

**APPEALS PROCESS
UNDER
HEALTH CARE REFORM**

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Notes for PowerPoint

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Overview of Training

PP slide 3

Note: The Affordable Care Act refers to the person requesting a hearing as the “appellant”. In Medi-Cal hearings, this person is called the “claimant”. In this training, “claimant” and “appellant” have the same meaning. Also, the words, “hearing” and “appeal” are interchangeable.

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BACKGROUND TO AFFORDABLE CARE ACT

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The Affordable Care Act (ACA) aims to increase the number of Americans with health insurance and cut the overall costs of health care. Beginning on October 1, 2013, for coverage starting on January 1, 2014, eligible individuals and employers will be able to enroll in qualified health plans (QHPs) – private health insurance that has been certified as meeting certain standards – through competitive marketplaces called Exchanges.

Effective January 1, 2014, eligible individual taxpayers, whose household income is between 100 and 400 percent of the Federal Poverty Level (FPL), are eligible to receive an advanceable and refundable premium tax credit (APTC) based on the individual's income for coverage under a QHP offered in the Exchange. The ACA requires a cost-sharing reduction (CSR) for individuals with incomes below 250 percent of the FPL. The CSR lowers out of pocket expenditures in the form of deductibles, co-insurance and copayments in the health plan.

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California has created the California Health Benefit Exchange also called Covered California. Beginning October 1, 2013 Covered California offers a choice of health plans, establishes common rules regarding offering and pricing of insurance and provides information to consumers to help consumers better understand options. It serves as a one-stop shop where applicants will be assessed for eligibility for the various programs, purchase private insurance and enroll with coverage beginning in January 2014.

A new automated system, jointly developed by Covered California and the Department of Health Care Services, that supports Covered California’s program, the California

Healthcare Eligibility, Enrollment and Retention System (CalHEERS), has been developed to handle applications for health coverage.

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MEDI-CAL EXPANSION

MODIFIED ADJUSTED GROSS INCOME (MAGI) MEDI-CAL

Under the ACA, beginning in 2014, there are changes in how public programs determine who is eligible for Medi-Cal. The criteria depends on whether the applicant is eligible based on the applicant's Modified Adjusted Gross Income (MAGI) or whether the applicant qualifies as non-MAGI. MAGI Medi-Cal changes the way income and household size is determined for Medi-Cal eligibility for certain groups of applicants and recipients.

In addition, there will be an expansion of Medi-Cal eligibility for childless adults as part of the Affordable Care Act's increasing access to health insurance. Most adults, including people with disabilities who do not receive Medicare, who have a MAGI that is 138% or less of the Federal Poverty Level (FPL) (equal to or less than \$15,856 for a single individual in 2013) will be eligible. Also, children with MAGI up to 266% FPL will be eligible for Medi-Cal. There is no asset test for MAGI Medi-Cal populations.

NON-MAGI MEDI-CAL

Some existing Non-MAGI Medi-Cal programs will still exist. Non-MAGI Medi-Cal recipients will have to meet the income and asset and other Medi-Cal rules in place prior to 2014, with the exception of deprivation in the Aid to Families with Dependent Children (AFDC) medically needy program. Non-MAGI eligibility rules continue to apply for recipients of AFDC medically needy Medi-Cal, with or without a share of cost; aged, blind and disabled; long-term care; and cash-linked eligibility such as CalWORKs, foster care, and adoption assistance.

Applicants eligible for either MAGI Medi-Cal or Non MAGI Medi-Cal are generally not eligible for premium assistance or cost-sharing reduction (APTC or CSR) Possible exceptions may include newly qualified adult immigrants and certain pregnant women.

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SINGLE STREAMLINED APPLICATION (SSApp)

Applicants may apply for coverage in person, by mail, fax and phone and online as follows:

- Covered California by phone or mail;

- Covered California: online at www.CoveredCA.com
- Certified Enrollment Counselors or Certified Insurance Agents in person;
- County: in person, by mail, fax and phone.

Applicants can file one application, known as the SSApp (Single, Streamlined Application), to determine eligibility for MAGI Medi-Cal, Covered California and Access for Infants and Mothers (AIM), although inclusion of AIM in CalHEERS is delayed. The SSApp can be used to determine eligibility for Non-MAGI Medi-Cal with a supplemental application, available primarily from the counties.

Consumers, County Eligibility Workers and the Certified Enrollment Counselors input basic information into the SSApp. CalHEERS will process all applicant information, regardless of who initially receives it, for QHP, APTC, CSR and MAGI-Based Medi-Cal eligibility.

Covered California will determine an applicant's eligibility within 10 calendar days from the date it receives the applicant's paper application. For online and telephone applications it should occur immediately or less than 10 days. Covered California will guide consumers through the process and determine all their options. If Covered California determines that the applicant is eligible, the applicant will then select a QHP. Covered California will transmit all the necessary information directly to the QHP issuer, so that the health plan can enroll the applicant. The applicant must then make an initial premium payment to the QHP issuer they have chosen before coverage is effective.

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REFERRAL FOR NON-MAGI MEDI-CAL EVALUATION

If the information on the application indicates the applicant is not eligible for MAGI Medi-Cal and may be eligible for Non MAGI Medi-Cal, e.g. the applicant is over 65, or the applicant chooses to request Non MAGI-based Medi-Cal; Covered California will transfer the application to the counties to determine eligibility for non-MAGI Medi-Cal. The applicant, once determined eligible for MAGI Medi-Cal, is not required to complete the Non-MAGI determination process, including the Supplemental Application, unless the applicant seeks a full non-MAGI Medi-Cal evaluation. Counties will continue to process eligibility for Non-MAGI Medi-Cal as before. If the client wants a Non-MAGI Medi-Cal determination, the county would process that as usual in SAWS.

If a family applies for health coverage, the family will also be offered other services such as CalFresh, CalWORKS, etc., if they are potentially eligible. Potential eligibility is defined as when the information provided on the SSApp and information otherwise available to the county indicates that the applicant may be eligible for aid if the

information on the Statement of Facts were verified. In order to preserve the individual's right to apply and receive written determination, counties should offer the applications.

While the applicant is being evaluated for Non-MAGI Medi-Cal, if the applicant is eligible for Covered California, the applicant can enroll temporarily in a Covered California QHP and is eligible for any applicable premium assistance and cost-sharing reduction. If the county determines that the applicant is eligible for Non-MAGI Medi-Cal, then the applicant would disenroll from the Covered California QHP and obtain coverage in Medi-Cal.

If the applicant is seeking health coverage prior to January 1, 2014, his or her application will be handled by the county for a determination of the applicant's eligibility for Non-MAGI Medi-Cal, pursuant to the existent rules, including retroactive Medi-Cal benefits.

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JURISDICTION

Covered California and the CDSS have entered into an Inter-Agency (IA) Agreement that authorizes SHD to conduct hearings based on consumer appeals that arise out of the Covered California application and enrollment process.

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The SHD will have jurisdiction over the following Covered California appeals:

- a. An eligibility determination, including:
 - i. An initial determination and redetermination of eligibility, including the amount of APTC and level of CSR, and including enrollment issues; and
 - b. Covered California's failure to provide a timely eligibility determination, or failure to provide timely notice of an eligibility determination or redetermination.
- c. Fraud Cases: When the QHP Issuer terminates a QHP with the enrollee due to the enrollee's fraud/intentional misrepresentation
- d. Small Business Health Options Program (SHOP) Appeals.

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- e. "Continued Enrollment": [similar to Aid Paid Pending] When Covered California receives a valid appeal request regarding a redetermination, Covered California shall continue to consider the applicant eligible while the appeal is pending, and:

- i. If the appellant accepts eligibility during appeal, Covered California shall continue or reinstate within 5 business days, the Appellant's eligibility for enrollment in QHP, APTC and CSR as applicable ("previous level of coverage"), in accordance with the level of eligibility immediately before the redetermination being appealed.
- ii. Federal Government has instructed Covered California to continue or reinstate "previous level of coverage" on any appeal of a discontinuance or decrease filed within 90 calendar days from the Notice of Action date until the decision is issued, as long as the recipient pays any required premium.

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APPEALS PROCESS

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MAGI Medi-Cal Appeals

Initial determination of eligibility and redeterminations are subject to the same due process rights and substantive review as is provided in any Medi-Cal appeal, including Non-MAGI Medi-Cal appeals.

All MAGI Medi-Cal initial determinations are based on policies developed by DHCS and are contained in CalHEERS; however, it will be the counties' responsibility to verify any additional information needed for any final determination which is then forwarded to SAWS and Medi-Cal Eligibility Data System (MEDS). The counties also have the responsibility to defend any MAGI Medi-Cal appeal, including any appeal of any MAGI Medi-Cal 'decision' made by CalHEERS.

The Counties are responsible for processing all Non-MAGI Medi-Cal appeals.

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The SHD will also continue to handle all Medi-Cal appeals, including MAGI Medi-Cal appeals, through the IA Agreement with DHCS.

The basic existing hearing process that the SHD has utilized for many years to handle Medi-Cal hearing requests will apply to Covered California and MAGI Medi-Cal appeals, with a few exceptions. Claimants will retain the appeal rights as they exist under the current Medi-Cal appeal process. This includes the right to have an in-person hearing, or a home hearing alternative for individuals with disabilities who are unable to appear by telephone.

SHD existing jurisdiction over Non-MAGI Medi-Cal appeals remains unaffected.

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PREHEARING PROCEDURES

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All MAGI Medi-Cal applications will be inputted into the CalHEERS system. When operational, the eligibility information from CalHEERS will be uploaded to SAWS where the counties will be able to verify eligibility of the information on the claimant's application. Upon verification of eligibility (or non-eligibility), the counties will send out the appropriate Notice of Action to the claimant.

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In response to the significant number of Medi-Cal applications received through the Covered California portal, DHCS is providing temporary eligibility for approximately 200,000 individuals while the counties complete the necessary administrative verifications. These are cases in 'pending' status in CalHEERS as of December 14, 2013. Letters are being sent to consumers informing them that their Medi-Cal coverage will begin January 1, 2014, subject to any verification requested by the counties.

Any applicant subsequent to December 14, 2013 will receive a letter from Covered California informing the applicant either that they qualify for MAGI Medi-Cal and a Benefit Identification Card (BIC) will be sent to them in the mail or a letter from Covered California stating that they may be eligible for Medi-Cal and will be contacted by the county if more information is needed. The final notice of action pertaining to Medi-Cal eligibility will be generated from CalHEERS and mailed to the beneficiary from the eligibility worker.

Any appeal from a denial of MAGI Medi-Cal will be based on the Notice of Action (NOA) sent by the county subsequent to verification of the applicant's information or upon the claimant's request for a hearing based on the untimely processing of any MAGI Medi-Cal application.

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The claimant may submit an ACA request for an appeal in person, or by telephone, email, online, mail or fax to Covered California, DHCS, counties or SHD.

New 800 telephone and fax lines have been established devoted exclusively to ACA appeals.

All ACA appeal requests received by other agencies are to be forwarded directly to the Affordable Care Act Hearings Bureau (ACAB).

The ACAB will online all ACA appeals. Counties with the ability to currently online onto HWDC must no longer do so and must forward all Medi-Cal appeals to the ACAB.

Upon receipt of an ACA appeal, the ACAB will enter information into the new interim ACAB appeal database. All MAGI Medi-Cal information from the counties, including Requests for Hearing and Statements of Position and all Non-MAGI Medi-Cal Requests for Hearing from the counties must be transmitted through the ACAB Secured File Transfer (SFT). In the event SFT is unavailable, information may be transmitted via facsimile or by mail.

Claimant may represent himself or herself, or be represented by an authorized representative or by legal counsel, a relative, a friend, or another spokesperson, during the appeal. Proper documentation must be submitted to SHD verifying the claimant's AR designation.

The ACAB will send acknowledgement of receipt via mail of the appeal and PUB 412A (Notice of Hearing Rights) to the claimant and/or the AR. The ACAB will notify Covered California and/or the county of the appeal via the secure transfer (SFT) process.

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ACAB schedules the hearing and sends Notice of Hearing (NOH), providing at least 15 days' notice of the hearing date. The hearing may be scheduled as an in-person, video conference or telephone hearing. If the hearing is set as a telephone or video conference hearing, the claimant has the right to request an in-person hearing.

ACAB will schedule cases in the same manner as is currently used in General Jurisdiction using the County four week calendar model.

Postponements: The current process of applying the "good cause" provisions in Division 22 will be used for determining whether to grant requests for postponements in these appeals.

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Dismissals. Federal and state regulations provide for dismissals of ACA appeals as follows:

- a. Claimant unconditionally or conditionally requests a withdrawal in writing prior to the hearing date.
- b. Claimant fails to appear at the hearing without good cause.
- c. Claimant fails to submit a valid appeal request without good cause. 10 CCR 6606(a)(4),
- d. Claimant dies while the appeal is pending, unless the appeal affects remaining member(s) of the claimant's household or the appeal can be carried forward by the representative of the claimant's estate.

- e. If appeal is dismissed, the SHD shall provide timely notice in 5 business days, including:
 - i. Reason for the dismissal.
 - ii. Explanation of the dismissal's effect on the claimant's eligibility.
 - iii. Explanation how, with good cause, the dismissal may be vacated.
 - iv. Notify Covered California and the county, as applicable, within 3 business days of the dismissal, and give instructions regarding the eligibility determination to implement and discontinue eligibility pending appeal, if applicable, no earlier than 5 business days of the dismissal.
- f. SHD may vacate a dismissal if the claimant makes a written request within 30 days and shows good cause. SHD must notify the claimant within 5 business days of denial to vacate. This is an appealable issue.
- g. If claimant's request to reopen the hearing request is granted, the hearing will be rescheduled.
 - i. Pending the hearing, Covered California and/or the county will engage in the informal resolution process, which may result in an Unconditional or Conditional Withdrawal of the hearing request.

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- 2. Unconditional Withdrawal: If, as a result of the informal resolution process, the claimant elects to withdraw, without conditions, the appeal request shall be dismissed.

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Conditional Withdrawal: As a result of the informal resolution process, if the claimant and the agency reach agreement, the claimant withdraws the hearing request on the understanding that the terms and conditions of the agreement are to be met by the parties. The responsibilities of either or both parties shall be listed with sufficient detail so as to establish a meeting of the minds and to permit enforcement. The counties will rescind the NOA after receipt of the signed Conditional Withdrawal. However, as a best practice, Covered California and the county should begin to take action as soon as practicable after the agreement with the claimant has been made, even if the signed Conditional Withdrawal is not received before the hearing. Covered California or the County should, as a best practice, advise the claimant if the written Conditional Withdrawal has not been received two business days before the hearing.

ACAB will provide a "Duty Judge," who will be available on short notice to provide to the parties a telephone hearing for the purpose of a pre-hearing disposition on the record. This process is not intended to alleviate the responsibilities of Covered California or the

counties to provide a signed written Conditional Withdrawal, but rather as a convenience for the parties which can be used where a signature cannot be readily obtained from or provided by the claimant prior to the hearing.

Effect of Withdrawal: SHD shall dismiss an appeal if the claimant:

- a. Unconditionally or conditionally requests a withdrawal in writing prior to the hearing date:
 - i. If Written Unconditional Withdrawal request, the appeal request is immediately dismissed.
 - i. If Verbal Unconditional Withdrawal request, the SHD will attempt to contact the claimant and verify the withdrawal. If SHD is unable to contact the claimant, SHD will send written confirmation within 5 business days to the claimant's last known address on record. The claimant will be informed that if s/he does not contact the SHD within 15 calendar days of mailing the request for confirmation of withdrawal, the SHD will take this to mean that the claimant wishes to withdraw the appeal, and the case shall be dismissed. A final Notice of Dismissal is thereafter mailed informing the claimant that the appeal is dismissed, unless good cause is provided within 30 calendar days for setting aside the dismissal. If the dismissal is set aside, the matter will be set for hearing. If the request is denied, the SHD must notify the claimant within 5 business days of denial to vacate. This is an appealable issue to HHS.
 - ii. If Conditional Withdrawal request, withdrawal shall be accompanied by agreement signed by claimant and Covered California (CC) or the county, as part of informal resolution process. The written agreement must be received by SHD before the hearing. Upon receipt of the written Conditional Withdrawal, the SHD shall dismiss appeals request. If the claimant verbally agreed to a conditional withdrawal, but CC/the County has not received the signed agreement by the close of the second business day prior to the hearing, the CC/County should, as a best practice, notify the claimant that the form was not received and the claimant must appear at hearing. The ACAB will provide a "Duty Judge," as mentioned previously.
- b. If the appeal is resolved through the Covered California informal resolution process:
 - i. Covered California shall notify the claimant within 5 business days of terms and effective date of informal resolution.
 - ii. Covered California shall notify the SHD within 3 business days of any informal resolution.

- iii. The informal resolution is final and binding on all parties once terms and conditions of the agreement are completed.
- c. In the event the appeal is not resolved during the informal resolution process, the case will proceed to hearing. If conditions of the agreement are not met, the hearing will go forward or be reinstated and rescheduled if already dismissed.

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Statement of Positions (SOP): Covered California will prepare all SOPs involving eligibility determinations within its jurisdiction. The county of claimant's residence will prepare all SOPs involving MAGI and Non-MAGI Medi-Cal eligibility determinations. The claimant and/or the AR have a right to submit a SOP.

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Availability of SOP: The agency's SOP must be made available no less than two business days before hearing. Covered California will provide its SOP electronically to counties in a manner that complies with this requirement. Upon request of the claimant, the counties will provide the claimant with a copy, if available, of Covered California's Statement of Position. The claimant and his/her AR shall have the opportunity to review his or her case record and all non-privileged information used by the county prior to or at the hearing.

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Dual Agency Determinations: Where claimant's appeal raises disputes that involve both Covered California and the county, the agencies will coordinate and decide whether all issues can be set forth in one SOP, or whether separate SOPs will be submitted.

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Expedited Hearings: Request for expedited hearings will be processed as follows: Requests for expedited hearings shall be made to the ACAB. If the appeal involves a Covered California issue, the Presiding Judge (PJ) of the ACAB will determine if an expedited state hearing is required. The standard used to determine whether an expedited state hearing is required is: *"where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function."*

If the SHD denies an Expedited Appeals request, it shall handle the appeal request under the standard appeal process and notify the claimant by electronic mail or orally within 3 business days of the denial. If notification is oral, the SHD will follow up with written notice within 5 business days.

If the Expedited Appeal request is granted, the ACAB shall, within 10 days of claimant's request for an Expedited Appeal, provide claimant with a notice stating the date, time and place of the

Expedited Hearing. The ACA Bureau will notify Covered California and the county, if applicable, within 3 business days of the determination to grant the expedited hearing.

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An Expedited Appeals decision shall be issued within 10 calendar days of the Notice of Hearing or within 5 days of the close of the record, whichever is later.

In all other respects, requests for expedited hearings will be processed in accordance with the provisions of ACL No. 13-40.

Expedited appeals will not go through the Informal Resolution Process.

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HEARING PROCEDURES

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The hearing may be held in person, via video conference or by telephone by an impartial administrative law judge (ALJ) employed by the California Department of Social Services. When any participant in the hearing is not in-person at the designated hearing site, the SHD shall explain the process and timing of submitting any documentary evidence prior to or during the hearing.

The existing process for ensuring that a certified interpreter be available when required will apply in these appeals.

The hearing will be an evidentiary hearing where the claimant may present evidence, bring witnesses, establish all relevant facts and circumstances, and question or refute any testimony or evidence, including, but not limited to, the opportunity to confront and cross-examine adverse witnesses, if any.

The ALJ will conduct a de novo review of the case and evidence presented at hearing.

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POST-HEARING PROCEDURES

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The decision will be sent to the claimant by mail and will be transmitted to Covered California and/or the county via a secured electronic transfer.

All decisions will be based on the application of the pertinent laws and eligibility and enrollment rules to the information used to make the eligibility or enrollment decision, as well as any other information provided by the claimant and/or the agency with proper notice during the course of the appeal.

The decision will make a determination of the claimant's eligibility or enrollment, and include a summary of the relevant facts in support of the determination, an identification of the legal basis for the decision, and the effective date of the decision, which may be retroactive.

1. Favorable Decision – Compliance for Covered California: If the decision is in claimant’s favor, Covered California shall comply and implement the decision as follows:
 - i. Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with 10 CCR Section 6496(l), if applicable; or
 - ii. Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant; and
 - iii. Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in 10 CCR Section 6472 and 6474.

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APPEAL RIGHTS

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Decision – Claimant’s Appeal Rights: If the claimant disagrees with the decision, the SHD will notify the claimant that he or she can make an appeal as follows:

- iv. Covered California Issues: All decisions relating to issues within the jurisdiction of Covered California are final unless, the claimant requests an appeal regarding issues relating to Covered California to the federal Department of Health and Human Services (DHHS) within 30 days of receipt of the decision, unless good cause is shown why the conditions of a Conditional Withdrawal were not satisfied. .
- v. MAGI or Non-MAGI Medi-Cal Issues: MAGI and Non-MAGI Medi-Cal rehearing requests regarding any issues relating to Medi-Cal coverage shall be submitted to the DHCS Rehearing Unit within 30 days of receipt of the decision.
- vi. All Other Issues (i.e. CalFresh, CalWORKS, IHSS, etc.): rehearing requests for all other programs shall be submitted to the SHD Rehearing Unit within 30 days of receipt of the decision.
- vii. Judicial Review: The claimant is permitted to also seek judicial review to the extent provided by law. Exhaustion of an appeal to HHS or DHCS is not a prerequisite for seeking judicial review.

Claimant’s Access to Appeal Record: Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the ACAB will make the appeal record accessible to the appellant for no less than five years after the date of the written notice of the appeal decision.

Public Access to Decisions: The SHD will provide public access to appeal decisions, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.