofit organization founded in 1978 that defends, advances, and strengthens the rights and opportunities of people with disabilities.

www.disabilityrightsca.org

Disability Rights California

Agenda

- Navigating Due Process Rights
  - CCS Program
  - Introduction to Medicaid Due Process
  - Notices & Right to File a Grievance
  - Appeals & Hearings
- CCS Hot Topics
  - H.R. 1
  - Immigration Changes



Background: CCS Program

Overview of the CCS Program

- A state program for children and youth up to age 21 years old with special health care needs.
  - CCS-eligible conditions include: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, among others.
- Other eligibility criteria include: California residency and family annual income.
- Services: Diagnostic and treatment services, medical case management, physical and occupational therapy services, and medical therapy at public schools through the Medical Therapy Program (MTP).

Overview of the CCS Program

- How to access services depends on whether they live in a Whole Child Model (WCM) county or not.
  - Members in a WCM county with Medi-Cal: a Managed Care Plan (MCP) is responsible for authorizing CCS eligible services, case management, and more.
  - In non-WCM, or "classic counties," the county CCS program is responsible for these duties.
- Authorization of CCS services:
  - Service Authorization Request (SAR): Applies to CCS members without Medi-Cal, as well as CCS members with Medi-Cal who live in non-WCM counties.
  - Treatment Authorization Request (TAR): Applies to CCS members in WCM counties.

Navigating Medicaid Due Process Rights

Introduction to Medicaid Due Process

- **Medicaid Due Process:**
  - Medi-Cal members' rights to benefits are protected by
    - Due Process Clause of the U.S. Constitution: 14th Amendment
    - *Goldberg v. Kelly, 397 U.S. 254 (1970)*
    - Medicaid statute and regulations
  - 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.

- **Why?** About 90% of children in the CCS program also have Medi-Cal. CCS members and those supporting them need to understand how CCS and Medi-Cal rules overlap.

CCS Program Rules for Notices - Services

- Members have notice and appeal rights when negative actions are taken regarding their CCS benefits, including treatment, services, or supplies.
  - Right to written notice for delays, denials, reductions, discontinuances of services, or issues with eligibility and benefits.
- CCS-only members right to written notice **at least seven (7) days** before the action takes place.
- CCS members w/ Medi-Cal right to written notice **at least ten (10) days** before the action takes place.

CCS Program Rules for Notices - Exceptions

- Written notice is not required when:
  - A CCS-paneled provider does not think the member needs the CCS service or supplies any more.
  - A member or their family voluntarily cancels enrollment or services
  - The treatment was authorized for a limited time.
  - The member is in a licensed acute care or sub-acute care medical facility.
- **Important!** CCS members w/ Medi-Cal are entitled to written notice for **any** negative action regardless of the reason(s).

Right to File a Grievance with the CCS Program

- If a CCS member (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 like a complaint and can be either informal or formal.
- Grievances can be filed for any concern, such as:
  - Concerns with coordination of care, services, equipment or appointments
  - Poor customer service
  - Discrimination against the CCS member 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 authorization of CCS program eligibility decisions

Right to File a Grievance with the CCS Program

- To file a formal grievance, a CCS member 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.
  - Submission can be verbally, in-person, via telephone, by mail, or email. Once the form is submitted, the formal grievance process begins.
- Standard CCS grievance: Must be resolved by the CCS program **within thirty (30) days**.
- Expedited CCS grievance: Must be resolved by the CCS program **within three (3) business days**.
  - Applies if threats to their health including severe pain or potential loss of life, limb, or major bodily function.

Appeals & Hearings

- Consider filing an appeal when there's a denial of a new CCS service or supply, a denial or reduction in CCS services or supplies currently receiving, or delays in processing approved services.
- CCS members can also appeal a denial of a CCS application or a termination from the CCS program.
- Medi-Cal rules must apply for CCS members with Medi-Cal.

Appeals – First Level Appeal

- Once written notice is received, the CCS member has **thirty (30) calendar days from the date of the NOA to request an appeal**.
  - Submitting a First Level Appeal:
    - Independent county - submit request to the local CCS office.
    - Dependent county - submit request to the State CCS Regional office.
  - The CCS program must send a written decision within **twenty-one (21) days** of receiving the first level appeal.
  - Members have the right to skip a First Level Appeal.

Appeals – Aid Paid Pending

- A CCS member can ask for CCS services to continue while the appeal is ongoing. This is called Aid Paid Pending (APP).
- Must request before the effective date of the "negative action."
- Submit request via 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 member's name and CCS case number.
- CCS members with Medi-Cal: right to request APP via all available channels required under Medi-Cal rules.

Appeals - CCS State Fair Hearings

- A State Fair Hearing is an informal hearing in front of an Administrative Law Judge (ALJ).
- Right to request a State Fair Hearing if the First Level Appeal is denied or CCS member does not agree with the First Level Appeal decision.
- CCS members without Medi-Cal have **fourteen (14) calendar days** from the date of written First Level Appeal decision to request a State Fair Hearing.
  - Good cause for late filing - severe illness or disability.
- CCS program may request additional information from the CCS member within **fourteen (14) calendar days** of the request.

Appeals – CCS Members With Medi-Cal

- Right to file a Medi-Cal State Fair Hearing **in addition to, or instead of**, a CCS appeal.
- CCS members with Medi-Cal have **ninety (90) calendar days** to request a State Fair Hearing.
- Application of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) medical necessity standard:
  - Must apply to CCS members with Medi-Cal.
  - *Why is this important?* The CCS "medical necessity" definition is too limiting to effectively treat certain CCS conditions.

Appeals – CCS Members With Medi-Cal

- How to request an appeal depends on the county & type of Medi-Cal
- FFS Medi-Cal.
  - May submit an authorization request to Medi-Cal for services denied by CCS.
    - If Medi-Cal also denies the request, then may request a Medi-Cal State Fair Hearing in addition to a CCS State Fair Hearing.
- Medi-Cal Managed Care in a **WCM County:**
  - Access CCS services through the Medi-Cal MCP.
  - Right to Medi-Cal MCP appeal process **in addition to** CCS appeal process.
- Medi-Cal Managed Care in a **Classic County:**
  - CCS appeals go through the county CCS program.
  - Can also submit authorization requests through Medi-Cal.
  - If they request 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.

State Fair Hearing – CCS Members With Medi-Cal

- After the CCS member requests either a CCS State Fair Hearing or a Medi-Cal State Fair Hearing, they will receive two notices from CDSS State Hearings Division.
  - First notice confirms the request for a hearing.
  - Second notice provides date, time, and place of the hearing.
- The county will assign a hearing representative.
  - Responsible for contacting the CCS member prior to the hearing to provide information about the case.
  - Must assist with trying to resolve the case prior to the State Fair Hearing.

State Fair Hearing – CCS Members With Medi-Cal

- Preparing for a State Fair Hearing
  - Review the Case Records
  - Gather Information
  - Review the CCS Program's Position Statement
  - Postponements

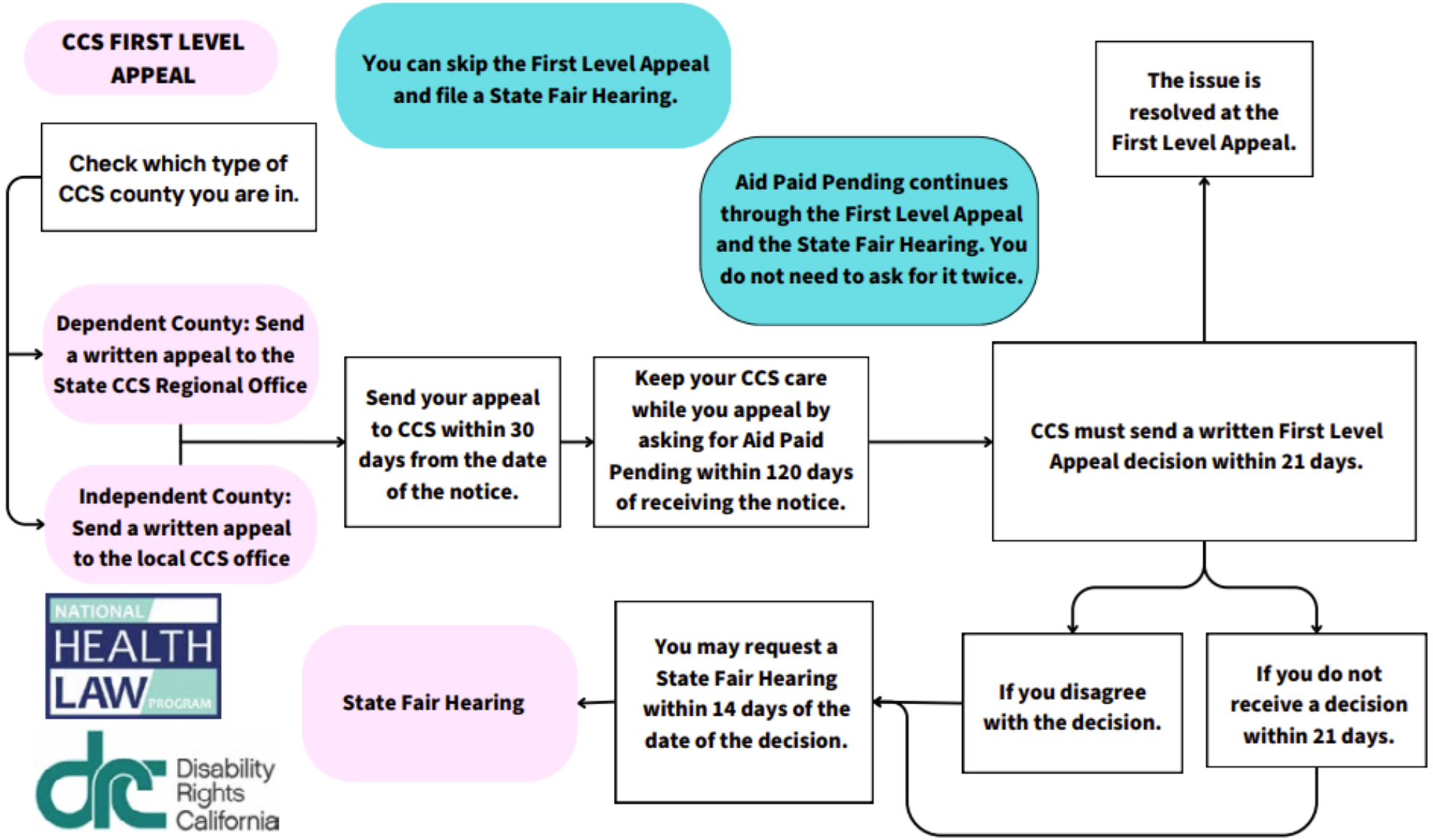
State Fair Hearing – CCS Members With Medi-Cal

- 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 member 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:
  - That the CCS services or supplies requested are medically necessary. The CCS member can discuss this with the CCS paneled provider involved in the case.
  - The services must be related to the CCS-eligible condition.

State Fair Hearing – CCS members With Medi-Cal

- Request for Rehearing
  - CCS members have the right to request a rehearing within thirty (30) days after receiving the hearing decision. To have a rehearing granted, the CCS member 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.
- Petition for Writ of Administrative Mandamus
  - If the CCS member disagrees with the hearing decision, they also have the option to file a Writ of Administrative Mandamus in California Superior Court.
  - The writ must be filed within 1 year of the date of the hearing decision and is a formal legal proceeding. The member should seek legal advice before doing this.

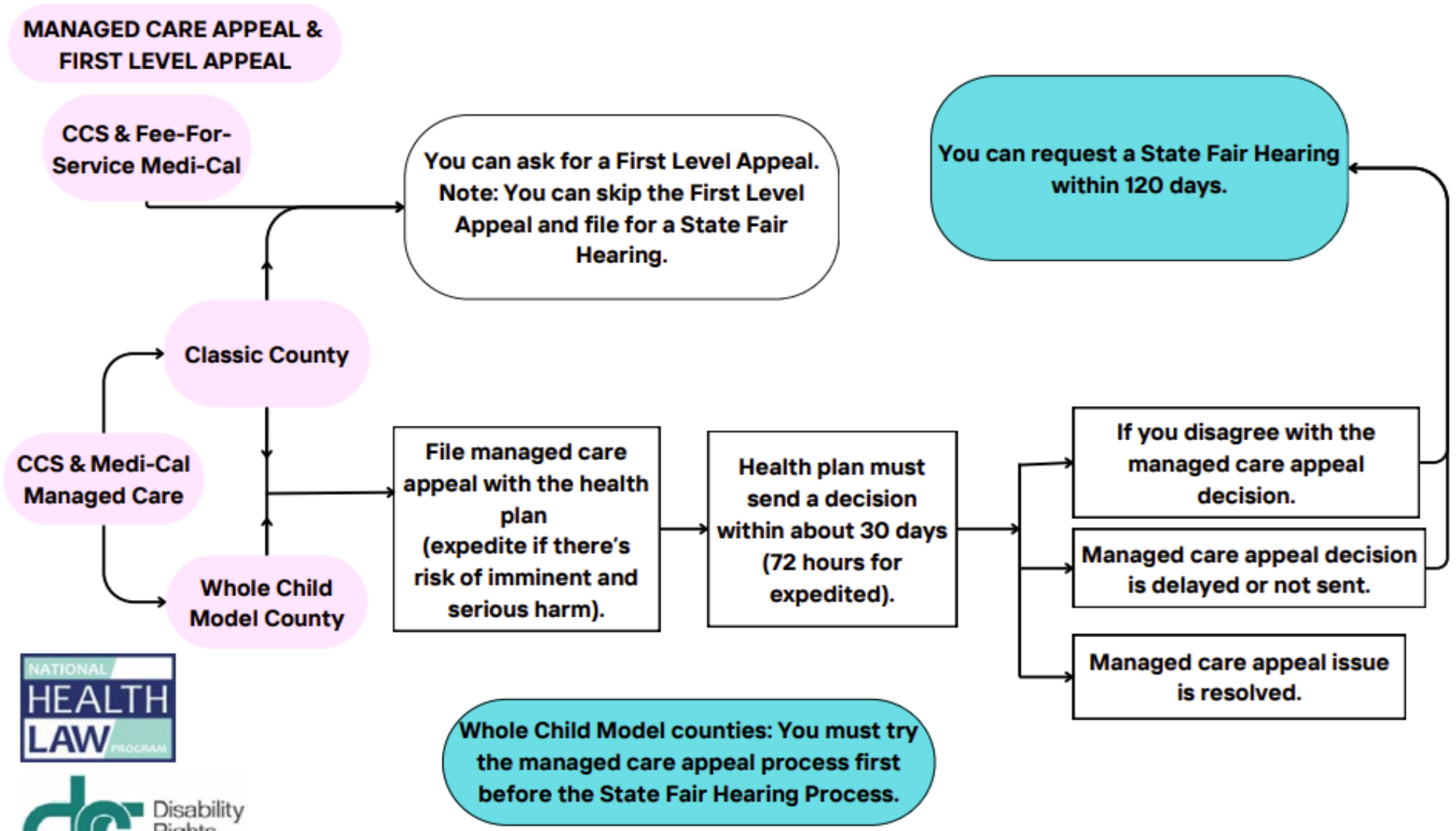
CCS FIRST LEVEL APPEAL: ALL CCS members*



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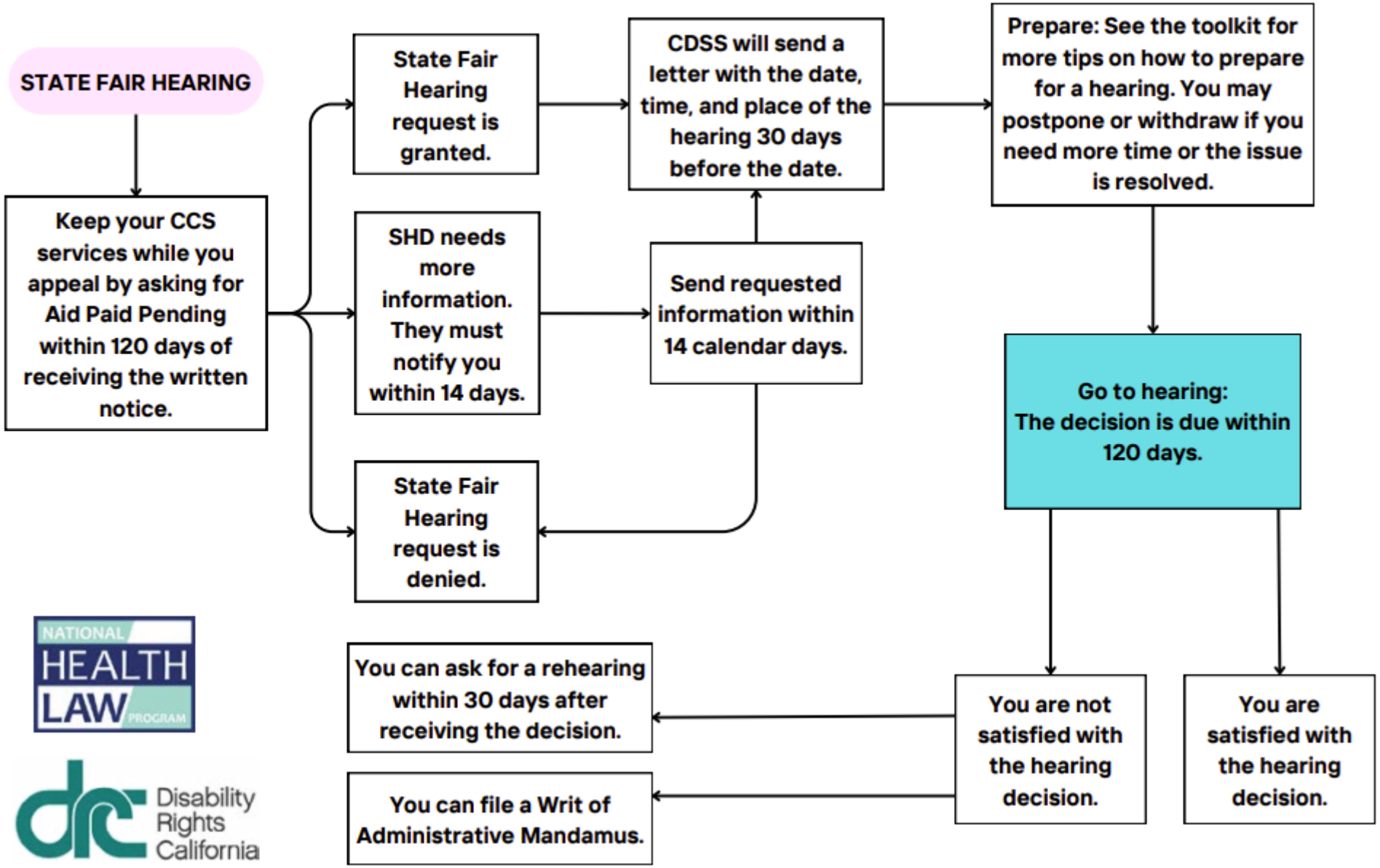
APPEALS FOR CCS Members WITH MEDI-CAL



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STATE FAIR HEARINGS: CCS & MEDI-CAL



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Practice Tips

- Use the **ACMS system** to file the state hearing request for easier tracking and to make it easier to request records.
- Remember to **request continuation of benefits** (also called Aid Paid Pending) as soon as you receive a notice reducing or terminating a child's services.
  - Reach out to both County and DHCS and do so in writing so you have a paper trail of when you made the request.
- Review the denial Notice carefully to determine why the service was denied. If it is not clear, reach out to the county to request additional information. Typical reasons for denial: not medically necessary, not related to a CCS-eligible condition, not signed by a CCS-paneled doctor, insufficient or incorrect documentation submitted.

Practice Tips, Continued

- Gather support from CCS-paneled doctors to show that the service at issue is medically necessary and that it is related to the CCS-eligible condition.
  - Medical records
  - Nursing notes
  - Hospital discharge records
  - Letters and/or testimony from CCS-paneled specialists
    - Ask your CCS-specialist if they would be willing to reach out to the CCS office to request a peer-to-peer conversation with the professional who denied the request. (or with the medical director of the CCS program) In our experience, CCS staff are much more responsive and willing to change their decision after discussing with the treating doctor.
  - Copies of prior authorizations

Practice Tips, Continued

- If the child also has Medi-Cal (most children with CCS do), be sure to remind the CCS program that the more favorable EPSDT medical necessity standard applies. Essentially, the service does not need to cure or improve the condition, it is enough for it to maintain the current condition or prevent or slow further worsening.
- Request a postponement of the hearing if you need more time to gather evidence to support medical necessity.
- Reach out to both the county appeals contact and the DHCS appeals contact to attempt to resolve the case.
- If the child has commercial insurance, be sure to provide evidence that the service is either not covered – or that the benefits have been exhausted.

CCS: Hot Topics

CCS & H.R. 1

New Work and Community Engagement Requirements in Medi-Cal

- H.R. 1 establishes Medicaid **work and community engagement requirements (WCER)** as a new condition of eligibility for members in the "New Adult Group."
- California must implement WCER by **January 1, 2027**—meaning individuals in this group will need to demonstrate compliance with or meet an exclusion or exception from WCER to be determined eligible for Medi-Cal.
- **CMS issued an interim final rule** on June 1 that establishes the operational framework for WCER. The rule is final effective July 31.

Individuals in the New Adult Group are:

(1) Ages 19-64;
(2) Not pregnant;
(3) Not enrolled in or entitled to Medicare Part A or B;
(4) Not otherwise eligible for another mandatory Medi-Cal eligibility group; and
(5) Have income that is less than 138% of the federal poverty level which is $22,025 for an individual ($45,540 for a family of four).

Pre-Decisional and For Discussion Only

25

Source: DHCS CCS Advisory Group Meeting July 2026

CCS & H.R. 1

Pre-Decisional and For Discussion Only

Key Guidance Under Interim Final Rule

- **Defines Qualifying Activities:** Provides more granular definitions for each qualifying compliance activity in more detail. (E.g., defines community service, adds in-kind and unpaid to work definition, explains how half-time education will be calculated.)
- **States Must Screen for Exclusion First:** Before applying work requirements, states must check whether someone qualifies for an exclusion, such as being medically frail or a parent of a child under 14. Only individuals who do not meet an exclusion are subject to WCER.
- **Medical Frailty:** Departs from statutory definition and narrows medical frailty exclusion by requiring that qualifying conditions "significantly impair" an individual's ability to work.
- **Short-Term Hardship Exceptions:** Establishes a lookback period (one-month in California) for these exceptions and provides more granular definitions.
- **Self-Attestation:** Allows states to accept self-attestation in 2027, but limits use in 2028 and beyond.
- **Noticing & Outreach:** Specifies when and under what circumstances states must conduct noticing and outreach to members.
- **Good Faith Waivers:** Clarifies that CMS may approve good faith waivers for up to six months at a time and projects approving these requests in only two states.

26

Source: DHCS CCS Advisory Group Meeting July 2026

CCS & Immigration

- As of January 1, 2026, DHCS froze new full-scope Medi-Cal enrollment for adults 19 and older who previously qualified under the state-funded Adult Expansion.
  - Unsatisfactory Immigration Status (UIS) CCS members 19-20 years old enrolled in Medi-Cal prior to Jan. 1, 2026 - Remain enrolled *if* meet renewal requirements & deadlines.
    - 90-day re-enrollment window
  - New enrollees as of Jan. 1, 2026 - Only eligible for emergency or pregnancy-related services.
  - Exception: 19 - 20-year-old foster youth or nonminor dependents with UIS.

Sources: CCS N.L. 06-1225
(*Superseded by CCS NL 03-0926 – CCS Members with Unsatisfactory Immigration Status)
All Plan Letter 26-016 - CCS Members With UIS

CCS & Immigration

- As of January 1, 2027, DHCS is moving all Medi-Cal members with Unsatisfactory Immigration Status (UIS), including CCS members with UIS, from their Medi-Cal managed care plan to fee-for-service (FFS) or "straight" Medi-Cal.
  - UIS CCS members in FFS will receive case management through their county CCS program.
  - Re-enrollment:
    - 2026 - Will stay in their Medi-Cal managed care plan for 2026 only
    - 2027 - Will be in FFS Medi-Cal

Sources: CCS N.L. 03-0926
(*Supersedes CCS N.L. 06-1225)
DHCS Policy Guide for Transition of UIS from Managed Care to FFS

Resources

- **NHeLP & DRC** Due California Children's Services Due Process Toolkit
- **DHCS** HR1 Implementation Plan - Jan. 2026
- **CCS N.L. 04-0424-** CCS Program Appeals and State Hearing Process
- **Health Consumer Alliance** for free legal help, call 888-804-3536/TTY 877-735-2929 or visit www.healthconsumer.org
- **Disability Rights California (DRC)** — 1-800-776-5746 or visit https://www.disabilityrightsca.org/get-help
- **Local Family Resource Centers** - 1-800-515-BABY or go to the Family Voices of California website at www.familyvoicesofca.org.
- **Family Voices of California** — call 415-282-7494 or visit www.familyvoicesofca.org

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