

Creating California's "No Wrong Door" for Health Coverage: Recommendations from Consumer Advocates

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Introduction

The Affordable Care Act (ACA) will fundamentally change the way millions of Californians will access health coverage. Instead of having to apply for a particular health coverage program, the ACA requires a seamless “no wrong door” approach to coverage, meaning that regardless of where a person applies for health coverage she or he is evaluated for all programs and enrolled into the most beneficial program based on income and other criteria.

A number of important decisions need to be made regarding how to structure this system in California so that it is up and running by January 1, 2014. Recognizing this, the Western Center on Law & Poverty started in the fall of 2010 working with advocacy partners, in some twenty organizations, to analyze the opportunities and challenges in the ACA and make recommendations as California moves to implement the Eligibility, Enrollment and Retention portions of the ACA. While we recognize that there are additional issues related to this topic, this paper presents our analysis, recommendations, and assessment of remaining questions regarding the architecture of the new system, including electronic applications and information technology issues.

This paper addresses the structural issues involved in building the needed Eligibility, Enrollment and Retention (EER) System. This includes the application and renewal processes, verification systems, real-time enrollment, transitions between programs, and appeals.

A. No Wrong Door

California's new Eligibility and Enrollment system should be designed to fully embrace the “no wrong door” approach envisioned by the ACA so that no matter where and with what knowledge people apply for coverage, they get full access to all public health coverage programs and are enrolled into the most beneficial program. To achieve this goal, the new system must:

- **Allow applicants to apply for health coverage through any venue without having to specify the program for which they are applying.** Regardless of where someone applies for coverage she should be evaluated for all health coverage programs. A person should not have to specify a program to be enrolled into it. For example, if someone thinks he is eligible for tax subsidies under the Exchange and applies for coverage online through the Exchange portal, but he is actually eligible for Medi-Cal, he must be offered enrollment into Medi-Cal. Similarly, if someone applies for Medi-Cal at a county welfare office or starts a Medi-Cal application through a short-cut from a provider's

office and is not eligible for Medi-Cal but is eligible for the Exchange, that person must be offered coverage in the Exchange. This is required by the ACA.¹

- **Ensure people are enrolled in the most beneficial program for which they are eligible.** Applicants for health coverage should be enrolled in the health care program with the most comprehensive coverage and lowest cost sharing. This would mean offering enrollment in Medi-Cal first, over the Exchange or Healthy Families. This too is required by law.²
- **Use simple, consistent rules in conducting screening, eligibility & enrollment activities.** Regardless of where someone applies, consistent eligibility rules must be used regarding counting income, family size and determining immigration status and residency. Without this consistency, a person might get a different result based on where she applies. A person applying online should get the same result as if they had applied in person, by phone or by mail. To achieve this, either all applications should go through the same eligibility system or they should go through systems programmed with consistent standards and managed by a single agency or entity (i.e. an inter-agency body).

California has not achieved this goal with the children's joint Medi-Cal/Healthy Families application. Sometimes applications processed by Medi-Cal and Healthy Families reach different conclusions regarding what program a child is eligible for. This is not an acceptable outcome.

In addition to consistent rules, the eligibility rules must also be simplified as much as possible to streamline determinations and adopt an efficient process without unnecessary barriers to coverage.

- **All programs and entities assisting with, taking, or processing applications and renewals must have access to the same data.** This point builds on using the same rules. Not only should applications be screened with the same rules and programming, but all entities involved with enrollment should have access to the full set of program rules and information. Thus a certified application assistant or county welfare worker could access the same information and system as those processing applications submitted online. To achieve this, there must be clear, consistent, and transparent standards.
- **Minimize information and documentation required.** Individuals should be required to submit only the essential eligibility elements, as required by federal law. The EER system should, at the individual's option, access and verify data from available databases using

¹ Patient Protection and Affordable Care Act, Publ. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), (hereafter ACA), section 2201(b)(1)(C).

² ACA § 2201(b)(1)(C), 42 U.S.C. § 1396w-3(b)(1)(C).

the minimum data elements required to determine eligibility and use that data to pre-populate an application or renewal form and complete the determination in real-time, to the greatest degree possible. When necessary, applicants can be prompted to submit additional information and documents. These issues are described in greater detail in various sections below.

- **Broad Coverage Options.** The EER System must connect applicants to the widest variety of coverage options available, including limited scope, state-only, and/or local coverage options. Further, the verification process for Medi-Cal, Healthy Families and the Exchange should be constructed in a manner that does not preclude applicants from gaining other sources of coverage that may be available and appropriate for their circumstances. For instance, where an applicant does not meet the immigration criteria, individuals that are eligible for limited-scope services such as pregnancy-related services or family planning services under the state plan should be able to maintain coverage under Medi-Cal without cost sharing for those services while also qualifying through the enrollment process for health coverage for all other benefits.
- **Support the Needs of All Californians:** The EER system should be designed to meet the diverse needs of all Californians seeking coverage, including:
 - Providing and soliciting information at an appropriate literacy level that meets the individual's language needs;
 - Providing language assistance to those who do not speak or read English well. This includes providing culturally appropriate services in person and by phone in the consumer's primary language and translating crucial written materials;
 - Accommodating the needs of seniors and persons with disabilities, including through the use of large print and assistive technologies; and
 - Accommodating the needs of families with members in different health coverage programs and different circumstances, including mixed immigration-status families.

1. The Application

- To achieve the no wrong door architecture, the state must adopt a **single simplified application** for use by Internet, mail, phone or in person.³ Note that while this application will collect the same information regardless of whether applicants access it by Internet, mail, phone or in person, the formatting may vary. For example, electronic applications can use pull-down menus and "decision trees."

³ Centers for Medicare and Medicaid Services (CMS) will design "a single, streamlined form" for applying to the Exchange. (ACA § 1413(b)(1)(A)). States "may develop and use [their] own single, streamlined form [for Medicaid, CHIP and the Exchange] as an alternative. . .if [it] is consistent with standards promulgated by the Secretary" under the ACA. (§ 1413(b)(1)(B)). The Secretary may also allow a state to use "a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income" (§ 1413(b)(1)(C)).

Application avenues: Existing application “doors” should continue to be available as new doors such as the Exchange portal and telephone route are added. Individuals and families should be able to submit applications, submit changes and new information, get information and assistance, and renew coverage through the following avenues:

- In person at social services offices, welfare offices and at community-based organizations
- By mail
- By phone
- At a hospital, clinic or doctor’s office
- With an application assistant
- Online
- Through categorical eligibility: SSI, CalWORKs, Foster Care, Adoption Assistance
- Through the Medicare Part D LIS application which goes to counties to screen for Medicare Savings Programs and Medi-Cal
- Through Presumptive Eligibility including:
 - Through the CHDP Gateway
 - Via Bridging from Healthy Families → Medi-Cal
 - Through Express Lane Eligibility⁴
- Deemed Eligibility:
 - When a baby is born to a Medi-Cal mother → to Medi-Cal
 - When a baby is born to an AIM mother → Healthy Families
- When an SSA disability application is referred to Medi-Cal

There may be additional pathways for application and renewal.

2. Design Considerations: Online v. Paper Applications

Differences between the paper and electronic applications should be minimized as much as possible recognizing that a paper application, unassisted, is less interactive. Regardless of any differences, both applications (and any version used over the phone) should utilize the same underlying rules engine for processing and result in the same evaluation of eligibility, and same opportunities to provide supplemental information and use all available electronic verifications to minimize the follow-up needed.

⁴ Express Lane Eligibility is a means of streamlining presumptive eligibility for kids’ access to services under Medi-Cal and Healthy Families based on findings of other need-based programs, such as the National School Lunch Program (NSLP), even if a different methodology is used to make that finding.

Some considerations for the electronic application:

- It will allow for electronic matching with federal and state data. While data matching is a powerful tool when it verifies current accurate information, reliable data will not always be available. Therefore, the system must allow for other means of obtaining and verifying information as well as allowing consumers the ability to correct information which is not accurate or current.
- Consumers must be able to apply and renew with an electronic signature.
- Information filled into the online application, including a partially complete application, should be able to be accessed at a later date by the applicant or an application assistant/agency official who is authorized by the applicant. Also, the electronic application should be flexible enough to allow an applicant to skip a section and move to another.

The state must find the right **balance** between a simple application that is less burdensome on the one hand and asking comprehensive questions to screen for all possible programs on the other. The balance is easiest to strike with an electronic application that uses a logic tree, but is also possible with a paper version.

B. Coordination Among Departments and Agencies

A complicated array of entities administer and/or oversee California's health coverage programs including the Department of Health Care Services which administers Medi-Cal with counties administering the eligibility process; the Managed Risk Medical Insurance Board which administers the Healthy Families Program with a vendor carrying out many eligibility processes; and the California Health Benefits Exchange Board which administers the Exchange, with eligibility mechanisms to be determined. In addition, many other entities provide crucial data or services to assist consumers in obtaining and retaining coverage (e.g., CalFresh, WIC, CHDP Gateway, hospitals, clinics, and certified application assistants). While some administrative simplification may occur, multiple agency and entity involvement is likely to persist.

Regardless of the array of entities involved, the EER process has to achieve accurate, timely, and consistent results for California's consumers through all available EER channels and for all available programs. This will require careful coordination across programs and entities, transparency in program rules and procedures, monitoring and enforcement of performance standards. One way to achieve this would be to have a single agency designated to administer the EER system. If California policymakers adopt this approach, we recommend the Department of Health Care Services (DHCS) as the appropriate entity to act as this single state agency. Upon full implementation as many as ten million Californians will be enrolled in the Medi-Cal program as compared to some 2.4 million with subsidies in the Exchange.⁵ Given the force of

⁵ Pourat, Martinez, & Kominski, *Californians Newly Eligible for Medi-Cal under Health Care Reform*, May 2011, available at <http://www.healthpolicy.ucla.edu/pubs/files/medicalpb-may2011.pdf> estimating that there will be 2.13

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these numbers and the many important beneficiary protections in the Medi-Cal program (from varying eligibility rules to due process procedures), it is neither practical nor beneficial for consumers for Medi-Cal's EER System to be administered by a new entity.

Another approach to ensure coordination, transparency and consistency among the different programs would be to assign one agency clear overarching responsibility and accountability for developing and monitoring consistent and coordinated policies across the programs. For example, the California Health and Human Services Agency (CHHSA) is involved in all three programs and could ensure that these programs' administering agencies coordinated on EER System operations and would be ultimately accountable that performance standards were transparent, consistent and achieved. It might be the case that CHHSA might designate a program agency like DHCS to arbitrate an eligibility dispute between program entities.

If, rather than designating a single entity to administer the EER System, California policymakers decide instead to have several entities coordinate EER – for example DHCS, the Exchange, MRMIB and counties, statute and regulations/guidance must outline very clearly the duties and responsibilities of each entity, and provide for corresponding accountability measures.

- Coordination. The accountable agency or agencies should ensure that EER rules and procedures across programs are carefully aligned, and consistently and accurately applied, such that there are no gaps or conflicts between programs as discussed above. As income or other relevant circumstances change, individuals should transition smoothly among types of coverage without breaks in coverage. **Consumers should never be caught between programs with each program asserting that the other should be providing coverage.**
- Transparency. EER rules and procedures across programs should be transparent. Individual consumers should have clear information available to them to understand why and how determinations are made. **All operating rules applied during the EER process should be available to the public in plain English and computable form for all programs and entities involved in the EER process.**⁶ These operating rules should be tested prior to implementation to ensure accurate, timely, and consistent results without gaps or conflicts across programs.

million Californians newly eligible for Medi-Cal in 2014 as well as an existing 900,000 currently eligible but unenrolled persons; Nadereh Pourat, Christina M. Kinane and Gerald F. Kominski, *Who Can Participate in the California Health Benefit Exchange?: A Profile of Subsidy-Eligible Uninsured and Individually Insured*, May 2011, available at <http://www.healthpolicy.ucla.edu/pubs/files/exchange-pb-may2011.pdf> estimating 2.4 Californians will be eligible for subsidies through the Exchange.

⁶ "Operating rules" are the standard business rules and guidelines envisioned by the ACA for health insurance plan administration, including electronic transactions. See ACA section 1104(b)(1).

- **Monitoring.** Clear performance standards for the EER System should be established in consultation with stakeholders and be monitored on an on-going basis. For example, metrics regarding the timeliness and accuracy of determinations, churning of consumers on and off coverage, and customer satisfaction should be developed. **These standards should set an equally high bar for performance for each individual program and across all programs.** These standards should be monitored by the single accountable agency or coordinating agencies, with regular reports to the public and Legislature on system performance and steps taken to address problems and improve performance. Reporting should be more frequent in the early stages of implementation (e.g., quarterly reports in the first year of implementation, semi-annual in the second year) and should occur no less frequently than annually.
- **Accountability.** The agency or agencies accountable for ensuring coordination, transparency, and performance must also provide a single point of contact for consumers to go to when they are having problems. This single point of contact should have the authority and responsibility to ensure that consumer complaints are appropriately resolved and that all due process requirements are met, regardless of the specific programs or entities involved. Moreover, the accountable agency or agencies must create clear mechanisms for continually monitoring EER System performance across all programs, so that it can take action to improve system performance as needed. The agency or agencies must direct changes in policies and procedures within individual programs to achieve high performance results for all consumers when such changes are needed.

C. Real-Time Determinations and Accelerated Enrollment.

When someone applies for coverage, that person should ideally be **enrolled in "real-time"** into the program for which they are eligible – Medi-Cal, Healthy Families, the Exchange, or other health coverage programs. Because final eligibility determinations in real time will not always be possible, **Accelerated Enrollment (AE)** should be granted for applicants who are screened eligible based on the information they provide, with this AE coverage continuing until the final eligibility determination is made.

1. A Note about Application Terminology

- a. **Real-time enrollment** means that when the person applies they are immediately enrolled into the program for which they are eligible and health coverage begins right away. This is the goal for most cases, but may not always be possible. For example, immediate verification of a person's income at the time of application may not be possible, such as when an applicant's income has dropped since her latest tax return was filed and wage databases lag by a quarter or more. All applicants

should be immediately enrolled into the program for which they otherwise appear to qualify based on the information provided in the application pending an opportunity to resolve verification discrepancies or other issues; this includes seniors and persons with disabilities who declare income at or below 133% of the Federal Poverty Level and who may need to transition to traditional Medi-Cal after a complete county eligibility review.

- b. **Presumptive Eligibility (PE)** is screening and enrolling someone who has submitted a screening form, with coverage starting right away. For example, pregnant women have PE for Medi-Cal in California initiated at the health service provider's office at the time of service. The PE only continues beyond the last day of the month following the screening if an application is submitted by then. If the application is submitted on time, PE becomes AE, meaning the coverage continues until a final eligibility determination is made.
- c. **Accelerated Enrollment (AE)** enrolls an applicant into coverage pending a final eligibility determination after that person has been screened eligible for coverage and has submitted an application. California uses AE for example for some children applying with the "joint application." When the application is submitted to the Single Point of Entry (SPE), each application is screened and referred to either the county for Medi-Cal or to Healthy Families as appropriate. AE is granted for the children screened to Medi-Cal and lasts until the county makes a final determination of eligibility.
- d. **Deemed Eligibility (DE)** is eligibility granted as a matter of law, *without* having to submit an application (though some kind of communication with Medi-Cal or Healthy Families is required). Infants whose mothers had Medi-Cal for the delivery are deemed eligible at birth for Medi-Cal and infants whose mothers had Access for Infants and Mothers (AIM) are deemed eligible at birth for the Healthy Families Program (unless eligible for Medi-Cal or covered by employment-based health insurance coverage).
- e. **Verification** means checking whether the information provided by the applicant, such as family income, is accurate. It can be done in real-time, i.e., instantaneously by matching with government databases as required by the ACA. Data-matching alone may be insufficient to verify a person's information because many of the databases are not up-to-date or contain errors. In such cases, applicants should be given the opportunity to provide additional information for verification purposes.

2. Enrollment Core Principles:

- Wherever possible final eligibility must be granted in **real-time**, with applicants being both enrolled into the program and starting coverage right away.
- While real-time processing of applications and determinations of eligibility should be the norm to the fullest extent possible, when it is not possible, **AE should be the back-up** to preserve access to benefits pending a final eligibility determination. It is essential that a one-step AE process be adopted, not a multiple-step process. In other words, coverage must start immediately for persons screened eligible and must continue without interruption until the final eligibility determination is made.
- Regardless of what avenue someone uses to apply, her or his application should be processed through a system programmed with **identical operating rules**.
- To the fullest extent possible, the individual, **entity or agency that initially receives the application should make the eligibility determination**.
- Where an electronic application is used, it should be designed with “an **electronic decision tree**,” so that people will only need to respond to subsequent questions when their responses to earlier questions indicate that additional information is required. Similarly, the phone application process should be designed with tree logic. This will minimize the number of questions each applicant has to answer based on their individual circumstances.
- **For seniors and people with disabilities (SPDs)**, the current SSI income counting rules and the assets test will continue to apply instead of the new MAGI rules and no assets test. Accordingly, applications will have to check for age and disability and the new eligibility system will have to be able to apply the old income rules and assets test to some populations. For people with disabilities who qualify under the MAGI rules but have not yet been determined disabled, we recommend that they be enrolled into Medi-Cal based on MAGI income rules and, if they are not eligible under these rules, they then be screened for disability. This would be affected by what the expansion Medi-Cal benefit package includes and whether CMS allows this.
- Electronic linkage to databases can assist the application or renewal process in two ways: (1) **prepopulation of data** whereby relevant eligibility information (e.g. address, income or citizenship information) is retrieved for the eligibility determination and (2) **electronic verification** whereby information provided by the applicant/enrollee is checked against available databases. Consumers should be given the option of using these processes. If they consent, consumers must also be given the opportunity to review, correct and update information retrieved from databases. (See further details on verification systems and rules below.) If the electronic verification systems do not have necessary information, self-certification should be allowed for all programs.

- Eligibility for **infants** under the age of one year who qualify for deemed eligibility (DE) because their mother has Medi-Cal coverage for the delivery should occur on-line in real time *without* an application. This happens for DE Medi-Cal infants today if they go through the CHDP Gateway and a similar on-line enrollment process should be adopted for hospitals as well as all other points of online enrollment and extended to infants born to mothers in AIM or the Exchange.
- **Only Asking Necessary Questions of Non-applicants.** One critical consideration for all application avenues, but which is highlighted in an online application, is the need to ask only necessary information of non-applicants / non-enrollees in the household. To assess eligibility, income for all household members must be reported to determine household income, but if they are not applying for coverage, other information is not necessary and therefore should not be asked. For example, the immigration status of a parent is not relevant to a child's eligibility for coverage. Therefore, a parent should not be required to give his or her Social Security number to apply for health coverage for the child. Enrollment processes should distinguish between applicants/enrollees and non-applicants in the household.

D. Electronic Pre-Population and Verification of Information

The ACA envisions using certain government databases containing personal information to either pre-populate income, citizenship, and immigration status information on an application or verify information entered by an applicant. Information maintained by state and federal agencies such as vital records, employment history, enrollment systems, immigration records and tax records would be used to verify and retrieve information.⁷ For example, data maintained by the Social Security Administration, Internal Revenue Service and Department of Homeland Security would prove useful as verifiable personal information that an individual would not have to provide again. Other databases, such as for wages, could also be consulted where appropriate and helpful.

While electronic verifications have the potential to simplify the application process for consumers by mitigating, or even eliminating, paper documentation requirements and may offer administrative efficiencies, the databases may also access information which is significantly out of date and otherwise prone to error. For example, Medi-Cal now relies and the Exchange will rely on the SSA database for verifying U.S. citizenship; yet SSA data-matching is not error free.⁸ A worker's wage information is not updated in the government's employment until the end of each quarter at the earliest, and even then, the data is for the whole quarter not a particular

⁷ ACA §§ 1411(c) and 1561.

⁸ See, e.g., *AFL-CIO et al. v. Chertoff*, Case No. C07-4472 CRB (ND Cal.) (order enjoining use of SSA databases to verify citizenship and immigration status for employment purposes issued October 15, 2007).

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month.⁹ This is of particular concern regarding low-wage earners because their income and job circumstances tend to fluctuate throughout the year. Frequent address changes also pose a challenge to correctly identifying low-income individuals in the databases.

Electronic data-sharing also gives rise to concerns about privacy and maintaining sensitive, personal information confidential. A separate but related issue is the need to provide applicants with meaningful opportunities for truly informed consent to have their information shared among multiple governmental agencies and private contractors or collaborators.

With these concerns in mind, we offer the following recommendations.

- **Timing:** Pre-population of information and verifications necessary to grant final eligibility should occur electronically and in real-time whenever possible, but should not preclude other forms of verification, including self-verification, and opportunities to correct, with benefits being granted during the interim.¹⁰
- **Privacy and Confidentiality:** The new system, including its verification process, must:
 - Ensure that only information that is “strictly necessary”¹¹ is collected or reviewed;
 - Implement strong security safeguards to ensure the privacy and security of personally identifiable information;
 - Follow the existing Health Insurance Portability and Accountability Act (HIPAA) and California health privacy laws and transaction standards when transferring consumer eligibility, enrollment, and disenrollment information between Affordable Care Act health insurance coverage programs (including Medi-Cal, Healthy Families and Exchange), public health plans, and other health and human service programs such as CalFresh and CalWORKS;¹²

⁹ http://www.edd.ca.gov/Payroll_Taxes/Required_Filings_and_Due_Dates.htm

¹⁰ “States should... quickly and accurately enroll individuals into coverage. For most people, this routing and enrollment in the Exchange, Medicaid or CHIP will happen in real time.” See Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, *Guidance for Exchange and Medicaid Information Technology (IT) Systems, Version 1.0*, November 3, 2010.

¹¹ ACA § 1411(g)(1).

¹² See, e.g., “PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 1561 RECOMMENDATIONS” submitted to the National Coordinator for Health Information Technology by the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee. Section 1561 requires HHS, in consultation with the Health Information Technology (HIT) Policy Committee and the HIT Standards Committee (the Committees), to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in Federal and State health and human services programs.

- Strictly adhere to Medi-Cal's and Healthy Families' privacy protections and the new privacy provisions of the ACA¹³; and
- Require and ensure that all application assistors, private vendors administering the system, and entities, whether public or private, conducting screening prior to an individual's submission of an application or request for renewal to the new system, abide by all of the above.
- **Pre-populating Application and Renewal Forms.** By pre-population we mean electronically retrieving information from databases to complete an application or renewal form, or part of it, without having to manually type or write in the information. Federal advisors support this, recommending that consumers be given: 1) timely, electronic access to their eligibility and enrollment data in a format they can use and reuse; and 2) knowledge of how their eligibility and enrollment information will be used, including sharing across programs to facilitate additional enrollments, and to the extent practicable, control over such uses.¹⁴ In addition, consumers should be granted the ability to make corrections to any pre-populated document.
- **Consumer Input.** Applicants must be able to review any pre-populated information from other sources as part of their application/renewal for coverage and to submit corrections or additions before submitting the application/renewal. Where feasible, such corrections should be made to the source of the pre-populated information to avoid future discrepancies.
- **Consumer Choice: "Opting in" to Electronic Verification.** Applicants and enrollees should have the option of authorizing the retrieval of information available electronically from the enrollment system or other sources to pre-populate or verify necessary eligibility information. Consumers must have the option to choose this process or not.

For the opt-in process to work, consumers will need to know how the information retrieval and verification process works, what the data will be used for, and how they can resolve disputes about the accuracy of the retrieved data. They will also have to be informed about the process for having eligibility verified should they not opt out for electronic verification.

- **Income Verification.** We advocate moving to a system of self-certification of income to simplify the process, avoid database pitfalls, and cut down on paperwork burdens (for non-tax filers or individuals who have had a material change in circumstance since the last available tax filing). If that recommendation is not adopted and applicants continue to have to provide proof of income, the EER system should be designed to:

¹³ ACA §1413(c)(2)(C).

¹⁴ See "PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 1561 RECOMMENDATIONS."

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- offer opportunities for proof of income to be provided / obtained electronically from relevant and accurate databases;
 - include a consumer-friendly process for an individual to correct database verification results believed to be inaccurate; and
 - as with citizenship and immigration status documentation, for individuals who otherwise meet all eligibility requirements based on the information they have provided, grant AE pending resolution of verification issues and the final eligibility determination.
- **Citizenship and Immigration Status Verification.** For persons claiming lawful presence, the Secretary will identify the verification process after consultation with Homeland Security. This is likely to involve the longstanding SAVE—Systematic Alien Verification of Eligibility—system, which uses the immigrant’s Alien Registration, or A, number to electronically verify eligibility for Medicaid and other public benefits programs. At present, Medi-Cal checks immigration status in the SAVE database, but only after reviewing the immigrant’s “paper” documents first. This paper documentation is not a requirement of the SAVE law. However, we recommend that the new system give individuals the option to e-verify through SAVE first, following up with paper documentation only when verifying immigration status through the databases fails. This “secondary” verification may be necessary in many cases, as there continue to be flaws in the SAVE database.¹⁵ The SAVE law requires that temporary benefits be granted pending completion of the immigration status verification process, an approach that would serve the new system well.
 - **State Residency Verification.** State residency is often verified in Medi-Cal and Healthy Families by proof of income, e.g., pay stubs and tax returns. The new system should adopt the same approach for the Exchange but add other database alternatives for providing proof of state residency such as school enrollment, CalFresh or CalWORKs recipient, voter registration, and self-certification. Opportunities for such proof to be provided/obtained electronically should be maximized. Current rules governing “paper” verification of state residency could continue to apply when electronic verification is not possible.

¹⁵ See, e.g., *Ruiz v. Kizer*, Case No. CIV S 88-1272 MLS and records therein (E.D. Cal. 1988); All County Welfare Directors Letter No. 88-87 (*Ruiz*); see also, Nebraska DMV’s LB 403 Report to the Legislature (January 31, 2010) (78% of SAVE queries by DMV that “failed” on the first try passed with secondary verification).

E. Making the IT Work for People

Efforts to build a streamlined architecture for health care enrollment, to simplify access to healthcare and other public benefits, using new technologies, must be measured not only by the number of people for whom they will increase access but also by how well these structures serve our most vulnerable residents.

Modernized enrollment, through information technology (IT), is a key component in achieving the new landscape of coverage required by the ACA. Modernized enrollment processes have the potential to radically improve access to health programs and other social services. However, this will only happen if the system is intentionally designed to achieve these goals without disenfranchising the most vulnerable recipients, including the poor, elderly, people with mental and physical disabilities, recent immigrants, and those who are limited in their ability to speak or write English. Moreover, several state agencies, in California, have had particular difficulty with large, complex IT projects, especially when they are statewide in scope.

The online application and web portal of the new EER system should encompass the following:

- **Policy Simplification:** As discussed above, policy simplification is essential if California is to achieve a seamless, efficient, and accurate system consistent with the requirements of the ACA. These policy changes must drive IT design and implementation. In addition to the simplification required by the ACA, California should also simplify the rules for non-MAGI populations. For example, questions about the cash surrender value of a life insurance policy or requirement for burial trusts are a barrier to needy applicants. Relatively small changes like automatically assuming a set-aside for burial without requiring a separate account and eliminating counting of cash surrender value of insurance when counting resources would streamline evaluations without compromising the integrity of the programs.
- **Transparency and Accountability:** All EER processes and IT solutions must be transparent. For example, health program eligibility rules used in IT programming must be made available for public review to check for accuracy and there must be an ongoing process for the public to report errors in the system for timely correction and remedy. Public access to the IT programming is also necessary to allow for formal pre- and post-implementation evaluation of all eligibility, enrollment, disenrollment, cost-sharing and outreach functions.
- **Seamless and Accurate Results:** The EER system must facilitate seamless and timely transitions between Medi-Cal, Healthy Families, the Exchange and other coverage in a manner that does not require an individual to submit additional information, avoids breaks in coverage, and results in an individual being placed in the most appropriate and beneficial program.

- **Multiple Points of Entry:** In addition to designing IT solutions that enable individuals to apply for and maintain coverage electronically on their own, there must continue to be other points of entry, including ways to apply in person, for those individuals who prefer to use them. For example, individuals should continue to be able to apply for coverage with the assistance of certified application assistants and health care providers, as well as through other public programs.
- **Supporting the Needs of All Californians:** As discussed above, the whole EER System must be designed to meet the needs of California's diverse residents. Special attention must be paid in designing the IT to ensure it can be successfully used by people who do not speak or read English well, people with disabilities (particularly visual impairments), people with low literacy levels, and mixed-immigration-status families.
- **Assistance for Individuals as Needed:** The EER system should incorporate human intervention as needed to assist and protect the rights of individuals as they go through the system. Such human review, by an eligibility worker employed by the health program(s), should occur to assist in completing incomplete forms, address inconsistencies and failed data matches, and prevent unwarranted disenrollment of eligible individuals. In addition, individuals should have access to assistance with the EER process online and by phone, as well as through community partners. The EER system should also support strong and transparent grievances and appeals processes.
- **A Solid Evaluation Plan:** It is too often the case that, during the modernization of public benefit programs, collaborators become myopically focused on evaluating the technology itself rather than the impact that the new technology and the underlying policies and procedures have on the people served. We suggest that protocols for evaluations of the EER IT be developed to comprehensively assess and systematically report on the impact of the new technologies on access for everyone and specifically for the more vulnerable populations, such as people with disabilities, the elderly, and new immigrants. In addition, California should establish meaningful avenues for diverse stakeholder contribution and mechanisms for timely consumer feedback between more formal evaluation and reporting.
- **Realistic Budget & Timeline:** Often, modernizing efforts can take longer and cost more than originally planned. We have seen modernizing efforts fail due to lack of a commitment to adequately fund the construction, testing and maintenance of the new system. Recent efforts to modernize eligibility and enrollment systems in social services programs in Indiana, Texas and Utah have cost more than expected and, as a result, threatened actual service delivery or resulted in compromised services. The timeline laid out by the ACA is rigorous and it is critical that California leaders move implementation efforts as expeditiously as possible. We also recognize that a two-step implementation may be needed: (1) modify current systems as quickly as possible to implement the MAGI and other ACA rules by January 1, 2014; and (2) simultaneously plan and implement a more major system overhaul. For example, MEDS – the Medi-Cal

Eligibility Data System – should be rebuilt as part of a new system, but we recognize that this may not be realistically possible to complete by 2014.

F. Old v. New Rules

The ACA changes the income counting, household and assets rules for most applicants for Medi-Cal, Healthy Families and the Exchange but not all. While the “new rules” under the ACA should be used to the fullest extent possible, sometimes the old rules will be intact and in some cases, the ACA expressly directs the state to use old rules. This raises questions of how the new system and old systems work together. When cases are fully processed under the old rules, how seamless are the two sets of rules? Can or should they be integrated into one set? How can we ensure that cases don't fall through the cracks? Below we lay out considerations including rules governing income, assets, household composition and employer coverage.

Regarding income we propose below new simplified income levels be used to determine eligibility for Medi-Cal recognizing the ACA requirement that states use “equivalent” income standards to cover those currently eligible.¹⁶

1. Income:

- The application system should be sufficient to assess both MAGI and non-MAGI based countable income. This will require an opportunity to provide tax-based income data as well as more up-to-date information. This is similar to the flexibility allowed today, where families can provide a variety of different types of proof of income.
- The new MAGI rules should be the default and the application should be structured to ask people for information accordingly. However, there will also have to be triggers among the application's questions to get needed information for the minority of applicants to whom the old rules apply, e.g. those over 65, those with a disability and foster youth. For the electronic and telephone applications, questions relevant to the old rules should be solicited only as necessary to establish eligibility using a logic tree.
- **The income levels should be significantly simplified as follows:**
 - Childless adults: 133% FPL;
 - Children and parents: 150% FPL; and
 - Pregnant women and infants: 200% FPL.

¹⁶ States must “establish an equivalent income test that ensures individuals eligible for [Medicaid] on the date of enactment of the Patient Protection and Affordable Care Act, do not lose coverage under the State plan or under a waiver of the plan.” ACA §2002(a).

- There also need to be simple, understandable triggers for requesting additional information related to special circumstances, such as self-employment, unemployment, fluctuating income, or lump sums. For instance, there could be a section in the application that requests information on the source and frequency of income. And/or there could be a list of simple checkboxes, similar to the TurboTax model, for the applicant to indicate whether they have any of these circumstances; only if they do would they need to fill out additional information.

2. Resources / Assets

- There will be no assets test for most persons who apply for public health coverage. Seniors and persons with disabilities will still be subject to an assets test.
- As discussed, electronic and tree logic designs could skip the questions that ask about assets for all applicants but those who indicate that they have relevant circumstances. This would require the design of the preliminary questions to be clear so that anyone who might be categorized as needing to meet an assets test will be identified. There should be a simple summary of who does and does not have to report assets information. At a minimum, persons whose exemption from the assets test cannot be determined in real-time could be asked to mark a simple check-box question that would elicit information that would indicate whether they are likely to have assets above the eligibility limit. Only if an applicant appears to have a level of assets that might bar eligibility, would the applicant be required to provide more detailed assets information.
- Problems may arise when some family members are required to complete assets information and others are not, which creates a greater risk of mistakes. No applicant should be denied for failure to complete assets information, and instead should be given an opportunity to follow up as needed.
- It will be important to prepare simple and clear information about what precise circumstances require an assets test, and what the consequence of providing such information is. It may be far more affordable for a senior to get Medi-Cal than be enrolled in the Exchange, but she needs to be informed of the responsibility to provide assets information instead of being guided into the Exchange because it is easier (i.e., because there is enough information in the application to enroll someone into the Exchange without the assets information).

3. Household Composition:

- The MAGI-based income counting rules determine the household composition based on whom the applicant can claim as a tax dependent. This is different from the current rules for determining a Medi-Cal "budget unit." The application will have to ask the relationship of the persons to each other and have a checkbox or other indicator for who is a tax dependent of whom. The application forms may be able to ask numerically (e.g., how many people including yourself can you claim on your taxes as a dependent?).
 - The new federal household rules will shrink the household size for some families, especially with split custody where the custody arrangement determines who gets to take the tax dependent status or alternates between parents, or where there is a caretaker relative who could count the child as part of her household under Medi-Cal's old rules but not as a tax dependent. The new systems will not change how income is counted amongst household members under the *Sneede* and *Gamma* rules. Following existing rules and procedures, the information will be easily discernable (and can be done on the back end) once the applicant says who lives in the home and how they are related.
 - Medi-Cal should allow families to use the less restrictive family size, by allowing them to include persons they would have included under the previous rules if they cannot qualify under the new MAGI household composition rules. This ensures that the intricacies of family law and, for instance, the structuring of a divorce decree, or circumstances requiring that grandparents step in to care for their grandchildren, do not unintentionally make a child or family ineligible for Medi-Cal.
4. Employer Coverage. Under the ACA, people are not eligible for Exchange premium subsidies if they have access to affordable employer-sponsored coverage.¹⁷ Accordingly, the application will have to ask whether employer-sponsored coverage is offered and what the amount is of the employee contribution to the least-expensive plan option offered to determine eligibility for Exchange subsidies.

¹⁷ ACA §1401(a), 26 U.S.C. §36B(c)(2)(C). The employer-sponsored coverage must be affordable (contribution of employee is less than 9.5% household income) and must provide minimum essential coverage (e.g., it cannot consist of excepted benefits such as those only for accident or disability, or based on specific illnesses, etc.) See ACA §1501, 26 U.S.C. §5000A(f)(3).

H. Coordination with Other Public Programs

While California develops a new EER System for health care coverage programs, the state ideally would use the opportunity to design a comprehensive system that can also determine eligibility for and enroll people in other public benefits programs such as CalWORKs, CalFresh, WIC and Refugee Assistance. The goal must be to share applicant information between programs in order to *maximize possible benefits* to the applicant and *maintain benefits coverage* – not to obtain information solely to find reasons to terminate or conduct fraud investigations. For example, an individual's failure to cooperate or turn in appropriate documentation in one program cannot be grounds for termination in another program.

1. **Notice.** At the end of the application process, a single notice should be sent summarizing the applicant's eligibility determination results for all programs. This will give the applicant a clear overview on a single document of the programs they applied for and of any additional programs for which they were found eligible or likely to be eligible.
2. **Common Screening Tool or Information Transfer.** If the decision is made to coordinate with other programs, there would need to be either a common screening tool for the various programs or a method whereby eligibility information about an applicant could be transferred from one program application to another. If a common screening tool is used, then a balance will need to be struck between accommodating the complexities of different eligibility rules for different programs and design simplification. If information is transferred from one program to another, e.g. Medi-Cal to CalFresh, the systems will need to be streamlined to allow for this sharing of data.
3. **Voluntary Screening?** Another key policy issue is whether screening for other programs an applicant may be eligible for should be automatic or should the individual have to take affirmative action to request screening. Similarly, should enrollment in other programs an individual is eligible for be automatic or should the person have to affirmatively agree to enrollment in that program? This is discussed more in the next section where we recommend an "opt-out" approach for closely linked programs and an "opt-in" approach for closely linked programs.
4. **Coordination with Medicare.** The EER system should be designed with the capacity for real-time or at least daily sharing of Medi-Cal eligibility information with Medicare. This is critical for Medicare Part D Low Income Subsidy and Part D plans. More frequent data exchanges with CMS would also be helpful in curing lags related to payment of Medicare Part B and Part A premiums and for the state to know when people are approaching Medicare eligibility. Since Medicare-eligible applicants should be screened for Medicare Savings Programs (MSP), the information collected to determine MSP should automatically populate a Part D Low-Income Subsidy

application which, with the applicant's permission, should be sent if the applicant does not appear to qualify for full scope Medi-Cal or for MSP. There also should be some coding showing that the individual has already been screened for MSP. Otherwise, the Social Security Administration is required to send the information back to the state for screening.

I. Privacy & Confidentiality Protections

Whether dealing with coordination of public non-health programs as in the preceding section or just coordination among health programs, confidentiality and privacy concerns require careful attention.

- **Opt-in / Opt-out / Consent:** First, the state needs to decide whether there should be some common consent form that individuals complete when they first apply for any program so they are aware of how much of their information is being shared, and with whom. Our recommendation is that this depends what the applicant's reasonable expectation in what she is applying for as follows:

If the application is for a health program or a commonly linked public benefit program (like CalWORKs, CalFresh or SSI), we recommend that an Opt-out method of consent be utilized both to maximize the number of successful applications and because many families will want their eligibility evaluations maximized.

Even when the Opt-out approach is used, this option must be clearly and prominently communicated to applicants when they want limited services and want to keep those services confidential (e.g. services for reproductive health).

If the application or communication is NOT with a public health or other benefits program, an Opt-in approach should be utilized so that persons who do not understand they are having any contact with a public health program are not surprised, upset, or concerned at the use of their information without an opportunity to affirmatively agree to it. For example, a person who fills out a form at the DMV has no reason to think she will subsequently be evaluated for Medi-Cal and the Exchange as a result.

- Coordination between programs will likely mean that individuals at various municipal/county/state agencies that administer the programs will have access to applicant data. Standards must be developed regarding when information sharing is appropriate and what privacy protections are in place. Care must be taken to safeguard the confidentiality of personal information such as home addresses, and phone numbers.

- Separate special consideration must be made for programs which are by their very nature sensitive – such as sensitive care services for minors (Minor Consent services) – to ensure that their confidentiality is protected. Thus, here an “Opt-in” protocol should be used to ensure that information is protected.
- There must be protocols in place to address security breaches of private information, including a plan to quickly inform persons whose information has been confirmed or suspected to have been compromised, stolen or viewed by anyone without authorized access.

J. Retention / Continuity of Coverage

While much of this paper has centered on application, all improvements, simplifications and other systems adopted at application should be utilized to ensure continuity of coverage when the individual or family interacts with the system. This includes ensuring continuous eligibility to the maximum extent allowed, improving renewal procedures, and troubleshooting specific transitions to maximize retention.

1. Principles

- **Continuous Coverage.** The state's goal should be that once someone has health coverage, that person should keep coverage and transition as necessary with the onus on the system to help the consumer transition to the right program as automatically as possible. During a transition, consumers should not lose one form of coverage before the other begins. In addition, the system should automatically trigger an outreach notice to individuals moving from MAGI to non-MAGI status, for example when they are about to turn 65.
- There must be a process in place for all health programs such that coverage is not terminated until an *ex parte* review of information is conducted to see if the person is eligible for another program. The findings of the review must be communicated promptly to the individual.
- There should be “**continuous eligibility**” for one year for each of the programs – meaning that an individual who qualifies for Medi-Cal or a certain level of subsidy in the Exchange keeps that coverage for one year, even if her income increases. However, if her income declines, she should be able to request a screening for a new level of subsidy or Medi-Cal. Because family circumstances in lower income levels change frequently, this would both minimize the associated administrative burden across programs and help to ensure continuity of coverage for consistency in treatment delivery. California currently has continuous eligibility for children.

Consumers would need to be educated about possible penalties if their eligibility for tax subsidies under the Exchange changes during the course of a year. An applicant's income level will be determined when they apply for coverage, but if their income goes up enough to change their subsidy level and they remain enrolled in the initial level of subsidy, they will be charged a penalty on their tax return.

Right now Medi-Cal beneficiaries have to report changes within ten days. With continuous eligibility, the state would need to either change that requirement or change how it is acted on, e.g. only use the information to enroll into Medi-Cal, not to deny continuous eligibility.

Federal guidance is needed to clarify whether continuous eligibility is allowable for Exchange subsidies.

Special consideration also needs to be given to those who are eligible for coverage under the Exchange, but have ongoing eligibility for certain limited-scope Medicaid covered services, like Family Planning Services and pregnancy-related services under the state's new State Plan. Care should be taken to preserve the limited scope benefits available, while also supplementing these benefits in the Exchange in order to obtain a full package of minimum essential benefits at the most affordable cost.

2. Annual Renewal

- The state will have to check eligibility for public health coverage annually. Once enrolled in health coverage, the only elements that must be checked for changes are age, coverage, income, household size, and county of residence. Other data should not be needed at annual renewal. For example, once someone has proven that he is a citizen, he should not be asked to verify citizenship again if he moves from one coverage program to another. Also, certain groups need to provide even less information and should not be asked for unnecessary information. For example, former foster youth are automatically eligible for Medi-Cal until they are 21 (this will be extended to 26 under the ACA) regardless of their income information so they should be automatically continued on Medi-Cal without having to fill out renewal paperwork.
- When consumers apply for coverage they should be asked whether they want the state to automatically check for information regarding eligibility and keep them on if eligible. Under this system, the state would first conduct an *ex parte* process for health coverage renewal, e.g. check of tax return, other public benefit programs, etc. for family size, address and income. If a consumer is still eligible for the same health program or level of subsidy, she or he would keep coverage for another year. If her or his coverage is renewed, a consumer should receive a notice telling them this, laying out the information upon which the renewal is based and advising them to contact the program if this information is incorrect.

- One option would be to have a check-box on state tax return for people who want to have their return checked to see if they're eligible for public health coverage. If the tax return check shows that someone is eligible for a more beneficial program than they are enrolled in, the state should send them a notice saying, "you are eligible for a more generous health coverage program based on the following information. If you believe this is incorrect, please send in the correct information." The system should enroll with clear consumer notice and allowing for correction.
- In screening for Exchange eligibility the system will have to check if a consumer has access to affordable employment-based coverage. The state should assess whether there is required employer reporting that could be used to make this determination.

One streamlining approach would be to align private and public health coverage systems with a uniform **open enrollment period after tax filing**. This would help families with members in different types of coverage. Annual renewal would be timed to follow tax-filing. A simple uniform notice of annual renewal could be sent to individuals upon filing a return (or by a date certain in case a return is not filed by May or June), in order for them to report any changes in circumstances.¹⁸

3. Specific Transitions

There are specific moments in people's lives where they should have safeguards to ease the transition from one health program to another and ensure no gaps in coverage.

- **Turning 65 Years Old.** If a person in Medi-Cal when she is 64 has been enrolled using the MAGI rules and no assets test, when she turns 65, the program will have to evaluate whether she is still eligible for Medi-Cal using SSI income counting rules and applying the assets test. If she does not qualify for full Medi-Cal, she should be screened for the Medicare Savings Programs (MSP) and the Low-Income Subsidy (LIS). Persons in the Exchange population will also need to be screened for all programs.
 - 1) It will be important to educate people about this change. Consumers may be confused when they are asked for new income information and for new information about assets.
 - 2) Ideally the program would evaluate a consumer's ongoing eligibility for Medi-Cal before he or she turns 65, but Medi-Cal is set up to look at the person's income that month. Some pre-qualification/enrollment capacity and concomitant rule changes should be adopted to allow for this.

¹⁸ The annual renewal notice form should only be sent to those who are not Seniors, Persons with Disabilities or those eligible for Medi-Cal or subsidies through the Exchange.

- 3) For the person who has full-scope Medi-Cal based on disability, turning 65 will not change their eligibility criteria vis-à-vis Medi-Cal because they are already subject to asset and income-counting rules.
- **Losing job/hours/income.** Loss of employment is one of the main causes of losing health coverage. Employers should be required to give notice about health coverage options when someone has a loss of a job, of hours or of income. The notice should advise that the employee can apply for Medi-Cal or Exchange coverage if income went down and she or he no longer has access to affordable employer-based health coverage.
 - 1) Application for Unemployment Insurance or State Disability Insurance should trigger a notice about health coverage options and initiate the application process with consumer consent.
 - **Child aging out of dependent status.** When a young adult has been in a budget unit with their family as a dependent, but then is no longer a dependent, this will create a new budget unit and their eligibility should be reevaluated.
 - **Foster Youth "Aging Out."** Foster youth are categorically eligible for Medi-Cal and should have continuous coverage when they emancipate without having to submit a new application or other procedure. Similarly, there should be a simplified procedure for youth who apply for Medi-Cal after they have left foster care, including identifying children in foster care who do not receive AFDC-FC (foster care benefits), *e.g.*, CalWORKs and SSI. Further, a streamlined redetermination process for former foster youth should not require anything from the youth given that eligibility is based on status as a former foster care child and does not include income or resource criteria.
 - **AIM enrollees after the 60th day post-partum:** Pregnant women with income from 201% to 300% of poverty are eligible for the AIM program until the 60th day postpartum. Because a woman may work less toward the end of her pregnancy or after a baby is born, an AIM enrollee may experience a significant drop in income by the time her AIM eligibility ends. If a woman's income falls she may qualify for Medi-Cal or, if it remains similar, after AIM eligibility ends, she may instead qualify for Exchange coverage. Such transitions should not require a new application of the woman and must be simple and easy for her to navigate.

4. Overarching Considerations for Renewal

- When transitioning from one program to another, information about the consumer needs to travel with them to maximize enrollment and minimize burdens. This information would include both eligibility-related information such as income, family size and immigration status, as well as personal information such as primary language.

- If a consumer has Medicare and is also income-eligible for the Exchange, it appears that he cannot get the premium subsidies, but can get other cost-sharing assistance. More information is needed about the interaction between LIS/MSP and the Exchange. Much of this is unclear from the statute and will need clarification in federal regulations yet to be promulgated.
- An important policy question is how California will ensure full-scope coverage for pregnant women enrolled in Medi-Cal's 200% Program for pregnant women where the benefits are limited to pregnancy-related care. The state should expand Medi-Cal to full-scope for pregnant women with incomes up to 200% FPL. Another option would be to wrap around services in Medi-Cal's childless adult expansion to 133% FPL and in the Exchange for higher incomes but this would be an administrative challenge for the state and the women alike.

K. Appeals and Due Process

The ACA does not fully answer one issue of vital importance to consumers and advocates: With whom and how can decisions made within the new architecture be appealed? Therefore, we outline the following governing principles:

- **A single, integrated appeal process for determining eligibility for all benefits at issue should be utilized and that process should meet the due process standards that apply to Medicaid fair hearings.** The ACA suggests a federal appeals process for determinations made regarding eligibility for the Exchange, including subsidies, but a state process, Medi-Cal fair hearings, will be used for eligibility determinations regarding Medi-Cal. Whether a person can choose a federal or state appeals process, it is more appropriate as well as feasible for beneficiaries that a single integrated appeals process be developed that meets the due process requirements for Medicaid – adequate and timely notice, a fair and independent hearing, etc. At a minimum, the federal government should establish a floor for minimum protections that states must provide and make clear that federal Medicaid protections for notice and due process apply. Federal guidance is needed regarding minimum standards for Exchange appeals processes. The appeals process should include two steps: an internal review (e.g. initial paper appeal for reconsideration) in addition to an external review (i.e. a hearing process before by a neutral party).
- **Any determination of eligibility for the Exchange must be treated as a determination of Medicaid and subject to the Medicaid due process requirements.** Whenever a determination of eligibility for coverage (e.g. Medi-Cal or Healthy Families) is made, including coverage for subsidies in the Exchange, or a determination to terminate or modify coverage (e.g., determination that a consumer is eligible for a lower level of tax credit), the consumer must receive a plainly worded notice telling her of the decision and how to appeal it if she believes it is incorrect. The notice should include information about which program she is being transferred to or what process is being undertaken to determine placement. There should be no termination from coverage without an assessment of eligibility for each

of these other programs and until the individual is actually enrolled in the new health coverage. Decisions to terminate or modify Medi-Cal coverage should go through the current fair hearing appeals process, including the right to maintain aid/coverage during an appeal.

- **Decisions regarding treatment and benefits, e.g. when a plan denies care as not medically necessary, should also be integrated and follow the current Medicaid due process protections and rules for Medicaid beneficiaries as well as for those with Exchange coverage.** The process should provide for both an internal review (e.g. complaint or grievance within a health plan) and an external appeal (e.g. a hearing before a neutral third party). At a minimum, the federal government should establish a floor and current state rules, where more protective, (e.g. the Knox-Keene Act in California), should be adhered to.

Conclusion

With only two years to have a new EER System ready to be tested, California can waste no time in making the key policy decisions which will shape this system. Advocates have laid out our vision for the architecture of the state's EER System and welcome the opportunity to engage with policymakers to ensure that we successfully implement the "no wrong door" vision of the ACA and maximize enrollment into health coverage as expeditiously as possible.