Eligibility & Enrollment

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California Health Benefit Exchange Board Meeting
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Eligibility and Enrollment Guiding Principles

- Through a “No Wrong Door” approach, promote maximum enrollment into coverage.
- Facilitate a smooth enrollment process beginning with the use of a single streamline application and seamless renewal process.
- Present information in a manner that is accurate, accessible, understandable and transparent to consumers to inform and educate them.
- Continue to learn and adjust strategies and tactics based on input from our national partners, California stakeholders, ongoing research, evaluation and measurement of the programs’ impact on awareness and enrollment.

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Eligibility & Enrollment State Regulations Timeline

Activity:	Proposed Timeline:
1st package of final proposed Eligibility & Enrollment State Regulations presented at Board Meeting (for Board action – this does not include discussion items presented to the Board)	June 20, 2013
Submission of 1st package of Board Adopted Eligibility & Enrollment State Regulations to the Office of Administrative Law	June 24, 2013
Stakeholder webinar to solicit public feedback and input on Board Discussion Items	July 2013
Final proposed Eligibility & Enrollment Regulations (2nd package) presented at Board Meeting (for Board action)	August 22, 2013
Submission of 2nd package of Board Adopted Eligibility & Enrollment State Regulations to the Office of Administrative Law	August 26, 2013

Eligibility & Enrollment

Key Policy Issues and Final Recommendation

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Covered California's Key Policy Issue

Timeframes to Conduct Eligibility Determinations – Board Action

Key Policy Issue:	April 23, 2013 Staff Recommendations:
Processing Time Frames to Conduct Eligibility Determinations: Affordable Care Act (ACA) and Federal Regulations do not explicitly identify the processing timeframe (e.g., how many days) to conduct an eligibility determination once an application is received. Federal statutes and Regulations state that the eligibility determination must be conducted in "real time" and without "undue delay."	• **Complete on-line applications** (e.g., self-service or in-person assistance) and **telephone applications** will occur "real time" and within minutes. • **Complete paper** (e.g., self-service or in-person assistance) or **faxed applications** that do not require resolution of any inconsistency will be processed within 10 calendar days of receipt.***** • **Incomplete paper** (e.g., self-service or in-person assistance) **or faxed applications** that require follow-up as a result of missing information will be processed within 10 calendar days of receipt.***** * It is recommended that the administrative service level standards to process applications and eligibility determinations occur within 5 business days. • All applications resulting in conditionally eligibility for Covered California will allow the consumer at least 90 days to resolve the inconsistency.

Original Stakeholder Feedback:

- The 10 calendar days to process paper applications seems to be more time than needed to complete the processing.
- Suggest an individual should be able to submit an online application that is incomplete.

Final Staff Recommendation incorporated into final State Regulations:

- When the initial implementation occurs, staff recommends the State Regulations identify a processing timeframe of 10 calendar days.
- Once implementation occurs, staff will re-evaluate and analyze the processing timeframe to determine whether or not State Regulations need to be amended to reflect a shorter timeframe that is consistent with the 5 business day administrative service level standards.*****
- When applying on-line, consumers will be required to enter in all required data elements. However, consumers may provide additional documentation during the 90 day reasonable opportunity period.

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Covered California's Key Policy Issue

Special Exceptions to Maintain Enrollment After 90-Day Reasonable Opportunity Period – Board Action

Key Policy Issue:	April 23, 2013 Staff Recommendations:
Special Exceptions to Maintain Enrollment After 90-Day Reasonable Opportunity Period: Federal Regulations require Covered California to extend the 90-day reasonable opportunity period on a "case by case" basis.	• Consumers may submit a request to extend the 90-day reasonable opportunity period: ✓ Must provide the reason why the consumer is unable to furnish documents or why documents do not exist to resolve the inconsistency. Examples below model policies adopted by Department of Health Care Services for Medi-Cal Programs: ▪ Applicant provides a copy of a request to obtain documentation such as a photocopy of letter or e-mail to the agency who will issue documentation. ▪ Provide a copy of a check, receipt, order form, or other documentation notating that the documentation has been ordered. ▪ Provide a written or verbal statement describing the applicant's efforts to obtain documentation needed. ✓ Consumer's justification will be reviewed and must be approved by Covered California in order for the 90-day reasonable opportunity period be extended. Recommend a 15 business day processing timeframe. • If approved, Covered California will follow-up with the consumer, reminding them that they need to resolve the inconsistency during this exception period. • Written notification will be sent to the consumer with the outcome of the decision.

Original Stakeholder Feedback:

- Recommend Covered California specify the avenues through which a consumer will be able to submit a request to extend the 90-day reasonable opportunity period e.g., (online, fax, by telephone, etc.), as well as specify how consumers can request an exception.
- Consumers should be notified of the special exception process at least 30 days before the end of the 90-day reasonable opportunity period.

Final Staff Recommendation incorporated into final State Regulations:

- Staff recommends to preserve the original recommendations provided at the April 23, 2013 Board Meeting.
- However, the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) will generate a notification letter at least 15 business days before the reasonable opportunity period ends explaining the special exemption process.

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Covered California's Key Policy Issue

Requirements for Consumers to Self-Report Changes – Board Action

Key Policy Issue:	April 23, 2013 Staff Recommendations:
Requirements for Consumers to Self-Report Changes: Federal Regulations require that consumers self-report changes to Covered California within 30 calendar days from the date of a change. Specifically for: 1) Change in U.S. Citizenship, National or lawfully present status, 2) Change in state residency status, or 3) Incarceration status. Federal Regulations allow Covered California to establish a reasonable threshold which an individual is not required to report a change of income.	• Consumers be required to report a change of income that may impact the amount of their tax credit or cost sharing reduction. • This approach has the following benefits to the consumer: ✓ Help inform and educate consumers about any potential impact to their eligibility for tax credit or cost sharing reductions due to changes in income. ✓ Enable consumers to adjust their tax credit accordingly based on their needs, which will help minimize repayment of excess advance tax credit taken during the benefit year. ✓ Increase the ability to obtain more affordable coverage when income decreases. ✓ Ensure clear messaging and explanations are provided to consumers regarding when (and under what circumstances) they must report changes in their status.

Original Stakeholder Feedback:

- Do not require consumers to report change of income, in the event the change does not impact the consumer's tax credit or cost sharing reduction eligibility.
- Or, require the consumers to report a change of income if their income changes by 10%.
- Require that notices to enrollees include a clear explanation that requires an enrollee to report changes within 30 days.

Final Staff Recommendation incorporated into final State Regulations:

- Consumers will be required to report a change of income that may impact the amount of their tax credit or cost sharing reduction.
- Covered California will ensure clear messaging and explanations are provided to consumers regarding when and under what circumstances they must report changes in their status.

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Covered California's Key Policy Issue

Allowing Covered California Qualified Health Plans to Assist Applicants to Apply for Coverage
Board Action

Key Policy Issue:	April 23, 2013 Staff Recommendations:
Allowing Covered California Qualified Health Plan to assist Applicants to apply for coverage: • Federal regulations indicate; "If an applicant initiates enrollment directly with the QHP issuer for enrollment through the Exchange, the QHP issuer must either: (1) Direct the individual to file an application with the Exchange in accordance , or (2) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet website."	• Preserve the language as specified in the draft State Regulations for the following reasons: ✓ Federal Regulations permit Covered California QHPs to assist consumers apply for coverage, which is an important policy in order to reach high enrollment goals. ✓ The Board Recommendations Brief, titled "Partnering with Health Plan Issuers to Promote Enrollment," was previously approved by the Board during the August 2012 Board Meeting. ✓ Health plan issuers are important partners to Covered California and their expertise and resources will be important to maximize enrollment. Individuals who are currently covered through the QHP outside of the Exchange in the individual market will be eligible for subsidized coverage available through Covered California. Therefore, QHPs already have established relationships with consumers and have an important role in conducting outreach, education and enrollment activities to populations that already have coverage through the existing individual commercial market. ✓ Partnering with health plan issuers is consistent with the approach taken by other state Exchanges. ✓ Covered California Qualified Health Plan Model Contract includes provisions which will identify the rules of engagement for plans who assist consumers that apply for coverage.

Original Stakeholder Feedback:

- Allowing issuers to assist consumers to apply for coverage may allow insurers access to private information about income and health status, which should only be available once the consumer is enrolled in the Covered California qualified health plan (QHP).

Final Staff Recommendation incorporated into final State Regulations:

- Staff recommends to preserve original recommendations and State Regulations language provided at the April 23, 2013 Board Meeting.
- Final draft of the State Regulations read: "If an applicant initiates enrollment directly with a QHP issuer for enrollment through the Exchange, the QHP issuer shall either:
  (1) Direct the individual to file an application with the Exchange, or
  (2) Assist the applicant, upon the applicant's request, to apply for and receive an eligibility determination for coverage through the Exchange through the Exchange Internet website."

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Covered California's Key Policy Issue

Requiring Initial Premium Payment to Effectuate Coverage – Board Action

Key Policy Issue:	April 23, 2013 Staff Recommendations:
Requiring Initial Premium Payment to Effectuate Coverage: • While Federal Regulations do not explicitly indicate that consumers are required to make a full initial premium payment in order to effectuate coverage, the Center for Consumer Information and Insurance Oversight (CCIIO) provided direction and guidance to Covered California and other states, informing Exchanges that a full initial premium payment is required in order to effectuate coverage.	• Preserve the language as specified in the draft State Regulations for the following reasons: ✓ Requiring an initial full premium payment to effectuate coverage is standard industry practice and is also consistent with the guidance provided by CCIIO. ✓ Previous draft of proposed State Regulations specified the following: "Enrollment shall be deemed complete when the applicant's coverage is effectuated, which shall occur when the Qualified Health Plan (QHP) issuer receives the applicant's initial premium payment in full."

Original Stakeholder Feedback:

- Federal Regulations do not specify that consumers must make a full initial premium payment during the open enrollment and special enrollment period, in order to effectuate coverage.

Final Staff Recommendation incorporated into final State Regulations:

- Staff recommends to preserve original recommendations provided at the April 23, 2013 Board Meeting.
- However, remove the proposed language stated above, since other areas of the final draft State Regulations explains the process of effectuating coverage with a Covered California health plan.

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Covered California's Key Policy Issue
Collection of Social Security Numbers – Board Action

Key Policy Issue:	April 23, 2013 Staff Recommendations:
Collection of Social Security Numbers: • Federal regulations indicate; "The Exchange may not require an individual who is not seeking coverage for himself or herself to provide a Social Security number except as specified: (1) "The Exchange must require an application filer to provide the Social Security Number of a tax filer who is not an applicant, only if an applicant attests that the tax filer has a Social Security Number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size."	• Preserve the language as specified in the draft State Regulations for the following reasons: ✓ State Regulations are consistent with Federal Regulations. ✓ Covered California will message the use of the individual's SSN will be confidential and be used for only the purposes of eligibility determination and administration of enrollment in Covered California. ✓ Messaging to the consumer will be critical to ensure that they are aware of the confidentiality standards and safeguards of personnel and financial information.

Original Stakeholder Feedback:

- Social Security Number(s) (SSN) should only be required and verified for applicants applying for coverage and not for other individuals. Draft State Regulations require that the SSN be provided for non-applicant tax filer, in the event the filer has a SSN and files for the relevant tax year. If draft State Regulations continue to request the non-applicant's SSN, there should be a requirement that the application filer be notified that their SSN will be used **only** for purposes of income verification and cannot be shared for any other purposes and will only be used for eligibility determination.

Final Staff Recommendation incorporated into final State Regulations:

- Staff recommends to preserve original recommendations provided at the April 23, 2013 Board Meeting.
- Final draft State Regulations indicate that the Social Security Number of an individual who is a tax filer (however, the tax filer is not seeking coverage for themselves) will **only** be used to verify the household income and family size of other household members who are applying for coverage.

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Covered California's Key Policy Issue
Readability Standards – Board Action

Key Policy Issue:	April 23, 2013 Staff Recommendations:
Readability Standards: • Proposed regulations indicate: "Information, shall be provided to applicants and enrollees in plain language, and all written correspondence shall also: (1) Be formatted in such a way that it can be understood at the ninth-grade level."	• Preserve the language as specified in the draft State Regulations for the following reasons: ✓ Whenever feasible, the goal will be to produce written materials at a 6th grade reading level. ✓ In circumstances in which complex information is being presented to the consumer (e.g., advance premium tax credits, cost sharing reductions, or reconciliation of the tax credit at the end of the year through annual tax filing), then written materials will not exceed a 9th grade reading level.

Original Stakeholder Feedback:

- The readability standards identified in the draft State Regulations should be no higher than a 6th grade level (not at a 9th grade level as proposed by Covered California). A 6th grade is the level used by Medi-Cal and there will be many individuals with low literacy levels applying for coverage and receiving written notices.

Final Staff Recommendation incorporated into final State Regulations:

- Staff recommends to preserve original intent presented at the April 23, 2013 Board Meeting.
- Include additional language in the final draft State Regulations which specify the goal of producing written materials at a 6th grade level whenever possible.

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Eligibility & Enrollment

Draft Proposed State Regulations

(Covered California Individual Subsidized and Non-Subsidized Programs)

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Draft Proposed State Regulations
Previously Reserved Sections

ARTICLE	SECTION	SECTION TITLE
4	§ 6454 *(Discussion Item Only)*	Exemption from Individual Responsibility.
5	§ 6472 ***(Board Action)***	Eligibility Requirements for Enrollment in a Qualified Health Program through the Exchange. Special rule for tax households with members in multiple Exchange service areas.
5	§ 6488 *(Discussion Item Only)*	Verification Process for modified adjusted gross income (MAGI)-Based Medi-Cal and Children's Health Insurance Program.
5	§ 6490 *(Discussion Item Only)*	Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-Sponsored Plan Related to Eligibility Determination for Advanced Premium Tax Credits and Cost Sharing Reductions.
7	§ 6600 through § 6620 *(Discussion Item Only)*	Appeals of Eligibility Determinations for the Exchange Participation.

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ARTICLE 4:
GENERAL PROVISIONS

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ARTICLE 4:
Individual Responsibility Exemption - For Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6454. Exemption from Individual Responsibility.	➢ Proposed Federal Regulations permit state Exchanges to rely on federal services to process requests for exemption from the individual responsibility. Covered California will rely on federal services to process these requests for exemptions. • However, in the event the federal services is unable to process requests for exemptions based on final Federal Regulations, Covered California will amend State Regulations accordingly to give authority for Covered California to process exemption requests. ➢ Individuals may request a certificate of exemption if individuals are: • Unable to afford coverage • A member of a recognized religious sect or health sharing ministry • Not lawfully present in the United States • incarcerated individuals • A member of Indian tribes ➢ Except in some cases, exemptions shall be granted only for the calendar year. ➢ Upon receipt of an application for exemption, Covered California shall transmit all information obtained with the request to the U.S. Department of Health and Human Services (HHS) promptly and without delay for verification and eligibility determination for one or more categories of exemptions. ➢ The Internal Revenue Service (IRS) exclusively determine through the tax filing process of whether an individual is eligible for: any of the exemptions for inability to afford coverage; household income below the applicable income tax return filing threshold, not being lawfully present, or short coverage gaps. ➢ Individuals requesting exemptions shall provide applicable information. ➢ Individuals have the right to appeal an eligibility determination or redetermination for an exemption and shall request such an appeal directly to HHS. ➢ Covered California shall include the notice of the right to appeal and instructions regarding how to file an appeal with HHS in any notification issued. ➢ Covered California shall provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption and has elected to receive electronic notifications, unless he or she has declined to receive such notifications.

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ARTICLE 5:

APPLICATION, ELIGIBILITY AND ENROLLMENT, PROCESS FOR THE INDIVIDUAL EXCHANGE

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ARTICLE 5: Application, Eligibility and Enrollment Process for the Individual Exchange

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6472(e)(4). Special Rule for Tax Households With Members in Multiple Exchange Service Areas ***(Board Action)***	➢ If all of the tax household members are not within the same Exchange service area: • Any member may enroll in a Qualified Health Plan (QHP) through any of the Exchanges for which one of the tax filers meets the residency standard. ➢ If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may enroll in a QHP through that Exchange or the Exchange that services the area in which the dependent meets the residency standard. ➢ Covered California shall not deny or terminate an individual's eligibility for enrollment in a Covered California Health Plan or a QHP in another State Exchange if the individual: • Meets the residency standards except for a temporary absence from the service area of the Exchange; and • Intends to return when the purpose of the absence has been accomplished, unless another Exchange verifies that the individual meets the residency standard of such Exchange.
§ 6488. Verification Process for Modified Adjusted Gross Income (MAGI)-based Medi-Cal and Children's Health Insurance Program (CHIP). *(Discussion Item Only)*	➢ An applicant's household size shall be verified by accepting the applicant's attestation without further verification except if: • An applicant's attestation of his or her household is not reasonably compatible with other information provided by the application filer or in the records of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS), the applicant's attestation shall be verified using data obtained through electronic data sources. ➢ In addition, draft State Regulations describe the verification process for household income, U.S. citizen, national or lawfully present status. ➢ If the data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the applicant shall provide additional documentation requested by Covered California to support the attestation.
§ 6490. Verifications of Enrollment in an Eligible Employer-Sponsored Plan and Eligibility for Qualifying Coverage in an Eligible Employer-sponsored Plan Related to Eligibility Determination for Advanced Premium Tax Credits and Cost Sharing Reductions. *(Discussion Item Only)*	➢ Covered California shall rely on a verification process performed by the U.S. Department of Health and Human Services (HHS) for verification of enrollment, and eligibility for qualifying coverage in an eligible employer-sponsored plan. Covered California shall:

ARTICLE 7:
Appeals Process

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ARTICLE 7:
Appeal Process – For Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6602. General Eligibility Appeals Requirements. *(Discussion Item Only)*	➢ An applicant or enrollee may appeal: • Eligibility Determinations/Redeterminations. • Covered California's failure to provide a timely eligibility determination. • Eligibility Determination of an exemption request (Note: Appeal of an Exemption request will be reviewed by the U.S. Department of Health and Human Services). ➢ An appellant may designate an authorized representative to act on his or her behalf, including making an appeal request.
§ 6604. Notice of Appeal Procedures. *(Discussion Item Only)*	➢ Covered California shall provide notice of appeal procedures at the time that: • The Applicant submits an application; and • Covered California sends notice of eligibility. ➢ Notice of appeal procedures shall contain: • An explanation of the applicant or enrollee's appeal rights; • A description of the procedures by which the applicant or enrollee may request an appeal; • Information on the applicant or enrollee's right to represent himself or herself, or to be represented by legal counsel or an authorized representative; • An explanation of the circumstances under which the appellant's eligibility may be maintained or reinstated pending an appeal decision; and • An explanation that an appeal decision for one household member may result in a change in eligibility for other household members and may be handled as a redetermination.

ARTICLE 7:
Appeal Process – For Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6606. Appeal Requests. *(Discussion Item Only)*	➢ Covered California must accept appeal requests submitted by all avenues in which an application may be submitted; ➢ Covered California shall consider an appeal request to be valid if: • The appeals is based on the following: ○ Eligibility Determinations/ Redeterminations; ○ Covered California's failure to provide a timely eligibility determination; or ○ Eligibility determination of exemption request .(**Note:** Appeal of an Exemption request will be reviewed by the U.S. Department of Health and Human Services [HHS]) • The appeal is submitted within 90 days of the date of the notice of eligibility determination. ➢ Upon receipt of a valid appeal request, the appeals entity: • Shall send timely acknowledgment to the appellant of the receipt of his or her valid appeal request. • Shall send timely notice via secure electronic interface of the appeal request and, if applicable, instructions to provide eligibility pending appeal to the Covered California and to the Department of Health Care Services, where applicable; and • Shall promptly confirm receipt of the records transferred by Covered California. ➢ Upon receipt of an appeal request that is not valid, the appeals entity shall: • Promptly and without undue delay send written notice to the applicant or enrollee that the appeal request has not been accepted and of the nature of the defect in the appeal request; and • Treat as valid an amended appeal request that meets the requirements. ➢ Upon receipt of a valid appeal request or upon receipt amended appeal Covered California shall transmit via secure electronic interface to the appeals entity: • The appeal request, if the appeal request was initially made to Covered California; and • The appellant's eligibility record. ➢ Upon receipt of the notice of an appeals request made to the HHS, Covered California appeals entity shall transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from Covered California, to the HHS.

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ARTICLE 7:
Appeal Process – For Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6608. Eligibility Pending Appeal. *(Discussion Item Only)*	➢ Upon receipt of a valid appeal request an appellant previously determined eligible shall continue to be considered eligible while the appeal is pending. ➢ Covered California shall continue the appellant's eligibility for enrollment in a Qualified Health Plan, Advanced Premium Tax Credits, and Cost Sharing Reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.
§ 6610. Dismissals. *(Discussion Item Only)*	➢ The appeals entity shall dismiss an appeal if the appellant: • Withdraws the appeal request in writing; • Fails to appear at a scheduled hearing; • Fails to submit a valid appeal request; or • Dies while the appeal is pending. ➢ If an appeal is dismissed, the appeals entity shall provide notice to the appellant, that includes the reason for dismissal, an explanation of the dismissal's effect on the appellant's eligibility; and an explanation of how the appellant may show good cause why the dismissal should be vacated. ➢ If an appeal is dismissed, the appeals entity shall provide notice to Covered California, and to the California Department of Health Care Services, as applicable, including instruction regarding the eligibility determination to implement; and discontinuing eligibility pending appeal. ➢ The appeals entity may vacate a dismissal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.
§ 6612. Informal Resolution. *(Discussion Item Only)*	➢ An appellant shall have an opportunity for informal resolution prior to a hearing in accordance with the requirements of this section. ➢ The informal resolution process shall comply with the scope of review specified the Hearing Process. ➢ An appellant's right to a hearing shall be preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process. ➢ If the appeal advances to hearing, the appellant shall not be asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process. ➢ If the appeal does not advance to hearing, the informal resolution decision shall be final and binding.

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ARTICLE 7:
Appeal Process – For Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6614. Hearing Requirements. *(Discussion Item Only)*	➢ An appellant shall have an opportunity for a hearing in accordance with the requirements of this section. ➢ When a hearing is scheduled, the appeals entity shall send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 calendar days prior to the hearing date. ➢ The hearing shall be conducted: • At a reasonable date, time, and location or format; • After notice of the hearing; • As an evidentiary hearing; and • By one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter. ➢ The appeals entity shall provide the appellant with the opportunity to: • Review their appeal record at a reasonable time before the hearing as well as during the hearing; • Bring witnesses to testify; • Establish all relevant facts and circumstances; • Present an argument without undue interference; and • Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses. ➢ The appeals entity shall consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeal, including at the hearing. ➢ The appeals entity shall review the appeal de novo and shall consider all relevant facts and evidence adduced during the appeal.
§ 6616. Expedited Appeals. *(Discussion Item Only)*	➢ The appeals entity shall establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could seriously jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function. ➢ If the appeals entity denies a request for an expedited appeal, it shall: • Handle the appeal request under the standard process and issue the appeal decision; and • Make reasonable efforts to inform the appellant through electronic or oral notification of the denial and, if notified orally, follow up with the appellant by written notice within 2 business days of the denial.

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ARTICLE 7:
Appeal Process – For Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6618. Appeals Decisions. *(Discussion Item Only)*	➢ Appeal decisions shall: • Be based exclusively on the evidence information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeal, including at the hearing and the eligibility requirements. • State the decision, including a plain language description of the effect of the decision on the appellant's eligibility; • Summarize the facts relevant to the appeal; • Identify the legal basis, including the regulations that support the decision; • State the effective date of the decision; and • Provide an explanation of the appellant's right to pursue the appeal at the Health and Human Services Agency if the appellant remains dissatisfied with the eligibility determination. ➢ The appeals entity shall: • Issue written notice of the appeal decision to the appellant within 90 days (Covered California has requested HHS an extended 120-day timeframe so that an appropriate and effective informal resolution process can be implemented) of the date an appeal request is received, as administratively feasible; • In the case of an expedited appeal request that the appeals entity determines meets the criteria for an expedited appeal, issue the notice as expeditiously as the appellant's health condition requires, but no later than 3 working days after the appeals entity receives the request for an expedited appeal; and • Provide notice of the appeal decision and instructions to cease the appellant's pended eligibility, if applicable, via secure electronic interface, to Covered California or the DHCS, as applicable. ➢ Upon receiving the notice from the Appeals Entity, Covered California shall promptly: • Implement the appeal decision: ◦ Retroactive to the date the incorrect eligibility determination was made; ◦ At a time determined, as applicable; or in accordance with Medi-Cal or CHIP standards. • Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision.

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ARTICLE 7:
Appeal Process – For Discussion Only

SUMMARY OF DRAFT REGULATION SECTION	SECTION SUMMARY
§ 6620. Appeal Record. *(Discussion Item Only)*	➢ Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the appeals entity shall make the appeal record accessible to the appellant at a convenient place and time. ➢ The appeals entity shall provide public access to all appeal records, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

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QUESTIONS and SUGGESTIONS?

Submit written comments/suggestions for discussion items to:

Eligibility@covered.ca.gov

Due Date: July 19, 2013

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