Comments to the Board - External

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November 19, 2015 Board Meeting

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Congress of the United States
Washington, DC 20515

October 22, 2015

Mr. Peter V. Lee
Executive Director
Covered California
1601 Exposition Boulevard
Sacramento, California 95815

Dear Mr. Lee:

We, Members of Congress in the California Delegation, write to express our concerns about the security of the Covered California website and request further information and action.

Medical identity theft is on the rise; in 2014 it increased 22% from the previous year.[1] To enroll beneficiaries, Covered California collects and stores Social Security numbers, personal addresses, income and employment records, and tax returns of over a million Californians. Clearly, Covered California has a responsibility to ensure it has implemented proper security controls and oversight protections to safeguard consumer information in accordance with federal requirements.

In our opinion, the report released in September 2015 by the Government Accountability Office (GAO) on Covered California's security liabilities indicates the mismanagement of the website by California's Health Benefit Exchange has created numerous security vulnerabilities.[2] This report echoes the security concerns outlined by a previous report released in April 2015 by the Department of Health and Human Services (HHS) Office of Inspector General.[3] These two reports combined with recent cyberattacks on the Office of Personnel Management, University of California Los Angeles, and numerous private sector health care companies highlight the need for better oversight and security policies for Covered California.

GAO reviewed the risk assessments, security plans, system control assessments, contingency plans, and remedial action plans of Covered California and found Covered California has implemented some information security and privacy controls, but weaknesses place California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) data at risk.

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[1] *Salon,* "Hackers see rewarding targets in health care companies," February 5, 2015.
[2] Government Accountability Office. (2015, September). Information Security: GAO Review of State-Based Marketplace Security and Privacy – California. gao.gov
[3] Health and Human Services Office of Inspector General. (2015, April). California Implemented Security Controls Over the Web Site and Databases for its Health Insurance Exchange but Could Improve Protection of Personally Identifiable Information. oig.hhs.gov

The weaknesses GAO found and our concerns include:

- Centers for Medicare and Medicaid Services provides guidance on security boundaries in Minimum Acceptable Risk Controls for Exchanges – Exchange Reference Architecture Supplement (MARS-E), which requires marketplaces to define a system security boundary and provide specific controls for data. Covered California's system security plan did not define an authorization boundary for CalHEERS.
- Covered California did not have policies in place for an ongoing privacy risk management process.
- Covered California's policies did not address or clarify how they train their staff about the sharing of personally identifiable information (PII) with third parties.
- Of the 2,212 users for whom Covered California provided training data, 307 had not completed part or all of their required training.
- Covered California did not define the incident response plan capabilities, organization and structure, or metrics for evaluating the incident response plan efficacy.
- Covered California did not encrypt connections to the authentication servers supporting CalHEERS.
- Covered California provided incomplete information on if and what type of background checks its staff and contractors received.
- Covered California did not use unique usernames and passwords to administer its network devices and firewalls.
- Employees without background checks had inappropriate levels of access to the marketplace system.

So Congress may better understand Covered California's actions related to the security of taxpayers' information, please provide the following information as soon as possible but no later than November 1, 2015:

1. Are there privacy guidelines, such as Fair Information Practices (GAO-08-536 p.9) or the Security and Privacy Controls for Federal Information Systems and Organizations (NIST SP 800-53 Rev. 4, Privacy appendix), that CoveredCA.com has in effect to protect sensitive personal information? To Covered California's knowledge, has there been an incident since October 1, 2013 when the website was not in full compliance with applicable guidelines?

2. To your knowledge, how many unauthorized attempts have occurred to access or compromise CoveredCA.com? Please provide detailed information about each incident including the date, the type of compromise, the information implicated, and any actions Covered California took to address or respond to the attempted attack.

3. How many times has PII processed by CoveredCA.com or CalHEERS been compromised? Please provide details about each incident including the date, what system weaknesses allowed the information to become compromised, and what actions Covered California took to address, and respond, and resolve the incident.

4. Since the GAO investigation concluded and their findings were shared directly with Covered California, what specific steps have been taken to ensure PII is now protected?

5. Since the HHS Inspector General's investigation concluded and their findings were shared directly with Covered California, what actions have been implemented to ensure PII is now protected?

6. To date, has Covered California addressed all security issues identified by security contractors? If not, please provide a detailed explanation of the failure to address these issues.

7. If Covered California did not concur with any of the findings and recommendations made by GAO or the HHS Inspector General, please provide a detailed explanation as to why.

We recognize the answers to some of these questions contain sensitive operational security information. It is our mission to protect the people of California and contain any sensitive information in Covered California's response that could reasonably be expected to cause an unforeseen harm to the U.S. Government.

We urge Covered California to execute GAO's management and technical security recommendations prior to the start of the next Open Enrollment Period, on November 15, 2015. Thank you for your attention to these security matters. We look forward to receiving your written response directly to each of our Washington, D.C. offices. If you have questions, please contact Yvette Wissmann in Congresswoman Mimi Walters' Office at yvette.wissmann@mail.house.gov or at (202) 225-5611.

Sincerely,

Mimi Walters
Member of Congress

Darrell Issa
Member of Congress

Congress of the United States
Washington, DC 20515

Ken Calvert
Member of Congress

Paul Cook
Member of Congress

Jeff Denahm
Member of Congress

Duncan Hunter
Member of Congress

Steve Knight
Member of Congress

Doug LaMalfa
Member of Congress

Tom McClintock
Member of Congress

Devin Nunes
Member of Congress

Dana Rohrabacher
Member of Congress

Ed Royce
Member of Congress

David G. Valadao
Member of Congress

COVERED CALIFORNIA

October 26, 2015

The Honorable Mimi Walters
236 Cannon House Office Building
Washington, DC 20515

The Honorable Darrell Issa
2269 Rayburn House Office Building
Washington, DC 20515

Dear Members of Congress,

Thank you for your recent letter regarding Covered California's privacy protection practices. Covered California maintains comprehensive internal processes that ensure the ongoing security of our consumer's personally identifiable information, and we welcome the opportunity to provide you an update.

Protecting data is our highest priority. From day one, Covered California has followed the rigorous guidelines outlined in federal and state security regulations designed to protect our consumers' private information. As a public entity tasked with stewarding public information, we have been subject to numerous routine audits and inquiries. We have cooperated in all instances and it is important to note that the findings generally recommended *stronger* measures (such as stronger encryption or stronger passwords), but did not expose a lack of controls.

The Government Accountability Office (GAO) letter from September 2015 that your letter refers to was a preliminary report sharing their interim findings. The findings, while they should be addressed, do not have any findings that private information has been compromised or that CoveredCA.com has not effectively managed this important area. We utilize multifaceted security protocols, and an individual would have to successfully evade several layers of security measures to even begin to have access to private information as they relate to the findings presented by the GAO. Also, as is our practice as a learning organization, any critical or high-risk security vulnerabilities that are identified during any audit or review are always rectified immediately without waiting for a final report.

Additionally, your letter cites recent data attacks on the Office of Personnel Management, UCLA and private health care companies. While any data breach is a serious concern, we must stress that Covered California adheres to rigorous federal standards that apply only to health benefit exchanges. It is inaccurate to claim that any security vulnerabilities found in other agencies,

albeit public agencies, would also necessarily apply to a health benefit exchange like Covered California.

Finally, we would note that the September 2015 GAO letter was designated for Limited Official Use Only, was not made public and contains confidential details of our internal security protocols. We understand that your letter acknowledges the sensitive nature of your inquiries. However, without more specifics on how any sensitive details would be kept secure and confidential we cannot comment on certain details without possibly compromising our systems. A more thorough discussion of security protocol would be more appropriate in a secure medium.

With that in mind, here is the information you have requested:

1. **Are there privacy guidelines, such as Fair Information Practices (GAO-08-536 p.9) or the Security and Privacy Controls for Federal Information Systems and Organizations (NIST SP 800-53 Rev. 4, Privacy appendix), that CoveredCA.com has in effect to protect sensitive personal information?**

Covered California, as a state-based exchange, is overseen by the Center for Medicare and Medicaid Services (CMS). In order to ensure that state exchanges are taking appropriate steps to ensure the security of sensitive personal information, CMS has issued minimum security standards known as MARS-E (Catalog of Acceptable Risk Controls for Exchanges—Exchange Reference Architecture Supplement) that all state exchanges must comply with.

MARS-E, in turn, incorporates the minimum standards laid out in a number of Federal guidelines for privacy protection such as FISMA (Federal Information Security Modernization Act of 2014), the Health Insurance Portability and Accountability Act of 1996 and The Privacy Act of 1974 and information security protocol laid out by the Internal Revenue Service (IRS).

Further, MARS-E aligns with National Institute of Standards and Technology's (NIST) Special Publication 800-53, which includes an appendix detailing privacy controls and correlating security controls that are to be used together to achieve comprehensive security and privacy protection. Since then, as noted in the question, Revision 4 has been released, and Covered California is finalizing necessary enhancements to ensure we meet or exceed the guidelines set forth in that latest revision.

2. **To Covered California's knowledge, has there been an incident since October 1, 2013 when the website was not in full compliance with applicable guidelines?**

No. Covered California is and has always been in compliance with applicable guidelines as outlined above.

3. **To your knowledge, how many unauthorized attempts have occurred to access or compromise CoveredCA.com? Please provide detailed information about each incident including the date, the type of compromise, the information implicated, and any actions Covered California took to address or respond to the attempted attack.**

CoveredCA.com is a large, highly-visible, public-facing website designed to allow consumers to easily navigate between and enroll in all of the affordable options provided by Covered California as well as qualify for Federal tax benefits. With this visibility, Covered California sees attempts every day to access the website without authorization. As your own letter notes, tax and healthcare information is a common target of attempted security breaches. Many of the attempts are innocent in nature, but many are not. There have been no successful breaches of the security on the CoveredCA.com website. We credit this to our successful implementation and monitoring per the guidelines set forth for the Exchanges under MARS-E.

We cannot prudently provide in this public letter any of the details of any attempts to compromise CoveredCA.com. To do so could alert bad actors as to our specific security measures and potentially introduce unnecessary vulnerability.

What we can share is the strength of our many systems that effectively block unauthorized access. The Covered California online enrollment system applies a depth-in-defense strategy to ensure that we protect California Personally Identifiable Information to its fullest potential. In other words, CoveredCA.com utilizes a multi-layer monitoring and response process that alerts the monitoring team to any unusual activity (such as denial of service attacks, unusual traffic patterns, etc.) and automatically blocks and quarantines this activity for additional analysis and response by the monitoring team. The monitoring team ensures that any attack has been fully contained within the existing defense systems. If at any time a threat is able to penetrate the outermost security layers, then that threat is evaluated by a post-incident response team and addressed immediately. If an attempted attack represents a risk, but potentially a lower risk (e.g. may not represent a risk of compromise to consumer data or system), it will be remediated based on a developed plan. It is important to note that a system could have a vulnerability that doesn't pose any risk to systems or data.

And where a *weakness* or opportunity to strengthen a particular security control is identified, Covered California has a very robust process to develop clear Plan of Action and Milestones (PoAM) to outline exactly what enhancements will be performed and on what timeline. Our PoAM tracks and prioritizes every step necessary to effectuate a security enhancement to ensure progress and accountability in our internal processes.

In addition, Covered California has a system in place for handling complaints, questions or concerns from consumers regarding security or fraud protection, and there are several options available for getting information or reporting security concerns.

4. **How many times has PII processed by CoveredCA.com or CalHEERS been compromised? Please provide details about each incident including the date, what system weaknesses allowed the information to become compromised, and what actions Covered California took to address, and respond, and resolve the incident.**

As stated above, the Personally-Identifiable Information our consumers are required to share with CoveredCA.com has never been compromised as a result of security vulnerabilities. There have been a handful of instances of human error and even application errors resulting in the potential compromise of some PII data. In those instances, procedures set forth by CMS were followed to specifications, including notice to consumers where needed and appropriate remediation was completed immediately. There has been no instances of fraudulent use of PII data or identity theft.

5. **Since the GAO investigation concluded and their findings were shared directly with Covered California, what specific steps have been taken to ensure PII is now protected?**

Covered California has always protected the PII of California's consumers. The security of this information is our first and foremost concern.

With regard to the September GAO letter, Covered California reviewed and concurred with seven of the eight recommended activities to strengthen the information security program, including 30 of the 33 activities to improve information security controls. We have continued to use our existing protocols to identify instances where our security systems could be strengthened.

Those recommended activities were then each placed in our PoAM, prioritized in order of urgency, and tracked through implementation. We cannot comment directly on the nature of each of those specific action items outside of a secure setting.

6. **Since the HHS Inspector General's investigation concluded and their findings were shared directly with Covered California, what actions have been implemented to ensure PII is now protected?**

Again, Covered California has always protected the PII of California's consumers and the security of this information is our first and foremost concern.

We would like to make sure to point out that the OIG report (report A-09-14-03005) specifies that there was no evidence that weaknesses had been exploited.

Scans to identify any new or emerging threats are now performed more frequently and in the event that any high or critical findings are detected, they will be immediately remediated. Covered California adheres to the Minimal Acceptable Risks and Standards for Exchanges (MARS-E) guidelines in order to ensure proper protection of all user accounts and PII. Although

MARS-E 2.0 is not final, Covered California is participating in the development and finalization of this standard and already working to make any necessary enhancements to facilitate compliance with this new standard.

7. To date, has Covered California addressed all security issues identified by security contractors? If not, please provide a detailed explanation of the failure to address these issues.

Covered California immediately addresses all security issues identified by our security contractors. There are no issues that we have left unaddressed. As noted earlier, any critical or high vulnerabilities that could be discovered are be addressed immediately. Other suggested enhancements to strengthen controls are documented through our PoAM process (outlined above) to ensure that all security updates are prioritized and implemented appropriately.

8. **If Covered California did not concur with any of the findings and recommendations made by GAO or the HHS Inspector General, please provide a detailed explanation as to why.**

With regards to the HHS OIG report, as noted in the report itself, Covered California concurred with all of the recommendations and we have immediately implemented them.

However, with regards to the September 2015 GAO letter, we will reiterate here that Covered California did not concur all of the findings or recommendations. As we discussed with the GAO in secure correspondence, of the 41 mitigation activities, we did not concur with one general policy recommendation and three technical security protocols.

The generalized agency policy that we did not concur with relates to the level of screening required of all employees with access to the marketplace system. MARS-E requires all employees are screened, which we do not disagree with. However, the GAO stated that individuals without background checks were in positions that allowed them access to the system, including those staff that were hired before background checks were required. We objected to that recommendation because we are limited by state law and union regulations on how we can ask existing employees to undergo a background check. However, we are working within legal and union regulations to ensure that everyone with access to our marketplace system has received a background check.

Covered California also objected to three technical security recommendations. We do not comment publicly on these processes as a matter of IT security standards.

Thank you again for your interest in Covered California. We appreciate your support and oversight as we work together toward providing high-quality, affordable health care options to all of your constituents.

Sincerely,

Peter V. Lee
Executive Director

cc: The Covered California Board
The Honorable Ken Calvert
The Honorable Paul Cook
The Honorable Jeff Denham
The Honorable Duncan Hunter
The Honorable Steve Knight
The Honorable Doug LaMalfa
The Honorable Tom McClintock
The Honorable Devin Nunes
The Honorable Dana Rohrabacher
The Honorable Ed Royce
The Honorable David G. Valadao

November 17, 2015

Diana Dooley, Chair
Covered California Board

Peter Lee, Director
Covered California
1601 Exposition Way
Sacramento, CA, 95815
VIA Electronic Submission

Re: **Prioritizing Health Disparities Reduction in Covered California Qualified Health Plan Contracting**

Dear Ms. Dooley and Mr. Lee,

The undersigned organizations write in support of requiring concrete reductions in health disparities for specified disease conditions as key elements of the exchange's 2017 contract with Qualified Health Plans (QHPs).

An important component of Covered California's mission is to "reduce health disparities." Covered California's membership is 60% communities of color and close to three-quarters of members are low-income (earning less than 250% FPL),

many of whom face disproportionate rates of chronic diseases. The 2017 QHP contract is an important opportunity for Covered California to go beyond asking for data and act “as a catalyst for change in California’s health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.” (Director Peter Lee, March 2015)

Specifically, we urge Covered California to require QHPs to meet year-over-year reductions in the control and management of specified chronic conditions prevalent in communities of color, including diabetes, hypertension and asthma. For future years, we urge the exchange to require QHPs to meet specified benchmarks consistent with the Let’s Get Healthy California taskforce targets, the California Wellness Plan developed by the California Department of Public Health, and subsequent efforts to improve public health. As with all quality improvement efforts, Covered California should make critical data available including information on disparities by condition and progress on disparities reduction by race, ethnicity and condition. In addition, information regarding the Quality Improvement Strategies (QIS) that QHPs implement similar to reporting in Medi-Cal should also be made publically available.

Once again, California has an opportunity to lead the nation in health reform and systems transformation, this time by ensuring that health equity is not only important, but also central to California's quality improvement strategy. We believe including the aforementioned provisions in the 2017 QHP contract will enhance the Exchange’s ability to achieve its mission of reducing health disparities in our state. We strongly urge the Board to take action now to ensure the 2017 QHP contract requirements provide this meaningful step towards reducing persistent health disparities.

Sincerely,

Doreena Wong, Project Director
Asian Americans Advancing Justice-Los Angeles

Caroline Sanders, Director Policy Analysis
California Pan-Ethnic Health Network

Sonya Vasquez, MSW, Policy Director
Community Health Councils

Betsy Imholz, Special Projects Director
Consumers Union

Anthony Wright, Executive Director
Health Access

Cori Racela, Staff Attorney
National Health Law Program

Michelle Cabrera, Healthcare and Research Director
SEIU California

Maria Lemus, Executive Director
Visión y Compromiso

Elizabeth Landsberg, Director of Legislative Advocacy
Western Center on Law & Poverty

Cc: Covered California Board members

CPEHN
California Pan-Ethnic Health Network

November 13, 2015

Diana Dooley, Chair
Covered California Board

Peter Lee, Director
Covered California
1601 Exposition Way
Sacramento, CA, 95815
Via Electronic Submission

Re: Prioritizing Health Disparities Reduction in Covered California Qualified Health Plan Contracting

Dear Ms. Dooley and Mr. Lee,

The California Pan-Ethnic Health Network (CPEHN) writes in support of including concrete requirements in the reduction of health disparities for specified disease conditions as key elements of Covered California's 2017 contract with Qualified Health Plans (QHPs).

The mission of Covered California is "to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities." Covered California's membership is 60% communities of color, many of whom experience disproportionate rates of chronic diseases. The 2017 QHP contract is an important opportunity for Covered California to go beyond asking for data and act "as a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities." (Director Peter Lee, March 2015)[1]

Specifically, CPEHN supports requiring QHPs to meet year over year reductions in control and management of specified chronic conditions including diabetes, hypertension and asthma. We understand that quality improvement strategies for plans may result in additional efforts on other conditions and we welcome those efforts. However we recommend a focus in 2017 on these fundamental chronic conditions based on our decades of work in the area of health disparities reduction.

For future years, we ask Covered California to add tobacco cessation, obesity, and mental health as additional targets for disparities reduction. Mental health, obesity

[1] Peter Lee, Executive Director's Report, March 2015: http://board.coveredca.com/meetings/2015/3-15/PPT%20-%20Executive%20Director's%20Report_March%205,%202015.pdf

and tobacco use are co-morbid with diabetes, hypertension and asthma. Thus targeting these areas for health disparities reduction will build on the efforts to reduce disparities in control of diabetes, hypertension and asthma.

Additionally, in future years we also ask that Covered California require contracting health plans to meet specified benchmarks consistent with the Let's Get Healthy California taskforce targets, the California Wellness Plan developed by the California Department of Public Health, and subsequent efforts to improve public health.

As with all quality initiatives, Covered California should make public, information on disparities by condition, progress on disparities reduction by race/ethnicity by condition as well as information regarding the Quality Improvement Strategies (QIS) that QHPs implement. As a model, California's Medi-Cal program already makes this type of quality information publically available on its website.

Conclusion
As a leading exchange in the nation, Covered California should move forward in reducing the health disparities of its members by directing its QHPs to meet concrete disparities reduction goals in specific target areas starting in 2017 and publicly reporting on the results of those efforts. Once again, California has the opportunity to lead the nation by ensuring that health equity is not only important but central to your quality improvement strategy and to the exchange's ability to achieve its mission of reducing health disparities in our state.

We strongly urge you to take action now to ensure the 2017 QHP contract requirements provide an important and meaningful step towards reducing persistent health disparities. Please contact myself or Cary Sanders, Director of Policy Analysis, if you have any further questions at (510) 832-1160.

Sincerely,

Sarah de Guia, JD
Executive Director/CPEHN

Cc: Members, Covered California Board

Background:
We focus in this letter on disparities related to race and ethnicity because this data should be available to the health plans. Medi-Cal managed care has required the collection of data on race and ethnicity for the last twenty years. Similarly commercial plans have been required by California law to collect data on race and ethnicity since 2003. We strongly support reducing other health disparities, including those associated with the LGBTQ community. However, we recognize that due to impediments at the federal level, Covered California and its QHPs currently lack data on sexual orientation and gender identity. We are disappointed by this fact but recognize that the lack of such information impedes the reduction in disparities that should occur for the LGBTQ communities.

We identify four potential areas for quality improvement strategies that will advance health equity in Covered California contracts: diabetes, hypertension, asthma and mental health. In addition, since obesity and tobacco use are co-morbid with each of these, we suggest targeting obesity and tobacco use. In each of these areas, we ask that for the 2017 contract, health plans use 2016 data and be required to demonstrate improvement in managing these conditions and eliminating disparities year over year starting with the 2017 contract year. We also provide specific recommendations for steps Covered California can take to ensure that diverse patient/consumer experiences are adequately reflected in quality improvement and health disparities reduction strategies below:

Chronic Conditions in California:
Chronic conditions are the leading cause of death in the United States and the biggest contributor to health care costs. Sociodemographic factors such as income, race, ethnicity and geographic location can impact the prevalence of these types of conditions. According to the California Health Care Foundation (CHCF), about 40% of adults in California — over 11 million people — reported having one or more chronic condition, and about 3 million adults reported having two or more.[2] Adults on public insurance plans were more likely to have one or more chronic conditions compared to those on private plans or the uninsured.

Covered California's membership shares some similarities with the Medi-Cal program. Beneficiaries are diverse, 60% are communities of color and close to three-quarters (70%) are low-income (earning less than 250% FPL). About 95% of the Covered California enrollment has been adults, ages 19-64. Because of the evolving program standards for pregnant women which now allow pregnant women up to 321%FPL to be enrolled in Medi-Cal with zero premiums and zero cost sharing, we anticipate that few pregnant women will be enrolled in Covered California during the course of their pregnancy. Because the enrollees of Covered California are predominantly low and moderate income, non-pregnant adults from communities of color, we strongly suggest that there be a focus on improving the overall quality of care in areas with clear evidence of health disparities, diabetes, hypertension, asthma and mental health, along with reducing obesity and tobacco use. Focusing on these target areas will assist Covered California in making progress toward meeting the quadruple aim of reducing cost, improving quality and population health while

[2] "Californians with the Top Chronic Conditions: 11 Million and Counting," California Health Care Almanac 2015. California Health Care Foundation, April 2015.

reducing health care disparities.

The Medi-Cal program in its Managed Care Quality Strategy, revised October 2015, is specifically targeting control of hypertension, diabetes care and tobacco cessation for its adult population, which given Covered California's primary enrollees, low-moderate income adults, many of whom are from communities of color, we highlight to hopefully bring some alignment in health disparities reduction strategies across the state.

Diabetes/Hypertension

Over 2.3 million California adults report having been diagnosed with diabetes, representing one out of every 12 adult Californians, or about 8.3%, a significantly higher proportion than reported by most QHPs.[3] Prevalence is even higher among racial and ethnic groups, Californians with low educational attainment, and poor families, the majority of Covered California's membership. Latinos and African Americans have twice the prevalence of type 2 diabetes and are twice as likely to die from the disease.[4]

Diabetes is the seventh leading cause of death in California and the underlying cause of death in almost 8,000 people each year. As diabetes is a contributing factor to many deaths from heart disease and stroke, diabetes may be under-represented as a contributing cause of death. The Centers for Disease Control (CDC) estimates as many as 37% of adults in the U.S. have prediabetes and are at risk for developing diabetes. Most are unaware they have the condition.[5]

The cost of diabetes care, if left untreated, is high. Spending associated with adults in Medi-Cal treated for diabetes totaled $3.6 billion or roughly 14% of total spending on non-dual eligibles.[6] The most costly 1% of the diabetes population, just 1,006 individuals, generated roughly 13% of total spending or $248 million. Improving diabetes prevention and symptom management will help to allay treatment costs.

Obesity and smoking are strong risk factors for type 2 diabetes. Obese adults have a four times higher risk of type 2 diabetes compared to normal weight adults in California. Adults with type 2 diabetes are also more likely to have other health problems, including cardiovascular disease and arthritis. One of every two adults with type 2 diabetes also has hypertension.[7]

Recommended Measures for Quality Improvement Strategies for Diabetes, Hypertension, Tobacco Cessation and Obesity:

Measures on diabetes control, tobacco cessation, controlling high blood pressure and measuring obesity are currently in use by the Centers for Medicare and Medicaid Services (CMS) and the

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[3] "Burden of Diabetes in California," California Department of Public Health Chronic Disease Control Branch, September 2014

[4] Ibid

[5] Ibid

[6] "Understanding Medi-Cal's High-Cost Populations," Department of Health Care Services, Research and Analytic Studies Division (RASD), June 2015.

[7] "Californians with the Top Chronic Conditions: 11 Million and Counting," California Health Care Almanac 2015. California Health Care Foundation, April 2015.

National Committee for Quality Assurance (NCQA) as part of the Quality Rating System (QRS) for Marketplaces and the Core Set of Adult Health Care Quality Measures for Medicaid.

Focus Area for Improvement	Recommended Quality Measures	2016 QRS Measure	Adult Core Set Medicaid
Diabetes	Comprehensive/Optimal Diabetes Care: o Hemoglobin A1c Poor Control o Hemoglobin A1c testing o Eye exam o Medical attention for nephropathy	✓	✓
	Medical Assistance with Smoking and Tobacco Use Cessation	✓	✓
	Aspirin Use and Discussion	✓	✓
	Controlling High Blood Pressure	✓	✓
	Adult BMI Assessment	✓	

In every instance, Covered California should already have access to stratified data on these measures in 2016, making it easier to hold plans accountable for meeting the rudimentary standard of year over year improvement in diabetes control, tobacco cessation, hypertension control, and obesity. For each of these measures, plans should be expected to show reductions, stratified by race and ethnicity for the 2017 plan year.

Asthma

Asthma is a significant public health problem. In California, roughly 1 in 7 people (close to 5 million) has been diagnosed with asthma.[8] Across all measures of asthma burden, there are large disparities by race and ethnicity, income, age, sex, to name just a few. The prevalence of current asthma among American Indians and Alaska Natives is three times greater than the state average. African-Americans have exceptionally higher rates of asthma prevalence (40%), four times higher asthma ED visit and hospitalization rates, and two times higher asthma death rates than Whites.[9]

Low-income populations have higher asthma severity, poorer asthma control, and higher rates of asthma emergency department visits and hospitalizations.[10] Recent Covered California enrollees, particularly those below 250%FPL, are more likely to have asthma that has not been well managed or well controlled. Progress in control of adult asthma is important in reducing mortality, morbidity, lost work days and co-morbidities such as stress on the cardiac system.

[8] California Health Interview Survey data. 2011. UCLA Center for Health Policy Research. http://ask.chis.ucla.edu/main/default.asp. Accessed August 11, 2015.
[9] Asthma in California: A Surveillance Report, May 2013. California Department of Public Health: https://www.cdph.ca.gov/programs/ohsep/Documents/Asthma_in_California2013.pdf
[10] Milet M, Lutzker L, Flattery J. Asthma in California: A Surveillance Report. Richmond, CA: California Department of Public Health, Environmental Health Investigations Branch, May 2013.

Asthma management can achieve year over year improvements. There are well demonstrated efforts for pediatric asthma patients in reducing emergency room visits and achieving better control of their asthma. Conversely, the cost of not treating asthma is high. Adults with asthma had higher emergency department visit rates than the overall California adult population (34% vs. 19%). Among adults with asthma, one-third of emergency department visits in the past year were asthma-related. Some of these visits might have been prevented through appropriate and accessible primary care, regular medications, and good asthma management.

CMS is recommending the use of an additional measure: Medication Management for People with Asthma as part of the 2016 QRS survey which Covered California should adopt for 2016. Neither the 2016 QRS nor the Medicaid Adult Core Set includes a comprehensive/optimal measure set for asthma. However some states, most notably Minnesota has adopted a measure: Optimal Asthma Care, as part of their quality measurement and related reporting of payment approaches of the state's Medicaid Accountable Care Organizations. The National Quality Forum (NQF) endorsed measure is an all-or-none, Composite ("optimal" care) measure of the percentage of pediatric and adult patients who have asthma and meet specified targets to control their asthma. Since this is not currently part of CMS' 2016 QRS, this would be an additional asthma measure we would encourage Covered California to consider adopting.

In addition, being obese and smoking are major risk factors for asthma. Among California adults with asthma, 16%, or an estimated 340,000 people, reported being current smokers. A larger percentage of adults with asthma were obese (33%) compared to the general adult population (25%). Measures on obesity (Adult BMI Assessment) and smoking (Medical Assistance with Smoking and Tobacco Use Cessation) as referenced above, are currently in use by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) as part of the Quality Rating System (QRS) for Marketplaces and Core Set of Adult Health Care Quality Measures for Medicaid.

Covered California should ask CMS to align its asthma measures with those in the Medicaid adult core set. Specifically, the QRS measures should include admission rates for older adults with asthma and asthma in younger adults' admission rates. Adoption of these measures would help to better align quality strategies between the two programs, Medi-Cal and Covered California.

Focus Area	**Specific Quality Measures**	**2016 QRS Measure**	**Adult Core Set Medicaid**
Asthma	Medication Management for People with Asthma	✓	
	NQF #1876 Optimal Asthma Care*		
	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rates (age 40 and up)		✓
	Asthma in Younger Adults Admission Rate		✓

*This composite measure reflects the percentage of adults and children who have optimally managed asthma with all of following components met: a) Asthma is well-controlled; b) Patient is not at increased risk of exacerbations; and c) Patient has been educated and has a current, written asthma action/management plan.[11]

Recommended Measures for Quality Improvement Strategies
While Covered California will have only one asthma measure in place in 2016, medication management for people with asthma, showing year over year improvement in medication management for people with asthma as well as reduction in disparities associated with race and ethnicity would be progress in meeting the quadruple aim. For future years, we would hope that Covered California would set asthma management targets comparable to what have been achieved in other efforts in California.

Mental Health
According to the California Health Care Foundation (CHCF), 2.2 million Californians are experiencing severe psychological distress. Notable disparities exist in mental health by income, race and ethnicity. For example, serious psychological distress was more than two times greater among lowest income adults overall (138% FPL and lower) than those in the highest income group (400+% FPL). Additionally approximately 1 in 10 American Indians and Alaskan Natives, African Americans, and Latinos experienced serious psychological distress in the past year. The prevalence of serious psychological distress was more than twice as high among those with Medi-Cal or other public insurance (14%) and nearly 1.5 times greater among the uninsured (9%) than among those with private insurance.

Mental health is frequently co-morbid with other chronic conditions. The 2007 California Health Interview Survey (CHIS) found that adults with mental health needs were 1.5 times more likely to have high blood pressure, heart disease, or asthma – or to have two or more of these select chronic conditions – compared to other adults.[12] Without appropriate preventive measures, these patients are often the most costly to treat. In California's Medi-Cal program individuals treated for diabetes and serious mental illness or alcohol and drug dependency produced an acute care hospital inpatient rate of 795, a rate that was nearly 3 times greater than those treated for diabetes only.

Excessive alcohol consumption and smoking have been identified as risk factors associated with serious psychological distress among adults. Among Californians who reported serious psychological distress in the past year, the prevalence of binge drinking and current smoking was higher than the state average.[13]

Measures on the initiation and engagement of alcohol and other drug dependent treatment are currently in use by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA) as part of the 2016 QRS and the Core Set of Adult Health Care Quality Measures for Medicaid. Additionally, CMS' 2016 QRS will include a measure

[11] "Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs," Center for Health Care Strategies, Inc. Technical Assistance Tool, September 2014.
[12] California Health Interview Survey, 2007
[13] "Californians with the Top Chronic Conditions: 11 Million and Counting," California Health Care Almanac 2015. California Health Care Foundation, April 2015.

on follow-up after hospitalization for mental illness. Medicaid currently measures screening for clinical depression and follow-up plan.

Focus Area	Specific Quality Measures	2016 QRS Measure	Adult Core Set Medicaid
Mental Health	Screening for Clinical Depression and Follow-Up Plan		✓
	Follow-Up After Hospitalization for Mental Illness	✓	
	Initiation and Engagement of Alcohol and Other Drug Dependent Treatment	✓	✓

Recommended Measures for Quality Improvement Strategies:
Covered California should have access to stratified data on two out of three measures in place in 2016, Follow-up After Hospitalization for Mental Illness and Initiation and Engagement of Alcohol and Other Drug Dependent Treatment. For future years, we would hope that Covered California would ask for access to data on the third measure, Screening for Clinical Depression and Follow-Up Plan to ensure consistency between programs. Covered California should require it's contracting QHPs to show year over year improvement from 2016 to the 2017 plan year. For future years, it should hold plans accountable for meeting specified benchmarks to be developed during 2016.

Patient Experience of Care
Standardized consumer surveys like the Consumer Assessment of Health Plan (CAHPS) survey is another important tool to measure the progress of QHPs towards reaching concrete disparities reduction goals. Thus we were keenly disappointed to learn of the impact of small sample size requirements on the validity of data gleaned from this year's CAHPS surveys. With an ambitious disparities reduction strategy, Covered California cannot wait till 2017 for consumer information that more accurately reflects the unique experiences of the exchange's diverse enrollees.

We strongly support Covered California's request that CMS require plans to survey larger sample sizes and allow for big states like California to move towards regional surveys in 2016 and beyond. Additionally, although CAHPS can be a useful tool for measuring overall quality of care, the sample size for consumer surveys as saw this year, is often too small to support generalizations about the experiences of people from smaller ethnic, racial, and language subgroups within each individual plan. Below are some recommendations for steps Covered California can take to overcome some sample size challenges so 2016 data can be used effectively to reduce disparities for the exchange's diverse enrollees. Specifically Covered California should:

- Pool survey data by demographics across plans to have an understanding of the diverse experience of Covered California enrollees.
- Work with plans to boost response rates to surveys, especially among limited English proficient communities, This could include providing technical assistance and resources such as marketing dollars to educate consumers about the importance of CAHPS surveys

and incentivizing QHPs to use translated, validated CAHPS surveys in other languages besides English, Spanish and Chinese.

- Develop alternative methods for capturing experiences of diverse enrollees by conducting supplemental surveys or focus groups.

HCA
Health Consumer Alliance

1764 San Diego Avenue, Suite 200 San Diego, CA 92110
Phone 619-471-2637 Statewide Toll Free 888-804-3536 HealthConsumer.org

November 16, 2015

Jennifer Kent
Department of Health Care Services
Via email to Jennifer.Kent@dhcs.ca.gov

Diana Dooley, Chair
Paul Fearer,
Genoveva Islas,
Marty Morganstern,
Art Torres,
Covered California Board
Via email to boardcomments@covered.ca.gov

Dear Ms. Kent and Covered California Board,

We write to you as members of the Health Consumer Alliance to elevate the issue of the inability of consumers who lose their Medi-Cal to enroll in Covered California without a gap in coverage. The Health Consumer Alliance (HCA) is a partnership of community-based legal services organizations serving low-income health consumers in all 58 counties. We help consumers navigate barriers to enrollment and access to services and meet regularly with DHCS and Covered California staff to ensure that consumers are able to access and maintain health coverage.

The failure of the Department of Health Care Services (DHCS), Covered California, and county social services offices to work together to assist consumers during this vulnerable transition time is contrary to law and the spirit of health care reform.

In 2011, AB1296 was signed into law implementing the key framework for coordination between Covered California and Medi-Cal to ensure that consumers faced no wrong door in accessing health coverage. Essential to this framework is the means to move between programs as life circumstances change without losing coverage or access to healthcare. As such, the law specified,

> "***During the processing of*** an application, renewal, or ***a transition due to a change in circumstances, an entity making eligibility determinations*** for an insurance affordability program ***shall ensure that an eligible applicant and recipient*** of insurance affordability programs 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. . . ."
>
> Welfare & Institutions Code § 15926(h) (Emphasis added).

There has been no process for ensuring continued coverage for Medi-Cal recipients who become eligible for Covered California since the implementation of health reform in 2014. Advocates have had several meetings with DHCS and Covered California staff to try to work together to create such a process since late 2014 including "deep dive" meetings in March and April of this year, an ongoing workgroup on notices, and a newly started transitions workgroup this month. Advocates also forwarded consumer case examples and faulty notices to both agencies early this past spring and made recommendations on several occasions to current DHCS policy guidance ACWDL 15-33 that were not incorporated. Several consumer advocates continue to participate, in good faith, in AB 1296 transitions and notices workgroups to try to again resolve these issues. Despite these efforts, we feel it imperative to call to your attention the serious, ongoing problems with these transitions. We alerted the current workgroups that we would be outlining our concerns in a letter.

In the meantime, Medi-Cal recipients continue to lose access to health care services with no assistance in enrolling in a Covered California plan. Even worse, the only information such recipients are sent indicates they have 60 days to choose a Covered California plan without informing them that failure to pick a plan before their Medi-Cal coverage ends will result in a gap in coverage. DHCS staff and county eligibility workers continue to wrongly state that it is not possible for a person losing Medi-Cal to enroll in a Covered California health plan without a gap in coverage due to a misunderstanding of the Covered California special enrollment rules and consequently do not even attempt to help consumers bridge the gap.[1] Some Covered California call center representatives fail to understand that individuals losing Medi-Cal coverage are entitled to enroll in a Covered California health plan without a gap in coverage and fail to advise consumers that if they pick a plan by the end of the month it will be effective the first of the next month.

One of our Los Angeles consumers started working in September and reported his new income. As a result, his Medi-Cal was terminated October 1. Because he was not informed about the possibility of having immediate coverage if he selected a Covered California plan before his Medi-Cal ended, he did not call Covered California until October to enroll in a plan and was told his new plan would not be effective until December 1. It was not until he was nearly out of his medication to control his diabetes that he found Neighborhood Legal Services of Los Angeles County to assist in his case. This consumer never received information from either Medi-Cal or Covered California on how to enroll without a gap in coverage.

Similarly, we've seen other cases where consumers are wrongly referred to Medi-Cal, and when found to be income ineligible, are simply denied, rather than referred back to Covered California and assisted with plan enrollment. Finally, when there is a gap in coverage and consumers do not find legal

[1] The Covered California special enrollment regulations allow coverage "on the first day of the month following the loss of coverage if the plan selection is made on or before the date of the loss of coverage." 10 CCR 6504(h)(3), referencing 10 CCR 6504(a)(1)(A), referencing 10 CCR 6504(b)(1)(B). Thus, a Medi-Cal beneficiary need only choose a Covered California plan prior to the loss of Medi-Cal to avoid a gap in coverage. The governing federal regulations provides "In a case where a consumer loses coverage . . . if the plan selection is made before or on the day of the loss of coverage, *the Exchange must ensure that the coverage effective date is on the first day of the month following the loss of coverage*." 45 CFR 155.420(b)(2)(iv).

assistance to help them rectify the situation or are unable to pay many months premiums in arrears, consumers can face tax penalties. For example, a young mother enrolled in a limited Medi-Cal program rather than Covered California in January 2014. After over a year of attempting to resolve her health coverage situation on her own, she found an advocate who assisted her with enrolling into a Covered California plan in July 2015 but now faces potential tax penalties for the period of time she did not have minimum essential coverage.

Such loss of coverage violates the letter and intent of AB1296 and California's longstanding due process principles that require that consumers be sufficiently informed so that they can take appropriate actions when fundamental interests are at stake. Perpetuating the coverage gap further violates the requirement that DHCS and the county social services agencies must "endeavor at all times to perform [their] duties in such manner as to secure for every person the amount of aid to which he is entitled." Welfare & Institutions Code § 10500. The statute delineating additional duties of the Covered California Board requires that it coordinate with other state and local agencies administering health care programs "to ensure consistent eligibility and enrollment processes and *seamless transitions* between coverage." Government Code § 100503(a).

Swift action is required by both DHCS and Covered California to ensure that no more Medi-Cal recipients wrongly lose coverage or receive incorrect, incomplete or confusing information; and are able to move from Medi-Cal to Covered California without assistance. Specifically, we ask that the following steps be taken:

1. DHCS must issue guidance to the counties instructing counties on how to process renewals and changes in circumstances so that when a Medi-Cal recipient reports a change in income or household size that makes the recipient ineligible for Medi-Cal and thus eligible for Covered California, the recipient is seamlessly transferred to Covered California without a break in coverage.
2. The recipient must be given sufficient time and information to choose a Covered California health plan – a termination notice with only 10 days warning is not adequate. Such guidance must clearly delineate the responsibilities of county eligibility workers in assisting consumers in choosing Covered California health plans and include clear instructions on how to resolve technical issues like removing cases from the pending status known as "soft pause."
3. DHCS must revise the Medi-Cal notice of discontinuance attached to its guidance ACDWL 15-33 so that it meets due process standards. Specifically, it must be revised to include a specific finding of facts for the determination, as required by law. The position that DHCS has taken on this matter, that they are unable to effectuate a legally adequate notice until February 2016 at the earliest, is wholly unacceptable. The notice must also inform recipients of the actions they must take to effectuate coverage in a Covered California health plan and the fact that both county and Covered CA staff are available to assist them in making a transition without a break in coverage by choosing a plan before the end of the month.
4. Covered California must revise the notice that a consumer gets when moving from Medi-Cal to Covered California so that it does not tell a Medi-Cal recipient who reported a change in income to Medi-Cal "thank you applying for health insurance through Covered California." As Medi-Cal

recipients have generally not even contacted Covered California when they receive this notice, this is very confusing information. Further, the notice should be changed so as not to wrongly imply that consumers can wait 60 days to get into a Covered California health plan; on the contrary, consumers must be warned about the consequences of waiting to enroll.

5. Covered California must issue guidance to call center workers regarding the policy and internal procedures for effectuating seamless transitions between Medi-Cal and Covered California. Covered California must also assign individuals responsible for assisting consumers who are losing their Medi-Cal who need assistance to ensure that their Covered California health plan is in place as soon as their Medi-Cal coverage ends.
6. DHCS and Covered California must ensure that there are sufficient methods of flagging recipients losing Medi-Cal for increases in income or decreases in household size so that they can be identified by Covered California staff as consumers who need special assistance. While these consumers have already been determined eligible for Covered California many of them have had no contact with Covered California and are not familiar with plan selection and payment procedures or the Covered California online system.

We have already met with your staff on numerous occasions on these issues with little tangible progress. While we believe the response of DHCS and Covered CA has been well-intentioned, it has thus far been inadequate to address the reality of how the process is currently failing consumers who are struggling to maintain health insurance coverage in a post-ACA environment. At this point we would like to see the guidance, procedures, and notices described above and stand ready as always to advise and assist in this effort.

Please contact Jen Flory at (916) 282-5141 or jflory@wclp.org or Cori Racela at (310) 736-1646 or racela@healthlaw.org to discuss these comments.

Sincerely,

The Health Consumer Alliance

Covered California
PO Box 989725
West Sacramento, CA 95798-9725

COVERED CALIFORNIA

Your destination for affordable healthcare, including Medi-Cal

[redacted]
San Francisco, CA 94109

Important news about your health benefits

03/31/2015 Case Number [redacted]

Dear [redacted]

Thank you for applying for health insurance through Covered California for you and your household members. We used the information you gave us and state and federal data to make this decision:

[redacted]

Based on the change you reported:

You qualify to sign up for a health insurance plan through Covered California. You have 60 days from **April 30, 2015** to pick your health plan. Your special enrollment period ends **June 29, 2015.** You also qualify for up to **$786** per month in premium assistance to help pay for your health insurance coverage. If you choose a silver plan, you will get lower out-of- pocket expenses, such as lower copays and deductibles.

About financial help

There are two types of financial help you may qualify for. Help with paying your monthly premiums is called premium assistance. Help you get when you use your coverage is called silver cost sharing reductions.

Premium Assistance

Premium assistance is a federal tax credit that helps make health insurance more affordable. The amount of premium assistance you can get depends on your household size, family income and where you live. There are three ways you can use your premium assistance:

- Apply **all** of your tax credits in advance to lower the amount you pay each month,
- Take **some** of the tax credits each month and get the rest at the end of the year, or
- **Wait** until the end of the year to get the credit as a payment to you after you file taxes.

If you take some or all in advance (before you file taxes), the tax credit is paid directly to your health insurance plan.

p/s. pay attention to p.2 of this NOA 1

Changing your premium assistance
You can change the way you get premium assistance you take any time. To take less premium assistance, please call your Covered California Certified Enrollment Counselor or Certified Agent or the Covered California Service Center.

Silver cost sharing reductions
You may also qualify for silver cost sharing reductions. This means, based on your household income, when you choose a silver plan, you will have lower out-of-pocket costs. Out-of-pocket costs include co-pays, co-insurance and deductibles. If your income qualifies, you can get the benefits of a gold or platinum plan for the price of a silver plan. With silver cost sharing reductions, on average, the plan pays 94%, 87% or 73% for covered benefits and you pay for the rest. For example with a silver 94 plan, there is no deductible and primary care visit co-pays are only $3.

We have evaluated you for Medi-Cal. You do not qualify for Medi-Cal health coverage because your income is above the Medi-Cal limit.

If you think we made a mistake, you have the right to appeal the eligibility decision for Premium Assistance, enhanced silver benefits and/or purchasing a health insurance plan. Read **"If you think we made a mistake"** below.

About Special Enrollment Periods

Now that open enrollment is closed, you can only enroll in a Covered California health insurance plan if you experience a "qualifying life event". You have 60 days from the date on which the qualifying life event happens to enroll in a Covered California health insurance plan or change your existing Covered California plan. If 60 days pass and you do not sign up for health coverage, you will have to wait until the next open-enrollment period, which will be in the fall.

Keep in mind that you can enroll in Medi-Cal or AIM (Access for Infants and Mothers) at any time. You do not need a special enrollment period to enroll in Medi-Cal.

What's a qualifying life event?

A qualifying life event is a change in your life that can make you eligible for a Special Enrollment Period. Some examples of qualifying life events are:

- Lost or will soon lose my health insurance
- Permanently moved to/within California
- Had a baby or adopted a child
- Got married or entered into domestic partnership
- Returned from active duty military service
- Gained citizenship/lawful presence
- Released from jail or prison
- Other qualifying life event (determined on a case by case basis)

Members of federally recognized tribes and Alaska Native shareholders can sign up for health insurance any time of year. There is no limited enrollment period for these groups, and they can change plans as often as once a month.

If you have questions about Special Enrollment Periods or qualifying life events a Service Center Representative can help you. Call the Service Center at 1-800-300-1506.

What to do next

If this letter says that you or someone in your household qualifies for coverage through Covered California, you must pick a health plan before your special enrollment period ends. Your special enrollment period ends on **June 29, 2015**. Your coverage will start after you pick a plan and pay your first premium (monthly cost) directly to the health plan you chose. If you have not already picked the health plan that best fits your needs, please log into your account at **www.CoveredCA.com**. Then click the "Choose Health Plan" button located at the bottom of the Eligibility results screen. You can also call the service center for help choosing a health plan.

If you do not pick a plan by **June 29, 2015** and pay your first payment by the due date provided by your health plan, your special enrollment period will have expired. If your special enrollment period expires, you may have to wait until the next open enrollment period.

You may also re-apply if you have a qualifying life event. A service center representative can help you if you are not sure whether a situation is as a qualifying life event.

Note: If this letter says you or someone in your household was advised that they may be eligible for Medi-Cal, then those household members do not need to pick a plan now. Please wait to hear from your County worker.

If you have changes

You must tell Covered California within **30** days of any changes that may affect whether you qualify for health insurance, or to get premium assistance to help with paying for your health insurance. You should report changes such as;

- If you add a new member to your household
- If you lose a member of your household
- If your income increases or decreases
- If your citizenship status changes

To report changes, log into your account at **www.CoveredCA.com** or call the Service Center.

If you think we made a mistake

If you think we made a mistake or you don't agree with our decision, you can appeal. If you appeal and we agree with you, we may change our decision. If we change our decision, your family members' eligibility may also change, even if they do not file their own appeal.

You have the right to appeal any of the following:

- I was denied eligibility to enroll in a Covered California health plan
- I was denied enrollment into Medi-Cal
- The amount of premium assistance (tax credit to help lower my monthly premium) is not correct
- The level of Cost Sharing Reduction (help paying my co-payments and deductibles) is not correct
- Covered California did not process my eligibility information in a timely manner
- Covered California stated that I am not a US Citizen or US National or a lawfully present individual living in the United States
- Covered California stated that my application was incomplete

- I do not have other health coverage (such as free Medi-Cal or employer sponsored insurance or COBRA) that prevents me from qualifying for insurance through Covered California
- Covered California stated that I am not a California Resident
- Covered California stated that I did not pay my premiums by my due date
- Covered California stated that my income is too low to qualify for premium assistance

The instructions on how to file an appeal are on the **"Request for a State Fair Hearing to Appeal a Covered California Eligibility Determination"** form. You can view this form on the CoveredCA.com website. Or you can call the Service Center and a representative will send a copy to you.

You can request an appeal in several ways:

- You can go to on www.CoveredCA.com to download a **"Request for a State Fair Hearing to Appeal a Covered California Eligibility Determination"** form.
- Fax to the State Hearings Division at: (916) 651-2789
- Mail your appeal to:

  CA Department of Social Services
  Attn: ACA Bureau
  P.O. Box 944243
  Mail Station 9-17-37
  Sacramento, California 94244-2430
- Email your appeal to: SHDACABureau@DSS.CA.gov (please do not email private information such as your Social Security Number)
- Request an appeal in person at your County Welfare Department
- Call the State Hearings Division and submit your appeal over the phone: 1-855-795-0634.

Questions?

- If you have created a CoveredCA account, log on to your account at **www.CoveredCA.com**; or
- Call the Covered California Service Center at **1-800-300-1506.** You can call Monday through Friday 8 a.m. to 6 p.m. and Saturdays 8 a.m. to 5 p.m. The call is free.

This notice is being sent to you in compliance with the Affordable Care Act:
45 CFR 155.305, 45 CFR 155.310, 26 USC 36B, 45 CFR 155.320, 45 CFR 155.320(c), 45 CFR 155.315, 45 CFR 155.420(c), 45 CFR 155.420(d), Cal. Code Regs., tit. 10, §§ 6472, 6474, 6476

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
Director

EDMUND G. BROWN JR.
Governor

October 9, 2015

To: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS
ALL COUNTY MEDI-CAL PROGRAM SPECIALISTS/LIAISONS
ALL COUNTY PUBLIC HEALTH DIRECTORS
ALL COUNTY MENTAL HEALTH DIRECTORS

Letter No: 15-33

SUBJECT: Discontinuance Notice of Action – Over Income and Not Otherwise Medi-Cal Eligible

Purpose

The purpose of this All County Welfare Directors Letter (ACWDL) is to provide clarification to counties and Statewide Automated Welfare Systems consortia on the requirements for issuing a Notice of Action (NOA) to individuals who lose Medi-Cal eligibility as a result of the following:

- Being over income for the appropriate Modified Adjusted Gross Income (MAGI) program;
- Not eligible for Consumer Protection Programs (CPP); and
- Having no potential eligibility for Non-MAGI Medi-Cal programs after ex parte review or declining a non-MAGI assessment.

Currently, the approval notice generated by the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) for individuals who are discontinued from MAGI Medi-Cal and transitioned to coverage with Advanced Premium Tax Credit (APTC) through Covered California indicates ineligibility for Medi-Cal. However, this notice may not be received prior to discontinuance and does not clearly state what day Medi-Cal eligibility will end. Therefore, the Department of Health Care Services (DHCS) is taking measures to clearly indicate the Medi-Cal discontinuance status to impacted beneficiaries prior to the discontinuance and transition, should it occur. There may be other MAGI beneficiaries who are found Medi-Cal ineligible for reasons other than the reason provided in this ACWDL. Future guidance will be issued to address any gaps that are brought to DHCS' attention that may result in individuals not receiving an appropriate Medi-Cal discontinuance NOA.

Discontinuance NOAs for Loss of Medi-Cal due to Over Income for MAGI Limit

An over income eligibility determination for Medi-Cal may result from a change in circumstances, such as an increase in income, change in household size, or an individual's age where program eligibility is based on age and income limits. Effective immediately, counties must ensure that a timely and adequate manual discontinuance notice is issued to all individuals who lose eligibility for Medi-Cal due to an increase in income for the appropriate MAGI eligibility group, where the individual has no potential eligibility for CPP or non-MAGI Medi-Cal after ex parte review or who declines an assessment for non-MAGI Medi-Cal after receiving the non-MAGI screening packet. Please see ACWDL 14-18 for guidance on the ex parte and non-MAGI review process. Sending the discontinuance notice to individuals losing Medi-Cal for the reasons outlined in this ACWDL is required whether or not an individual has new eligibility for APTCs, Cost Sharing Reductions or unsubsidized coverage per Welfare and Institutions (W & I) Code, Section 14005.37(o).

Note: Please refer to ACWDL 14-18 for information about individuals who are no longer eligible for MAGI Medi-Cal and are approved for Non-MAGI Medi-Cal.

Over Income NOA Included with this ACWDL

Included with this letter is the manual discontinuance NOA (Attachment 1) that counties must use to notify individuals of their discontinuance from Medi-Cal, where the individual has no potential eligibility for CPP or non-MAGI Medi-Cal after ex parte review or who declines an assessment for non-MAGI Medi-Cal and the individual is over income for the appropriate Medi-Cal program. Counties must ensure that the appropriate boxes within the NOA are marked to identify the specific reason(s) the individual was determined to be over income for the Medi-Cal program. Counties must check one or more of the boxes depending on the individual's circumstances.

The chart below lists the rules and regulations that must be listed on the discontinuance NOA when income is found above the MAGI Federal Poverty Level (FPL) limit, depending on the individual's circumstances.

Rules and Regulations – Income Is Above MAGI FPL

Parent/Caretaker Relative	CA W & I Code §§ 14005.30, 14005.64
Undocumented Parent/Caretaker Relative	CA W & I Code §§ 14005.30, 14005.64, CA Code Regs. tit. 22, § 50302
Adults 19-64 Years Old	CA W & I Code §§ 14005.60, 14005.64
Undocumented Adults 19-64 Years Old	CA W & I Code §§ 14005.60, 14005.64, CA Code Regs. tit. 22, § 50302
Full Scope Pregnant Women	Current full-scope up to 60%, use: CA W & I. Code §§ 14005.1, 14050.1, 14005.64
	Once full scope is 109%, use: CA W & I Code §§ 14005.22, 14005.64
	Once full scope is 138%, use: CA W & I Code §§ 14005.22, 14005.225, 14005.64
Undocumented Pregnant Women up to 60 percent	CA W & I Code §§ 14005.1, 14050.1, 14005.64, CA Code Regs. tit. 22, § 50302
Limited Scope Pregnant Women	CA W & I Code § 14005.64
Undocumented Pregnant Women up to 213 percent	CA W & I Code § 14005.64, CA. Code Regs. tit. 22, § 50302
Children - 6-18 years old, 0-138 percent FPL	CA W & I. Code § 14005.64
Undocumented Children – 6-18 years old, 0-138 percent FPL	CA W & I Code § 14005.64, CA Code Regs. tit. 22, § 50302
Children - 6-18 years old, 139 percent-266 percent	CA W & I Code §§ 14005.26, 14005.64
Undocumented Children - 6-18 years old, 139 percent-266 percent	CA W & I. Code §§ 14005.26, 14005.64, CA Code Regs. tit. 22, § 50302
Children - 1-5 years old, 0 -147 percent FPL	CA W & I Code § 14005.64
Undocumented Children - 1-5 years old, 0 - 147 percent FPL	CA W & I Code § 14005.64, CA Code Regs. tit. 22, § 50302
Children - 1-5 years old, 148 -266 percent FPL	CA W & I Code §§ 14005.26, 14005.64
Undocumented Children - 1-5 years old, 148 - 266 percent FPL	CA W & I Code §§ 14005.26, 14005.64, CA Code Regs. tit. 22, § 50302
Infant - under 1 year old, 0-213 percent FPL	CA W & I Code § 14005.64
Undocumented Infant - under 1 year old, 0-213 percent FPL	CA W & I Code § 14005.64, CA Code Regs. tit. 22, § 50302
Infant - under 1 year old, 214-266 percent FPL	CA W & I Code §§ 14005.26, 14005.64
Undocumented Infant - under 1 year old, 214-266 percent FPL	CA W & I Code §§ 14005.26, 14005.64, CA Code Regs. tit. 22, § 50302

Senate Bill 1341

Senate Bill (SB) 1341 was signed into law September 2014 and requires the Statewide Automated Welfare System (SAWS) to create and send NOAs for the Medi-Cal program, including the MAGI NOAs currently generated by CalHEERS. As a result of transitioning MAGI NOAs to SAWS, it is expected that the Over Income NOA will be programmed to generate automatically for the appropriate scenarios with the implementation of SB 1341. The manual process described in this letter is intended to be used only until such time as SAWS programs the Over Income NOA to be generated automatically.

NOA Policy Requirements

Counties are reminded that all requirements outlined in ACWDL 13-13: *Medi-Cal General Notice of Action (NOA) Policy*, including the requirement to include the NA Back 9 hearing rights information and the multilingual notification, and the requirement to adhere to timely 10-day notice must be followed.

Additionally, for MAGI eligibility evaluations, counties must include the Affordable Care Act Bureau designation on the NA Back 9, as required by the California Department of Social Services, in order to ensure the hearing requests, based on MAGI eligibility evaluations, are routed to the correct hearing location. The English and Spanish versions of the correct NA Back 9 to be used for MAGI eligibility evaluations are included with this letter as attachments 2 and 3. Counties may include the local legal aid agency within the designated area of the NA Back 9.

If you have any questions or require additional information, please contact Ms. Alison Brown at (916) 319-9565 or by email at Alison.Brown@dhcs.ca.gov.

Original Signed By

Alice Mak
Acting Chief
Medi-Cal Eligibility Division

Attachments

NOTICE OF ACTION
DISCONTINUANCE OF BENEFITS

Notice Date: _____
Case Number: _____
Worker Name: _____
Worker ID Number: _____
Worker Telephone Number: _____
Office Hours: _____
Office Address: _____

DISCONTINUANCE NOTICE FOR:
Insert Name(s) Here

We have looked at all information available to us about your circumstances and based on this information, your Medi-Cal will be discontinued on _____.

The reason your benefits are stopping is:

You no longer qualify for Medi-Cal because your household income is above the applicable Medi-Cal limit. We counted your household size and income to make our decision. This is the result of:

- ☐ A change in income
- ☐ A change in household size
- ☐ Your age is above the age range allowed, where program eligibility is based on age and income.

As a result of this determination your case has been referred for an evaluation for health coverage through Covered California. If eligible, you will receive notification from Covered California.

Please Note: Other family members with different eligibility status may receive a separate notice.

We used the information you gave us and our records to make our decision. If you have questions or think we made a mistake, or if you have more information to give us, call or write to your worker right away.

DO NOT THROW AWAY YOUR BENEFITS IDENTIFICATION CARD (BIC)
If you already have a plastic Benefits Identification Card (BIC), do not throw it away. You can use it again if you become eligible for Medi-Cal.

<_____> is the regulation or law we used to make this decision. If you think we made a mistake, you can appeal. See the reverse side of this notice to learn how to appeal. You have only 90 days to ask for a hearing. The 90 days started the day after the county sent you this notice.

YOUR HEARING RIGHTS

You have the right to ask for a hearing if you disagree with any county action. You have only 90 days to ask for a hearing. The 90 days started the day after the county gave or mailed you this notice. If you have good cause as to why you were not able to file for a hearing within the 90 days, you may still file for a hearing. If you provide good cause, a hearing may still be scheduled.

If you ask for a hearing <u>before</u> an action on Cash Aid, Medi-Cal, CalFresh, or Child Care takes place:

- Your Cash Aid or Medi-Cal will stay the same while you wait for a hearing.
- Your Child Care Services may stay the same while you wait for a hearing.
- Your CalFresh benefits will stay the same until the hearing or the end of your certification period, whichever is earlier.

If the hearing decision says we are right, you will owe us for any extra Cash Aid, CalFresh or Child Care Services you got. To let us lower or stop your benefits before the hearing, check below:

Yes, lower or stop: ☐ Cash Aid ☐ CalFresh
☐ Child Care

While You Wait for a Hearing Decision for:

<u>Welfare to Work</u>:

You do not have to take part in the activities.

You may receive child care payments for employment and for activities approved by the county before this notice.

If we told you your other supportive services payments will stop, you will not get any more payments, even if you go to your activity.

If we told you we will pay your other supportive services, they will be paid in the amount and in the way we told you in this notice.

- To get those supportive services, you must go to the activity the county told you to attend.
- If the amount of supportive services the county pays while you wait for a hearing decision is not enough to allow you to participate, you can stop going to the activity.

<u>Cal-Learn</u>:

- You cannot participate in the Cal-Learn Program if we told you we cannot serve you.
- We will only pay for Cal-Learn supportive services for an approved activity.

OTHER INFORMATION

Medi-Cal Managed Care Plan Members: The action on this notice may stop you from getting services from your managed care health plan. You may wish to contact your health plan membership services if you have questions.

Child and/or Medical Support: The local child support agency will help collect support at no cost even if you are not on cash aid. If they now collect support for you, they will keep doing so unless you tell them in writing to stop. They will send you current support money collected but will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask for it.

Hearing File: If you ask for a hearing, the State Hearing Division will set up a file. You have the right to see this file before your hearing and to get a copy of the county's written position on your case at least two days before the hearing. The state may give your hearing file to the Welfare Department and the U.S. Departments of Health and Human Services and Agriculture. **(W&I Code Sections 10850 and 10950.)**

TO ASK FOR A HEARING:

- **Fill out this page.**
- Make a copy of the front and back of this page for your records. If you ask, your worker will get you a copy of this page.
- **Send or take this page to:**
  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814
  OR fax to 1-916-651-2789
- **Call toll free:** **or** for hearing or speech impaired who use TDD, **1-800-952-8349**.

To Get Help: You can ask about your hearing rights or for a legal aid referral at the toll-free state phone numbers listed above. You may get free legal help at your local legal aid or welfare rights office.

If you do not want to go to the hearing alone, you can bring a friend or someone with you.

HEARING REQUEST

I want a hearing due to an action by the Welfare Department of _____ County about my:

☐ Cash Aid ☐ CalFresh ☐ Medi-Cal

☐ Other (list) _____

Here's Why: _____

_____

_____

_____

_____

_____

☐ **If you need more space, check here and add a page.**

☐ I need the state to provide me with an interpreter at no cost to me. (A relative or friend cannot interpret for you at the hearing.)

My language or dialect is: _____

NAME OF PERSON WHOSE BENEFITS WERE DENIED, CHANGED OR STOPPED

BIRTH DATE | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SIGNATURE | DATE

NAME OF PERSON COMPLETING THIS FORM | PHONE NUMBER

☐ **I want the person named below to represent me at this hearing. I give my permission for this person to see my records or go to the hearing for me. (This person <u>can be</u> a friend or relative but cannot interpret for you.)**

NAME | PHONE NUMBER

STREET ADDRESS

CITY | STATE | ZIP CODE

SU DERECHO A UNA AUDIENCIA

Usted tiene derecho a solicitar una audiencia si no está de acuerdo con cualquier acción que el Condado tome. Solamente tiene 90 días para solicitar una audiencia. Los 90 días comenzaron el día después de la fecha en que el Condado le dio o envió esta notificación. Si tiene un motivo justificado para no haber solicitado una audiencia antes de los 90 días, usted todavía puede solicitar una audiencia. Si proporciona un motivo justificado, es posible que todavía se programe una audiencia.

Si solicita una audiencia <u>antes</u> de que entre en vigor una acción en relación a la asistencia monetaria, Medi-Cal (Programa de Asistencia Médica de California), CalFresh, o cuidado de niños:

- Su asistencia monetaria/Medi-Cal no cambiará mientras espera a que se lleve a cabo la audiencia.
- Es posible que sus servicios de cuidado de niños no cambien mientras espera a que se lleve a cabo la audiencia.
- Sus beneficios de CalFresh no cambiarán mientras espera a que se lleve a cabo la audiencia o hasta el final de su período de certificación, lo que ocurra antes.

Si la decisión de la audiencia indica que estamos en lo correcto, usted nos deberá cualquier asistencia monetaria, beneficios de CalFresh o servicios de cuidado de niños que haya recibido de más. Para que reduzcamos o descontinuemos sus beneficios antes de la audiencia, marque a continuación:

Sí, reduzcan o descontinúen: ☐ Asistencia monetaria ☐ CalFresh ☐ Cuidado de niños

Mientras que espera la decisión de una audiencia relacionada a:

<u>Programa para la Transición de la Asistencia Pública al Trabajo *(Welfare to Work)*</u>:

No tiene que participar en las actividades.

Es posible que reciba pagos en relación al cuidado de niños para trabajar y participar en actividades aprobadas por el Condado antes de esta notificación.

Si le dijimos que los pagos para sus otros servicios de apoyo se iban a descontinuar, no recibirá más pagos, aunque participe en la actividad.

Si le dijimos que pagaríamos sus otros servicios de apoyo, se le pagarán de acuerdo a la cantidad y de la manera que le indicamos en esta notificación.

- Para recibir esos servicios de apoyo, tiene que participar en la actividad en que el Condado le pidió que participara.
- Si la cantidad que el Condado le paga para servicios de apoyo mientras que espera la decisión de la audiencia no es suficiente para que usted pueda participar, puede dejar de participar en la actividad.

<u>Cal-Learn (un programa de California para la educación de los padres adolescentes que reciben asistencia monetaria)</u>:

- No puede participar en el Programa de Cal-Learn si le dijimos que no le podemos asistir.
- Solamente pagaremos los servicios de apoyo de Cal-Learn si se trata de una actividad aprobada.

OTRA INFORMACIÓN

Miembros de planes de cuidado médico administrado de Medi-Cal: Es posible que la acción de esta notificación no le permita recibir servicios de su plan de salud de cuidado médico administrado. Puede comunicarse con la oficina de servicios de membresía de su plan de salud si tiene preguntas.

Mantenimiento de niños y/o en relación al cuidado de la salud: La oficina local de mantenimiento de hijos le ayudará gratuitamente a cobrar mantenimiento de hijos, aunque usted no esté recibiendo asistencia monetaria. Si ahora cobran mantenimiento de hijos para usted, continuarán haciéndolo a no ser que usted les pida por escrito que lo dejen de hacer. Le mandarán la cantidad actual de mantenimiento que se cobre pero se quedarán con los atrasos que se cobren que se le deban al Condado.

Planificación familiar: La oficina de bienestar público le dará información cuando usted la pida.

Expediente de audiencia: Si solicita una audiencia, la División de Audiencias con el Estado abrirá un expediente. Usted tiene derecho a ver este expediente antes de la audiencia y a recibir una copia de la declaración escrita de posición del Condado relacionada a su caso por lo menos dos días antes de la audiencia. Es posible que el Estado le dé el expediente de audiencia de usted al Departamento de Bienestar, y a los Departamentos de Salud y Servicios Humanos y de Agricultura de los Estados Unidos. **(Secciones 10850 y 10950 del Código de Bienestar Público e Instituciones - W&IC.)**

PARA SOLICITAR UNA AUDIENCIA:

- **Complete esta página.**
- Haga una copia de esta página y de la primera página para sus expedientes.
  Si la pide, su trabajador le dará una copia de esta página.
- **Envíe o lleve esta página a:**

  California Department of Social Services
  State Hearings Division, ACAB
  744 P Street, MS 9-17-97
  Sacramento, CA 95814

  O fax a 1-916-651-2789
- **Llame gratuitamente al: 1-855-795-0634.** Las personas sordas/con problemas del habla que usan TDD* pueden llamar al **1-800-952-8349**.

Para obtener ayuda: Puede pedir información acerca de su derecho a una audiencia o sobre oficinas de asesoramiento legal llamando a los teléfonos estatales gratuitos mencionados arriba. Es posible que pueda recibir asesoramiento legal gratuito en la oficina local de asesoramiento legal o en la oficina de defensa de los derechos relacionados a la asistencia pública.

Si no quiere ir a la audiencia solo, puede llevar a un amigo o a otra persona con usted.

PETICIÓN PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción tomada por el Departamento de Bienestar Público del Condado de _____ acerca de mi(s):

☐ Asistencia monetaria ☐ CalFresh ☐ Medi-Cal

☐ Otro (anote)_____

La razón es la siguiente:_____

_____

_____

_____

_____

☐ **Si necesita más espacio, marque aquí y adjunte otra página.**

☐ Necesito que el Estado me proporcione un intérprete gratuitamente. (Un familiar o un amigo no puede actuar como intérprete de usted en la audiencia.)
Mi idioma o dialecto es el: _____

NOMBRE DE LA PERSONA A QUIEN LE NEGARON, CAMBIARON O DESCONTINUARON LOS BENEFICIOS	
FECHA DE NACIMIENTO	NÚMERO DE TELÉFONO
DIRECCIÓN: CALLE	
CIUDAD	ESTADO CÓDIGO POSTAL
FIRMA	FECHA
NOMBRE DE LA PERSONA QUE COMPLETA ESTE FORMULARIO	NÚMERO DE TELÉFONO

☐ **Quiero que la persona nombrada a continuación me represente en esta audiencia. Doy permiso para que esta persona vea mis expedientes o vaya a la audiencia por mí. (Esta persona <u>puede</u> ser un amigo o familiar, pero no puede actuar como su intérprete.)**

NOMBRE	NÚMERO DE TELÉFONO
DIRECCIÓN: CALLE	
CIUDAD	ESTADO CÓDIGO POSTAL

*TDD: aparato de telecomunicaciones para las personas sordas

Comment Received via E-mail

Covered California: Agent Responsibilities - Medi-Cal Enrollment

Dear Board Member,

Dear Executive Director Lee and Covered California Board Members:

I am a licensed health insurance professional and want to express my support of the comments submitted by California Association of Health Underwriters, the Independent Insurance Agents and Brokers of California, and the National Association of Insurance and Financial Advisors of California regarding updates to the agent contract covering the duties of Certified Insurance Agents (CIAs).

The current agent agreement essentially says agents must help all Californians that ask for help, including those that might be eligible for Medi-Cal. I believe that the proposed change, worded to ensure a warm hand to hand transfer of potential clients, comports with and preserves the "no wrong door" model

A revised policy is needed that allows agents to refer consumers to other certified agents (CIA), county offices or certified enrollment counselors (CEC) when agents have exceeded their capacity or have complex eligibility issues to resolve. I am asking the Board to make additional training available to CIAs and to work to find a new source of funding for agent compensation for Medi-Cal enrollments.

Sincerely,

The individuals named below each submitted the above form letter to Covered California:

Bobbie Ly
Cheryl Lombardi
William Reed
Chris Bender

***General* Comment Received via E-mail**

Public Comment for 10.8.2015 Meeting - Agenda Items V A ii & B i Medi-Cal Pro Bono Work

Steve . . .

I'm right there with you. And LA County DPSS is the worst offender among all 58 county Medi-Cal agencies.

I just spent 40 minutes on the phone on Tuesday this week in a telephonic Medi-Cal determination appeal, in which my health insurance client's CoveredCA application, without her knowledge or consent (or mine as her authorized representative), was altered in the CalHEERS system by an unidentified LA Co DPSS employee to the extent that it was completely locked up, and the DPSS employee then went on to create an entirely new application -- WITHOUT ANYONE'S CONSENT -- that showed annual income of $900, forcing my client off her insurance plan and onto Medi-Cal, despite the FACT that when LA Co DPSS first reviewed the application I submitted in Nov 2014 it determined that she was NOT eligible for Medi-Cal.

The client only discovered her termination from health insurance when she showed up for a doctor's appointment in May and was told her insurance was cancelled. A couple of weeks later is when she first received any correspondence from LA Co DPSS. Of course, that was entirely useless. It directed her to contact her eligibility worker at a phone number that was never answered at any time during normal work hours. In lieu of that, the letter told her she could come to the office to schedule an appointment -- except that the office address was a PO Box. No way to visit that.

After a month of trying to contact DPSS, the client turned to me for additional help,and I was able to file the appeal directly with CA DSS in early July. But it took three months for the hearing to be scheduled. In advance of that I spent nearly two weeks trying to contact the LA Co DPSS appeals person, Rhonda Pleasant, who eventually returned my call, only to tell me that, "Yes, we know she's probably not eligible for Medi-Cal, but we prefer to be ordered by the (Administrative Law) Judge to take her off Medi-Cal." At the hearing, Ms. Pleasant had to admit that she failed to send me an advance copy of LA Co DPSS' response to the appeal, as require by law.

So, the upshot of the hearing is that LA Co DPSS is supposed go into the CalHEERS system to release my client, effective October 31, early enough for me to reenroll her in a health plan with an effective date of November 1. But I have no confidence this will happen as ordered.

As a result, I have literally been robbed of at least six months' commissions on this one account by LA Co DPSS, not to mention the hours I spent making phone calls to CoveredCA back in May and August, and to LA Co DPSS in June, July, and August, and the hours spent with the client, either in person, by phone, text, or email. And even though the alteration of the health insurance application is a specified misdemeanor in the Insurance Code, I'm sure I have no recourse.

I don't necessarily mind assisting folks apply for Medi-Cal, because that is part of our public responsibility as licensed agents, and most of them are appreciative of my efforts. But I will certainly agree that it is entirely unfair not to compensate us to some extent for doing so. CoveredCA knows this, DHCS knows this, the legislature knows this, and yet, apparently, no one cares. Especially CAHU, which is why I could care less about that organization and its "advocacy" on behalf of California health insurance agents.

MAX HERR, MA