Chapter 6: Staying On

Chapter 6. Staying On

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6. Staying On

A. How to Keep Coverage

Individuals who have been found eligible and are enrolled in Medi-Cal or Covered California with financial assistance (premium tax credits or cost-sharing reductions) must have their eligibility redetermined every 12 months in order to retain coverage for the next year.[1] If during the 12-month period new information that affects eligibility becomes available to the county or Covered California – either reported by the individual or accessed through other electronic data sources – a beneficiary or enrollee will automatically have their eligibility for the insurance affordability program redetermined based on the new information.

As a result of a redetermination, a Medi-Cal beneficiary or Covered California enrollee with financial assistance could:

- Remain eligible for the same program, *e.g.,* remain on Medi-Cal under the same basis of eligibility;
- Remain eligible for the same insurance affordability program, but be eligible for a higher or lower cost premium plan due to a change in income;
- Become eligible for a different insurance affordability program entirely, *e.g.,* move from Medi-Cal to Covered California; or
- Become ineligible for all insurance affordability programs.

A Medi-Cal beneficiary or Covered California enrollee found to be ineligible for their existing insurance affordability program must be automatically determined for eligibility for other programs, rather than reapplying to the other program.[2]

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1. While this guide also covers the Medi-Cal Access Program, women in the program do not have an annual determination as the program ends 60 days after the birth of the baby, nor are they reassessed for the program when their income changes. See Section A.3.d for the renewal rules for babies born on the Medi-Cal Access Program.
2. 42 C.F.R. § 435.916(f); 45 C.F.R. § 155.335(f); 10 CCR §§ 6472, 6474; ACWDL 14-18 (Apr. 8, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.

1. Changes in Circumstances

Changes in income, family composition and other types of household changes may affect a Medi-Cal beneficiary's or Covered California enrollee's continuing eligibility for coverage. These changes could relate to

- Income;
- Household composition (*e.g.,* birth, death, adoption);
- Moving;
- Immigration status;
- Incarceration; or
- Access to other health coverage.

In general, Medi-Cal beneficiaries and Covered California enrollees are required to report any changes affecting eligibility during the 12-month period. In addition, the county/state may receive information periodically from data sources that could trigger a redetermination.

a. Medi-Cal

i. Beneficiary Obligation to Report

Beneficiaries must report to the county any change in their circumstances that may affect their Medi-Cal eligibility within ten calendar days of the change.[3] The primary types of changes that affect eligibility are changes in income or household composition.[4] Beneficiaries may report changes via website (logging into their account in CalHEERS at www.coveredca.com), telephone, fax, mail, in person or any other commonly available electronic means authorized by the county or DHCS.[5]

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3. Welf. & Inst. Code § 14005.37(h).
4. *See* ACWDL 14-22 (Apr. 25, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf.
5. 42 C.F.R. § 435.907(a); Welf. & Inst. Code § 14005.37(q).

Advocacy Tip: The website **www.coveredca.gov** is part of CalHEERS, the California Healthcare Eligibility, Enrollment and Retention System, and is a portal through which one can apply for Medi-Cal or Covered California. The system also maintains accounts through which consumers can manage their Medi-Cal or Covered California coverage. If someone applied for Medi-Cal through the county, however, due to remaining technical issues with the system, they might not be able to access CalHEERS without assistance from the county. Consumers should also beware that going into one's CalHEERS account and changing information might trigger a redetermination!

ii. Periodic Data Review

The county may periodically access the federal data hub, along with other state databases, such as the Department of Motor Vehicles or the Franchise Tax Board, along with the county's own system for administering benefits between annual eligibility redeterminations to obtain more current eligibility information, such as income.

iii. Redetermination of Eligibility

The county must determine a beneficiary's ongoing eligibility upon learning of a change potentially affecting eligibility from the beneficiary or from its own review as follows:[6]

- Determine if the change in circumstances affects eligibility. For example, a change of address may not affect eligibility for Medi-Cal, but a change in household size might. If there is no change in eligibility based on the new information, no other action is needed.[7] Another example: If income increases $100/month, but the annual household income remains below the eligibility limit, the individual remains eligible for the same program so no further action is needed.
- If the county determines that the change in circumstances may affect

6. Welf. & Inst. Code § 14005.37(g) and its subdivisions, unless otherwise indicated.
7. Welf. & Inst. Code § (e)(2)(4).

eligibility, the county must attempt to gather all eligibility information using the *ex parte* process - a review of all available data resources such as the beneficiary's CalWORKs file or the federal data services hub.

- If the *ex parte* process does not provide the county the information it needs to find the beneficiary still eligible, the county shall ask the beneficiary for the information it needs. To request information from a beneficiary, the county must use a pre-populated form containing the information that the county already has and that requests *only* the information needed from the beneficiary to renew eligibility.[8] The beneficiary has 30 days from the date the pre-populated form is mailed to respond. The beneficiary must be allowed to provide the information requested on the pre-populated form by mail, phone, in person, or any other commonly available electronic means authorized by the county or DHCS.
- During this 30-day period, the county must try to contact the beneficiary by phone, in writing or other commonly available electronic means at least once in an effort to obtain the necessary information. If the beneficiary has identified a preferred method of contact, the county must use that method, otherwise, the county must use reasonable efforts to determine the best method of contact.[9]
- **If the beneficiary responds**, the county must determine if the beneficiary remains eligible based on the information provided by the beneficiary. If they remain eligible, the county completes the redetermination and sends written notice to the beneficiary. The beneficiary's next renewal date should be reset to 12 months from the date the county determines the beneficiary is eligible.[10]
    - In evaluating information regarding changed circumstances, the county must follow the SB 87 process described at Section A.3.a.iv below and in Welfare & Institutions Code 14005.37 subsection (d) and evaluate the beneficiary for eligibility for *all* Medi-Cal programs (MAGI

8. At publication of this manual, the computer-generated prepopulated form contemplated by the redetermination statute was not yet in operation, thus counties were sending beneficiaries other forms requesting the documents necessary to determine ongoing eligibility.
9. Welf. & Inst. Code § 14005.37(t).
10. Welf. & Inst. Code § 14005.37(n).

and non-MAGI) before terminating the beneficiary from Medi-Cal.[11] If based on the new information the beneficiary is found not eligible for any Medi-Cal program (if they are over income due to an increase in income or change in family composition, for example) the county must determine eligibility for Covered California with financial assistance.[12] If eligible, the county should assist the individual with enrollment into Covered California and, if requested, with Covered California plan selection.[13] After completing the beneficiary's eligibility determination for Covered California, the county is required to send the beneficiary a ten-day Notice of Action terminating their Medi-Cal.[14] Note that the county is supposed to take any steps necessary to ensure that a Covered California-eligible beneficiary being discontinued from Medi-Cal can transition to Covered California without a break in coverage.[15] Beneficiaries found eligible for Share of Cost Medi-Cal must also be evaluated for Covered California financial assistance.[16] Beneficiaries eligible for Covered California have the choice of having just Share of Cost Medi-Cal, Covered California, or both.[17]

- **If the beneficiary does not provide the necessary information** to the county within the 30-day period, the county may send the beneficiary a ten-day Notice of Action of terminating Medi-Cal.[18] At this point in the

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11. Welf. & Inst. Code § 14005.37(d); ACWDL 14-18 at pp. 1- 2, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.
12. *Id.* at pp. 4, 9. Remember, however, many parents and children can move into Transitional Medi-Cal or Continuous Eligibility for children when the family's income increases. See Chapter 3, Sections C.5 and C.6.
13. *Id.* at p. 4.
14. The requirements for the Notice of Action are set forth in ACWDL 15-33 (Oct, 9, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-33.pdf.
15. Welf. & Inst. Code § 15926(h).
16. ACWDL 14-18 at pp. 3 – 4, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.
17. *Id.*, p. 3. Share of Cost Medi-Cal is not considered minimum essential coverage, but note that persons with Share of Cost Medi-Cal and no other coverage may meet the criteria for a Covered California Special Enrollment Period and are currently eligible for an exemption from the individual mandate. 10 CCR § 6504 § (a)(1)(D); MEDIL 15-29 (Oct. 22, 2015), p. 2, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-29.pdf. *See also* Instructions for IRS Form 8965 for 2015, p. 3 available at https://www.irs.gov/pub/irs-pdf/i8965.pdf.
18. Welf. & Inst. Code § 14005.37(g)(3); ACWDL 14-18 at p. 2, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.

process, the county is required to immediately evaluate the beneficiary for premium tax credits and forward the case to Covered California.[19] At the end of the ten days, the beneficiary may be discontinued or terminated from Medi-Cal; however, if the beneficiary provides the requested information prior to the termination date, the county must rescind the termination action and conduct an eligibility evaluation and redetermination.[20]

- If terminated, the beneficiary still has 90 days from termination to "cure" or provide the information requested and if they do so, the county must treat the information as if it was received timely.[21] Note that the "good cause" rule regarding submitting information even beyond the 90 days applies.[22] See also Section B.1 later in this chapter for the Medi-Cal notice and hearing rights, including the right to continue receiving Medi-Cal pending appeal (aid paid pending).

Note that these rules generally apply to both MAGI and Non-MAGI Medi-Cal beneficiaries.[23]

Also note that the county can terminate without doing a redetermination only when it has proof that the beneficiary cannot be eligible for Medi-Cal such as proof that the beneficiary died or moved out of state.[24]

iv. Relationship with Other Public Assistance Programs

If a Medi-Cal beneficiary is enrolled in another public assistance program such as

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19. ACWDL 14-18, at p. 4, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.
20. *Id.*
21. *Id.* *See also* Welf. & Inst. Code § 14005.37(i).
22. ACWDL 14-35 (Sep. 29, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, pp. 5 – 6. *See* 22 CCR § 50175(c).
23. ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf. *See* ACWDL 14-18 for more detail on these rules and where the processes that the county must follow differ for MAGI versus Non-MAGI Medi-Cal. The section in this manual on annual redeterminations for MAGI and Non-MAGI beneficiaries, found *infra* at Section A.3.a., also contains additional detail.
24. Welf. & Inst. Code § 14005.39.

CalFresh[25] and reports a change to that program that would affect their Medi-Cal eligibility, the county should conduct a Medi-Cal eligibility redetermination using the information the beneficiary provided to the other program, without requesting additional information from the beneficiary.[26] If the beneficiary remains Medi-Cal eligible, the beneficiary must be granted a new 12-month eligibility period.[27]

Counties may align a beneficiary's annual Medi-Cal redetermination date with their CalFresh redetermination date so long as the resulting Medi-Cal annual redetermination date (discussed below) is set for no less and no more than 12 months out.[28]

Advocacy Tips: Advise your clients to give the county their updated addresses anytime they move so the county has their most current information. Even if they remain in the same city or county, they should report their new address.

Advise your clients to respond to requests for information from Medi-Cal by phone, fax, or mail as soon as possible. If they are past the deadline to respond, advise them to still respond as there is a 90-day cure period as well as good faith exceptions if they were unable to respond for a reason.

Ensure your clients' language access rights are enforced. If your client is terminated from Medi-Cal and is still eligible, but the renewal forms or Notice of Action that were sent are not in your client's primary language, you can assert that the termination is not valid because your client did not receive proper notice.[29] The county must reinstate eligibility and reissue the forms or Notice of Action in your client's primary language before the client can be lawfully terminated from Medi-Cal. See Section B.1.a later in this chapter.

25. CalFresh is California's Supplemental Nutrition Assistance Program, which gives eligible persons electronic benefits to purchase many foods. *See* Welf. & Inst. Code §§ 18900 *et seq.*
26. ACWDL 14-22 at pp. 2-3, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf.
27. Welf. & Inst. Code § 14005.37(n).
28. ACWDL 14-22 at p.3, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf.
29. *See* 42 U.S.C. § 1396u-2; 42 C.F.R. § 438.10(c); Welf. & Inst. Code §§ 14005.37(p), 15926(k).

b. Covered California

i. Enrollee Obligation to Report

Enrollees are required to report to Covered California any changes that affect eligibility within 30 days of such change.[30] Similar to Medi-Cal, changes that should be reported include[31]

- Income;
- Tax household composition;
- Moving;
- Immigration status;
- Incarceration; and
- Access to other health coverage.

Enrollees may report changes online through Covered California's website, or by phone, fax, mail or in person.[32] However, an enrollee has no obligation to report changes in income that do not affect the amount of the enrollee's premium tax credits or level of cost-sharing reductions.[33]

After obtaining updated information from the enrollee, Covered California must first verify the information per the procedures used when the initial application was processed.[34] These verification procedures are discussed in detail in Chapter 5, Section B.

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30. 45 C.F.R. § 155.330(b)(1); 10 CCR §§ 6496(b) and 6498(g). Enrollees of unsubsidized coverage who experience a change of circumstances should report the change, but in general, there should be no change in their coverage during the year. Further, enrollees who have not requested an eligibility determination for insurance affordability programs do not have to report changes affecting eligibility for such programs. 45 C.F.R. § 155.330(b)(2); 10 CCR § 6496(c). Unsubsidized enrollees whose income decreases and who would like to apply for financial assistance during the year may do so. *See* 10 CCR § 6504(a)(6).
31. 10 CCR §§ 6472, 6474. See Ch. 4 regarding eligibility for premium tax credits and minimum essential coverage.
32. *Id.* 10 CCR §§ 6496(b) and 6498(g).
33. 45 C.F.R. § 155.330(b)(3); 10 CCR § 6496(d).
34. 45 C.F.R. § 155.330(c); 10 CCR § 6496(e); 10 CCR §§ 6478 through 6492.

Once Covered California verifies the change in information reported by an enrollee, it must redetermine the enrollee's eligibility for enrollment in the existing plan or, if applicable, for eligibility for financial assistance.[35] Covered California must notify the enrollee of the outcome of the redetermination within five business days of the redetermination.[36] For an enrollee's rights regarding adverse actions resulting from redetermination, see Section B.2.a later in this chapter.

ii. Semi-annual Data Review

Covered California is required to examine available data sources twice a year to determine if an enrollee has died and if the enrollee is receiving advanced premium tax credits or cost-sharing reductions, and whether the enrollee has been determined eligible for Medicare, Medi-Cal, or a CHIP.[37] Covered California must use a different redetermination process when the changes are reported by an enrollee or qualified individual versus when changes are identified based on information through semi-annual data review.

Covered California must follow this process if the semi-annual data review results in updated information about death, or eligibility for Medicare, Medi-Cal, or CHIP:[38]

- Notify the enrollee about the updated (changed) information and the projected outcome of the eligibility redetermination after considering the new information;
- Give the enrollee 30 days to notify Covered California if the information is inaccurate;
- If the enrollee responds within 30 days to contest the updated information, Covered California must treat the information as an inconsistency and provide the enrollee a reasonable opportunity period to resolve the problem; and[39]
- If the enrollee does not respond within 30 days, Covered California must

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35. 45 C.F.R. § 155.330(e)(1)(i); 10 CCR § 6496(h)(1), referencing §§ 6472 and 6474. Such redetermination may affect the eligibility of other household members for insurance affordability programs, including Medi-Cal.
36. 45 C.F.R. § 155.330(e)(1)(ii), 10 CCR § 6496(h)(2), referencing § 6476(h).
37. 45 C.F.R. § 155.330(d)(1); 10 CCR § 6496(g).
38. 45 C.F.R. § 155.330(e)(2)(i); 10 CCR § 6496(i).
39. *See* 10 CCR § 6492 for procedures to resolve inconsistencies.

complete the redetermination based on the information found and send notice of the final outcome.

iii. Additional Rules Regarding Redetermination Outcomes Due to Changes in Circumstances

For a redetermination that results in a change in cost-sharing reductions, the enrollee should be determined eligible for the category of cost-sharing reductions that corresponds to her expected annual household income for the current benefit year.[40] A redetermination during the benefit year that results in a change in eligibility for cost-sharing reductions or becoming newly eligible or ineligible for premium tax credits is a qualifying event for a Special Enrollment Period, allowing that enrollee to change plans.[41]

Advocacy Tip: If an enrollee in a cost-sharing reduction plan reports a change that would change their eligibility for cost-sharing reductions, the change will require the enrollee to change health plans. Thus, so long as the enrollee complies with the obligation to report that change within 30 days, if they have an important medical appointment scheduled, they may want to wait until after that appointment to notify Covered California of the change to avoid billing problems. Another thing to consider is that any out-of-pocket expenses attributed to the previous plan must be credited to the new plan in order to calculate annual deductibles or maximum out-of-pocket limits.[42]

Any change in coverage that results from a new eligibility determination would begin either the first of the following month or the second month depending on whether Covered California was notified of the change before or after the 15th of the month.[43]

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40. 45 C.F.R. § 155.330(g)(2); 10 CCR § 6496(n).
41. 10 CCR § 6504(a)(6).
42. 45 C.F.R. § 156.425(b); 10 CCR § 6506(d)(9)D).
43. 10 CCR § 6496(k), (l).

c. Medi-Cal Access Program (MCAP)

While there is no "redetermination" process for MCAP, *per se*, advocates should be aware of the following reporting obligations:

- If a woman's pregnancy ends during the first trimester, she may have her contribution reduced to one-third of the original cost by notifying MCAP within 30 days of the date the pregnancy ended.[44]
- The baby's birth must be reported within 30 days so MCAP can determine the last valid day of eligible benefits, which is the end of the month in which the 60th day after birth occurs.[45]
- Drops in income should be reported so that women can have their monthly contribution reconsidered or be moved into Medi-Cal.[46]
- Drops in income should be reported for babies in their second year of MCAP so as to assess whether the MCAP premium can be eliminated.

2. Moving

a. Medi-Cal and Inter-County Transfers (ICTs)

Medi-Cal is a statewide benefit and is "portable" from county to county. Portability means that when Medi-Cal beneficiaries move to a new county, they *do not* have to re-apply for Medi-Cal in their new county of residence and there should be *no interruption* in their coverage.

But because the Medi-Cal program is administered at the county level, a beneficiary's Medi-Cal case must be transferred from the current county of residence to the

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44. 10 CCR § 2699.400(a)(5).
45. 10 CCR § 2699.209(b).
46. This is a recent change to the MCAP program as of October 2015. The form to change the monthly premium amount can be found at http://mcap.dhcs.ca.gov/Downloads/MCAP_Contribution_Re-Evaluation_Form.aspx.

new county of residence. This process is called an Inter-County Transfer (ICT).[47] Because the majority of Medi-Cal beneficiaries receive their health services through managed care plans that are organized at the county level, Medi-Cal managed care beneficiaries who move to a different county will also likely have to enroll in a new managed care plan. Both the ICT process and how beneficiaries can help ensure they are able to access services when they move are discussed below.

i. The ICT Process

When beneficiaries move and inform[48] either the county they are leaving (known in ICT terms as the "Sending County") or the county they are moving to (the "Receiving County") of the new address, the two counties must work together to transfer the case with no interruption in benefits and without having to re-apply.[49]

Ideally, Medi-Cal beneficiaries will report an upcoming change of address to their county workers in their Sending County before they move so their Medi-Cal case may be activated in the Receiving County by the time they relocate. State policy guidance directs Sending Counties to initiate the transfer process with the Receiving County within seven calendar days.[50] During that time, the Sending County sends an ICT Informing Notice to the beneficiary about the address change and the initiation

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47. The state regulations on ICTs are at Title 22 of the California Code of Regulations, Sections 50136 to 50138. But it is important to note that portions of those regulations have been superseded by ACWDL 03-12 (Feb. 21, 2003), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-12.pdf. For example, according to Section 50136(a)(1) and (3), an ICT triggers a redetermination of eligibility. But following federal guidance, ACWDL 03-12 provides that an ICT does not automatically trigger a redetermination, and that a redetermination is only required if the move coincides with a change in circumstance that may impact eligibility, such as a change in income or a change in the number of people in the family's household.
48. At the time this manual was being drafted, DHCS issued guidance to counties to accept address change information received from Medi-Cal managed care plans when the beneficiary approved the updated contact information or the county can otherwise verify the updated contact information. ACWDL 15-30 (Sept. 22, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-30.pdf. Presumably that means an ICT may be triggered not only when a beneficiary informs a county of a move, but also when a Medi-Cal managed care plan notifies a county of a beneficiary's move to a different county.
49. ACWDL 03-12, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-12.pdf.
50. *Id*. at p. 3.

of the transfer process with the Receiving County; enters the address change in the county's system, and completes the online transaction in the state's Medi-Cal Eligibility Data System (MEDS) so the MEDS record reflects the consumer's correct new residence county code and address; notifies the Receiving County of the impending transfer; and sends the Receiving County the ICT form and packet.[51]

But an ICT may also be triggered when Medi-Cal beneficiaries inform their Receiving County that they will be moving, have moved, or otherwise request Medi-Cal in their Receiving County. In that scenario, the Receiving County must contact the beneficiary's caseworker in the Sending County and request that a transfer be initiated.[52] The Sending County then processes the transfer, *i.e.*, sends an Informing Notice to the beneficiary; completes the address change in the county's system; sends the Receiving County the ICT form and packet, etc.

Once the Receiving County has been notified of the transfer, it must complete the ICT process no later than the first of the month after the 30-day ICT notification period.[53] The 30 days begin on the date the Sending County mailed or electronically sent the ICT notification and ICT packet to the Receiving County.[54]

During the transfer process, the Sending County retains responsibility for the beneficiary's Medi-Cal benefits and case record.[55] The Receiving County completes the transfer process by reviewing the case documents, notifying the Sending County of the effective date of Medi-Cal benefits in the new county so the case worker in the Sending County can close out the case, and sending a Notice of Action to the beneficiary at the new address to inform the beneficiary of the beneficiary's new casework name, phone number and office hours.[56] The ICT process is considered completed at the county-level once the Receiving County has the case active in its county system and the beneficiary's new address and county code is in MEDS.[57]

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51. *Id.* at pp. 3-4.
52. *Id.* at p. 5.
53. *Id.*
54. ACWDL 04-14 (Apr. 30, 2004), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c04-14.pdf at p. 7. A list of the documents for the ICT packet the Sending County sends to the Receiving County is in Section IV of ACWDL 03-12 at page 7.
55. *Id.* at p.9, Section V.
56. ACWDL 03-12, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c03-12.pdf.
57. ACWDL 04-14, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c04-14.pdf.

Advocacy Tip: An ICT does not immediately trigger a redetermination of eligibility for Medi-Cal, even if the move coincides with other life changes that may affect eligibility. If there are no changes other than the move itself, there is no change in the beneficiary's eligibility and no need for any redetermination.[58] In situations where the beneficiary experiences other changes along with the move such as a new job and change in income, or a change in the number of people in the household, the Receiving County must not delay transfer of the beneficiary's Medi-Cal case. The Receiving County will redetermine the beneficiary's eligibility only once the transfer is complete.

ii. Accessing Care During the ICT Process

While the transfer is being processed, the Medi-Cal beneficiary will receive fee for service Medi-Cal, meaning the consumer can access services from any provider that accepts fee for service Medi-Cal rather than through a managed care plan.[59] In situations where beneficiaries who are moving and need to be disenrolled immediately from their managed care plan in order to access services, they may contact Health Care Options or the Office of the Ombudsman and request an emergency disenrollment.[60]

For an ICT where an emergency disenrollment from a health plan is not needed, once the transfer is complete and the Receiving County has changed the county code in MEDS, the managed care enrollment process may begin. If the beneficiary is a mandatory managed care beneficiary, such as a MAGI expansion adult, and moves to a County Organized Health System county where there is only one health plan, the beneficiary will be automatically enrolled in the county's plan. But if the receiving county is a Geographic Managed Care county or a Two-Plan model county, the beneficiary will be placed in fee for service during the transfer and the change in county residence code will trigger Health Care Options to send the consumer health plan information. Voluntary managed care beneficiaries can remain in fee for service Medi-Cal.

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58. *Id.*
59. *Id.* at p. 11.
60. *Id.* at p. 10.

b. Covered California: Inter-Regional Moves and Choosing a New Health Plan

As discussed in more detail in Chapter 4, health insurance plans offered through Covered California are organized by region. As of 2016, the state is divided into 19 regions, with different health plans and premium rates across the regions. If Covered California enrollees move, they may have to change health plans and their rates may change.

i. Choosing a New Health Plan Due to a Move

Moving is a qualifying "life event" that triggers a special enrollment period, which allows enrollees to change health plans outside of open enrollment. For a complete discussion of special enrollment for Covered California plans, see Chapter 5, Section C.2.b.

When they move, Covered California enrollees can change plans online by going to the Covered California website at www.coveredca.com. They can also call the Covered California Service Center at (800) 300-1506, or get help from a Covered California Certified Enrollment Counselor, Covered California Certified Insurance Agent, Certified Plan Based Enroller, or county eligibility worker.

ii. Avoiding Gaps in Coverage

To avoid gaps in health coverage, it is important to remember that in general the start date for coverage depends on the date of enrollment. If consumers enroll by the 15th day of the month, their coverage will start on the first day of the next month. If consumers enroll after the 15th day of the month, their coverage will start on the first day of the second following month. For example, a consumer who enrolls on June 13 will start their coverage on July 1. A consumer who enrolls on June 16 will start their coverage on August 1. The Special Enrollment rules do have exceptions for certain circumstances, including loss of Medi-Cal.[61]

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61. See Chapter 5, Section C.2.b.

3. Annual Renewal or Redetermination

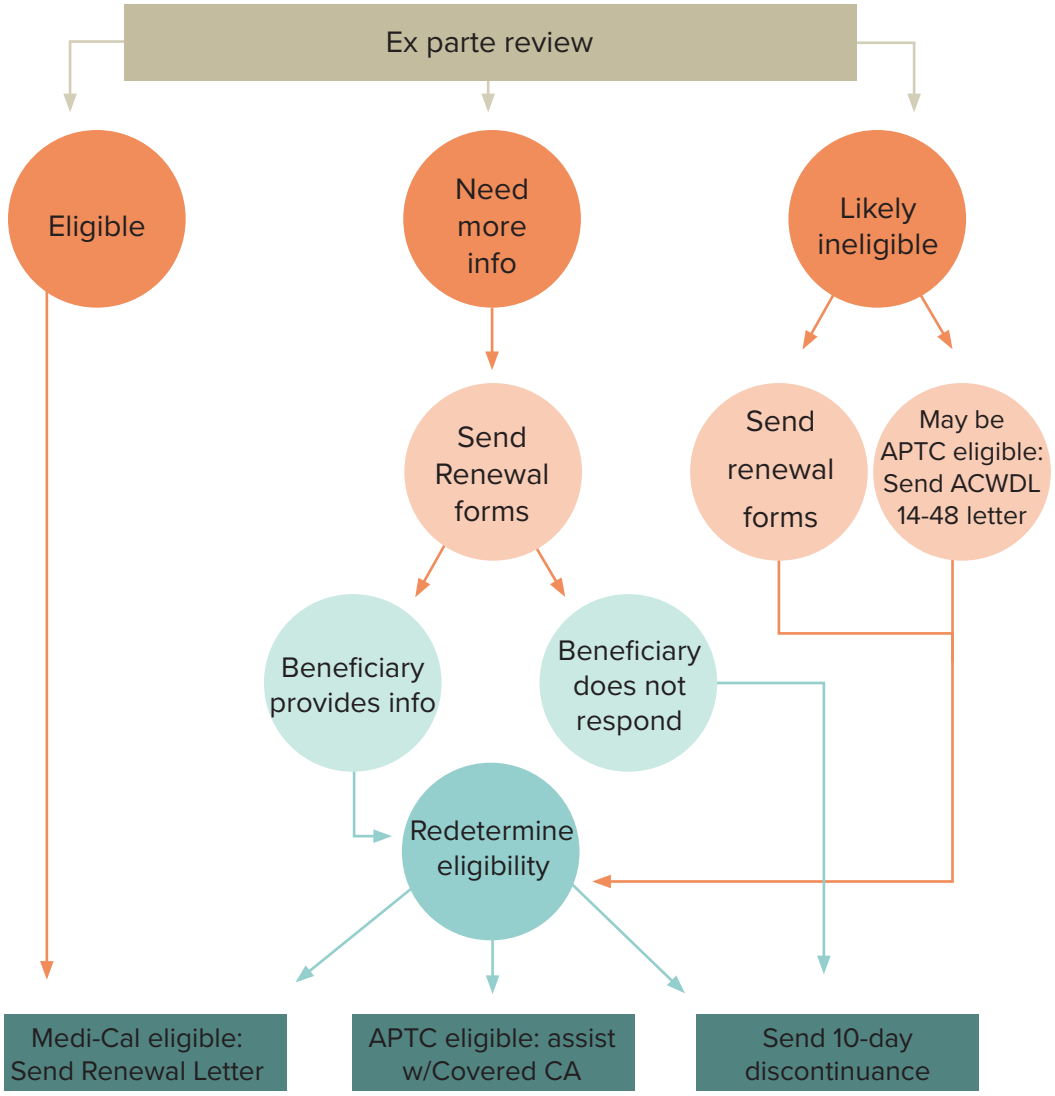
In addition to eligibility reviews or redeterminations prompted by changes in an individual's circumstances, Medi-Cal beneficiaries and Covered California enrollees must have their eligibility redetermined for coverage every 12 months.[62]

a. Medi-Cal

All Medi-Cal beneficiaries must have their eligibility redetermined once every 12 months, either on the anniversary of their initial application date or their most recent redetermination of eligibility.[63] There are differences among the processes for MAGI and non-MAGI beneficiaries and for households with both MAGI and non-MAGI members. The following chart illustrates the overall process and the narrative that follows details the redetermination processes for MAGI and non-MAGI beneficiaries:[64]

62. 42 C.F.R. § 435.916(f); 45 C.F.R. § 155.335(f); 10 CCR §§ 6472, 6474; ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.
63. 42 C.F.R. § 435.916; Welf. & Inst. Code § 14005.37(a) and (n).
64. The chart was created by Cori Racela of the National Health Law Program.

Medi-Cal Redtermination Process



i. Process for MAGI beneficiaries

- At least 65 days before the annual redetermination date, the county does an *ex parte* review — a review using data resources available to the county such as the beneficiary's CalWORKS file or the federal data services hub.[65]
- If the county can establish eligibility based on information obtained *ex parte*, it sends the beneficiary a Notice of Action stating that eligibility continues

65. 42 C.F.R. § 435.916 (a)(2); Welf. & Inst. Code § 14005.37(e)(1); ACWDL 14-32 (Sep. 9, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 2.

for another year and no additional information is required.[66] The notice must include the MAGI household size and income used to determine eligibility.

- If the information in the notice is incorrect, the beneficiary has 90 days to provide the county with correct information.[67]
- If the county cannot redetermine eligibility with the information obtained *ex parte or* the information obtained is not reasonably compatible to find the beneficiary still eligible, the county may ask the beneficiary only for the information needed to renew eligibility. Beneficiaries should not be asked to re-confirm all eligibility criteria.
- The county sends the beneficiary a Pre-Populated MAGI Medi-Cal Annual Renewal form (Form MC 216).[68] This form contains the information that the county already has and thus asks the beneficiary only for the remaining information that is necessary to establish eligibility.[69]
- The beneficiary has 60 days from the date the pre-populated form is mailed to respond.[70] The beneficiary must be allowed to provide the information requested on the MC 216 form by mail, phone, in person, or any other commonly available electronic means authorized by the county or DHCS.[71]
- The county must attempt to contact the beneficiary at least once in an effort to obtain the needed information, ideally at least 30 days after sending the pre-populated MC 216 form.[72] If the beneficiary has identified a preferred method of contact, the county must use that method; otherwise, the county must use reasonable efforts to determine the best method of contact.[73]
- **If the beneficiary responds**, the county must follow the SB 87 process

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66. 42 C.F.R. § 435.916 (a)(2); Welf. & Inst. Code § 14005.37(e)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 3.
67. 42 C.F.R. § 435.916 (a)(3)(iii); Welf. & Inst. Code § 14005.37(e)(2). The county will redetermine eligibility based on the new information provided by the beneficiary and reconfirm by NOA if the beneficiary is still eligible.
68. 42 C.F.R. § 435.916 (a)(3); Welf. & Inst. Code § 14005.37(f)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 3.
69. *Id.*
70. Welf. & Inst. Code § 14005.37(f)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 4.
71. Welf. & Inst. Code § 14005.37(f)(1)(B).
72. *Id.* at (f)(1)(D)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 4.
73. Welf. & Inst. Code § 14005.37(t).

described at Section A.3.a.iv and Welfare & Institutions Code Section 14005.37 subsection (d) and evaluate the beneficiary for eligibility for *all* Medi-Cal programs (*e.g.,* non-MAGI) before terminating the beneficiary from Medi-Cal.[74] If based on the information provided to the county the beneficiary is found not eligible for any Medi-Cal program (if they are over income due to an increase in income or change in family composition, for example) the county should determine eligibility for financial assistance through Covered California.[75] If eligible, the county should assist the individual with the enrollment process and, if requested, with Covered California plan selection.[76] After completing the beneficiary's eligibility determination for Covered California financial assistance, the county is required to send the beneficiary a ten-day Notice of Action terminating their Medi-Cal.[77] Note that the county is required to take any steps necessary to ensure that a Covered California-eligible beneficiary being discontinued from Medi-Cal can transition to Covered California without a break in coverage.[78] Further, beneficiaries found eligible for Share of Cost Medi-Cal must be evaluated for financial assistance through Covered California.[79] Beneficiaries eligible for Covered California have the choice of having just Share of Cost Medi-Cal, Covered California, or both.[80]

- If, after the county follows the proper redetermination procedures outlined above and the **beneficiary does not respond**, the county may send the beneficiary a ten-day Notice of Action terminating Medi-Cal.[81] At this point in

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74. Welf. & Inst. Code § 14005.37(d); ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf, pp. 1- 2.
75. *Id.* at pp. 4, 9.
76. *Id.* at p.4.
77. The requirements for such a NOA are set forth in ACWDL 15-33 (Oct. 9, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-33.pdf.
78. Welf. & Inst. Code § 15926(h).
79. ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf, pp. 3 – 4.
80. *Id.*, p. 3. Share of Cost Medi-Cal is not considered minimum essential coverage, but note that persons with Share of Cost Medi-Cal and no other coverage may meet the criteria for a Covered California Special Enrollment Period and are currently eligible for an exemption from the individual mandate. 10 CCR § 6504 § (a)(1)(D); MEDIL 15-29 (Oct. 22, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-29.pdf, p. 2. *See also* Instructions for IRS Form 8965 for 2015, p. 3 available at https://www.irs.gov/pub/irs-pdf/i8965.pdf.
81. Welf. & Inst. Code § 14005.37(f)(3); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 5.

the process, the county is required to immediately evaluate the beneficiary for Covered California financial assistance and forward the case to Covered California.[82] At the end of the ten days, the beneficiary may be terminated from Medi-Cal, but if the beneficiary provides the requested information prior to the termination date, the county must rescind the termination action and work the case.[83]

- If terminated, the beneficiary still has 90 days from termination to "cure" and provide the information requested. If they do so, the county must treat the information as if it was received timely.[84] Note that the "good cause" rule regarding submitting information even beyond the 90 days applies.[85] See also Section B.1 in this chapter for Medi-Cal notice and hearing rights, including the right to continue receiving Medi-Cal pending appeal (aid paid pending).
- The notice must comply with ACWDL 13-13 on Medi-Cal Notice of Action Policy, and all of the federal and state regulations upon which the notice is based. See Section B.1.a later in this chapter.

ii. Process for Non-MAGI Beneficiaries

- **Screening for MAGI:** For non-MAGI beneficiaries the county must first do an *ex parte* review of the case file or other electronic data sources to see if any individual in the household should now be considered as MAGI eligible, such as a parent, or adult with income below 138% FPL. The county must review any Request for Tax Household Information that may be in the case file or others sources that may indicate MAGI eligibility.[86] If an individual is potentially MAGI eligible, then the county should evaluate her *ex parte* utilizing the MAGI processes outlined earlier in Section A.3.a.i. The county may request tax information from data sources or from the beneficiary via the Request for Household Tax Information form, which the beneficiary has 30

82. ACWDL 14-18 (Apr. 8, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf, p. 4
83. *Id.*
84. *Id. See also* Welf. & Inst. Code § 14005.37(i).
85. *See* 22 CCR § 50175(c).
86. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p. 1.

days to complete and return.[87] However, generally, the county may not send or use that form for individuals who are enrolled in Medi-Cal programs for the aged, blind, or disabled.[88] Even absent a Request for Household Tax Information form, the county may simply use annual projected income and non-tax filer MAGI household rules to determine MAGI eligibility. If the case has one or more non-MAGI individuals, counties must complete the *ex parte* determination using the steps that follow, as applicable.[89] If any household member is in long term care, see below for next steps.

- ***Ex parte* Review**: For the non-MAGI beneficiaries, the county must first gather available information *ex parte* (on its own without contacting the beneficiary), *e.g.,* from the beneficiary's Medi-Cal, CalWORKs and CalFresh files and those of immediate family members that are open or that were closed in the prior 90 days from the federal hub and other state databases.[90] If based on the *ex parte* review there is sufficient information to establish continuing Medi-Cal eligibility, the county must send the beneficiary a Notice of Action stating that her eligibility continues and the basis for such determination.[91]
- **Resource/Asset Review**: The county must also review resources/assets at redetermination for non-MAGI beneficiaries. (See Chapter 3 of this manual for non-MAGI Medi-Cal asset limits.)

Beyond *ex parte* review

- If there is not enough information to complete the redetermination *ex parte* the county must request the missing information using the MC 210 RV "Medi-Cal Annual Redetermination" form.[92] Because the county will likely need to redetermine a non-MAGI beneficiary's resources, it should send the "Additional Income and Property Information Needed for Medi-

87. ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf, pp. 5 – 9.
88. ACWDL 15-03 (Jan. 20, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-03.pdf.
89. *Id.*
90. Welf. & Inst. Code § 14005.37(e); ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p. 2.
91. Welf. & Inst. Code § 14005.37(e)
92. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p. 2.

Cal" (MC 604) form along with the MC 210 RV form.[93] **For households with a family member in long term care**, the county sends both the MC 210 RV "Medi-Cal Annual Redetermination" and a "Redetermination for Medi-Cal Beneficiaries (Long-Term Care in own MFBU [Medi-Cal Family Budget Unit])" MC 262 form.[94]

- The beneficiary has 60 days from the date of mailing to provide the requested information by phone, fax, in person or by mail.[95] There is a good cause exception if the beneficiary does not respond within the 60 days.[96]
- The county must attempt to contact the beneficiary at least once during these 60 days to request the needed information.[97] If the beneficiary has identified a preferred method of contact, the county must use that method; otherwise, the county must use reasonable efforts to determine the best method of contact.[98]
- If the county needs more information to make a property (asset) determination, it mails a "Property Settlement" form (MC 210 PS) to which the beneficiary has 30 days to respond.[99] At this stage, it is possible that the county will find potential MAGI eligibility. If this happens, the county sends the beneficiary a Request for Household Tax Information which the beneficiary has 30 days to complete and return. Then the county proceeds in accordance with the MAGI annual redetermination process described earlier in Section A.3.a.i.[100]
- If the beneficiary remains eligible for non-MAGI Medi-Cal, the county

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93. Form revised in 2014: available at: http://www.dhcs.ca.gov/formsandpubs/forms/Forms/MC%20600/MC_604_IPS_ENG_0514%20(2).pdf
94. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p. 3.
95. Welf. & Inst. Code § 14005.37(f).
96. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf. The circumstances constituting good cause are found at 22 CCR § 50175(c).
97. Welf. & Inst. Code § 14005.37(f)(2), ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p. 3,
98. Welf. & Inst. Code § 14005.37(t).
99. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p. 3.
100. *Id. See also* ACWDL 14-32 (Sep. 19, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf.

must send the beneficiary a Notice of Action stating that her eligibility continues and the basis for such determination.[101]

- **If an individual provides the information necessary for redetermining eligibility** and is determined to be ineligible for non-MAGI Medi-Cal, the county must follow the SB 87 process described at Section A.3.a.iv and Welfare & Institutions Code Section 14005.37 subsection (d) and evaluate the beneficiary for eligibility for *all* Medi-Cal programs (*e.g.*, MAGI) before terminating the beneficiary from Medi-Cal.[102] If based on the information provided to the county the beneficiary is found not eligible for any Medi-Cal program (if they are over income due to an increase in income or change in family composition, for example) the county is required to determine eligibility for Covered California financial assistance benefits.[103] If eligible, the county should assist the individual with enrollment, and, if requested, with Covered California plan selection.[104] After completing the beneficiary's eligibility determination for Covered California, the county is supposed to send the beneficiary a ten-day Notice of Action terminating her Medi-Cal.[105] Note that the county is required to take any steps necessary to ensure that a Covered California-eligible beneficiary being discontinued from Medi-Cal can transition to Covered California without a break in coverage.[106] Further, beneficiaries found eligible for Share of Cost Medi-Cal must be evaluated for financial assistance through Covered California.[107] Beneficiaries eligible for Covered California have the choice of having

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101. Welf. & Inst. Code § 14005.37(e)
102. ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf, pp. 1- 2.
103. *Id.* at pp. 9.
104. *Id.* at p.4. Note that although this section of ACWDL 14-18 references the MAGI redetermination process, there is no reason that it should not apply to non-MAGI as well.
105. The requirements for the Notice of Action are set forth in ACWDL 15-33, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-33.pdf.
106. Welf. & Inst. Code § 15926(h).
107. ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf, pp. 3 – 4.

just Share of Cost Medi-Cal, Covered California, or both.[108]

- If after the county follows the proper redetermination procedures outlines above, the **beneficiary does not respond**, the county may send the beneficiary a ten-day Notice of Action terminating Medi-Cal.[109] At this point in the process, the county is required to immediately evaluate the beneficiary for Covered California financial assistance and forward the case to Covered California.[110] At the end of the ten days, the beneficiary may be terminated from Medi-Cal, but if the beneficiary provides the requested information prior to the termination date, the county must rescind the termination action and work the case.
- If terminated, the beneficiary still has 90 days from termination to "cure" and provide the information requested and if they do so, the county must treat the information as if it was received timely.[111] Note that the "good cause" rule applies for information submitted beyond the 90 days.[112] See Section B.1 later in this chapter for Medi-Cal notice and hearing rights, including the right to continue receiving Medi-Cal pending appeal (aid paid pending).
- The notice must comply with ACWDL 13-13 on Medi-Cal Notice of Action Policy, and all of the federal and state regulations upon which the notice is based. See Section B.1.a.

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108. *Id.*, p. 3. Share of Cost Medi-Cal is not considered minimum essential coverage, but note that persons with Share of Cost Medi-Cal and no other coverage may meet the criteria for a Covered California Special Enrollment Period and are currently eligible for an exemption from the individual mandate. 10 CCR § 6504 § (a)(1)(D); MEDIL 15-29 (Oct. 22, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-29.pdf, p. 2. *See also* Instructions for IRS Form 8965 for 2015, p. 3 available at https://www.irs.gov/pub/irs-pdf/i8965.pdf.
109. Welf. & Inst. Code § 14005.37(f)(3).
110. ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf, p. 9.
111. *Id.* *See also* Welf. & Inst. Code § 14005.37(i).
112. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf,pp. 5 – 6. *See* 22 CCR § 50175(c).

iii. Process for Households that Have Both MAGI and Non-MAGI Members

The county must follow both the MAGI and non-MAGI redetermination processes.[113] *Ex parte* redetermination is the first step the county must take.[114] The county should designate non-MAGI household members as "non-applying" household members of the tax filing unit to achieve an accurate MAGI determination. MAGI household members should be designated as "ineligible" household members to achieve an accurate non-MAGI determination.[115] If eligibility cannot be established *ex parte*, the county may request more information from MAGI household members using the pre-populated MAGI redetermination form (MC 216 RV) and from non-MAGI household members using the "Additional Income and Property Information Needed for Medi-Cal" form (MC 604 IPS).[116]

If any family member is in long term care**,** the county should mail both the pre-populated MAGI redetermination form (MC 210 RV) and the "Additional Income and Property Information Needed for Medi-Cal" form (MC 604 IPS).[117]

Once determined eligible, the annual redetermination date for both MAGI and non-MAGI beneficiaries is reset for another 12 months.[118]

iv. SB 87 and Medi-Cal Eligibility Reviews

In 2001, the Legislature enacted SB 87, which requires counties to evaluate beneficiaries to see if they are eligible for all other Medi-Cal programs before terminating them from Medi-Cal. The implementation of the Affordable Care Act and Medi-Cal expansion did not change this important county obligation and, in fact

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113. *See* ACWDLs 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf and 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf.
114. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p.4.
115. *Id.*
116. *Id.* at 4.
117. *Id.*
118. Welf. & Inst. Code § 14005.37(a).

expanded the obligation to provide even more protections for beneficiaries.[119] Before Medi-Cal beneficiaries can be terminated from Medi-Cal, where beneficiaries have provided information necessary to redetermine eligibility, counties must evaluate them for potential eligibility for all Medi-Cal programs and for Covered California, including advanced premium tax credits and cost-sharing reductions.[120]

- **MAGI Medi-Cal Beneficiaries.** If the county determines, based on the *ex parte* review and request for additional information during the annual review, that a MAGI beneficiary is no longer eligible under MAGI rules, the county must determine if they could have "potential linkage" to non-MAGI Medi-Cal.[121] DHCS has interpreted this potential linkage rule to mean that generally, if a beneficiary is between the ages of 22 and 64 and is not disabled, not a parent/caretaker, not pregnant and not in long term care, then the beneficiary is *not* potentially linked to non-MAGI. In any case, if the beneficiary requests to be reviewed for non-MAGI eligibility, the county must do so.[122]
- **Non-MAGI Medi-Cal Beneficiaries.** If the county determines, based on the *ex parte* review and request for additional information during the annual review, that a beneficiary is no longer eligible under non-MAGI eligibility rules (*e.g.*, excess resources), the beneficiary must be evaluated for MAGI Medi-Cal.[123]

The county's obligation to evaluate a beneficiary who it has determined is no longer eligible for any Medi-Cal program and is eligible for Covered California and APTCs and to assist such an individual with the transition to Covered California is discussed in Section C later in this chapter.

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119. Welf. & Inst. Code § 14005.37(d)
120. 42 C.F.R. § 435.916(f); ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.
121. Welf. & Inst. Code § 14005.37(d)(A) [sic], ACWDL 14-18, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-18-w-attch.pdf.
122. Welf. & Inst. Code § 14005.37(d)(B)[sic].
123. Welf. & Inst. Code § 14005.37(d).

v. 90 Day Right to "Cure" or Reinstate Medi-Cal after Termination.

If a beneficiary is terminated from Medi-Cal because the county does not have sufficient information to make an eligibility determination, a beneficiary has 90 days from the date of termination to reinstate Medi-Cal benefits.[124] The beneficiary must be informed of this right and what needs to be done, *e.g.*, what alleged missing information needs to be submitted to the county, to cure her termination in the termination notice.[125] If the beneficiary provides the necessary information within the 90 days, the county must redetermine eligibility and rescind the termination as though the beneficiary provided the information in a timely manner.[126] Further, the "good cause" rule applies to information submitted after the 90 days.[127]

Advocacy Tip: If a beneficiary is terminated from Medi-Cal, they and anyone acting on their behalf should always explore the option of using the cure or reinstatement process to get back on Medi-Cal.

vi. Process When There is a Loss of Contact

If the MAGI Medi-Cal Annual Renewal Form (MC 216) is returned to the county with a "return to sender" or "no forwarding address," before proceeding with steps to terminate the beneficiary, the county must first check all available sources to determine if any household member may be a deemed infant or former foster youth.[128] If so, the county must follow the procedures in Section A.3.a.viii. 1 and

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124. Welf & Inst. Code § 14005.37(i); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 5.
125. ACWDL 15-27 (Jul. 31, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-27.pdf; MEDIL 15-21 (Aug. 13, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-21.pdf.
126. Welf. & Inst. Code § 14005.37(i).
127. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, pp. 5 – 6. The circumstances constituting good cause are found at 22 CCR § 50175(c).
128. Welf. & Inst. Code § 14005.37(g)(2); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 6.

3. If not, the county must do an *ex parte* review of available information on the beneficiary or his or her family members, and then, if necessary, must attempt to contact the beneficiary by email, phone or other means available to the county according to the beneficiary's preferred mode of contact, if such mode has been identified.[129] If all required attempts to contact the beneficiary fail, the county must send a ten day notice of termination with all required appeal rights and document the inability to make appropriate contact in the case file.[130]

vii. Special Processes for Certain Categories of Medi-Cal Beneficiaries

1) Former Foster Youth up to Age 26

Former foster youth should be automatically renewed by the county based on *ex parte* information. Income or resources are not counted for eligibility purposes for this population until they age out of the program.[131] They should not be sent a pre-populated form MC 216 unless they are part of a household in which the information is needed to redetermine other members.[132] Further, former foster youth up to age 26 may not be terminated from Medi-Cal due to a loss of contact with the county.[133] If the county cannot contact the beneficiary, the county must ensure the beneficiary is in fee-for-service Medi-Cal until contact is reestablished or the county receives information that would require discontinuance from Medi-Cal such as death or loss of California residency.[134] Once the beneficiary turns 26, the county must evaluate the individual for other insurance affordability programs, including MAGI Medi-Cal.

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129. *Id.*
130. *Id.*
131. However, the former foster youth's income is counted as part of the household income when determining eligibility for other household members. See eligibility rules for former foster youths in Chapter 3.
132. Welf. & Inst. Code § 14005.28(a)(3); ACWDL 14-32, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-32_attchmnt.pdf, p. 6
133. ACWDL 14-32, p. 6.
134. *Id.*, pp. 6 – 7.

Advocacy Tip: Note that a family with a member who is a former foster youth may get a renewal packet. In that case, the former foster youth will not have to renew, but the other family members will.[135] The former foster youth should stay on Medi-Cal regardless of whether they return the packet, but their income is needed to determine eligibility for the rest of the household.

2) "Mega Mandatory" Groups

Annual redeterminations for Medi-Cal beneficiaries in what are referred to as the "Mega Mandatory" coverage groups should be conducted in accordance with the rules that existed for these groups before the rules under the ACA went into effect. These groups include cash aid recipients, Pickle, Disabled Adult Children, Disabled Widows/ers, Foster Care, Former Foster Care, Kin-Gap and Adoption Assistance groups.[136] Medi-Cal eligibility in these categories must be preserved as long as the beneficiary remains eligible for them because eligibility for these groups is higher on the Medi-Cal hierarchy than MAGI mandatory coverage, and their eligibility for Medi-Cal is largely derivative from their eligibility for the other program.[137] Thus, generally, so long as a beneficiary remains in a Mega Mandatory category, they should not have to be redetermined, unless they lose eligibility for the other program, and should not be evaluated for MAGI and hence, should not be sent a Request for Tax Household Information form.

Mega-Mandatory individuals in a household with members other than themselves must be included as "not applying" within the tax household for any household members who are MAGI. On the other hand, Mega-Mandatory individuals are *not* included in the Medi-Cal Family Budget Unit for non-MAGI eligibility redeterminations.[138] Counties must ensure that redeterminations for family members in households with Mega-Mandatory beneficiaries do not effect the eligibility of those beneficiaries.

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135. *Id.,* p. 6.
136. ACWDL 14-35, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-35.pdf, p. 5.
137. *Id.*
138. *Id.*

3) Deemed Eligible (DE) Infants

Deemed Eligible infants whose eligibility is Medi-Cal linked must have their eligibility redetermined at their first birthday, even if the rest of the household's annual redetermination date is at a later date. If the newborn is still eligible for no-cost Medi-Cal, a 12-month Continuous Eligibility for Children period will begin.[139] *See* Chapter 3, Section C.6. If the newborn is not eligible for free Medi-Cal, the county will evaluate the newborn for Medi-Cal with a premium via the Optional Targeted Low-Income Children's Program (formerly Healthy Families) or Covered California.

Infants who are eligible for Medi-Cal in their first year because they are MCAP-linked may be eligible for MCAP for a second year if the household income remains below 322%. *See* Chapter 2, Section C.3.b. and C.4.b.

4) Foster Children Returning Home

Once a child leaves foster care before their 18th birthday, they remain eligible for Medi-Cal until the next scheduled annual redetermination. This is called Continuous Eligibility for Children and is described in more detail in Chapter 3, Section C.6. Continuous Eligibility for Children also applies to situations where a child has run away from their foster care home or whose whereabouts are otherwise unknown.[140]

For example , after a child in foster care is returned home, they should remain eligible for Medi-Cal without interruption, regardless of the birth parent's financial circumstances, until at least the annual redetermination (the end of the continuous eligibility period) when eligibility will be reviewed by the county. If at annual redetermination, the entire household's income is within Medi-Cal limits, the youth is eligible for no-cost Medi-Cal for another 12-month period.[141]

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139. 42 U.S.C. § 1396a(e)(4). Note that 22 CCR § 50262.3 also regulates the deemed eligibility program but it reflects an old version of 42 U.S.C. § 1396(e)(4) and is out-of-date. *See* ACWDL 09-17 (Apr. 13, 2009), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-17.pdf.
140. ACL 02-59 (Aug. 5, 2002), http://www.cdss.ca.gov/lettersnotices/entres/getinfo/acl02/pdf/02-59.pdf.
141. ACDWL 02-20 (Apr. 5, 2002), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/02-20c.pdf.

5) Minor Consent

As the Minor Consent program is a limited-scope and temporary program, the standard redetermination rules do not apply. Currently, counties only issue eligibility for the Minor Consent Program on a month-to-month basis. The minor will receive their Medi-Cal benefits card in person at the same time services are requested. The eligibility should continue each month as long as the child meets the eligibility criteria (See Chapter 3, Section D.1) and is in need of the services.

6) Transitional Medi-Cal

During the first six months on Transitional Medi-Cal, families qualify regardless of income.[142] However, to remain on Transitional Medi-Cal for an additional six month period, the household income may not exceed 185% of the federal poverty level.[143] In the sixth month, the household must complete a status form (provided by the county) to enable the county to assess, based on earnings information for months four through six, if the family is qualified for another six months.[144] The beneficiary must return the completed form to the county by the 21st day of the seventh month and must submit another earnings status report by the 21st day of the tenth month for months seven through nine.[145] If the beneficiary fails to submit the status form timely, the county sends a ten-day termination notice of action unless the county determines the beneficiary had good cause for filing late.[146] If the beneficiary submits forms timely, but the county determines that the household is no longer eligible for Transitional Medi-Cal, the county must evaluate the household and should not terminate Medi-Cal unless there is no eligibility for any other Medi-Cal program.[147] This redetermination must take place before termination of Transitional Medi-Cal so that if the beneficiary is eligible for another Medi-Cal program, there is no break in aid.[148]

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142. See Ch 3, Section C.5 of this manual for a description of Transitional Medi-Cal.
143. *Id.*
144. *Medi-Cal Eligibility Procedures Manual,* 5B, p. 8, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c288.pdf.
145. *Id.*
146. *Id.*
147. *Id.*
148. *Id.* at p.12.

7) Breast & Cervical Cancer Treatment Programs

Consumers in Federal and State BCCTPs must report any changes that may affect their eligibility to a state BCCTP eligibility specialist within ten calendar days.[149] How long a person remains eligible for the BCCTP depends on which program the person qualifies for, the federal or state-only program:

- ***Federal BCCTP:*** Once an applicant is placed into the federal BCCTP program through Accelerated Eligibility (AE), they will continue to receive full-scope benefits until the state or county determines her to be no longer eligible for Medi-Cal on any other basis.[150]
- ***State BCCTP:*** This is a time-limited program that only covers services related to breast and/or cervical cancer treatment, therefore coverage ends when 18 months of breast cancer treatment or 24 months of cervical cancer treatment are rendered.[151] At the end of the BCCTP period, the county must redetermine eligibility for all insurance affordability programs, including other Medi-Cal categories.

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149. ACWDL 06-09 (Feb. 24, 2006), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf, pp. 7 and 9.
150. Welf. & Inst. Code § 14007.71(e); ACWDL 06-09, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf, at p.7 ("If a beneficiary is found to no longer qualify for federal BCCTP … the case may be sent to the beneficiary's county of residence for a determination of Medi-Cal eligibility under any other program"). *See also* ACWDL 06-25 (Aug. 2, 2006), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-25.pdf (describing the process for how consumers terminated from Federal BCCTP are placed in an interim Medi-Cal aid code while the county assesses eligibility under other Medi-Cal programs). The interim aid code 0W is for women who longer meet federal eligibility requirements and will continue to receive transitional Medi-Cal full-scope Medi-Cal services until the county completes an eligibility determination for other Medi-Cal programs.
151. Welf. & Inst. Code § 104161.1.

Advocacy Tip: A person may qualify for more than one period of state-only BCCTP coverage if they have a "new tissue diagnosis," have been screened and diagnosed with this more recent qualifying cancer condition by an Every Woman Counts or Family PACT provider, and meets the other remaining State BCCTP eligibility requirements.[152] A former or current State BCCTP beneficiary who later meets all eligibility requirements for Federal BCCTP, *i.e.*, a woman under 65 who gains satisfactory immigration status, may qualify for Federal BCCTP without requiring a new tissue diagnosis.

8) Refugee Medical Assistance

For most Medi-Cal programs, including time limited programs such as state-only BCCTP, redetermination occurs at the end of the eligibility period. For Refugee Medical Assistance, because the funding is time limited by the federal Office of Refugee Resettlement who regularly audits the state to make sure funding is not extended, counties begin the redetermination process two months before the end of the eight-month eligibility period. At the end of the eight months, the recipient will be transferred to another Medi-Cal program, Covered California, or terminated.[153]

b. Covered California

There are two parts to annual renewal in Covered California: 1) An eligibility redetermination for enrollees who receive financial assistance that is similar to Medi-Cal beneficiaries, and 2) Re-enrollment into a plan for the next benefit year. Both parts of the annual renewal process occurs in the early fall prior to the annual open enrollment period.

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152. ACWDL 06-09, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c06-09.pdf, p.8.
153. *See* ACWDL 15-16 (Mar. 20, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-16.pdf and ACWDL 14-16 (Apr. 1, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-16.pdf for information on transitioning RMA beneficiaries into the M1 adult expansion aid code or moving to Covered California as necessary at the end of the RMA period.

i. Open Enrollment

An individual may enroll in a qualified health plan, or an enrollee may change plans only during the annual open enrollment period, except individuals in specified circumstances may enroll during special enrollment periods.[154] See Chapter 5 for information about Special Enrollment. For plan year 2016, the open enrollment period started on November 1, 2015 and ran through January 31, 2016. The open enrollment period for the exchange each year is adopted into federal and state regulations, generally following the dates used for the federal Exchange.[155]

During the open enrollment period, all Covered California enrollees – whether or not they have financial assistance – have the opportunity to choose their coverage for the next benefit year.[156] They can choose to remain with the same health plan, change metal tiers (*e.g.*, silver to bronze), change to another health plan, or terminate coverage.[157] If existing enrollees want a new plan to start on January 1st, they must change plans by December 15th.[158] If they miss that deadline, they have until the end of open enrollment to change plans or they will remain automatically re-enrolled in their current plan or a similar one if necessary. See Section A.3.b.iii. below for more on automatic plan re-enrollment.

ii. Notice Requirements

The open enrollment period is the time for new consumers to purchase Covered California coverage if they are newly eligible or were not able to qualify for a special enrollment period during the year. To reduce confusion, Covered California must notify current enrollees as well as qualified individuals – those who were determined

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154. 10 CCR § 6502(a); *see also* 45 C.F.R. § 155.420; 10 CCR § 6504 (special enrollment periods).
155. Health & Safety Code § 1399.849(c)(1); Ins. Code § 10965.3(c)(1); 10 CCR § 6502(f). The federal Exchange (known as the federally-facilitated marketplace) is for states that do not administer their own Exchanges.
156. The one exception is if an enrollee qualifies for a special enrollment period during the year. For Medi-Cal beneficiaries enrolled in a health plan, they are able to change plans throughout the year and there is no similar open enrollment period in Medi-Cal. For more information, see Chapter 5 on Medi-Cal managed care enrollment.
157. They may actually terminate coverage at any time throughout the year.
158. See 10 CCR § 6498(e)(2)(A).

eligible for coverage but did not enroll – of the annual renewal process and the annual open enrollment period in a "single, coordinated notice," no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.[159]

The content requirements of the "single, coordinated" notice differ depending upon whether the individual is an existing enrollee or qualified individual, and whether the enrollee has requested an eligibility determination for financial assistance.[160] For qualified individuals not currently enrolled in a qualified health plan, the notice must include at least the following:[161]

- A description of the annual redetermination and renewal process;
- An explanation of the obligation to report changes to information affecting eligibility during the benefit year;
- Instructions on how to report a change to Covered California; and
- The open enrollment date and the last day on which plan selection may be made for coverage effective on January first of the following benefit year to avoid any coverage gap.[162]

For existing Covered California enrollees who are receiving financial assistance for the current benefit year, the notice must include at least all of the above information plus the following:[163]

- An explanation that the plan premiums and the amount of premium tax credits and the level of cost-sharing reductions, for which they may be eligible, may change each benefit year;
- A description of the reconciliation process for advanced premium tax credits;
- The data used in the enrollee's most recent eligibility determination and the amount of monthly advanced premium tax credit and the level of cost-sharing reductions the enrollee has been receiving during the current benefit year;

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159. 45 C.F.R. § 155.335(c); 10 CCR §§ 6498(f), 6502(e).
160. 45 C.F.R. § 155.335(d); 10 CCR § 6498(f)
161. See 10 CCR § 6498(e)(1) for specifics on this obligation.
162. 10 CCR § 6498(e)(1).
163. 10 CCR § 6498(e)(2).

- An explanation that if they do not complete the renewal process by December 15 of the current benefit year for coverage effective January first of the following benefit year, Covered California will redetermine eligibility and renew coverage for the following benefit year using the last information the enrollee provided to it; and
- An explanation that to obtain the most accurate eligibility determination, including for financial assistance, the enrollee must contact Covered California and update their information, or make a plan selection by the end of the open enrollment period.

For existing enrollees with unsubsidized coverage (who did not receive financial assistance), the notice must include at least all of the information Covered California is required to provide to qualified individuals not currently enrolled (see above) plus explain the following:[164]

- That the plan premiums may change each benefit year;
- That unless the enrollee completes the renewal process by December 15 of the current benefit year for coverage effective January first of the following benefit year, Covered California will redetermine eligibility and renew coverage for the following benefit year using the most recent information (*e.g.*, address, household members) the enrollee provided to Covered California; and
- That to obtain the most accurate eligibility determination, the enrollee must contact Covered California and update her information or make a plan selection by the end of the open enrollment period.

iii. Redetermination for Financial Assistance

Annual redetermination of eligibility for enrollees who receive financial assistance (Advanced Premium Tax Credits (APTCs) or Cost-sharing Reductions (CSRs)) begins before open enrollment so that Covered California can let enrollees know what financial assistance they are eligible for the next benefit year to help them choose a plan during open enrollment.[165] The following chart illustrates the beginning steps of this process and is followed by a detailed narrative description.

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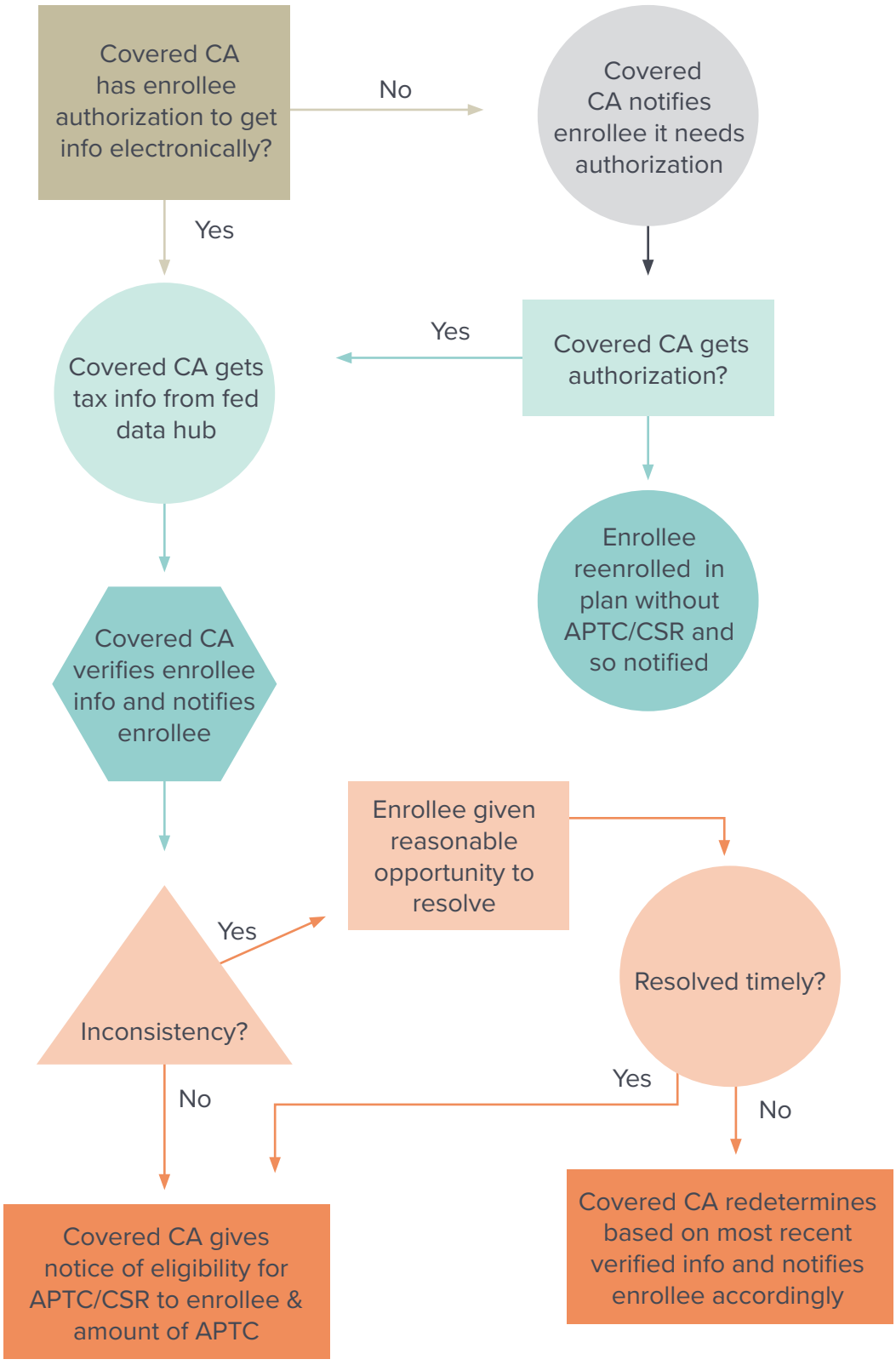
164. 10 CCR § 6498(e)(3).
165. 45 C.F.R. § 155.335 (a); 10 CCR § 6498(a).

Covered California Renewal



Step 1: Updating Electronic Data and Authorization

Covered California needs to obtain income tax information electronically via the federal data services hub to ensure the eligibility redetermination for financial assistance is based on enrollees most recently reported income. However, enrollees must provide Covered California authorization to access the annual household income per federal tax records.[166] Authorization may be provided by the enrollee at the time of the initial application for a period of one to five years.[167] If Covered California already has authorization from the enrollee at the time of annual redetermination, Covered California will automatically obtain the most recent federal tax information and amount of Social Security benefits (if applicable) from the federal data hub, as well as income data from state databases such as the Franchise Tax Board to begin the eligibility redetermination of their financial assistance.[168]

If Covered California still needs authorization to check tax information beyond the initial year, Covered California will notify enrollees before the annual renewal process begins that their authorization is required to be able to redetermine their eligibility for APTCs and CSRs for the following plan year.[169]

If Covered California is not provided this authorization by a specified date during the renewal period, Covered California is unable to redetermine eligibility for financial assistance, and the enrollee will not be able to receive financial assistance for the following year.[170] Due to automatic plan re-enrollment (discussed below), these

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166. 10 CCR § 6498(b).
167. *Id.* However, the enrollee or qualified individual may decline to provide such authorization, may provide authorization for a period of less than five years, and may "[d]iscontinue, change or renew his or her authorization at any time."
168. *Id.* at subsec. (c).
169. 10 CCR § 6498(d). Notice must be provided at least 30 days prior to the date of the first annual redetermination notice. Covered California can provide this notice earlier to allow more time for enrollees to respond and give authorization. *Id. See also* 10 CCR § 6498(f) for notice requirements.
170. 10 CCR § 6498; 45 C.F.R. § 155.335. Permission to access electronic records is required even if an enrollee can provide Covered California updated income because any information provided must be electronic verified before it can be used to redetermine eligibility. Thus, without this permission, Covered California cannot make any eligibility redetermination for financial assistance. 45 C.F.R. § 155.335(l). Ultimately, the goal for use of electronic records is to reduce the burden on consumers and have their eligibility redetermined every year electronically without any action required by the consumer.

enrollees will automatically be re-enrolled into their Covered California plan but will be required to pay the issuer the full amount of the premium for coverage starting January 1.

Step 2: Redetermining Eligibility

An enrollee must complete the renewal process within 34 days from the date of the annual redetermination notice.[171] The enrollee may complete the redetermination process through the Covered California website, in person with an enrollment counselor, or by telephone.[172]

Once an enrollee has updated her information, Covered California will electronically verify that information. If there is an inconsistency, Covered California must notify the enrollee and provide a reasonable opportunity to resolve the problem. Otherwise, Covered California will provide notice of eligibility for financial assistance for the next benefit year, and the amount of the premium tax credits.[173]

If the enrollee or the qualified individual does not complete the renewal process within the prescribed 34 days, Covered California will proceed with redetermination of eligibility for financial assistance based on the most recent information the individual provided to it and renew the enrollee's coverage for the following benefit year.[174] Covered California must provide written notice of the eligibility determination within five business days of the determination.[175] Individuals have similar appeal rights when renewing their coverage as they do when initially applying for coverage.[176] If the enrollee does not actively update their information and choose a plan, Covered California must use the individual's most recent tax information and keep them in the same plan, if possible.[177]

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171. *See* 10 CCR § 6498(i) for all of the steps.
172. 10 CCR § 6498(i)(2). Because there is no paper renewal form, providing updated information by fax or mail is not available.
173. 10 CCR §§ 6476(h), 6498(j)(2).
174. 10 CCR § 6498(l)(1). In doing so, Covered California must adhere to the standards in subsection "l" of § 6498 and to the requirements of §§ 6472 and 6474 which cover eligibility requirements for enrollment in a plan through Covered California and eligibility requirements for financial assistance.
175. 10 CCR §§ 6476(h), 6498(j)(2).
176. 10 CCR § 6604(a)(2).
177. 10 CCR § 6498(l)(1).

Step 3: Automatic or "Passive" Plan Re-Enrollment

Plan re-enrollment occurs during open enrollment for all current Covered California enrollees – whether or not they receive financial assistance or have been redetermined eligible for financial assistance. Re-enrollment must be completed by December 15th for the new coverage to have an effective date of January 1st.

If Covered California is able to redetermine an enrollee's financial assistance during this period, Covered California will also notify the health plan selected by the enrollee. Health plan issuers will then send a notice to its existing enrollees regarding the amount of the new premium, their updated advanced premium tax credit amount, and an updated Summary of Benefits and Coverage.[178]

If the enrollee does not terminate coverage nor actively chooses a plan for the next benefit year by December 15th, Covered California and the health plan issuers will automatically enroll the individual in a plan most similar to their existing plan and metal tier to avoid a gap in coverage the following year.[179] If the enrollee is no longer eligible for a silver plan with cost-sharing reductions, they will be enrolled in a silver plan without cost-sharing reductions.[180] If the issuer of the existing plan is no longer offering any coverage under Covered California, Covered California may not automatically enroll the individual into a plan with another issuer. Instead, Covered California must notify the enrollee they must choose a new plan with a new issuer by the end of open enrollment or they will lose coverage for the following year.[181]

Other than this exception, most Covered California enrollees will be re-enrolled in a plan as of January 1st whether or not they selected a plan themselves. They may change plans until the end of the open enrollment period with the same effective dates as regular plan enrollment. However, after open enrollment ends, enrollees

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178. 45 C.F.R. § 155.400(a); 45 C.F.R. 156.1255 (issuer); see also CMS Bulletin 16: Guidance for Issuers on 2016 Reenrollment in the Federally-facilitated Marketplace (FFM) (August 25, 2015), pp. 5-6 at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016AutoReenrollmentBulletin16.pdf.
179. 45 C.F.R. §§ 155.335 (j) and 155.410(g); 10 CCR § 6498(l)(1). CMS provided exchanges details on how to determine which plan is most similar to last year's plan to ensure enrollees are not inadvertently placed in a plan that is more expensive or less comprehensive than what coverage they currently have. *See* 45 CFR 155.335(j).
180. 10 CCR § 6498 (l)(2).
181. *Id*. at subsections (3) and (5).

may not change plans until the next open enrollment period unless they qualify for a special enrollment period.[182] If they do finally report and authorize verification of their income, they will be able to start receiving the premium tax credits they are eligible for.

c. Redetermination for Mixed Coverage Families

For purposes of this section, a mixed coverage household means a household with at least one member in Modified Adjusted Gross Income (MAGI) Medi-Cal and at least one household member receiving Covered California benefits.

Household members in a mixed coverage family will have two different annual redetermination periods — one for Medi-Cal, which can take place at any time of the year so long as it is 12 months after the last time their eligibility was determined, and one for Covered California, which only takes place during open enrollment.[183] The annual redetermination notice that Covered California sends to enrollees should include information about which family members are required to renew and which members have Medi-Cal coverage and will need to renew separately with the county in order to avoid confusion.[184] Counties have jurisdiction for all mixed household redeterminations.[185] As a result, counties must assist with renewals for mixed households where changes are reported for Covered California that may affect Medi-Cal eligibility.[186]

When a household has members whose Medi-Cal redetermination occurs before the Covered California redetermination period, the county will conduct the annual renewal process as described above for both MAGI and non-MAGI beneficiaries in the household. The county will enter the updated information for the household into county's eligibility determination system, redetermine eligibility for those members,

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182. See Chapter 5, Section C.2.b.
183. ACWDL 14-38 (Oct. 23, 2014), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf, p. 1.
184. ACWDL 14-38, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf, p. 2.
185. Welf. & Inst. Code § 14005.37; ACWDL 14-38, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf, p. 8, citing Welf. & Inst. Code § 14015.7(b).
186. ACWDL 14-38, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf, p. 9.

and provide notice of renewal. The county will set the next annual redetermination date for 12 months for those members who have Medi-Cal.

The updated household information obtained by the county during the Medi-Cal determination is automatically entered into CalHEERS – the statewide eligibility system for Covered California and MAGI Medi-Cal. Covered California will consider this updated information as a change of circumstance if there have been changes that affect eligibility, and follow the redetermination process described above for the members of the household who are enrolled in Covered California. Covered California must notify the enrollees that their eligibility was reviewed again as a result of the new information and provide a written eligibility determination. The annual redetermination date for Covered California household members, however, is not changed.

If the Covered California annual redetermination period occurs before the Medi-Cal annual redetermination date, Covered California will conduct the annual redetermination process as described above for those household members who are enrolled in a Covered California plan. The household should provide Covered California with any updated eligibility information on-line or by phone as discussed earlier in Section A.3.b. Covered California will redetermine eligibility for the Covered California household members and provide a notice of renewal.

The updated information provided by the family or the federal data hub to Covered California will be automatically electronically shared with the county via the CalHEERS computer system and sent to the county's computer system. The county must consider any changed information that affects eligibility, such as a change in income or household size, as a change in circumstances and redetermine eligibility for the Medi-Cal members as described earlier in Section A.3.a.[187] This results in a re-setting of the annual redetermination date for the Medi-Cal household members to 12 months from the redetermination.[188]

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187. ACWDL 14-38, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf, p. 8.
188. 42 C.F.R. § 435.916(d)(1)(ii); Welf. & Inst. Code § 14005.37(n); ACWDL 14-38, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-38.pdf, p. 8. *See* also ACWDL 14-22, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2014/14-22.pdf.

d. Redetermination for MCAP

A woman on MCAP does not go through an annual redetermination because her coverage ends at the end of the month that is 60 days after her child was born.[189] Infants born to mothers who were on MCAP at the time may remain on MCAP for 12 months (or move to Medi-Cal if the household income drops).[190] At the end of the 12 months, the family is sent a request for income information. If the household income is below 322% FPL, the infant may remain enrolled in MCAP for another 12 months.[191] At the end of the second 12 months, the infant is screened for Medi-Cal eligibility.[192]

B. Due Process Rights

Medi-Cal applicants and beneficiaries have well-established due process rights that govern their legal rights to enroll or stay on the program. Likewise, the Affordable Care Act established rights for applicants and enrollees in plans administered by health benefit exchanges such as Covered California. The processes for consumers to appeal adverse actions related to Medi-Cal and to Covered California are closely aligned. Following federal and state mandates, the State established an appeals process for prospective and current Covered California and MCAP enrollees by enacting Assembly Bill 617 (Nazarian), which took effect on January 1, 2015.[193] Some of the statutory scheme created by AB 617 also amended the Medi-Cal hearing process.[194] This section discusses the Medi-Cal and Covered California appeals processes separately, specifying the parts of the processes that are the same as well as the points where they diverge, and also discusses some important aspects of dual agency (combined Medi-Cal and Covered California) appeals.

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189. Welf. & Inst. Code § 15840.
190. Welf. & Inst. Code § 15832(a)(3)(A).
191. Welf. & Inst. Code § 15832(a)(3)(B).
192. Welf. & Inst. Code § 15832(a)(3)(C).
193. Stats. 2014, c. 869 (A.B.617), § 7, eff. Jan. 1, 2015.
194. *See* Welf. & Inst. Code §§ 10950, 10951, and 10960.

1. Medi-Cal Eligibility Appeals[195]

Medi-Cal applicants and beneficiaries have due process notice and hearing rights when an adverse action is taken against them such as a Medi-Cal denial or termination, or a reduction in services or benefits.[196] Adverse actions also include increasing a household's share of cost.[197] This section focuses on the notice and appeals process for Medi-Cal eligibility denials and terminations. The Department of Health Care Services has delegated the provision of hearings to the Department of Social Services' State Hearings Division, who also conducts other benefits hearings such as hearings related to CalFRESH.[198] Non-MAGI Medi-Cal hearings continue to be handled by the regional offices of the State Hearings Division, while the MAGI Medi-Cal hearings are handled by the State Hearings Division's Affordable Care Act Bureau, which also handles Covered California appeals.

a. Notice: Content and Timing Requirements

The county must send the applicant or beneficiary a written Notice of Action before terminating, suspending, or reducing benefits.[199] The notice must give recipients timely and adequate notice of the proposed action.[200] The notice must state the intended action, the reasons and legal authority for such action, an explanation of hearing rights and the right to representation, and how a beneficiary might receive continuing benefits while the appeal is pending or it is not adequate.[201] Where the intended action is to terminate benefits based on missing eligibility information,

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195. This section relies in part on sections of Chapter 19 of the Health Consumer Alliance's Medi-Cal Overview (2008) authored by the National Health Law Program, which can be found at http://healthconsumer.org/publications.htm#manuals. Information has been expanded and updated as appropriate.
196. *See Goldberg v. Kelly*, 397 U.S. 254, 266 (1970) (procedural due process requires evidentiary hearing before public assistance payments to welfare recipient are discontinued.); 42 C.F.R. § 431.201; Welf. & Inst. Code § 51014.1; 22 CCR § 50015.
197. 22 CCR § 50015.
198. Welf. & Inst. Code § 10950 allows the Department of Health Care Services to contract with the Department of Social Services for the provision of state fair hearings. The delegation documents are available at http://www.cdss.ca.gov/shd/PG1160.htm.
199. 42 C.F.R. § 435.919(a); 22 CCR § 50179(a).
200. 42 C.F.R. § 435.919.
201. 42 C.F.R. § 431.206(b); 22 CCR §§ 50179(c), 51014(c); ACWDL 13-13 (May 14, 2013), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf, pp. 3 – 4.

the notice from the county must also advise the beneficiary of the right to reinstate benefits, or "cure," after termination of Medi-Cal and how to exercise it.[202]

The county must send the beneficiary a notice regarding termination of Medi-Cal ten days prior to the date of intended termination.[203] The ten days does not include the date of mailing or the effective date of the action.[204]

With regard to initial eligibility determinations, the county must determine eligibility and provide a notice of approval or denial within 45 days of the date of application, or 90 days if a disability determination is required.[205]

Advocacy Tip: Advocates should always consider asserting a notice argument when the clients do not receive the notices to which they are entitled or when the notices they receive are defective in terms of content or timeliness. Potential remedies for such defects include undoing the adverse action, requiring the county to restart the process, or reinstating aid paid pending.[206]

Notices of Action should be provided in the language indicated by the beneficiary to the county.[207] DHCS should translate the notices into the Medi-Cal "threshold languages," and counties must use DHCS's translated notices for applicants and

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202. Welf & Inst. Code § 14005.37(i); 22 CCR § 50179(c)(7).
203. 42 C.F.R. § 431.211, 22 CCR § 50179(d). ACWDL 13-13, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf, p. 4. *See also Rivera v. Douglas*, No. RG14740911 (Cal. Superior Ct. (Alameda), August 14, 2015).
204. 22 CCR § 50179(d)(1); ACWDL 13-13, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf, p. 4; California Dept. of Social Services Manual of Policies & Procedures ("MPP"), § 22-072.4 available at http://www.dss.cahwnet.gov/getinfo/pdf/4cfcman.pdf.
205. 42 C.F.R. § 435.912(e); Welf. & Inst. Code § 15926(f)(5); 22 CCR § 50179(a) (notice of action required for eligibility decisions); 22 CCR § 50177(a) (promptness requirements for Medi-Cal eligibility decisions).
206. Welf. & Inst. Code § 10967.
207. Welf. & Inst. Code § 15926(k); ACWDL 13-13, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf, p. 8; ACWDL 10-03 (Jan. 12, 2010), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c10-03.pdf, p. 6.

beneficiaries in their primary language, regardless of whether that language is a threshold language in a particular county.[208] The current written threshold languages required for Medi-Cal are: Spanish, Vietnamese, Chinese,[209] Korean, Russian, Armenian, Farsi, Khmer (Cambodian), Hmong, Arabic and Tagalog.

Advocacy Tip: Advocates should challenge notices that are not translated into a beneficiary's primary language bearing in mind that the Department of Social Services Manual of Policies and Procedures' definition of a language-compliant notice sets forth "a rebuttable presumption that a claimant chose to receive written communications in her primary language."[210] Any hearing request made in response to a non-language compliant notice "shall be deemed to be a timely hearing request."[211] Further, "a case shall be postponed" if the Administrative Law Judge determines that a language-compliant notice was not provided, unless the claimant waives the language-compliant notice.[212] Finally, a claimant can generally get aid reinstated retroactively, if they received a non-language-compliant notice that involves discontinuance, suspension, termination or reduction of aid.[213]

b. Requesting a Fair Hearing

Medi-Cal applicants and beneficiaries have the right to challenge adverse actions, such as denials of eligibility or termination of benefits, through the fair hearing process. "Claimants," as persons requesting a hearing are called, have 90 days from

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208. ACWDL 13-13, p. 8. See also ACWDL 10-03, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c10-03.pdf for additional guidance on language access requirements in Medi-Cal.
209. For spoken languages, Mandarin, Cantonese and Other Chinese are all threshold languages thereby the state and counties must employ a sufficient number of qualified bilingual persons to ensure provision of services in those languages. ACWDL 10-03 (Jan. 12, 2010), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c10-03.pdf, p. 2.
210. MPP 22-001(l)(1)(a).
211. MPP 22-009.11.
212. MPP 22-049.522.
213. MPP 22-049.522.

the date of the mailing of the notice to request a hearing.[214] A claimant has the right to be represented in the hearing process by an "authorized representative," who can be an advocate, attorney, or someone else the claimant chooses.[215] For good cause, the time to request a hearing can extend beyond 90 days for up to 180 days from the date of the adverse action.[216] However a notice is not required in order to request for a fair hearing. An individual may file a hearing request whenever they are not satisfied with the county's action regarding their Medi-Cal or if their Medi-Cal application has not been determined quickly enough.[217]

Advocacy Tip: If an applicant has been waiting for more than 45 days (or 90 days for applications requiring a disability determination) for an eligibility determination or if a beneficiary is not sure whether they got a notice, they should file for a fair hearing immediately. Note that applicants on the 45 day timeline who have received neither an eligibility determination nor a notice must be sent a Notice of Inaction informing them how to appeal; however, such applicants should not wait for such notice to request an eligibility hearing.[218] If the applicant has immediate health needs, file for an expedited hearing.[219]

Beneficiaries terminated from Medi-Cal based on lack of information to redetermine eligibility also have 90 days from termination to "cure" the termination and get back on Medi-Cal by submitting to the county the information it claims is missing.[220] When a termination is cured, an individual's eligibility is restored back to the date of termination. Curing the termination may be a better way to resolve a problem related to incomplete information, even when the individual is sure they turned such

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214. 42 C.F.R. §431.221(d), Welf. & Inst. Code § 10951. Note that the 90-day limit does not apply if the beneficiary gets no written notice or if the NOA is defective. *Morales v. McMahon*, 223 Cal.App.3d 184 (1990).
215. 42 C.F.R. § 435.923; MPP 22-085.
216. Welf. & Inst. Code § 10951(b).
217. Welf. & Inst. Code § 10950(a).
218. MEDIL 15-11 (Apr. 7, 2015), http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEDIL2015/MEDIL15-11.pdf.
219. 45 CFR § 155.540(a); Gov't Code § 100506.4(a)(2); 10 CCR § 6616(a); ACL 14-14 (Feb. 7, 2014), http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 14.
220. Welf. & Inst. Code § 14005.37(i).

information in, because the cure process can be faster.

A request for hearing need only be "a clear expression by the applicant or beneficiary, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority."[221] No magic words are required. Generally, an individual may request a hearing by filling out the form on back of the notice called the "NA Back 9" and sending the completed form to the state Department of Social Services State Hearings Division or by making a request to the State Hearings Division.[222] There is a place on the NA Back 9 form to request an interpreter. In whatever form a request for a hearing is made, it should contain identifying information such as the requester's name, address, phone number and Medi-Cal number (if already a beneficiary). It should make clear that it is a request for a Medi-Cal hearing and the reason for the request—why the claimant disagrees with the particular action or inaction at issue.[223] The claimant should also state if they need an interpreter and identify the language needed.[224] If a claimant requests help with filing a hearing request, the county or Covered California staff must provide such assistance.[225]

c. Expedited Hearings

Medi-Cal applicants or beneficiaries are entitled to an expedited appeals process "where there is immediate need for health services because a standard appeal could seriously jeopardize the appellant's life, health, or the ability to attain, maintain, or regain maximum function."[226] A request for an expedited hearing solely on a Medi-Cal issue must be made to the Presiding Judge of the county's regional State Hearings Division office by phone or facsimile.[227] If a Covered California

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221. 42 C.F.R. § 431.201.
222. ACWDL 13-13, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/13-13.pdf, p. 9. The NA Back 9 must be on the back of all NOAs and is also available at http://www.cdss.ca.gov/cdssweb/entres/forms/English/NABACK9.PDF. Refer to this ACWDL for general NOA requirements.
223. MPP 22-004.211.
224. *Id.*
225. Gov't. Code § 100506.4(c); 22 CCR § 50955.
226. Gov't. Code § 100506.4(a)(2). *See also* ACL 13-40 (May 20, 2013), http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-40.pdf, p. 2.
227. Phone numbers and other contact information regarding the foregoing are provided in Appendix D of this manual.

issue is involved, however, the request goes to the Affordable Care Act Bureau.[228] The Presiding Judge may set up a three-way call between the county appeals representative and the claimant to get the information necessary to determine whether an expedited hearing is warranted. If the Presiding Judge decides to grant the request for expedited hearing, they must ensure the hearing is calendared on an expedited basis and send the claimant and county written notice within ten days of the request for an expedited hearing.[229] If the request for expedited hearing is denied, notice of the denial must be provided within three days by phone or other common secure electronic means followed by notice in writing within five working days to the county and claimant. The matter must be set for fair hearing according to the regular hearing timelines.[230]

The Administrative Law Judge must issue a decision within five business days of closing the record.[231] Thereafter, the claimant may follow all of the procedures that apply when pursuing the regular hearing process.

d. Retaining Benefits During the Fair Hearing Process – Aid Paid Pending

Medi-Cal beneficiaries are allowed to keep their Medi-Cal during the fair hearing process under several conditions. In the case of a termination, reduction or suspension of existing eligibility, if a beneficiary requests a fair hearing within ten days from the date of the notice or before the intended action that is the subject of the notice takes place, Medi-Cal eligibility and benefits must be continued until the administrative law judge issues a hearing decision.[232] Eligibility and benefits maintained under these circumstances is called "aid paid pending." Further, the Department of Health Care Services also has the option to reinstate services to a beneficiary who requests a hearing within ten days after the adverse action.[233]

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228. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, pp. 14-15.
229. *Id.*
230. Gov't. Code § 100506.4(a)(2). *See also* ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, pp. 14-15.
231. Gov't. Code § 100506.4(a)(2). *See also* ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 3.
232. 42 C.F.R. §§ 431.230, 431. 231(c) & (d); 22 CCR § 51014.2(a).
233. 42 C.F.R. § 431.231.

Finally, where there has been a failure to provide a proper, language compliant, and timely notice, a beneficiary who requests a hearing must be reinstated within ten days of the mailing of a proper notice and must receive aid paid pending.[234]

Advocacy Tip: Whenever possible, in the case of a termination, reduction or suspension of Medi-Cal coverage, the claimant or their representative should request a hearing within ten days of receiving the notice, even if it appears that the issue can be resolved informally, so that the claimant continues to receive Medi-Cal coverage while working to resolve the problem. Similarly, request aid paid pending in all cases where the notice is defective or no notice was sent.

e. Informal Resolution

Once an applicant or beneficiary requests a hearing to challenge an adverse action, county appeals workers must try to resolve disputes informally, at the lowest administrative level, to avoid unnecessary hearings.[235] The county appeals worker initiates this process by reviewing an appeal request to determine whether the action being appealed is correct or incorrect.[236] If incorrect, the county appeals worker must contact the claimant and attempt to resolve the case without a hearing if the claimant agrees. The informal resolution process is strictly voluntary and refusal to participate in it does not affect the claimant's hearing rights.[237] The county appeals worker must also determine whether the appeal is a dual agency appeal that should also involve Covered California, and if so, notify Covered California; determine whether language services are required and arrange for them accordingly; and inform the claimant of other agencies that might resolve the issue.[238]

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234. *Id.*, subsec. (c); MPP 22-049.523.
235. Gov't. Code § 100506.4(g)(1); MPP 22-073.23.
236. Gov't. Code § 100506.4(g)(8)(A); MPP 22-073.231.
237. Gov't. Code § 100506.4(g)(1), (5) and (8)(B); MPP 22-073.231.
238. Gov't. Code § 100506.4(g) and (8)(C) – (E). Dual agency appeals are appeals where it is not clear which program the individual is eligible for. The requirement to inform of other agencies that may resolve the issue is more common in a Covered California hearing due to the more limited jurisdiction of those hearings. See Section B.2.

For eligibility determinations based on MAGI, a claimant or their authorized representative may initiate the informal resolution process with whichever agency made the eligibility determination, either the county or Covered California.[239]

If the claimant and county appeals worker succeed in resolving the appeal, it is often through the conditional withdrawal process. The claimant may withdraw their hearing request any time before the Director of DHCS signs the hearing decision.[240] Withdrawals may be unconditional or conditional.[241] *Unconditional withdrawal*s result in an immediate dismissal of the appeal, but without prejudice, meaning that the claimant can file a new hearing request on the same issue as long as it is timely.[242] *Conditional withdrawals* must be accompanied by a written agreement signed by the claimant and the county that require the party or parties to complete the actions agreed upon to conditionally resolve the appeal within 30 days.[243] Assuming the conditions are timely met, the appeal is dismissed. If the actions are not resolved within 30 days or if the claimant is unsatisfied with the resolution, the claimant can ask for a hearing within 90 days.[244]

If, after reviewing the appeal request, the county appeals worker determines that the action being appealed was correct or the claimant and county are not otherwise able to resolve the matter informally, the claimant's right to a hearing is preserved and the case can proceed to hearing.[245]

f. Dismissals

The Hearings Division must dismiss an appeal if the claimant withdraws the appeal

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239. *Id.* subsection (g)(6). See the section of this manual on dual agency appeals at Section B.3.
240. MPP 22-054.21.
241. *Id.*
242. *Id.*
243. *Id.* For guidance on what constitutes adequate conditional withdrawal language, see ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 11.
244. MPP 22-054.21(b)(3); ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, pp. 11-12.
245. Gov't. Code § 100506.4(g)(2); *Id.* at 22-073-232.

request or fails to appear at a scheduled hearing without good cause.[246] For MAGI Medi-Cal appeals handled by the Affordable Care Act Bureau, the claimant has 30 days to request in writing and for good cause that the dismissal be vacated.[247] For non-MAGI appeals heard in the regional offices, the claimant has only 15 days to make such a request.[248] MAGI Medi-Cal appeals have specific notice requirements for dismissal notices; non-MAGI appeal dismissals are handled via hearing decision dismissing the case.[249]

g. Setting and Notice of Hearing; Position Statement

The State Hearings Division must set the hearing within 30 working days after the request is filed.[250] The date of the hearing request is the date that the county receives the request.[251]

At least 15 days before the hearing, the State Hearings Division must notify the appellant in writing either electronically or by hard copy, of the date, time, and location of the hearing.[252] Subject to agreements between the county and the claimant to the contrary, the hearing must be held in the county where the claimant resides.[253] The notice must explain in what format the hearing will be held—phone, video conference, or in person. The notice must also advise the claimant of their right to request a hearing by phone, video conference, or in person, and include instructions on how to exercise this right.[254] If the date, time, and location indicated would prevent the claimant from participating in the hearing, the State Hearings Division must make reasonable efforts to reset the hearing for a "reasonable" and "mutually convenient" date, time, and location.[255] If the claimant is unable to attend the hearing at the hearing location because of poor health, the hearing can be held

246. 42 C.F.R. § 431.223.
247. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 13; *see also* MPP 22.053.113 (providing examples of good cause).
248. MPP 22-054.222; *see also* MPP 22.053.113 (providing examples of good cause).
249. AWCDL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p.13; MPP 22-054.221.
250. Welf. & Inst. Code § 10952.
251. *See* ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 10.
252. Gov't. Code § 100506.4(h)(2).
253. MPP 22-045.1.
254. *Id.*
255. *Id.*

in the claimant's home or other agreed upon location.[256]

At least two working days before the hearing, the county appeals worker must make available to the claimant a copy of a position statement that sets forth the issues in question at the fair hearing.[257] The county must make it available electronically, if it can be done securely.[258] If the county fails to make the position statement available in a timely fashion or decides to modify the statement, the hearing can be postponed, but only at the claimant's request and so as long as the claimant waives the right to obtain a decision on the hearing within the deadline that would otherwise apply.[259] A postponement for this reason constitutes a postponement for good cause.

h. The Fair Hearing

Medi-Cal fair hearings are conducted by Administrative Law Judges of the State Hearings Division of the Department of Social Services.[260] Hearings are held in at least one location in each county.[261]

The hearing may be held via telephone or videoconference, or, if the claimant requests, in person.[262] There is also a home hearing alternative for people with disabilities who are unable to appear by telephone.[263] The claimant must have the opportunity to review their appeal record, case file, and all documents to be used by the State Hearings Division at the hearing within a reasonable time before the

256. MPP 22-045.11.
257. Gov't. Code § 100506.4(h)(2); Welf. & Inst. Code § 10952.5.
258. Gov't. Code § 100506.4 (h)(1).
259. Welf. & Inst. Code § 10952.5. This leaves the claimant with the unsavory choice of moving forward with the hearing without knowing the position of the county ahead of time or waiting to have the hearing at all and further illustrates why asking for aid paid pending is so important.
260. Gov't. Code § 100506.4(h)(5); Welf. & Inst. Code §§ 10953, 10953.3.
261. For additional information on hearing sites, see the Department of Social Services webpage on hearings at http://www.dss.cahwnet.gov/shd/PG1163.htm.
262. Gov't. Code § 100506.4(h)(3).
263. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 8.

hearing as well as during the hearing.[264]

At the hearing, the Administrative Law Judge must allow the claimant to present evidence and bring witnesses in support of her appeal and to refute any evidence or testimony brought against her through cross-examination or otherwise.[265] The claimant cannot be asked to provide information or documentation already provided during the informal resolution process at the hearing.[266] The Department of Social Services must provide an interpreter if the claimant requests one or if the Administrative Law Judge determines an interpreter is necessary.[267] The Administrative Law Judge must determine if the interpreter is certified or if not certified, examine the qualifications of the interpreter and assure objective interpretation.[268] The Administrative Law Judge must review the appeal considering all relevant facts and evidence presented must be considered.[269]

Postponements and continuances of hearings, including those requested by claimants due to specified life emergencies such as a death in the family or personal illness or injury or due to process deficiencies, such as failure of the county to provide a timely position statement, must be handled in accordance with the state Department of Social Services' Manual of Policies and Procedures Section 22-053.

For more on the fair hearing process, including specific procedural rules during the hearing such as the use of witnesses and evidence, see the Health Consumer Alliance *Overview of the Medi-Cal Program*, Chapter 19, pp. 19-5 to 19 – 8 at http://healthconsumer.org/Medi-CalOverview2008Ch19.pdf, and the CDSS Manual of Policies and Procedures at http://www.dss.cahwnet.gov/getinfo/pdf/4cfcman.pdf, Sections 22-049 through 22-051.

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264. Gov't. Code § 100506.4(h)(6); MPP 22-051. Note that the regulations governing Covered California fair hearings specify that the appellant may review the file at least two (2) business days before the hearing. 10 CCR § 6614(d). Claimants and persons acting on their behalf should assert the right to review the hearing documents at least as early as this.
265. Gov't. Code § 100506.4(h)(4).
266. Gov't. Code § 100506.4(g)(3).
267. MPP 22-049.6.
268. MPP 22-049.611-612.
269. Gov't. Code § 100506.4(h)(7).

i. After the Fair Hearing

The Administrative Law Judge must complete a hearing decision within 90 days of the filing of the fair hearing request.[270] The decision must be in writing and sent to the claimant or authorized representative.[271] The decision must include "a decision with a plain language description of the effect of the decision on the [claimant's] eligibility or enrollment, a summary of the facts relevant to the appeal, an identification of the legal basis for the decision, and the effective date of the decision[.]"[272]

A Medi-Cal hearing decision by an Administrative Law Judge is a proposed decision that gets sent to the Director of the Department of Health Care Services within 75 days after the fair hearing concludes.[273] Within 30 days of receiving the proposed decision, the Director reviews it and either adopts or changes it or sets the matter for further hearing.[274] If the Director fails to take action on the decision within 30 days of receiving it, it is deemed adopted.[275] If the Director changes the decision, the "alternated" decision is sent to the claimant and county.[276]

If the decision is in favor of the claimant, the county must comply with the decision within 30 days.[277] Any corrective payments that Medi-Cal must make to comply with the decision, either to beneficiaries or providers, must be made retroactive to the date that such payments should have been made.[278]

If the claimant receives an unfavorable hearing decision, they may seek a rehearing by sending a written request to the Rehearing Unit of the State Hearings Division

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270. 42 C.F.R. § 431.244(f); Gov't. Code § 100506.4.
271. 42 C.F.R. § 431.245.
272. Gov't. Code § 100506.4(i).
273. Welf. & Inst. Code § 10958.
274. Welf. & Inst. Code § 10959.
275. *Id.*
276. *Id.*
277. Welf. & Inst. Code § 10961. *See also* 42 C.F.R. § 431.246 (regarding the requirement that "prompt" corrective action be taken if the hearing decision is favorable to the claimant, or if the agency decides in the claimant's favor before the hearing.)
278. *Id.* Regarding DHCS' obligation to make corrective payments to beneficiaries, *see Conlan v. Shewry*, 131 Cal. App. 4th 1354 (2005), *Conlan v. Bonta*, 102 Cal. App. 4th 745 (2002), and Welf. & Inst. Code § 14019.3.

within 30 days of receiving the decision.[279] The request should state the date of the adverse decision, state why a rehearing should be granted and describe any additional evidence that will be submitted and explain why it was not submitted at the original hearing.[280] The Director of the Department of Health Care Services must take action to grant or deny the request for rehearing within 15 days of receipt; otherwise the request is deemed denied.[281]

Another option for a claimant who gets an adverse hearing decision is to seek judicial review of the adverse decision. This is done by filing a petition for writ of mandate in Superior Court within one year of receiving notice of the Director's final decision.[282] No filing fee is required and if the claimant prevails, they are entitled to attorney fees and costs.[283] Going through the rehearing process is not required before going to court.[284] Thus, a claimant who is unsuccessful at her initial fair hearing may seek a rehearing first and if unsuccessful may file a writ in court, or may go straight to court.

2. Covered California Eligibility Appeals

As with Medi-Cal appeals, the State Hearings Division of the California Department of Social Services handles Covered California appeals.[285] While the rules governing the appeals hearing processes are the same or very similar in many places to those for Medi-Cal appeals, there are differences between the processes.[286] Most

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279. Welf. & Inst. Code § 10960.
280. MPP 22-065.
281. 42 C.F.R. § 431.232(b); Welf. & Inst. Code § 10960.
282. Welf. & Inst. Code § 10962. A writ of administrative mandamus (Cal. Code Proc. 1094.5) is an order from a California state judge reviews a final order of a state agency to determine if it is valid. It is a type of legal action against the state though it has its own procedure and terminology.
283. *Id.*
284. Welf. & Inst. Code § 10960(e).
285. Gov't. Code § 100506.3 (a); 10 CCR § 6600; ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 6.
286. The Covered California appeals process is primarily governed by Subpart F of Part 155 of Title 45 of the Code of Federal Regulations and Article 7, the relevant provisions of Title 22 of the California Government Code, and Chapter 12 of Title 10 of the California Code of Regulations. Gov't Code §100506.3 (a). If the foregoing is not applicable, the Medi-Cal hearing processes at Welfare & Institutions Code Sections 10950, *et seq.* govern.

significantly, the appeals process is not handled by the counties, but by Covered California. Covered California eligibility appeals encompass not only eligibility to enroll or remain enrolled in a Covered California qualified health plan, but also eligibility for, or the amount of, advanced premium tax credits and cost-sharing reductions. In general, Covered California appeals do not cover complaints about the health plans themselves or service denials, though there are situations where there may be a connection to eligibility such as disputes with a plan when coverage should have begun.[287]

This section focuses on appeals of eligibility determinations made by Covered California, through the State Hearings Division. Note however that Covered California and the State Hearings Division also have the jurisdiction to hear appeals regarding certain determinations for exemptions from the health coverage mandate.[288]

An applicant for Covered California or an enrollee in a Covered California plan may appeal 1) any action or inaction related to the individual's eligibility for Covered California or enrollment in a Covered California plan, including eligibility to enroll during a special enrollment period; 2) any action or inaction related to eligibility for or the amount of premium tax credits or cost-sharing reductions; 3) an eligibility determination for an exemption from the individual mandate penalty; or 4) Covered California's failure to provide "timely or adequate notice of an eligibility determination or redetermination or an enrollment-related determination."[289]

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287. Complaints about a health plan or a plan's denial of services are handled by the Department of Managed Health Care, or in limited situations, the Department of Insurance. Information is available at www.dmhc.ca.gov.
288. 45 C.F.R. § 155.505(b)(2); Gov't. Code § 100506.3(a). To date, these exemptions regarding the individual mandate are still being handled by the federal Health & Human Services administration though it is expected that exemption determinations will be handed over to the states that run their own Exchanges in the near future.
289. Gov't. Code § 100506.1. *See also* 45 CFR § 155.505. 10 CCR § 6602 also covers Covered California appeal requirements, however Government Code § 100506.1 governs. Note that decisions regarding special enrollment periods can be appealed per 45 C.F.R. § 155.505(b)(1)(i), which says that an appeal can be made of any eligibility decision based on 45 C.F.R. § 155.305(a)-(h). 45 C.F.R. § 155.305(b) covers eligibility for a qualified health plan based on enrollment periods. As noted above, to date, Health & Human Services is still handling exemption disputes.

a. Notice: Content and Time Requirements

Covered California must provide written notice to an applicant of any determination it makes regarding an applicant's eligibility to enroll in a qualified health plan or eligibility for financial assistance within five business days of making the determination.[290]

Likewise, Covered California must notify enrollees regarding ongoing eligibility to be enrolled in a qualified health plan and ongoing eligibility for or changes to levels of financial assistance within five business days of completing redetermination (either annual redetermination or redetermination due to the enrollee's changed circumstances).[291]

These notices must be in writing and must include:

- an explanation of the action stated in the notice, *e.g.,* eligibility or ineligibility for applicable programs;
- the effective date of the action, *e.g.*, eligibility or termination;
- the factual bases upon which the action was made;
- the relevant regulations and other legal authority supporting the action;
- "[c]ontact information for available customer service resources, including legal aid and welfare rights offices"; and
- an explanation of appeal rights.[292]

The explanation of appeal rights must state specific information, including the ways by which an applicant or enrollee may request an appeal, and an explanation as to how eligibility may be maintained pending appeal.[293]

Covered California must provide an enrollee notice at least 14 days before the "effective date of termination" when terminating coverage. [294]

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290. 45 C.F.R. § 155.310(g); 10 CCR § 6476(h).
291. 10 CCR §§ 6496(h)(2) and 6498(j)(2).
292. Gov't. Code § 100506.2(b); 10 CCR § 6454.
293. These content requirements are fully set forth at Government Code § 100506.2(b) and 10 CCR § 6604(b). *See also* 45 C.F.R. § 155.515(b).
294. 45 C.F.R. § 155.430(d)(1)(i); 10 CCR § 6506(d)(1).

All Covered California notices must be timely and accessible, provided at no cost to the individual, to persons with disabilities through use of auxiliary aids and services, and to persons who are limited English proficient through language services, including written translation.[295]

b. Request for Hearing

As with the Medi-Cal process, a Covered California applicant or enrollee has 90 days from the date of the notice of eligibility determination to request a hearing if they disagree with the outcome.[296] The time can be extended for good cause for up to 180 days after the notice of eligibility determination.[297]

A person appealing a Covered California action is referred to as an "appellant" rather than a "claimant."[298] An appellant may submit an appeal request to Covered California or the State Hearings Division through the Covered California website, by telephone, fax, mail, or in person.[299] Covered California and the State Hearings Division must assist an applicant or enrollee making an appeal request.[300] Further, Covered California and the State Hearings Division are prohibited from interfering with an applicant's or enrollee's right to make an appeal.[301] If the appeal request is made to Covered California, Covered California must immediately transmit the appeal request and the appellant's eligibility record to the State Hearings Division.[302] However, the date of the request is the date Covered California receives it.[303]

After Covered California or the State Hearings Division receives an appeal request, an Administrative Law Judge designated by the State Hearings Division must determine the validity of each appeal request, *e.g.,* whether the appeal is within the

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295. Welf. & Inst. Code § 15926(k); 10 CCR §§ 6452(c), 6454(b).
296. 45 C.F.R. § 155.520(b); Welf. & Inst. Code § 10951(a); 10 CCR § 6606(c).
297. 10 CCR § 6606(c), referencing Welf. & Inst. Code § 10951.
298. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, pp. 1 -2.
299. 10 CCR §§ 6470(j) and 6606 (a). Hearing Request Form available at https://www.coveredca.com/PDFs/HearingRequestFormCC.pdf.
300. 45 C.F.R. § 155.520(a)(2); Gov't. Code § 100506.4(c); 10 CCR § 6606(a).
301. 45 C.F.R. § 155.520(a)(3); Gov't. Code § 100506.4(c); 10 CCR § 6606(a).
302. 10 CCR § 6602(g).
303. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 10.

Department of Social Services' jurisdiction and whether it is timely and whether there is good cause for the request, and, if untimely (submitted later than 90 days from the notice of eligibility determination), whether there is good cause for its untimeliness.[304] The Administrative Law Judge must apply the "good cause" standard set forth in Welfare & Institutions Code Section 10591.[305] The Administrative Law Judge making the validity or good cause determination must complete the determination expeditiously so that the State Hearings Division may send the required written acknowledgement notices to the appellant within the prescribed five day timeline discussed below. If the appellant disagrees with the decision on validity or good cause, they may make an appeal request to the Health and Human Services Agency within 30 days of the date of the appeal decision.[306] This extra step to determine the validity of an appeal request before a hearing can be set is unique to the Covered California appeals process; it is not a requirement in the Medi-Cal process.

The State Hearings Division must send written notice to the appellant acknowledging receipt of the appeal within five business days.[307] The notice must provide information to the appellant about:

- the opportunity for an informal hearing;
- the appellant's eligibility to continue receiving Covered California benefits pending appeal; and
- an explanation that any advanced premium tax credits paid on behalf of the

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304. 42 C.F.R. § 155.520(a)(4) and (c); 10 CCR § 6602(c). Note that appeals based on denial of services, for example, are generally not within the Department of Social Services' jurisdiction, but generally must go through the appeal procedures provided through the Department of Managed Health Care or the Department of Insurance. Government Code § 100506.4(g)(8)(E) requires Covered California to refer an appellant to another agency that *may* be able to assist with their appeal if it cannot.
305. 10 CCR § 6606(c).
306. 10 CCR § 6606(d). The appeal form and instructions can be found at https://www.healthcare.gov/downloads/marketplace-appeal-request-form-s.pdf. At the time this manual was published, appeals could only be submitted by mail or phone. Further, there was uncertainty about how the HHS appeal process worked and based on anecdotal information, the authors determined it was infrequently used. Thus, while bearing in mind the 30 day deadline, applicants and their advocates should consider what steps might be taken other than appealing to HHS if an appeal is deemed not valid, such as quickly taking steps to cure whatever defects are in the appeal, if possible.
307. 10 CCR § 6606(e).

tax filer pending appeal is subject to reconciliation under the application federal laws and regulations.[308]

Except in the case of expedited appeals (discussed below), the Hearings Division must transmit via secure electronic interface notice of the appeal request and, if applicable, instructions to provide eligibility pending appeal to Covered California (and to the Department of Health Care Services,[309] as applicable) within three days from receiving a valid appeal request.[310]

Upon receipt of an appeal request that is determined not valid and without good cause for such defect, the written notice from the State Hearings Division to the appellant must state:

- that the appeal request has not been accepted;
- the nature of the defect in the appeal request; and
- if the defect specified is curable, that the appellant may cure the defect and resubmit the appeal request within 30 calendar days from the date on which the invalid appeal request was received.[311]

The State Hearings Division must treat as valid an amended appeal request that meets the applicable content and other requirements, *e.g.,* that it is on a subject over which the Hearings Division has jurisdiction.[312]

c. Expedited Appeals

"[W]here there is immediate need for health services because a standard appeal could seriously jeopardize the appellant's life, health or the ability to attain, maintain or regain maximum function," Covered California must provide a process for an

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308. *Id. See also* 45 C.F.R. § 155.520.
309. In practice, the county would be the likely recipient of this notice and information as opposed to DHCS as counties administer Medi-Cal.
310. 10 CCR § 6606(e). *See also* 45 C.F.R. § 155.520(d)(1).
311. 10 CCR § 6606(f). *See also* 45 C.F.R. § 155.520(d)(2).
312. 10 CCR § 6606(f). *See also* 45 C.F.R. § 155.520(d)(2)(ii).

expedited appeal.[313] The hearing for an expedited appeal must be set on an expedited basis.[314] Specifically, the State Hearings Division must give the appellant written notice that her request is granted within ten days of approving such request and include the date, time, and type of the hearing, *e.g.,* telephonic.[315] If an expedited appeal is granted, the decision must be issued "as expeditiously as possible"—no later than five business days after the expedited hearing, except if the appellant agrees to a delay to submit additional documents for the appeals record.[316] In turn, Covered California must act to implement the decision as expeditiously as possible. If an expedited appeal is denied, the State Hearings Division must notify the appellant within three days by phone or other commonly available secure electronic means, followed by a written notice within five business days, of the decision to deny the expedited appeal.[317] Thereafter, the appeal proceeds under the standard process.[318]

d. Eligibility Pending Appeal – Continuing Enrollment

As with Medi-Cal, it is critical that enrollees and those acting on their behalf understand their rights regarding maintenance of Covered California coverage in a qualified health plan, including the same level and amount of financial assistance, while appealing an eligibility determination. This is called "continuing enrollment."[319] It is akin to "aid paid pending" under Medi-Cal. Appellants challenging an eligibility redetermination by Covered California, or with the amount of approved financial assistance, may ask for continuing enrollment in the health plan as long as the individual is willing to continue paying their portion of the required premiums during

313. 45 C.F.R § 155.540(a), Gov't. Code § 100506.4(a)(2); ACL 14-14, pp. 14-15. *See also* 10 CCR § 6616(a).
314. Gov't. Code § 100506.4(a)(2), 10 CCR § 6616(c)(1)
315. 10 CCR § 6616(c). Further, within three business days of the date the appellant's request for an expedited appeal is granted, the Hearings Division must provide notice via secure electronic interface to Covered California (and if applicable, say, in a dual agency appeal, to DHCS) stating that the request for an expedited appeal is granted and a hearing will be set on an expedited basis.
316. Gov't. Code § 100506.4(a)(2).
317. Gov't. Code § 100506.4(a)(2). See also 10 CCR § 6616(b).
318. *Id.*
319. 45 C.F.R. §155.525; 10 CCR § 6608; ACL 14-14 (Feb. 7, 2014), http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, pp. 7 - 8.

the appeal.[320] Covered California must continue to consider the appellant eligible for the same level of premium tax credits as the level immediately before the redetermination or remain in the same cost-sharing reduction plan while the appeal is pending.[321] The trigger for "continuing enrollment" is the "receipt of a valid appeal request or notice."[322]

If the appeal decision ultimately goes against the appellant, the appellant is liable for any premium tax credits received they were not eligible for, which could well be the entire premium tax credit amount received.[323] Such amounts will be reconciled and ultimately collected through the reconciliation process when filing income taxes for the year.[324]

e. Informal Resolution

An appellant must be given the opportunity to pursue an informal resolution of their appeal prior to a hearing.[325] This option is strictly voluntary and whether they pursue informal resolution or not does not affect their right to a hearing, nor delay the timeline setting the hearing.[326] As part of the informal resolution process, a representative of Covered California must contact the appellant or their authorized representative and offer to discuss the challenged action, if the appellant agrees.[327] For eligibility determinations based on MAGI, an appellant or their authorized representative may initiate the informal resolution process with whichever agency made the eligibility determination, either the county or Covered California.[328]

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320. *Id.*
321. *Id.* Note that Government Code § 100506.5 states that Covered California should consider both enrollees and "applicants" eligible to maintain their APTC and CSR at the same level pending appeal, so advocates should look for situations in which applicants may be able to assert this right as well.
322. 45 C.F.R. § 155.525(a); 10 CCR § 6608(a).
323. Note there is no way to reconcile cost-sharing reductions, so these reductions in out-of-pocket costs are not paid back if the decision is unfavorable.
324. *See* 26 U.S.C. § 36B(f); 26 C.F.R. § 1.36B-4(a). For more on the reconciliation process, see Chapter 4, Section E.
325. Gov't. Code § 100506.4 (g). *See also* 45 C.F.R. 155.535 and 10 CCR § 6612.
326. *Id.* at (g)(4) and (5).
327. Gov't. Code § 100506.4(g)(1).
328. *Id.* subsection (g)(6).

In the informal resolution process, Covered California must follow these steps:

- review the file to determine whether the action appealed was appropriate and whether a hearing is needed;
- try to resolve the matter if the action that the individual is appealing was incorrect;
- determine whether a dual agency (both Medi-Cal and Covered California) appeal is required to resolve the problem at a hearing and notify the other agency thereof;
- determine whether interpretation services are necessary and make arrangements accordingly; and
- inform appellants of other agencies that may be available to help resolve the issue if it is an issue that Covered California does not have jurisdiction over.[329]

If the appellant is dissatisfied with the outcome of the informal resolution process, they need not accept it. They can reject the outcome and their right to a hearing is preserved.[330] The case can then proceed to hearing.

If the appellant is satisfied with the outcome of the informal resolution process, they may withdraw the hearing request or may agree to a conditional withdrawal agreement that contains the terms and conditions that the appellant and Covered California have agreed to.[331] The conditional withdrawal must specify with sufficient detail and clarity what action Covered California or the county will take and what obligations the claimant and/or county has (as applicable).[332] For example, stating that Covered California or the county will "review" the matter is not sufficient. The Affordable Care Act Bureau requires that the conditional withdrawal "must instead say what Covered California or the county is re-reviewing and what *action* after review will be taken. . ."[333] Under these circumstances, no hearing takes

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329. *Id.* at (g)(8). Because Covered California does not have jurisdiction over most disputes with the health plans themselves, appellants disputing denials of services by the plans should be referred to the Department of Managed Health Care (or in limited cases to the Department of Insurance).
330. 45 C.F.R. § 155.535(a)(2); Gov't Code § 100506.4 (g)(2).
331. *See* 10 CCR § 6610(a).
332. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 11.
333. *Id.*

place. Rather, both the appellant and Covered California must sign the conditional withdrawal, then Covered California will submit the conditional withdrawal request to State Hearings Division within five business days of the outcome of the informal process.[334] The appeal may then be dismissed.[335] If Covered California properly dismisses the appeal, the informal resolution decision is final and binding.[336] However, the administrative dismissal may be set aside and the case reopened at appellant's request if there is showing of good cause.[337]

Covered California must send notice of the outcome of the informal resolution to the State Hearings Division by secure electronic interface within three business days of the outcome.[338] Further, Covered California must provide a written notice to the appellant setting forth the outcome of the informal resolution process, the effective date of the outcome, if applicable, and a plain language description of the effect of the outcome on the appellant's appeal and eligibility within five business days of the date of the informal resolution decision.[339]

f. Notification of Hearing and Position Statement

The State Hearings Division must notify the appellant in writing either electronically or by hard copy, of the date, time and location of the hearing at least 15 days before the hearing.[340] The notice must explain in what format the hearing will be held – phone or video conference or in person. The notice must also advise the appellant of her right to request a hearing by phone or video conference or in person and include instructions on how to exercise this right.[341] The State Hearings Division has to make reasonable efforts to reset the hearing for a "reasonable" and "mutually convenient" date, time and location if the appellant cannot make the date, time, or

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334. 10 CCR § 6612(f)(1); ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 11.
335. 10 CCR § 6610.
336. 10 CCR § 6612(f)(3); ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 13.
337. 45 C.F.R. § 155.530(d); 10 CCR § 6610(a)(1)(C)(4); ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 13.
338. 10 CCR § 6612(f)(2).
339. 10 CCR § 6612(f).
340. Gov't. Code § 100506.4(h)(2).
341. *Id.*

location on the notice.[342]

Covered California must provide a position statement to the appellant and all the case documents and case record from the informal process to the appellant, their representative if they have one, and the Hearings Division, at least two business days before the hearing.[343] Additionally, Covered California must notify the appellant that the position statement will be available through the claimant's web portal, and, if applicable, will also give the appellan the contact information on how to obtain a copy of the statement from the county no less than two business days before the hearing.[344] The additional requirements regarding provision of the position statement are the same as for Medi-Cal appeal hearings.[345] See Section B.1.g.

g. The Fair Hearing

The hearing must be within 90 days from the date on which a valid appeal request is received, unless it is an expedited appeal.[346] For expedited appeal timelines, see the earlier discussion at Section B.2.c. The hearing must be conducted by an impartial official who has not been directly involved in the action which is the subject of the appeal, namely, an Administrative Law Judge in the Department of Social Services' State Hearings Division.[347]

The hearing may be held via telephone or videoconference, or, if the appellant requests, in person.[348] There is also a home hearing alternative for people with disabilities who are unable to appear by telephone.[349] The appellant must have the opportunity to review her appeal record, case file and all documents to be used by the Hearings Division at the hearing at least two business days before the hearing

342. *Id.*
343. Gov't. Code § 100506.4 (h)(1); 10 CCR § 6612(e)(2); ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 14.
344. ACL 14-14, p. 14.
345. *Id.* and Welf. & Inst. Code § 10952.5; ACL 14-14, p. 14.
346. 10 CCR § 6614(c)(1).
347. Gov't. Code § 100506.4 (h)(5); 10 CCR § 6614(c)(4).
348. Gov't. Code § 100506.4 (h)(3); 10 CCR § 6614(c)(5).
349. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 8.

as well as during the hearing.[350] At the hearing, the Administrative Law Judge must allow the appellant to present evidence and bring witnesses in support of her appeal and to refute any evidence or testimony brought against her through cross-examination or otherwise.[351] The appellant cannot be asked to provide information or documentation that they already provided during the informal resolution process at the hearing.[352] The Administrative Law Judge must review the appeal considering all relevant facts and evidence presented.[353]

h. Hearing Decision and Other Post-Hearing Processes

The hearing decision must be made within 90 days of the date the appeal is filed.[354] The decision must include:

- a decision;
- a plain language description of the effect of the decision on the appellant's eligibility or enrollment;
- a summary of the facts relevant to the appeal;
- the legal basis for the decision;
- the effective date of the decision, which the appellant may choose to have retroactive effect, assuming the decision to appellant is favorable;[355]
- appellant's right to pursue the appeal before the HHS appeals entity and process to do so;
- indication that the appeal decision is final, unless the appellant appeals to HHS; and
- appellant's right to judicial review of the decision under Section 1094.5 of the California Code of Civil Procedure.[356]

Upon adjudication of the appeal, the State Hearings Division must transmit the

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350. 10 CCR § 6614(d). *See also* Gov't. Code § 100506.4(h)(6) (requiring an opportunity to review "at a reasonable time" before the hearing date).
351. Gov't. Code § 100506.4(h)(4). *See also* 10 CCR § 6614(d).
352. Gov't. Code § 100506.4(g)(3); 10 CCR § 6614(e)(1).
353. Gov't. Code § 100506.4(h)(7); 10 CCR § 6614(f).
354. Gov't. Code § 100506.4 (h)(7).
355. Gov't. Code § 100506.4 (i).
356. 10 CCR § 6618(a).

decision to Covered California by secure electronic means.[357] Similar to the Medi-Cal appeals process, the decision must be transmitted to the Director of Covered California within 75 days after the fair hearing concludes.[358] The Director and Covered California then follow the same process that Medi-Cal (the Department of Health Care Services) must follow as to whether to adopt or alternate the decision.[359] See Section B.1.i. above.

Within 30 days, Covered California must implement the appeal decision.[360] At the option of the appellant, the decision shall be effective prospectively to the date of the decision or another date chosen by the appellant, or retroactively to the date the incorrect eligibility determination was made.[361] Receipt of the decision may also compel Covered California to redetermine the eligibility of other members of the appellant's household, if their eligibility may be affected by the appeal decision.[362]

If the appellant disagrees with the hearing decision, within 30 days of the hearing decision notice, they may submit an appeal request to the federal Health and Human Services Agency.[363]

Alternatively, an appellant who disagrees with the hearing decision may seek judicial review by filing a writ in state court.[364] There is no requirement to exhaust administrative remedies or mutual exclusion regarding these two options. The appellant need not appeal to the Health and Human Services Agency before exercising their right to seek judicial review; likewise, appealing to the Health and

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357. Gov't. Code § 100506.4 (j).
358. Welf. & Inst. Code § 10958.
359. Welf. & Inst. Code § 10959. *See also* Covered California Delegation Order 15-100.
360. 10 CCR § 6618(c).
361. *Id.* at subsection (c)(1).
362. *Id.* at subsection (c)(2).
363. Gov't. Code § 100506.4 subsections (b) and (k). See also 45 C.F.R. § 155.520(c). Instructions on how to appeal, the appeals process and an appeal request form are available at https://www.healthcare.gov/downloads/marketplace-appeal-request-form-s.pdf. When this manual was published, the specifics of this process were not clear or well-publicized. The authors were aware of just a few instances in which appeals were made to HHS and did not know the outcomes. Further, at the time, the only ways by which an HHS appeal could be submitted were by mail and phone. If this remains the status quo, enrollees and their advocates may be well-advised to opt for judicial review if they wish to challenge a hearing decision, rather than file an appeal with HHS.
364. *Id.*, subsec. (l).

Human Services Agency does not preclude judicial review.[365]

3. Dual Agency Appeals

Eligibility disputes often arise for new applicants for health coverage who are close to the Medi-Cal/Covered California income thresholds and for persons already in Medi-Cal or enrolled in a Covered California plan whose income has changed in a way that places them close to these income thresholds. In these appeals that implicate both programs, advocates should consider filing a combined Medi-Cal and Covered California hearing appeal request. This is so that if an individual gets a hearing decision that they are not eligible for one program, they can get a simultaneous decision that they are eligible for the other program, rather than have to obtain two separate consecutive decisions that may delay or interrupt health care coverage.

This section covers some rules and procedures that may be helpful to know when pursuing a dual agency appeal. You should also read both the Medi-Cal and Covered California eligibility appeals sections above for guidance. You may also refer to the table at Appendix C comparing the Medi-Cal and Covered California appeals for additional guidance.

a. Shared Appeals Entity

In navigating the two sets of often overlapping statutory, regulatory and sub-regulatory authorities that may apply in a dual agency case, it may be helpful to keep the following in mind: 1) Sections 100506.2 and 100506.4 of the Government Code apply to the Medi-Cal eligibility fair hearing process to the extent these Government Code sections conflict with the Welfare and Institutions Code sections on fair hearings contained at Welfare and Institutions Code Sections 10950, *et seq.*,[366] and 2) The Covered California appeals process is primarily governed by Subpart F of Part 155 of Title 45 of the Code of Federal Regulations, the relevant provisions of Article 7, Title 22 of the Government Code, and Chapter 12 of Title 10 of the California Code of Regulations; if the foregoing is not applicable, look to the Medi-Cal hearing

365. *Id.*
366. Welf. & Inst. Code § 10950(b)(1).

processes at Welfare & Institutions Code Sections 10950, *et seq*.[367]

b. Informal Resolution Process

It is not up to the claimant to know which type of hearing to ask for in the event that there is a dispute that implicates both agencies. If either agency determines on an informal process review that a dual agency appeal is required to resolve the matter, the determining agency must notice the other agency about the appeal if the latter has not already been included in the appeal request.[368]

For MAGI appeals, the agency that made the eligibility determination conducts the informal resolution process—the county for Medi-Cal and Covered California for itself.[369] This means either agency can review a MAGI income determination during informal resolution. However, informal resolutions involving an issue related only to Covered California rules such as rules regarding special enrollment or employer offers of affordable coverage must remain with Covered California; those involving non-MAGI issues must be handled by the counties.[370]

c. The Fair Hearing

Where an appeal raises issues that involve both Medi-Cal and Covered California, the agencies are supposed to coordinate and decide whether all issues can be presented in one Statement of Position or whether the respective agencies will submit separate statements.[371] A coordinated statement is the preferred practice, according to the Hearings Division.[372]

In dual agency appeals, whenever possible, the County Hearing Representative is supposed to present the Medi-Cal case and the Covered California Hearings Representative is supposed to present the Covered California case at the same

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367. Gov't. Code § 100506.3 (a).
368. Gov't. Code § 100506.4(g)(8)(C).
369. Gov't. Code § 100506.4(g)(6).
370. *Id.*
371. ACL 14-14, http://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2014/14-14.pdf, p. 14.
372. *Id.*

hearing and may work cooperatively in presenting evidence.[373]

4. Medi-Cal Access Program (MCAP) Eligibility Appeals

At the time of publication of this manual, parts of the regulatory scheme for the Medi-Cal Access Program (MCAP) for pregnant women were in flux, including the program's eligibility appeals processes, as administration of the program had recently been transferred from the Managed Risk Medical Insurance Board to the Department of Health Care Services.[374] The following reflects what the authors believe is the most practical information on the MCAP eligibility appeals process at publication.

Technically, there are three levels of appeal. First, an applicant denied MCAP makes a written appeal within 60 days of denial to the "Executive Director-Benefits Appeal." If the appeal is denied at this first level, the applicant is supposed to receive a denial letter advising of the basis for denial, the applicant's right to take the appeal to the second level—MCAP directly—and the process for doing so. If the appeal is denied at the second level, MCAP should send the applicant a written denial letter advising the applicant of her right to a fair hearing before an Administrative Law Judge, the third and "formal" level of appeal.[375] Once the hearing is before an Administrative Law Judge, the procedure should be similar to that of Medi-Cal or Covered California, though a state representative will be representing the MCAP program.

In reality, applicants denied coverage who wish to appeal might not move through these MCAP eligibility appeal levels sequentially. CalHEERS screening includes screening for MCAP if a woman is pregnant and over income for Medi-Cal. Thus, a pregnant woman might apply for health coverage on line and as the result of

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373. *Id.* at p. 18.
374. This manual does not cover MCAP benefits appeals. The regulations covering such appeals can be found at 10 CCR § 2699.500, *et seq.,* but given that many MCAP processes were in flux at the time this manual was published, as with eligibility appeals, the regulations may not reflect the procedures utilized by MCAP in reality. It may be best to contact MCAP at 1-800-433-2611 immediately upon denial of benefits for information on how to proceed with an appeal.
375. As of publication, the processes surrounding this denial letter were unclear.

CalHEERS screening, be denied for both Medi-Cal and MCAP and then receive a notice advising her she is eligible for Covered California.[376] If she appeals her Medi-Cal denial, her case will go to fair hearing before an Administrative Law Judge. Administrative Law Judges in the Affordable Care Act Bureau should review the eligibility determination as to both Medi-Cal and MCAP. On the other hand, the same form notice for women screened for MCAP eligibility contains a provision that explains how to proceed with a level one MCAP appeal. If the applicant decides to go that route, then she may end up going through the three levels of MCAP appeals.[377]

Caveat: While aspects of MCAP are in flux, the MCAP regulations on appeals[378] and MCAP's (DHCS) website may not provide the most complete or accurate guidance on MCAP eligibility appeals. Therefore applicants and advocates may want to contact MCAP directly at 1-800-433-2611 for the most current information on the processes.

C. Moving Between Programs

State law requires that both Covered California and the counties make an eligibility determination for all insurance affordability programs, such as Medi-Cal or APTCs in Covered California.[379] If eligibility of a recipient changes, then both agencies are required to facilitate a move between programs without a break in coverage.[380]

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376. See Gov't. Code § 100506.2(b) regarding the required combined eligibility notice that must be issued for all insurance affordability programs, including MCAP, if applicable.
377. 10 CCR § 2699.500(b)(1). Appeals regarding disenrollment of a subscriber or infant are likewise made to the Executive Director. *Id.*, subsec. (b)(2). Appellants and advocates can go to this link for the address of the Executive Director: http://mcap.dhcs.ca.gov/My_MCAP/Appeals.aspx. Alternatively, they may search for "MCAP eligibility appeals" on the Internet (as the link to the MCAP appeals information on the DHCS website may change.)
378. 10 CCR § 2699.500, *et seq.*
379. Welf. & Inst. Code § 15926(h)(1).
380. *Id.*

1. Covered California to Medi-Cal

A Covered California enrollee may experience a drop in income due to job loss or a change in household composition such as the birth of child that causes her to become eligible for Medi-Cal. Technically, a person in this position does not have to move into Medi-Cal, but if they stay in Covered California, they are no longer eligible for the premium tax credit that would make their health plan premium affordable.[381] Thus, to meet the general obligation to have health insurance (the individual mandate), they will most likely need to enroll in Medi-Cal.

Generally, Covered California becomes aware of changes that make a person eligible for Medi-Cal either from the person reporting the change or from the annual redetermination process. Both trigger Covered California's obligation to determine if an enrollee or qualified individual is still eligible for Covered California.[382]

If as a result of the eligibility review process Covered California determines that an enrollee is no longer eligible, Covered California must provide an enrollee at least 14 days' notice before the "effective date of termination."[383] If the enrollee appeals the termination, they have the right to remain covered and retain their benefits (premium tax credits and cost-sharing reductions) while the appeal is pending by requesting continued enrollment.[384] However if they are ultimately deemed ineligible for Covered California, they may owe back premium tax credits during the reconciliation process.

As part of the eligibility redetermination process, Covered California must assess the enrollee's potential eligibility for Medi-Cal.[385] If the enrollee is deemed potentially eligible for Medi-Cal, Covered California must send the case to the enrollee's county of residence for determination of eligibility for Medi-Cal.[386]

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381. See Chapter 4, Section C.2.b of this manual.
382. 45 C.F.R. § 155.330(e)(1)(i) and (e)(2)(i); 10 CCR § 6496(h)(1) and (i).
383. 45 C.F.R. § 155.430(d)(1)(i); 10 CCR § 6506(d)(1).
384. 45 C.F.R. § 155.525; Gov't. Code § 100506.5; 10 CCR § 6608.
385. Welf. & Inst. Code § 15926(h).
386. ACWDL 15-01 (Jan. 7, 2015), p. 2, http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/ACWDL2015/ACWDL15-01.pdf.

Covered California must send a notice to the enrollee explaining its finding of ineligibility for Covered California.[387] Once the county makes an eligibility determination, it must also send a notice of action finding eligibility.[388] Further, Covered California and the Department of Health Services are obligated to help the affected beneficiary make the transition without a gap in coverage and without requesting any information unnecessary to establishing eligibility for Medi-Cal.[389]

Consumers who face termination from Covered California and those acting on their behalf must consider all options, including ongoing Covered California eligibility and Medi-Cal eligibility, and the accompanying time requirements and continuing aid and appeal rights in order to avoid gaps in coverage.

Covered California enrollees who cannot keep making their premium payment and do not want to wait to be transferred to Medi-Cal also have the option of actively terminating their enrollment in the Covered California plan and applying for coverage through Medi-Cal. This strategy is not without its challenges as Covered California enrollees must generally provide at least 14 days notice to their plan that they want to terminate.[390] Then, they must make sure to have completed a Medi-Cal application in the same month to avoid a gap in coverage. While they would then be covered from their application date, it could take up to 45 days to process the application, so they may have difficulty accessing services. Additionally, from a practical standpoint, trying to submit an application for one program while there is still an active case on the other program can cause technical challenges that also lead to delays in accessing care. Consumer advocates continue to press for improvements to this transition process.

2. Medi-Cal to Covered California

If the income of a person on Medi-Cal increases or a change in tax household composition places them above the applicable Medi-Cal eligibility income threshold, they may still qualify for Medi-Cal with a Share of Cost and also be eligible to enroll in

387. 45 C.F.R. § 155.310(g); 10 CCR § 6476(h).
388. 22 CCR § 50179(a).
389. Welf. & Inst. Code § 15926(h)(1).
390. 10 CCR § 6506(d).

a health plan and receive financial assistance through Covered California.

Counties become aware of such changes in income or other changes that may make a beneficiary ineligible for Medi-Cal when the beneficiary reports the change to the county, as beneficiaries are obligated to report changes that affect eligibility, or because the county discovers the change during an eligibility review or redetermination.

If the county determines that a beneficiary is no longer eligible for Medi-Cal, the county must issue a Notice of Action to the beneficiary ten days prior to the date of termination.[391] The beneficiary has the right to appeal the termination, and, if they do so within ten days of the Notice of Action, they can continue to be on Medi-Cal pending the outcome of the appeal, thus avoiding a gap in coverage.[392] If the beneficiary does not receive a notice or receives a deficient notice (see Section B.1.a. above) the beneficiary should immediately request an appeal with aid paid pending in order to buy time to contest the termination or enroll in a Covered California plan.

Applicable state law requires an entity making the eligibility determination to ensure that an eligible applicant "that meets all program eligibility requirements and complies with all necessary requests for information moves between programs ***without any breaks in coverage*** and without being required to provide any forms, documents, or other information or undergo verification that is duplicative or otherwise unnecessary."[393] The loss of Medi-Cal eligibility based on being over-income would not result in a gap if the affected person is able to select a Covered California plan before Medi-Cal ends; however, the mere ten day window between receipt of the notice and termination makes this very challenging.[394] Thus, it is critical

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391. 42 C.F.R. § 431.213; 22 CCR §§ 50179(d). The requirements for termination notices are discussed in detail at Section B.1.a of this Chapter.
392. 42 C.F.R. §§ 431.230, 431. 231(c) & (d); 22 CCR § 51014.2(a). The right to "aid paid pending" during the Medi-Cal appeal process is discussed in Section B.1.d of this Chapter.
393. Welf. & Inst. Code § 15926(h)(1) (emphasis added).
394. Covered California special enrollment rules allow for coverage to start the next month when a plan is selected prior to the end of the previous coverage, in this case Medi-Cal. 10 CCR § 6504(h)(3)(A). To date, insufficient information is sent to terminated Medi-Cal beneficiaries to inform them how to enroll in an select a Covered California plan.

that counties, Covered California, and any advocate involved take every measure to ensure that the beneficiary being terminated from Medi-Cal is able to enroll in a plan without a gap in coverage.[395] Again, consumer advocates continue to press for improvements to this process.

395. As of the date of publication of this manual, the transition process between programs was not automated. Thus, if an individual is discontinued from Medi-Cal based on an inadequate or defective notice of action, the individual or her advocate should request aid paid pending during the process of finding and enrolling in a Covered California plan.