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**Due Process for Medi-Cal Mental Health Services**

Many youth in foster care in California are enrolled in Medi-Cal, and therefore have certain due process rights if they are dissatisfied with their services or disagree with an action or decision about their services. This includes filing a grievance, appealing an adverse action, or requesting a state fair hearing. There are different Medi-Cal systems from which beneficiaries may receive services, and to whom these actions need to be directed. This resource focuses on systems that deliver mental health services.

Beneficiaries may receive general medical or non-specialty mental health services through a Medi-Cal Managed Care Plan (MCP), which is an organized network of providers. However, many youth in foster care are on Fee-for-Service Medi-Cal, which means they are not on an organized plan and Medi-Cal instead pays providers directly. Youth in foster care are also categorically eligible for specialty mental health services,[[1]](#footnote-1) which are carved out of MCPs and provided through their county Mental Health Plan (MHP).

Please see the chart on pages 2-3 for information about these various Medi-Cal problem resolution options and corresponding timelines.[[2]](#footnote-2) Additionally, links to relevant contacts and resources are included on page 4. Please also see the attached template letters providing examples of these resolution options.

**AID PAID PENDING**

If a beneficiary is already receiving services and wants to continue those services without change while their appeal or hearing is being decided, they must include (with the appeal or hearing request) a **request to continue their benefits** (called “Aid Paid Pending”) and it must be made **within 10 days** of the Notice, or before the effective date of service changes. If they lose the appeal or hearing, **they may be required to pay** for services provided during that time.[[3]](#footnote-3)

**NOTICE REQUIREMENTS**

All managed care plans, including MCPs and MHPs, are legally required to send beneficiaries a “timely and adequate notice of an adverse benefit determination in writing.” An adverse benefit determination includes the denial or limited authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; the denial of payment for a service; the failure to provide services in a timely manner; the failure to act within the required timeframes for grievances and appeals; and more. This Notice must include the reasons for the adverse benefit determination and the beneficiary’s due process rights.[[4]](#footnote-4) Note that a beneficiary has due process rights even if they do not receive a Notice.

*Please note that the information provided in this document does not constitute legal advice.*

*All content is for general informational purposes only.*

|  |  |  |  |
| --- | --- | --- | --- |
| Resolution Process | Triggering Event | When and Where to File | Deadline for Decision |
| Grievance[[5]](#footnote-5) | The beneficiary is unhappy with the quality of their services or the way they have been treated.[[6]](#footnote-6) | File anytime.[[7]](#footnote-7)  File with either the MHP or MCP, depending on the services at issue. | The MHP has 90 days to resolve the grievance; the MCP has 30 days.[[8]](#footnote-8) |
| Appeal | Services are denied, reduced, terminated, or delayed.[[9]](#footnote-9)  The beneficiary may or may not receive a written Notice of Adverse Benefit Determination. | To continue the beneficiary’s services while the appeal is pending, file the appeal within 10 days of the written Notice or before the effective date of the adverse action.[[10]](#footnote-10)  Otherwise, if a written Notice is received, file within 60 days of receipt.[[11]](#footnote-11)  File with either the MHP or MCP, depending on the services at issue. | The MHP or MCP have 30 days to resolve the appeal.[[12]](#footnote-12) |
| Expedited Appeal | Same as a standard appeal, plus the beneficiary believes that waiting 30 days for a resolution may "seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.”[[13]](#footnote-13) | Same as a standard appeal, but urgent matters should be filed as soon as possible. | If it determines expedited review is necessary, the MHP or MCP must resolve the expedited appeal within 72 hours.[[14]](#footnote-14) |
| State Hearing | The beneficiary previously filed a grievance or appeal, and either disagrees with the outcome of that grievance or appeal, or it was not resolved within the timeframes listed above.[[15]](#footnote-15)  OR  Services were denied, terminated, reduced, or delayed, and the beneficiary did not receive a written Notice within the required timeframe. The appeal process is thus deemed exhausted.[[16]](#footnote-16) | To continue the beneficiary’s services while the hearing is pending, file the appeal (or hearing request if there was no appeal) within 10 days of the written Notice or before the effective date of the adverse action.[[17]](#footnote-17)  Otherwise, for youth in managed care, including MCPs and MHPs, file within 120 days of the notice of the appeal decision, or within 120 days of the expiration of the required timeframe for receiving notice of the appeal resolution or adverse benefit determination.[[18]](#footnote-18)  For youth in fee-for-service, file within 90 days of the adverse benefit determination.[[19]](#footnote-19) No appeal is required.  File with the CDSS State Hearings Division. | The State Hearings Division must resolve the hearing within 90 days from the appeal request, or from hearing request if no appeal was filed.[[20]](#footnote-20) |
| Expedited Hearing | Same as a standard hearing, plus the beneficiary believes that waiting 90 days for a resolution may "seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.”[[21]](#footnote-21) | Same as a standard hearing, but urgent matters should be filed as soon as possible. | If it determines expedited review is necessary, the State Hearings Division must resolve expedited hearings within 3 working days.[[22]](#footnote-22) |

**Additional Links and Contact Information**

* **For more information about the** **County Mental Health Plan (MHP) problem resolution process**, consult your county’s MHP Beneficiary Handbook. The Beneficiary Handbook can be downloaded from your county’s website or you can call your county MHP to ask for a copy. County MHP websites and phone numbers are listed [here](https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx).
* **For more information about the** **Managed Care Plan (MCP) problem resolution process**, consult the MCP’s Member Handbook, which can be downloaded [here](https://www.healthcareoptions.dhcs.ca.gov/en/health-plan-materials) or obtained through calling your MCP.

**For Know Your Rights materials from the Department of Health Care Services (DHCS)**:

[Medi-Cal for Kids & Teens](file:///C:\Users\Rachel%20Murphy\Desktop\SMHS\YLC%20Resources\General%20Medi-Cal%20Templates\•%09https:\www.dhcs.ca.gov\services\Medi-Cal-For-Kids-and-Teens\Documents\DHCS-MediCal-Rights-Letter-B.pdf)

[Notice of Adverse Benefit Determination](file:///Users/laptop/Desktop/•%09https:/www.dhcs.ca.gov/Documents/Enclosure-8-Your-Rights-Attachment-NOABD-Final.docx) template

[Your Rights Under Medi-Cal Managed Care – For Knox-Keene Plans](https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/NOA-Your-Rights-Knox-Keene.pdf)

[Your Rights Under Medi-Cal Managed Care – For Non-Know-Keene Plans](https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/NOA-Your-Rights-Non-Knox-Keene.pdf)

* **For assistance resolving problems with managed care health plans**,contact:
  + [DHCS Medi-Cal Managed Care and Mental Health Office of the Ombudsman](https://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx)

888-452-8609

[MMCDOmbudsmanOffice@dhcs.ca.gov](mailto:MMCDOmbudsmanOffice@dhcs.ca.gov)

* + [Department of Managed Health Care (DMHC) Help Center](https://www.dmhc.ca.gov/)

888-466-2219

<https://www.dmhc.ca.gov/FileaComplaint.aspx>

* **For more information about State Hearings:** [California Department of Social Services, State Hearings Division](https://www.cdss.ca.gov/inforesources/state-hearings)
  + *To request a hearing via mail:*

P.O. Box 944243, Mail Station 9-17-37

Sacramento, CA 94244-2430

Fax: 916-651-5210 or 916-651-2789

* + *To request a hearing online:*

<https://acms.dss.ca.gov/acms/login.request.do>

* + *To request a hearing by phone:*

800-743-8525 or 855-795-0634 (State Hearing Division)

800-952-5253 or 800-952-8349 TDD (Public Inquiry and Response Unit)

**TEMPLATE GRIEVANCE**

*If you are completing this on behalf of someone else, you should attach a completed form appointing you as their Authorized Representative.* *You can contact the health plan to request the appropriate form.*

**[Name]**

**[Address]**

**[City, State, and Zip Code]**

**[Phone Number]**

**[Date]**

**[Health Plan Name and Address]**

RE: Grievance regarding Medi-Cal Services Providedto [**Beneficiary Name, Date of Birth**; *e.g.*,John Doe, DOB 1/1/2013]

Dear [**Health Plan Staff***; e.g.*, Grievance Manager**]**:

I am writing to file a grievance about my Medi-Cal services provided by **[Health Plan]**. **[If submitting this on the beneficiary’s behalf, state:** I am an authorized representative for the beneficiary and have attached a completed Authorized Representative form to this request.**]**

[**Describe dissatisfaction with services, including any relevant dates, names, and details**. *E.g.*, My child and I have been receiving family therapy services for the past six months and have experienced several changes in staffing during that time. The frequent turnover has made it difficult for us to connect with and trust our therapists, and I believe it has delayed our family’s progress. I would like to have consistency in our therapists and other providers in order to build a relationship and receive the support and guidance necessary for myself and my child.]

Please contact me at **[email or phone number]**. Thank you for your time and consideration, and I look forward to your response.

Sincerely,

**[Signature]**

**[Name]**

CC: **[County Welfare Department]**

Atts. **[If applicable,** include the signed Appointment of Authorized Representative form and any documentation supporting the grievance**]**

**TEMPLATE REQUEST FOR STANDARD APPEAL**

*If you are completing this on behalf of someone else, you should attach a signed form appointing you as the Authorized Representative. You can contact the health plan to request the appropriate form.*

**[Name]**

**[Address]**

**[City, State, and Zip Code]**

**[Phone Number]**

**[Date]**

**[Health Plan Name and Address]**

RE: Appeal regarding Medi-Cal Services for [**Beneficiary Name, Date of Birth**; *e.g.*,John Doe, DOB 1/1/2007]

Dear [**Health Plan Staff**; *e.g.*,Quality Improvement Coordinator]:

I am writing to appeal the decision by **[Health Plan]** to **[state adverse benefit determination or action**; *e.g.*, to reduce my specialty mental health services**]**. **[If submitting this on the beneficiary’s behalf, state:** I am an authorized representative for the beneficiary and have attached a completed Authorized Representative form to this request.**]** On **[date]**, **[the beneficiary]** received a Notice of **[Adverse Benefit Determination / Action]** stating that **[describe in more detail**; *e.g.*, my Intensive Home Based Services (IHBS) would be reduced to three days a week, effective January 1. I am currently receiving IHBS five days a week, which has helped me learn skills to manage my emotions and express myself**]**.

As a Medi-Cal beneficiary under age 21 with an open child welfare services case, **[the beneficiary is]** entitled to receive all medically necessary Specialty Mental Health Services. Welf. & Inst. Code § 14184.402(d)(1); 42 U.S.C. § 1396d(r)(5). On **[date]**, **[medical provider]** conducted a clinical assessment and determined that **[services and frequency requested]** were medically necessary. I have attached the relevant supporting documentation. It is the responsibility of county Mental Health Plans to pay for, or arrange for payment of, these services and to ensure that beneficiaries have access to these critical services. Welf. & Inst. Code § 14184.402; Cal. Code Regs. tit. 9, § 1810.226.

**[If there was a reduction or termination of services, include request to continue services and submit within 10 days of Notice or before the effective date of the change in services**; *e.g.*,Additionally, I would like to continue receiving services pending the outcome of the appeal.]

Please contact me at **[email or phone number]**. Thank you for your time and consideration, and I look forward to your response.

Sincerely,

**[Signature]**

**[Name]**

CC: **[County Welfare Department]**

Atts. **[If applicable,** include the signed Appointment of Authorized Representative form, a copy of the Notice, and any documentation from medical providers supporting the appeal**]**

**TEMPLATE REQUEST FOR EXPEDITED APPEAL**

*If you are completing this on behalf of someone else, you should attach a signed form appointing you as the Authorized Representative. You can contact the health plan to request the appropriate form.*

**[Name]**

**[Address]**

**[City, State, and Zip Code]**

**[Phone Number]**

**[Date]**

**[Health Plan Name and Address]**

RE: Expedited Appeal regarding Medi-Cal Services for **[Beneficiary Name, Date of Birth**; *e.g.*,John Doe, DOB 1/1/2007**]**

Dear **[Health Plan Staff**; *e.g.*,Quality Improvement Coordinator**]**:

I am writing to request an expedited appeal of the decision by **[Health Plan]** to **[state adverse benefit determination or action**; *e.g.*, terminate my specialty mental health services**]**. **[If submitting this on the beneficiary’s behalf, state:** I am an authorized representative for the beneficiary and have attached a completed Authorized Representative form to this request.**]** On **[date]**, **[the beneficiary]** received a Notice of **[Adverse Benefit Determination / Action]** stating that **[describe in more detail**; *e.g.*, I no longer qualified to receive Intensive Home Based Services (IHBS) because I was also receiving Therapeutic Behavioral Services (TBS), and therefore my IHBS were being terminated, effective January 1**]**.

As a Medi-Cal beneficiary under age 21 with an open child welfare services case, **[the beneficiary is]** entitled to receive all medically necessary Specialty Mental Health Services. Welf. & Inst. Code § 14184.402(d)(1); 42 U.S.C. § 1396d(r)(5). On **[date]**, **[medical provider]** conducted a clinical assessment and determined that **[services requested]** were medically necessary. I have attached the relevant supporting documentation. It is the responsibility of county Mental Health Plans to pay for, or arrange for payment of, these services and to ensure that beneficiaries have access to these critical services. Cal. Code Regs. tit. 9, § 1810.226.

**[Detailed description of the urgency and harm that requires an expedited appeal**;*e.g.*, I have moved foster homes several times in the last two years and have often felt depressed and angry. For the last six months, I have received IHBS at school and at home nearly every day. My doctor has also referred me for TBS to support my progress. Without these services, I believe that my condition will worsen, putting me at risk of harm and/or causing me to leave my current foster home and become homeless or placed into an institution.**]** I believe that waiting 30 days for resolution of a standard appeal would seriously jeopardize **[the beneficiary’s]** life, health, and ability to attain, maintain, or regain maximum function. I respectfully request an expedited hearing.]

**[If there was a reduction or termination of services, include request to continue services and submit within 10 days of Notice or before the effective date of the change in services**; *e.g.*,Additionally, I would like to continue receiving services pending the outcome of the expedited appeal.**]**

Please contact me at **[email or phone number]**. Thank you for your time and consideration, and I look forward to your response.

Sincerely,

**[Signature]**

**[Name]**

CC: **[County Welfare Department]**

Atts. **[If applicable,** include the signed Appointment of Authorized Representative form, a copy of the Notice, and any documentation from medical providers supporting the urgent need for services**]**

**TEMPLATE REQUEST FOR STATE FAIR HEARING**

*If you are completing this on behalf of someone else, you should attach a completed* [*form*](https://www.cdss.ca.gov/Portals/9/Additional-Resources/Forms-and-Brochures/2020/A-D/DPA19.pdf?ver=2022-07-27-143043-867) *appointing you as their Authorized Representative.*

**[Name]**

**[Address]**

**[City, State, and Zip Code]**

**[Phone Number]**

**[Date]**

State Hearings Division

California Department of Social Services

P.O. Box 944243, Mail Station 9-17-37

Sacramento, CA 94244-2430

Fax: (833) 281-0905

RE: Request for State Hearing on Medi-Cal Services for **[Beneficiary Name, Date of Birth**; *e.g.*,John Doe, DOB 1/1/2013**]**

Dear State Hearing Officer:

I am writing to request a state hearing regarding [**description of adverse benefit determination and the responsible Health Plan**; *e.g.*, Fictional Health Plan’s (FHP) failure to provide timely services for my child and resolve my appeal in the required timeframe**]**. **[If submitting this on the beneficiary’s behalf, state:** I am an authorized representative for the beneficiary and have attached a completed Authorized Representative form to this request.**]**

**[Explain the issue with your services, including any relevant dates and names of providers; legal citations are useful for reference, but are not required.** *E.g.*, On September 5, 2023, my child’s primary care physician, [Name of Doctor], conducted an assessment and provided a referral for Enhanced Care Management (ECM). On September 6, I contacted FHP to request an appointment.

A health plan is required to offer an appointment for nonurgent care with a nonphysician mental health care provider within 10 business days of the request. Health & Safety Code § 1367.03(5)(E); Welf. & Inst. Code §14197.03(d)(1)(A). A health plan’s failure to provide services in the required timeframe is considered a denial and thus an adverse benefit determination. 42 C.F.R. §§ 438.400(b)(4), 438.404(c)(5); Welf. & Inst. Code § 10950(g)(1)(D). Furthermore, when a health plan fails to provide timely access to services, it is required to provide a Notice of Adverse Benefit Determination by the date that services should have been provided. 42 C.F.R. § 438.404(c)(5); Welf. & Inst. Code § 14197.3(a).

Ten business days from the date of my September 6, 2023 request was September 20, 2023. By September 20, I had not heard from FHP about my request for an appointment for my child to receive ECM, nor did I receive a Notice of Adverse Benefit Determination or Notice of Action. Therefore, FHP failed to provide timely services and failed to provide timely notice.

On September 22, 2023, I filed an appeal to FHP. A health plan is required to resolve appeals and provide notice of the resolution within 30 days. 42 C.F.R. § 438.408(b)(2); Welf. & Inst. Code § 14197.3(b). If a health plan fails to meet those requirements, the appeals process is “deemed exhausted” and the beneficiary may file a state fair hearing request. 42 C.F.R. §§ 438.402(c)(1)(i)(A), 438.408(f)(1)(i); Welf. & Inst. Code § 10951(b)(1)(B). It has been more than 30 days and FHP has not provided me with notice of the resolution of my appeal. My appeal is therefore deemed exhausted and I respectfully request a hearing to ensure my child can receive timely and medically necessary ECM services from FHP.**]**

**[If there was a reduction or termination of services, include request to continue services and submit within 10 days of Notice or before the effective date of the change in services**; *e.g.*,Additionally, I would like to continue receiving services pending the outcome of the hearing.**]**

Please contact me at **[email or phone number]**. Thank you for your time and consideration, and I look forward to your response.

Sincerely,

**[Signature]**

**[Name]**

CC: **[County Welfare Department]**; **[Health Plan]**

Atts. **[If applicable,** include the signed Appointment of Authorized Representative form, a copy of your requests and communications, and any documentation from medical providers supporting the need for services**]**

1. BHIN 21-073. [↑](#footnote-ref-1)
2. This chart does not include information on an Independent Medical Review (IMR), which is a review of a decision by a beneficiary’s health plan by independent doctors who are not part of that health plan. For more information on the IMR process, see the Department of Managed Health Care’s [Frequently Asked Questions](https://www.dmhc.ca.gov/fileacomplaint/frequentlyaskedquestions.aspx). [↑](#footnote-ref-2)
3. 42 CFR § 438.420; 9 CCR § 1810.215; 22 CCR § 51014.2. [↑](#footnote-ref-3)
4. WIC §§ 14197.3(a), 10950(g)(1); 42 CFR §§ 438.210(c), 438.404. [↑](#footnote-ref-4)
5. *See* APL 21-011 at 13 for information on expedited grievances with managed care plans. [↑](#footnote-ref-5)
6. 42 CFR § 438.400(b); 9 CCR § 1810.218.1; 28 CCR § 1300.68(a)(1). [↑](#footnote-ref-6)
7. 42 CFR § 438.402(c)(2)(i); 28 CCR § 1300.68(b)(9). State regulations allow grievances to be filed at least 180 days from the date of the relevant incident, but federal regulations have a less restrictive standard and allow grievances to be filed at any time. [↑](#footnote-ref-7)
8. 9 CCR § 1850.206(b); 28 CCR § 1300.68(a). [↑](#footnote-ref-8)
9. 42 CFR § 438.400(b); 9 CCR § 1810.203.5; APL 21-011 at 3. [↑](#footnote-ref-9)
10. 42 CFR § 438.420. [↑](#footnote-ref-10)
11. 42 CFR § 438.402(c)(2)(ii). [↑](#footnote-ref-11)
12. WIC §§ 14197.3(b), (d)(8); 42 CFR § 438.408(b)(2). [↑](#footnote-ref-12)
13. 42 CFR § 438.410(a). [↑](#footnote-ref-13)
14. WIC §§ 14197.3(c), (d)(3); 42 CFR § 438.408(b)(3). [↑](#footnote-ref-14)
15. 42 CFR § 438.408(f). [↑](#footnote-ref-15)
16. 42 CFR § 438.408(f)(i); WIC § 10951(b)(1)(B); APL 21-011 at 19-20. [↑](#footnote-ref-16)
17. 42 CFR § 438.420; 9 CCR § 1810.215; 22 CCR § 51014.2. [↑](#footnote-ref-17)
18. WIC §§ 10950, 10951(b)(1); 42 CFR § 438.408(f)(2). [↑](#footnote-ref-18)
19. WIC §§ 10950, 10951(a)(1); [↑](#footnote-ref-19)
20. 42 CFR § 431.244(f)(1). [↑](#footnote-ref-20)
21. WIC § 10951.5(a); 42 CFR § 438.410(a). [↑](#footnote-ref-21)
22. WIC § 10951.5(a); 42 CFR § 431.244(f)(2). [↑](#footnote-ref-22)