STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF SOCIAL SERVICES
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REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order
[ ] Clarification Requested by One or More Counties
[x] Initiated by CDSS

ALL COUNTY LETTER No. 14-14

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATOR OFFICERS
ALL COUNTY HEARING REPRESENTATIVES
ALL ADMINISTRATIVE LAW JUDGES
COVERED CALIFORNIA

SUBJECT: **STATE HEARINGS DIVISION PROCEDURES FOR PROCESSING COVERED CALIFORNIA AND MAGI MEDI-CAL APPEALS**

REFERENCE: Welfare and Institutions Code (W&IC) sections 10950 through 10967; CDSS Manual of Policies and Procedures (MPP) sections 22-001 through 22-085. Title 10 California Code Regulations sections 6408-6620; 45 Code of Federal Regulations sections 155.500-155.550

This All County Letter (ACL) provides information regarding the procedures for hearing requests related to Affordable Care Act (ACA) issues. This includes processing regular state hearing requests, as well as requests involving emergency circumstances requiring an expedited hearing process.

To improve access and communication about the availability of state hearings, this letter is located on the California Department of Social Services (CDSS), State Hearings Division (SHD) website, under the “Affordable Care Act” tab.

NOTE: Existing applicable State Hearings regulations use the term “claimant” and “hearing request” to refer to a person seeking a hearing from a disputed county or agency action. The federal and Covered California regulations use the term “appellant” instead of “claimant” and “appeal” instead of “hearing

request" to refer to a person seeking an appeal. These terms are therefore used interchangeably in this ACL, and mean the same.

BACKGROUND

A. FEDERAL LAW

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. The two statutes collectively are commonly referred to as the "Affordable Care Act" or "ACA." Among others, the ACA aims to increase the number of Americans with health insurance and cut the overall costs of health care, and it expands the options available to individuals and small businesses that need help paying for the cost of health insurance. Individuals who do not have health insurance coverage or do not have affordable health coverage through their employers can apply for help through various health assistance programs.

Beginning on October 1, 2013, for coverage starting as soon as January 1, 2014, qualified individuals and qualified employers will be able to enroll in Qualified Health Plans (QHPs) – private health insurances that have been certified as meeting certain standards – through competitive marketplaces called Exchanges or Health Insurance Marketplaces. The word "Exchanges" refers to State Exchanges, also called State-based Exchanges, as well as a Federally Facilitated Exchanges (FFEs) or Marketplace (FFM).

Effective January 1, 2014, eligible individual taxpayers, whose household income is between 100 and 400 percent of the Federal Poverty Level (FPL), are eligible to receive an Advance Payments of Premium Tax Credit (APTC) based on the individual's income for coverage under a QHP offered in the Exchange. The ACA requires a Cost-Sharing Reduction (CSR) for individuals with incomes below 250 percent of the FPL. For Native Americans and Alaskan Natives, the CSR income level is below 300 percent of the FPL. The CSR lowers out of pocket expenditures in the form of deductibles, co-insurance and copayments in the health plan.

B. STATE LAW

After the passage of the ACA, California enacted legislation to establish a state agency to implement key portions of the new law, the California Health Benefit Exchange, which is operated under the name "Covered California". SB 900 (Alquist), Chapter 659, Statutes of 2010, establishes Covered California as an independent public entity within state government, and requires Covered California to be governed by a board composed of the Secretary of California Health and Human Services Agency, or his or her designee, and four other members appointed by the Governor and the Legislature who meet specified criteria. AB 1602 (John A. Pérez), Chapter 655, Statutes of 2010, specifies the powers and duties of Covered California relative to determining eligibility for enrollment in Covered California and arranging for coverage under QHPs. State law

(AB 1602) also requires Covered California to establish an appeals process for prospective and current enrollees of the Exchange that complies with all requirements of the federal ACA concerning the role of a state Exchange in facilitating federal appeals of Exchange-related determinations.

Covered California is authorized to adopt rules and regulations, as necessary and permits, until January 1, 2016, emergency regulations to be promulgated. Covered California rules and regulations under Title 10 of the California Code of Regulations can be accessed at http://ccr.oal.ca.gov/linkedslice/default.asp?SP=CCR-1000&Action=Welcome.

Beginning October 1, 2013, Covered California, through its website, began offering the ability to enroll into health care coverage, including Medi-Cal and the ability to select and enroll in a health plan, with pricing commensurate with levels of coverage, http://coveredca.com/, which will allow consumers to compare plans and enroll in the plan of their choice. Plan coverage for individuals eligible for Covered California will begin no sooner than January 2014. Medi-Cal plan enrollment will follow the same processes as is current practice.

A new automated eligibility and enrollment system, jointly developed by Covered California and the Department of Health Care Services (DHCS), known as the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) has been developed to handle applications for health coverage via Medi-Cal or Covered California.

C. FEDERAL REGULATIONS

Federal exchange and Medicaid appeals regulations establish minimum federal requirements and state policy options that apply when someone wants to appeal an eligibility determination about coverage in a particular program under the ACA. For example, federal regulations require that an applicant or enrollee has the right to appeal:

1. An eligibility determination, including an initial determination of eligibility for enrollment in Medicaid, APTC and CSR, including the amount of APTC or the level of CSR, and enrollment issues, such as whether a special enrollment period applies;

2. A redetermination of eligibility, including the amount of the APTC and level of CSR;

3. A failure by the Exchange to make a timely eligibility determination or to provide timely notice of an eligibility determination; and

4. Eligibility and redetermination for an exemption (these appeals are handled by the federal Department of Health and Human Services (HHS)).

Federal regulations require that appeals be accepted by telephone, mail, in person or via the internet, and must be submitted within 90 calendar days of the date of the notice of eligibility determination, unless good cause exists beyond the 90 days. Federal regulations also establish requirements for eligibility pending an appeal, expedited appeals, and appeal decisions. States are given options in implementing the appeals. These options include which entity may conduct the appeals (the Exchange, a contracted agency or the federal HHS, after exhausting state-based appeals), whether the Exchange and the appeals entity is allowed to assist applicants/enrollees in making an appeals request, and whether the Exchange provides an informal resolution process prior to a hearing.

MEDI-CAL EXPANSION

A. MODIFIED ADJUSTED GROSS INCOME (MAGI) MEDI-CAL

Under the ACA, beginning January 1, 2014, there are changes in how public programs determine who is eligible for Medi-Cal. The criteria depends on whether the applicant is eligible based on their MAGI or whether they qualify as non-MAGI, discussed below. MAGI Medi-Cal changes the way income and household size is determined for Medi-Cal eligibility for certain groups of applicants and recipients. The appeals process will be substantially the same as for other Non-MAGI Medi-Cal eligibility groups.

In addition, there will be an expansion of Medi-Cal eligibility for childless adults as part of ACA, increasing access to health insurance. Most adults, including people who are childless, who do not receive Medicare, who have a MAGI that is 138% or less of the FPL (equal to or less than $15,856 for single individual as of the date of this letter) will be eligible. Also, children with MAGI up to 266% of the FPL will be eligible for Medi-Cal. There is no asset test for MAGI Medi-Cal populations. In most cases, if an applicant is determined eligible for MAGI Medi-Cal, the applicant is not eligible for APTC or CSR. There may be cases for newly qualified adult immigrants or certain pregnant women who will be eligible to receive both Medi-Cal and APTC or CSR financed, in part, by DHCS. Policy in this area is still being developed and will be in place in 2014.

B. NON-MAGI MEDI-CAL

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

For further guidance on Medi-Cal eligibility policies and procedures related to the ACA, please see Medi-Cal Eligibility Division Information Letters (MEDILs) Nos. I 13-03 through I 13-12, at http://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/2013MEDILs.aspx. To see policies and procedures that need to be

implemented no later than either October 1, 2013, or January 1, 2014, counties should reference Medi-Cal Eligibility Division Information Letter (MEDIL) Nos. I 13-12 "Affordable Care Act Follow-Up Guidance," issued by DHCS on September 16, 2013. This letter provides various ACA policy guidance to counties and Statewide Automated Welfare Systems (SAWS). DHCS has indicated it will continue to issue ACA related MEDILS, as needed, followed by All-County Welfare Directors' Letters (ACWDLs) and state regulations.

COVERED CALIFORNIA AND COUNTY RESPONSIBILITIES – APPLICATION PROCESS

A. SINGLE STREAMLINED APPLICATION (SSApp)

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

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

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

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

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

As noted above, in most cases applicants eligible for either MAGI or Non-MAGI Medi-Cal are not eligible for APTC or CSR. There may be cases for newly qualified adult immigrants or certain pregnant women who will be eligible to receive both Medi-Cal and APTC or CSR financed in part by DHCS. Policy in this area is still being developed and will be in place in 2014.

B. REFERRAL FOR NON-MAGI MEDI-CAL EVALUATION

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

If a family applies for health coverage, the family will also be offered other services such as CalFresh, CalWORKS, etc., if they are potentially eligible. Potential eligibility is defined as when the information provided on the SSApp and information otherwise available to the county indicates that the applicant may be eligible for aid if the information on the Statement of Facts were verified. In order to preserve the individual's right to apply and receive written determination, counties should offer the applications.

While the applicant is being evaluated for Non-MAGI Medi-Cal, if the applicant is eligible for Covered California, the applicant can enroll temporarily in a Covered California QHP and is eligible for any applicable APTC and CSR. This means that an applicant who is eligible for a tax credit and wants to be considered for Non-MAGI Medi-Cal may pay premiums to a QHP while the non-MAGI Medi-Cal evaluation is in process. If the county then later determines that the applicant is eligible for Non-MAGI Medi-Cal, the applicant must then disenroll from the Covered California QHP and obtain coverage in Medi-Cal.

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

CDSS STATE HEARING RESPONSIBILITIES

Covered California and the CDSS have entered into an Inter-Agency (IA) Agreement that authorizes SHD to conduct hearings based on consumer appeals that arise out of the Covered California application and enrollment process. The SHD will be handling all applicant appeals regarding eligibility determination, redetermination, and timeliness of Covered California coverage or grants of federal tax credits or federal subsidies. The SHD will also continue to handle all Medi-Cal appeals, including MAGI Medi-Cal appeals, through the IA Agreement with DHCS.

A. JURISDICTION

The SHD will have jurisdiction over Covered California appeals as follows:

1. All appeals regarding eligibility determination, redetermination, and timeliness of Covered California coverage or grants of federal tax credits or federal subsidies, *except* for appeals of an eligibility determination and redetermination for an exemption. Exemption appeals will be handled by the federal HHS.

   Specifically, the SHD will have jurisdiction over:

   a. An eligibility determination, including:

      i. An initial determination of eligibility, including the amount of APTC and level of CSR, made in accordance with the standards specified in Sections 6472 and 6474 of Article 5, Chapter 12, of the Covered California Regulations, and including enrollment issues as specified in 10 CCR § 6500; and

      ii. A redetermination of eligibility, including the amount of APTC and level of CSR, made in accordance with Sections 6496 and 6498 of Article 5.

   b. Covered California's failure to provide a timely eligibility determination in accordance with Section 6476(f) of Article 5 of Chapter 12, or failure to provide timely notice of an eligibility determination or redetermination in accordance with Sections 6476(h), 6496(h)(2), or 6498(j)(2) of Article 5.

   c. Fraud Cases: When the QHP Issuer terminates a QHP with the enrollee due to the enrollee's alleged fraud or intentional misrepresentation, it is the QHP Issuer, not Covered California, that sends the Notice of Termination to the enrollee under 10 CCR § 6506 (e)(1). The QHP Issuer also notifies Covered California. The SHD shall be responsible for hearing any appeal of that notice.

   d. Small Business Health Options Program (SHOP) Appeals: The SHD has been contacted by SHOP to handle employee and employer appeals. The details of the delegation and additional process will be forthcoming.

   e. "Aid Paid Pending": Upon receipt of an appeal request regarding a redetermination, Covered California shall continue to consider the applicant eligible while the appeal is pending, and:

      i. If the tax filer or appellant accepts eligibility during appeal, Covered California shall continue, or reinstate within 5 business days, the Appellant's eligibility for enrollment in QHP, APTC and CSR as applicable ("previous level of coverage"), in accordance with the level of eligibility immediately before the redetermination being appealed.

      ii. Federal Government has instructed Covered California to continue or reinstate "previous level of coverage" on any appeal of a discontinuance or decrease filed within 90 calendar days from the Notice of Action date

until the decision is issued, as long as the recipient pays any required premium.

2. All MAGI Medi-Cal appeals.

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

   b. All MAGI Medi-Cal initial determinations are based on policies developed by the DHCS and are contained in CalHEERS; however it will be the counties' responsibility to verify any additional information needed for a final determination. The counties also have the responsibility to defend any MAGI Medi-Cal appeal, including any appeal of a denial of MAGI Medi-Cal.

3. All Non-MAGI Medi-Cal appeals.

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

B. APPEALS PROCESS FOR COVERED CALIFORNIA AND MAGI MEDI-CAL CASES: CHANGES FROM CURRENT HEARING PROCEDURE

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

All appeals will be governed by the applicable federal regulations, the provisions of Title 10 of the California Code of Regulations, http://www.ccr.oal.ca.gov/linkedslice/default.asp?SP=CCR-1000&Action=Welcome, and the existing CDSS Manual of Policy and Procedure (MPP) regulations §22-000 et seq. http://www.dss.cahwnet.gov/ord/PG319.htm. Nothing in this ACL is intended to limit or reduce a claimant's rights to notice, hearing, and appeal under existing Medi-Cal, county indigent programs, or any other public programs.

Attachment I contains the basic provisions of the appeals process that will apply to hearing requests involving Covered California and MAGI appeals.

The key operational and procedural changes are as follows:

1. MAGI MEDI-CAL PREHEARING PROCESS

a. All MAGI Medi-Cal applications will be inputted into the CalHEERS system. Currently the communication between the SAWS and CalHEERS

has not yet been programmed. This programming is scheduled for later in January 2014.

After the programming is in place, the eligibility information from CalHEERS will be uploaded to SAWS where the counties will be able to verify eligibility of the information on the claimant's application. Upon verification of eligibility (or non-eligibility), the counties will send out the appropriate Notice of Action to the claimant.

b. In response to the significant number of Medi-Cal applications received through the Covered California portal, DHCS is providing temporary eligibility for approximately 200,000 individuals while the counties complete the necessary administrative verifications. These are cases in "pending," status in CalHEERS as of December 14, 2013. Letters are being sent to consumers informing them that their Medi-Cal coverage will begin January 1, 2014 and continue until a final determination is made by the county. The letters stress that the individuals need to comply with any verification requested by the counties.

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

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

2. The claimant may submit a Covered California and/or MAGI Medi-Cal request for an appeal, in person or by telephone, online, mail or fax to Covered California, counties or the SHD.

NOTE: DHCS does not have infrastructure to receive MAGI and non-MAGI hearing requests directly. DHCS conducts the fair hearing process through the counties and the SHD.

a. **New 800 telephone & Fax Lines**: New 800 and fax lines have been established devoted exclusively to ACA appeals – specifically Medi-Cal and Covered California eligibility and enrollment issues. The telephone number is **1-855-795-0634** and the fax number is **1-916-651-2789**. These phone numbers have been posted on the Covered California website.

b. **Separate Database**: Covered California and MAGI Medi-Cal hearing requests will not be entered into the Health and Welfare Data Center (HWDC). A separate interim database has been established to process these hearing requests. Non-MAGI Medi-Cal cases will continue to be onlined into HWDC by SHD only. The counties ability to check the status of a Non-MAGI Medi-Cal case in HWDC will not change.

c. **Daily Status Reports**: from the Affordable Care Act Hearings Bureau (ACAB) database will be provided via Secure File Transfer (SFT) to the counties in order that the counties can quickly determine the status of a case. If more precise or additional information is needed, the county should call or email the ACAB.

d. **Onlining Limited to SHD Only**: All Covered California, MAGI Medi-Cal and Non-MAGI Medi-Cal appeal requests received by the counties are to be forwarded directly to SHD's ACAB. The date of the hearing request is the date Covered California or the county received the request, not the date the ACAB receives it. The ACAB will online all Covered California, MAGI Medi-Cal and Non-MAGI Medi-Cal appeals. Counties with the ability to currently online to HWDC must stop onlining these cases, and forward all Covered California, MAGI Medi-Cal, and Non-MAGI Medi-Cal appeals to the ACAB, to be onlined into the new interim database.

e. **Transfer of Information via SFT**: A new County SFT has been set up for each county to transfer information to the ACAB. Each county will submit a list of users who will be assigned passwords. All MAGI Medi-Cal information, including Requests for Hearing and Statements of Position and regular Medi-Cal Requests for Hearing must be transmitted through the ACAB SFT. Once a regular Medi-Cal case has been onlined into HWDC, information may be transmitted using the current process and the current SFT. In the event SFT is unavailable, information may be transmitted via facsimile or by mail.

    i. The ACAB SFT folders are separate and distinct from the SFT folders the county's' are currently using for General Jurisdiction cases.

f. **Scheduling**: ACAB will schedule cases in the same manner as is currently used in General Jurisdiction using the County four week calendar model, and will coordinate the schedule of hearings with each county, taking into consideration, to the extent possible, each counties resources and needs.

g. **15 Day (instead of 10 day) Notice of Hearing**: SHD schedules hearing and sends Notice of Hearing (NOH), to all parties, providing at least 15 calendar days' notice of the hearing date.

h. **Position Statements**: County determinations of eligibility for Non-MAGI Medi-Cal require the county to have the position statement available to the claimant not less than 2 full business days prior to the hearing date.

i. **Written Withdrawals**: Written Unconditional or Conditional Withdrawals result in immediate dismissal of the appeal.

    i. **Conditional Withdrawal:** In all cases in which there is a Covered California and a Medi-Cal issue, all Conditional Withdrawals must be in writing. A request to withdraw a hearing based on a conditional withdrawal must be accompanied by the agreement signed (faxed or telephonic signature is allowed) by claimant and Covered California or the County, as part of the informal resolution process. Telephonic signature is allowed under the provisions set out in ACIN I-60-13. The agreement must specify what Covered California or the county is re-reviewing and the actions to be taken, after review, with sufficient detail that the obligations of the claimant and/or county (as applicable) are clear. For example, stating that Covered California or the county will "review" the matter is not sufficient. The agreement must instead say what Covered California or the county is re-reviewing and what the action after review will be, including rescission of the prior Notice of Action (NOA). The written agreement must be signed by all parties and received by the ACAB *prior to* the hearing. Upon receipt of a signed withdrawal, the appeal will be dismissed, subject to a good cause re-opening. The action by Covered California or the counties should be taken as soon as practicable after receipt of the signed Conditional Withdrawal but no later than 30 days after the execution of the Conditional Withdrawal. As a best practice, however, a Covered California or county action may be taken as soon as practicable after the agreement with the claimant has been made, even if the signed Conditional Withdrawal has not been received from the claimant. If the signed Conditional Withdrawal is not received before the hearing, the hearing will go forward and all parties must appear at the hearing. If the claimant fails to appear for the hearing, the ACAB will dismiss the case and notify the claimant that the case has been dismissed and provide information on how to reopen the case for good cause. Covered California and/or the County should, as a best practice, advise the claimant if the written Conditional Withdrawal has not been received two business days before the hearing, so the claimant is aware of the non-receipt of the agreement and the need to appear at the hearing.

        The ACAB will provide a "Duty Judge," who will be available on short notice to provide to the parties a telephone hearing for the

purpose of a pre- hearing disposition on the record. This process is not intended to alleviate the responsibilities of Covered California or the counties to provide signed written Conditional Withdrawal, but rather as a convenience for the parties which can be used where a signature cannot be readily obtained from the claimant prior to the hearing. Essentially, the telephone hearing would be a stipulated decision that provides for the parties to carry out the terms of the agreement.

ii. **Verbal Unconditional Withdrawals**: If a claimant makes a verbal Unconditional Withdrawal request directly to the ACAB, after confirming the person's identity, the case will be dismissed. If a verbal Unconditional Withdrawal is submitted by the county or Covered California, the ACAB must be notified immediately. The ACAB will attempt to contact the claimant and verify the verbal withdrawal. If the verbal withdrawal can be verified, the appeal will be dismissed. If the verbal Unconditional Withdrawal cannot be verified, the ACAB will mail a written inquiry to the claimant advising them that the County or Covered California has reported that the claimant wishes to withdraw the hearing request and that the SHD must confirm with the claimant that this is what they want. The written contact will advise the claimant that the withdrawal is voluntary and the person has a right to a judge's decision. The claimant will be informed that if he or she does not contact the SHD within 15 calendar days of mailing the request for confirmation of withdrawal, the SHD will take this to mean that the claimant wishes to withdraw the appeal, and the case shall be dismissed. A final Notice of Dismissal is mailed informing the claimant that the appeal is dismissed, unless good cause is provided within 30 calendar days for setting aside the dismissal.

j. **Informal Resolution:** An informal resolution is a written agreement reached between the appellant and the county or Covered California to resolve an appellant's appeal before the hearing, making the hearing unnecessary. If the appeal is resolved through the informal resolution process:

i. Covered California shall notify the claimant within 5 business days of the agreed upon terms and effective date of the informal resolution. This information shall include the statement in the agreement that by signing the Agreement the request for this hearing will be canceled and the appeal will be dismissed.

ii. Covered California shall notify the ACAB within 3 business days.

iii. Informal resolutions reached with Covered California are final and binding, and the appeal is administratively dismissed if the appellant unconditionally or conditionally withdraws his/her appeal request prior to the hearing date, in accordance with the procedure set forth in Section 6610(a)(1). See also 45 CFR 155.530(a)(1)

iv. Counties and Covered California shall notify the ACAB of any informal resolution reached with the appellant.

v. The claimant/appellant may request that the administrative dismissal be set aside and the case be re-opened upon a showing of good cause.

k. **Dismissals**: Federal and state regulations provide for dismissals of Covered California appeals as follows:

i. Claimant unconditionally or conditionally requests a withdrawal in writing prior to the hearing date.

ii. Claimant fails to appear at the hearing without good cause.

iii. Claimant fails to submit a valid appeal request pursuant to 10 CCR 6606(a) (4) without good cause.

iv. Claimant dies while the appeal is pending, unless the appeal affects remaining member(s) of the claimant's household or the appeal can be carried forward by a representative of the claimant's estate. (CDSS MPP §22-004.4.)

l. **Notice of Dismissal:** If a Covered California and MAGI Medi-Cal appeal is dismissed, the ACAB shall provide notice to the claimant in 5 business days, including:

i. Reason for the dismissal.

ii. Explanation of the dismissal's effect on the claimant's eligibility.

iii. Explanation of how, with good cause, the dismissal may be vacated, and the timeframe within which to make such a request.

iv. Statement explaining that ACAB may vacate a dismissal if the claimant makes a written request within 30 calendar days and shows good cause. SHD must notify the claimant within 5 business days if the request to vacate the dismissal for good cause is denied. The denial of a request to vacate a Covered California dismissal is an appealable issue to the federal HHS. This 30 day time period may be extended for good cause.

m. **Notice to Covered California and the Counties**

i. The ACAB shall notify Covered California and the county, as applicable, within 3 business days of the dismissal, and give instructions to Covered California (not the county) regarding the eligibility determination to implement and discontinue eligibility pending appeal under 10 CCR 6608, if applicable, no earlier than 5 business days of the dismissal.

n. **Statement of Position (SOP)**: Covered California will prepare all SOPs involving eligibility determinations within its jurisdiction. The county responsible for the MAGI or non-MAGI Medi-Cal eligibility determination will prepare all SOPs involving MAGI and Non-MAGI Medi-Cal eligibility determinations. The claimant and/or the AR have a right to submit a SOP.

i. Dual Agency Determinations: Where claimant's appeal raises disputes that involve both Covered California and Medi-Cal, the agencies will coordinate and decide whether all issues can be set forth in one SOP, or whether separate SOPs will be submitted. A coordinated Statement of Position is preferred, but not mandatory.

ii. Availability of SOP: Under the "No Wrong Door" policy any agency's SOP must be made available to the claimant not less than two full business days before hearing. Covered California will provide its SOP to counties electronically not less than two business days prior to the hearing. Covered California shall notify the claimant that the position statement will be available through the claimant's web portal, and will also give the claimant the contact information on how to obtain a copy of the SOP from the county no less than two business days before the hearing.

iii. Upon request of the claimant, the counties will make available to the claimant a copy, if available, of Covered California's Statement of Position no less than 2 full business days before the hearing.

o. **Expedited Hearings**: Federal and state Covered California regulations mandate an Expedited Appeals process for Covered California appeals where claimant has an ***"immediate need for health services and a standard appeal could seriously jeopardize the claimant's life or health or ability to attain, maintain or regain maximum function",*** 45 CFR Section 155.540(a) and 10 CCR Section 6616(a). All requests for expedited hearings will be processed as follows:

i. The ACAB will field requests for expedited state hearings from claimants/authorized representatives (ARs), Covered California and counties. If the appeal involves a Covered California issue, the Presiding Judge (PJ) of the ACAB will determine if an expedited state hearing is

required. If the appeal involves MAGI or Non-MAGI Medi-Cal issues only, the request for an expedited hearing shall be submitted to the SHD PJ for the county's regional office.

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

iii. If the Expedited Appeal request is granted such grant will be made within 3 business days of receipt of the request for an expedited hearing, the ACAB shall, within 10 calendar days of claimant's request for an Expedited Appeal, provide claimant with a notice stating the date, time and place of the Expedited Hearing. The ACAB will notify Covered California and the county, if applicable, within 3 business days of the determination to grant the expedited hearing.

iv. Decisions on Expedited Appeals shall be issued no later than 10 days after the Notice of Hearing is sent to the claimant, provided that the record is not left open to receive additional evidence, in which case the decision shall be due no later than five days after the close of the administrative record. Compliance with the Expedited Appeal is also expedited, and must be completed within 15 days after the decision is received by Covered California or the county.

v. Requests for these hearings shall be made to the ACAB at **1-855-795-0634** or to the SHD at **1-800-743-8525** or **fax (916) 651-2789,** or for hearings for speech impaired **(TDD) 1-800-952-8349**.

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

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

4. **POST-HEARING**:

a. **Decisions**: Generally, all non-expedited ALJ decisions in Covered California and Medi-Cal cases must be issued within 90 days of the hearing request.

i. For Covered California decisions: The decision is final, subject to the claimant pursuing an appeal with the HHS appeals entity. The decision will provide an explanation of the appellant's right to pursue an appeal before the HHS appeals entity, including the applicable timeframe and instructions to file.

ii. For Medi-Cal and MAGI Medi-Cal cases: The decision will indicate the current appeals process used for all Medi-Cal decisions, including the claimant's right to a rehearing.

iii. For Covered California, MAGI Medi-Cal and regular Medi-Cal decisions:

1. The decision will also provide information about judicial review available to the appellant pursuant to Section 1094.5 of the California Code of Civil Procedure.

b. **Favorable Decision – Compliance for Covered California**: If the decision is in claimant's favor, Covered California shall comply and implement the decision as follows:

i. Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with 10 CCR Section 6496(l), if applicable; or

ii. Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant; and

iii. Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the appeal decision, in accordance with the standards specified in 10 CCR Sections 6472 and 6474.

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

i. Covered California Issues: All decisions relating to issues within the jurisdiction of Covered California are final unless, the claimant requests an appeal regarding issues relating to Covered California to the HHS within 30 days of receipt of the decision by the ACAB/SHD.

ii. MAGI or Non-MAGI Medi-Cal Issues: MAGI and Non-MAGI Medi-Cal rehearing requests regarding any issues relating to Medi-Cal coverage shall be submitted to the DHCS Rehearing Unit within 30 days of the decision.

iii. All Other Issues (i.e. CalFresh, CalWORKS, IHSS, etc.): rehearing requests for all other programs shall be submitted to the SHD Rehearing Unit within 30 days of receipt of the decision.

iv. Judicial Review: The claimant is permitted to also seek judicial review to the extent provided by law. Exhaustion of an appeal to HHS or DHCS is not a prerequisite for seeking judicial review.

d. **Claimant's Access to Appeal Record**: Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the ACAB will make the appeal record accessible to the appellant for at least five years after the date of the written notice of the appeal decision as specified in 10 CCR Section 6618(b)(1).

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

REPRESENTATIVES RESPONSIBILITIES IN COVERED CALIFORNIA AND MAGI MEDI-CAL APPEALS

Covered California appeal representatives have responsibility for processing all Covered California appeals.

County Hearing Representatives (CHRs) are responsible for processing all MAGI Medi-Cal hearing appeals consistent with the provisions of Division 22 and, except as otherwise set forth in this ACL, in the same manner as existing Medi-Cal appeals have been handled, including any denial of MAGI Medi-Cal made by CalHEERS.

The changes to the CHR responsibilities are as follows:

1. **Prehearing:**

   a. **Hearing Requests**: Counties with onlining capacity must forward all Covered California, MAGI and Non-MAGI Medi-Cal hearing requests to the ACAB for onlining.

   b. **Informal Resolution**: Where the appeal involves both Covered California and Medi-Cal issues, the CHR should contact Covered California and coordinate any potential informal resolution of the appeal.

   c. **Statement of Position**: Where the claimant is appealing issues relating to both Covered California and MAGI-Medi-Cal issues, CHR must contact Covered California to coordinate the preparation and submission of the SOP. Where a single coordinated SOP cannot be submitted, the county should submit a timely SOP detailing the county issues. Where the appeal involves only Covered California, the CHR will assist the claimant in the receipt of Covered California's SOP by making the Statement of Position available to the claimant no less than two business days before the hearing if the Statement of Position has been made available to the county by Covered California.

   d. **Transfer of Information**: Counties will forward all ACA and Medi-Cal related appeal requests to the ACAB via the Secured File Transfer (SFT) process. County staff will be provided access to the ACAB specific SFT folders upon

request to SHD. In the event SFT is unavailable, information may be transmitted via facsimile or by mail.

2. **Hearing**: In dual cases, whenever possible, the CHR will present the MAGI Medi-Cal or the Non-MAGI Med-Cal case and the Covered California Hearings Representative will present the Covered California case in the same hearing. Nothing in the ACL prevents Covered California and the counties from working cooperatively in presentation of evidence at the hearing.

3. **Post-Hearing**: There will be no change in the post hearing processes for the MAGI Medi-Cal and Non-MAGI Medi-Cal cases. Covered California appeals of ACAB's decisions will go directly to the federal HHS. Non-Medi-Cal County rehearing processes will remain the same.

USE OF SEPARATE CASE MANAGEMENT SYSTEM FOR PROCESSING ACA APPEALS

Due to the anticipated volume of appeals generated by implementation of the ACA, and given the limitations of the SHD's Health and Welfare Data Center (HWDC) database, the SHD has developed a separate, interim case management system to input, track and process all ACA related appeals. The SHD will continue to utilize the HWDC to process all non-ACA appeals (i.e. CalFresh, CalWORKS, IHSS, foster care benefits, etc.). However, all Covered California and Medi-Cal appeals will be processed utilizing this interim solution.

Effective immediately, counties can no longer online MAGI Medi-Cal and Non-MAGI Medi-Cal appeals/hearing requests into HWDC. All MAGI Medi-Cal and Medi-Cal appeals/hearing requests must be forwarded to the ACAB for onlining on to the appropriate data base.

If the county receives an oral, written or online request for a state hearing regarding an ACA appeal, the county should assist the claimant in filing a hearing request and refer the claimant to the State Hearings Division at 1-855-795-0634. If the county receives a written request for a state hearing regarding a MAGI or Non-MAGI appeal, the county should fax the request to the State Hearings Division, at fax number (916) 651-2789. In the event SFT or facsimile is unavailable, appeal requests may be mailed to the ACAB at the following address:

California Department of Social Services
State Hearings Division
Affordable Care Act Appeals Bureau
MS 9-17-97
Sacramento, California 95814

ACAB MANAGEMENT TEAM CONTACT

An ACAB Presiding Administrative Law Judge will be available for Covered California and County Representatives by email or telephone during regular business hours for non-substantive issues unrelated to individual claims at the following email address and phone number:

shdacapj@dss.ca.gov Direct Email to ACAB Presiding Judge

916-651-5029 Direct Line to ACAB Presiding Judge

The following email address should be used to conduct regular daily business and will be checked daily during regular business hours by ACAB staff:

shdacabureau@cdss.ca.gov

For questions regarding the content of this letter, please contact Presiding Judge Charles DeCuir, ACAB, at (916) 916-651-5026 or by email, to charles.decuir@dss.ca.gov

Sincerely,

MANUEL A. ROMERO
Deputy Director
State Hearings Division

Attachment

ATTACHMENT I TO ALL COUNTY LETTER ___

PROCEDURE FOR COVERED CALIFORNIA AND MAGI MEDI-CAL DUAL CASES

The basic provisions of the appeals process that will apply to hearing requests involving Covered California and MAGI appeals are as follows:

Prehearing Procedures:

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

   NOTE: DHCS does not have infrastructure to receive MAGI and non-MAGI hearing requests directly. DHCS conducts the fair hearing process through the counties and the SHD.

2. New 800 telephone and fax lines have been established devoted exclusively to ACA appeals. The telephone number is 1-855-795-0634, and the fax number is 1-916-651-2789.

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

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

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

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

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

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

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

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

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

    a. Claimant unconditionally or conditionally requests a withdrawal in writing prior to the hearing date.

    b. Claimant fails to appear at the hearing without good cause.

    c. Claimant fails to submit a valid appeal request without good cause. 10 CCR 6606(a)(4),

    d. Claimant dies while the appeal is pending, unless the appeal affects remaining member(s) of the claimant's household or the appeal can be carried forward by the representative of the claimant's estate. (CDSS MPP §22-004.4.)

    e. If appeal is dismissed, the SHD shall provide timely notice in 5 business days, including:

        i. Reason for the dismissal.

        ii. Explanation of the dismissal's effect on the claimant's eligibility.

        iii. Explanation how, with good cause, the dismissal may be vacated.

        iv. Notify Covered California and the county, as applicable, within 3 business days of the dismissal, and give instructions regarding the eligibility determination to implement and discontinue eligibility pending appeal under 10 CCR 6608, if applicable, no earlier than 5 business days of the dismissal.

    f. SHD may vacate a dismissal if the claimant makes a written request within 30 days and shows good cause. SHD must notify the claimant within 5 business days of denial to vacate. This is an appealable issue.

    g. If claimant's request to reopen the hearing request is granted, the hearing will be rescheduled.

        i. Pending the hearing, Covered California and/or the county will engage in the informal resolution process, which may result in an Unconditional or Conditional Withdrawal of the hearing request.

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

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

    i. The ACAB will provide a "Duty Judge," who will be available on short notice to provide to the parties a telephone hearing for the purpose of a pre-hearing disposition on the record. This process is not intended to alleviate the responsibilities of Covered California or the counties to provide a signed written Conditional Withdrawal, but rather as a convenience for the parties which can be used where a signature cannot be readily obtained from or provided by the claimant prior to the hearing.

14. Effect of Withdrawal: If the case is fully resolved, the SHD is notified and shall dismiss the case and remove the matter from the hearing calendar. Federal and state regulation provides that the SHD shall dismiss an appeal if the claimant:

    a. Unconditionally or conditionally requests a withdrawal in writing prior to the hearing date:

        i. If written Unconditional Withdrawal request, the appeal request is immediately dismissed.

        i. If verbal unconditional Withdrawal request, the SHD will attempt to contact the claimant and verify the withdrawal. If SHD is unable to contact the claimant, SHD will send written confirmation within 5 business days to the claimant's last known address on record. The claimant will be informed that if s/he does not contact the SHD within 15 calendar days of mailing the request for confirmation of withdrawal, the SHD will take this to mean that the claimant wishes to withdraw the appeal, and the case shall be dismissed. A final Notice of Dismissal is thereafter mailed informing the claimant that the appeal is dismissed, unless good cause is provided within 30

calendar days for setting aside the dismissal. If the dismissal is set aside, the matter will be set for hearing. If the request is denied, the SHD must notify the claimant within 5 business days of denial to vacate. This is an appealable issue to HHS.

ii. If Conditional Withdrawal request, withdrawal shall be accompanied by agreement signed by claimant and Covered California (CC) or the county, as part of informal resolution process. The written agreement must be received by SHD before the hearing. Upon receipt of the written Conditional Withdrawal, the SHD shall dismiss appeals request. If the claimant verbally agreed to a conditional withdrawal, but CC/the County has not received the signed agreement by the close of the second business day prior to the hearing, the CC/County should, as a best practice, notify the claimant that the form was not received and the claimant must appear at hearing. The ACAB will provide a "Duty Judge," who will be available on short notice to provide to the parties a telephone hearing for the purpose of a pre-hearing disposition on the record. This process is not intended to alleviate the responsibilities of Covered California or the counties to provide a signed written Conditional Withdrawal, but rather as a convenience for the parties which can be used where a signature cannot be readily obtained from or provided by the claimant prior to the hearing.

b. If the appeal is resolved through the Covered California informal resolution process:

i. Covered California shall notify the claimant within 5 business days of terms and effective date of informal resolution.

ii. Covered California shall notify the SHD within 3 business days of any informal resolution.

iii. The informal resolution is final and binding on all parties once terms and conditions of the agreement are completed.

c. In the event the appeal is not resolved during the informal resolution process, the case will proceed to hearing. If conditions of the agreement are not met, the hearing will go forward or be reinstated and rescheduled if already dismissed.

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

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

17. Availability of SOP: The agency's SOP must be made available no less than two business days before hearing. Covered California will provide its SOP electronically to counties in a manner that complies with this requirement. Upon request of the claimant, the counties will provide the claimant with a copy, if available, of Covered California's Statement of Position. The claimant and his/her AR shall have the opportunity to review his or her appeal record, case file, and all documents to be used at the hearing, at a reasonable time before the date of the hearing as well as during the hearing. The appeal record includes: The appeal decision, all papers and requests filed in the proceeding, and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing and any exhibits introduced at the hearing.

18. Expedited Hearings: Request for expedited hearings will be processed as follows: Requests for expedited hearings shall be made to the ACAB at 1-855-795-0634 or to the SHD at 1-800-743-8525 or fax (916) 651-2789, or for hearings for speech impaired (TDD) 1-800-952-8349. The SHD will field requests for expedited state hearings from claimants/authorized representatives (ARs), Covered California and counties. If the appeal involves a Covered California issue, the Presiding Judge (PJ) of the ACAB will determine if an expedited state hearing is required. The standard used to determine whether an expedited state hearing is required is set forth in 45 CFR Section 155.540(a) and California Code of Regulations, Title 10, Chapter 12, Article 7, § 6616. An expedited hearing is required "*where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life or health or ability to attain, maintain, or regain maximum function."*

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

    b. If the Expedited Appeal request is granted, the ACAB shall, within 10 calendar days of claimant's request for an Expedited Appeal, provide claimant with a notice stating the date, time and place of the Expedited Hearing. The ACA Bureau will notify Covered California and the county, if applicable, within 3 business days of the determination to grant the expedited hearing.

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

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

Hearing Procedures:

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

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

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

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

Post-Hearing Procedures:

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

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

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

4. Favorable Decision – Compliance for Covered California: If the decision is in claimant's favor, Covered California shall comply and implement the decision as follows:

   i. Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with 10 CCR Section 6496(l), if applicable; or

   ii. Retroactively, to the date the incorrect eligibility determination was made, at the option of the appellant; and

   iii. Redetermine the eligibility of household members who have not appealed their own eligibility determinations but whose eligibility may be affected by the

appeal decision, in accordance with the standards specified in 10 CCR Section 6472 and 6474.

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

   i. Covered California Issues: All decisions relating to issues within the jurisdiction of Covered California are final unless, the claimant requests an appeal regarding issues relating to Covered California to the federal Department of Health and Human Services (HHS) within 30 calendar days of receipt of the decision, unless good cause is shown why the conditions of a Conditional Withdrawal were not satisfied.

   ii. MAGI or Non-MAGI Medi-Cal Issues: MAGI and Non-MAGI Medi-Cal rehearing requests regarding any issues relating to Medi-Cal coverage shall be submitted to the DHCS Rehearing Unit within 30 calendar days of receipt of the decision.

   iii. All Other Issues (i.e. CalFresh, CalWORKS, IHSS, etc.): rehearing requests for all other programs shall be submitted to the SHD Rehearing Unit within 30 calendar days of receipt of the decision.

   iv. Judicial Review: The claimant is permitted to also seek judicial review to the extent provided by law. Exhaustion of an appeal to the HHS or DHCS is not a prerequisite for seeking judicial review.

6. Claimant's Access to Appeal Record: Subject to the requirements of all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, the ACAB will make the appeal record accessible to the appellant for no less than five years after the date of the written notice of the appeal decision as specified in 10 CCR Section 6618(b) (1).

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

Sincerely,

Original Document Signed By:

MANUEL A. ROMERO
Deputy Director, Chief Administrative Law Judge
State Hearings Division