NHeLP
NATIONAL HEALTH LAW PROGRAM

Due Process in California's Early Medicaid Expansion Waiver Program

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I. Introduction: LIHP Due Process

Low Income Health Programs (LIHPs) were created in California in 2010 pursuant to a Medicaid Waiver, pursuant to Section 1115 of the Social Security Act. The waiver allowed California to begin expanding health care coverage to low-income individuals not otherwise eligible for Medi-Cal in 2011, as allowed under the Affordable Care Act, three years before the new Medi-Cal Expansion program was required, to be implemented. The LIHPs are governed by the Special Terms and Conditions (STCs) of the waiver, a contract between the state and federal government, which provides fifty-percent of the funding for the program. The STCs set out the notice and appeals process for the LIHPs.

This brief describes the notice and appeals rules in the LIHPs, and their implementation around the state. It also describes some lessons learned from the LIHPs' due process experience to prepare for California's implementation of the Affordable Care Act in 2014.

II. Overview of LIHP due process requirements

The notice and appeals process for the LIHPs draw largely from federal Medicaid due process requirements, particularly those that apply to Medicaid managed care organizations. While there are some differences between the LIHPs and Medi-Cal, it is important to understand the basic framework of due process protections, as well as the specific federal and state laws that apply to Medicaid beneficiaries in health plans, in order to better understand due process protections for LIHP enrollees.

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A. Medi-Cal Due Process Requirements

Because Medicaid is an entitlement program, eligible Medicaid beneficiaries have a right to Medicaid coverage and benefits. This longstanding and important right means that Medicaid applicants and recipients are entitled to adequate notice and to an administrative fair hearing when an adverse action is taken effecting their coverage and benefits. These rights are guaranteed by the Due Process Clause of the United States Constitution[1] as established by the Supreme Court in in the seminal case of *Goldberg v. Kelly*, which held that when (welfare) benefits are terminated, the beneficiary has due process rights to an effective notice and pre-termination hearing.[2]

1. Notice

In addition to the Constitution, federal and state regulations require that Medi-Cal applicants and recipients receive timely notice of any adverse agency determinations or other actions that affect a person's Medicaid claim.[3] Notice is required for any "action," a legal term that includes a denial, termination, suspension or reduction of Medicaid eligibility or covered services.[4] To be considered adequate, the notice must be in writing and contain a statement of the intended action, as well as the reasons and specific legal support for the action.[5] In addition, the notice must contain an explanation of the individual's hearing rights, rights to representation and to continued benefits.[6] To be timely, a notice generally must be sent at least ten days before the date of the action.[7]

2. Hearing Rights

An applicant or beneficiary has the right to challenge eligibility determinations, reductions, delays and denials in services and other adverse actions that the state, the county, or a managed care plan takes. The process of challenging these actions begins with requesting a fair hearing.[8] Individuals have 90 days from the date of the mailing of a notice to request a hearing.[9] Although the state or managed care plan is required to provide an applicant or beneficiary with notice, a notice of action is not required in order to request a fair hearing. The hearing must be set within 30 working days of filing the request, and written notice of the time and place of the hearing must be sent at least 10 days prior to the hearing.[10]

3. Continued Aid

Continued medical assistance or "aid paid pending" (the California term), refers to continuing the same level of benefits for a beneficiary while she is in the fair hearing process and awaiting a decision from the administrative law judge (ALJ).[11] If an individual or her representative requests a fair hearing within 10 days from the date of the notice or before the date of the action that is the subject of the notice, Medi-Cal eligibility and benefits will continue until the ALJ issues a hearing decision.[12] Medi-Cal

has the option of reinstating services to an individual who requests a hearing after the adverse action has taken place, if the request is made no more than 10 days after the date of the action.[13] In addition, if Medi-Cal failed to provide proper and timely advance notice of the adverse action, a recipient requesting a hearing within 10 days of the mailing of a proper notice of action must be reinstated and allowed to have services continue while a decision is pending.[14]

Under certain circumstances, Medi-Cal services can continue pending a hearing decision when Medi-Cal refuses to reauthorize the services. Some non-acute hospital services can continue pending a hearing decision provided that the (a) reauthorization treatment authorization request (TAR) is submitted to the Medi-Cal field office before (or within 10 days after) expiration of a prior authorization period; and (b) the request for hearing is submitted within 10 days of mailing the denial notice or before the expiration of the prior TAR approval period, whichever is later.[15] This includes long-term care, chronic hemodialysis, in-home medical care services, skilled nursing facility waiver services, model community based waiver services, and all other non-acute services, when the treating doctor substantiates that services should continue because the treatment goal of the original TAR has not been met.

B. Medi-Cal Managed Care Due Process Requirements

Beneficiaries enrolled in Medi-Cal managed care have the same right to a fair hearing as beneficiaries in fee for service Medi-Cal. In addition, managed care beneficiaries have the right to pursue a grievance within the managed care plan.[16] Federal regulations give states the option to require beneficiaries to exhaust the plan's grievance plan before proceeding to a fair hearing.[17] California has not elected to require exhaustion, so beneficiaries may file a grievance and a fair hearing request at the same time or consecutively. If the beneficiary decides to pursue the plan grievance first, the 90-day time period to request a fair hearing continues to run.

In addition, all Medi-Cal managed care plans are subject to the state's Knox-Keene Act, and thus the plan enrollee may, if her grievance is unsuccessful and involves medical judgment, choose to file for an independent medical review (IMR) with the Department of Managed Health Care (DMHC). The IMR process may also be used if services were denied on the basis of being either "investigational" or "experimental" and the enrollee has a life threatening or seriously debilitating condition, or when an enrollee is billed for emergency services when the plan later determines that his or her condition was not emergent.[18] The beneficiary also may be entitled to an expedited grievance and an expedited independent medical review of the denial if exigent circumstances exist.[19]

However, the DMHC has decided that a Medi-Cal beneficiary cannot have an IMR if a fair hearing has already been held or a decision issued.[20]

C. LIHP Due Process Requirements

The state's 1115 waiver Special terms and Conditions (STC) that govern the LIHPs required the state to develop "standards and procedures for hearings and appeals" in the LIHPs that meet certain federal Medicaid standards.[21] DHCS worked with stakeholders and the Center for Medicare and Medicaid Services (CMS) to develop these hearing and appeal standards, which were then approved by CMS in June, 2011.[22] The state requires each individual LIHP to adopt and implement these standards within its program.[23] These standards govern hearings and appeals in the LIHPs instead of the Medi-Cal rules described above. Although the standards largely combine elements of both traditional Medi-Cal and Medi-Cal Managed Care notice and appeals rules, they are different from the Medi-Cal rules in a few key respects.

1. LIHP Hearing and Appeal Standards

The LIHP Hearings and Appeals standards require LIHPs to provide an internal complaint process for nearly all situations in which a LIHP applicant or enrollee is dissatisfied with an aspect of the LIHP or a LIHP eligibility or service determination. Certain complaints may be taken to a Medi-Cal fair hearing if the applicant or enrollee is not satisfied with the internal resolution of the complaint.[24] Complaints that may be taken to a fair hearing are called "appeals." Appeals involve an "action" by the LIHP, which includes any of the following: a denial, termination or reduction of eligibility; a denial or limited authorization of a service request; a reduction, suspension, or termination of a previously authorized service; a failure of the LIHP to provide services in a timely manner; or a failure of the LIHP or State to act within the required timelines for resolving complaints.[25] All other complaints must be resolved internally with the LIHP or its health plan, and are called "grievances."[26] The LIHP must resolve non-expedited grievances within 60 days.[27] The LIHP must ensure that internal grievances and appeals are determined by a decision-maker who was not involved in any prior review of the matter at issue, and who has the appropriate clinical expertise in cases involving medical necessity or clinical judgment issues.[28]

Whenever a LIHP takes an "action," it must provide the applicant or enrollee with notice, and those notices must comply with the same adequacy and timeliness rules for notices as in Medi-Cal.[29] Applicants and enrollees may request internal appeals orally.[30] In addition, as with Medi-Cal, the applicant or enrollee is entitled to continued medical assistance, or aid paid pending, if she requests the hearing and continued benefits within 10 calendar days of the date the notice was mailed or before the action takes

effect, and her appeal involves a reduction or termination of eligibility; or the termination, suspension, or reduction of a previously authorized course of treatment.[31] In such cases, benefits will continue until she withdraws her appeal, receives an adverse hearing decision, or the original authorization period for the service expires.[32]

During the appeals process, applicants and enrollees have the right to review the LIHP's position statement, the case file and medical records; to confront and cross-examine witnesses; and to present evidence and allegations of fact or law.[33] Other than in expedited cases, the LIHP must resolve all appeals within 45 days.[34] LIHPs must allow expedited appeals when a faster resolution is required by the enrollee's health condition; the LIHP must resolve expedited appeals within three days, though the time may be extended by 14 calendar days if the LIHP needs additional information and the delay is in the enrollee's best interest.[35]

If a LIHP applicant or enrollee does not obtain a satisfactory result through the internal appeal, she may request a fair hearing. Unlike Medi-Cal managed care, which allows enrollees to file an internal appeal and a request a fair hearing simultaneously, the standards for LIHPs allow a LIHP to require exhaustion of the internal appeals process before a person may request a fair hearing.[36] The applicant or enrollee has 90 days from the date of the notice of resolution of the internal appeal to request a fair hearing.[37]

While each LIHP must comply with the state's due process standards, each LIHP is afforded considerable leeway in the local implementation of the standards. Thus, some LIHPs contract with a managed care plan to handle all grievances and appeals (the LIHP must retain ultimate oversight responsibility in these cases).[38] Others use the managed care plan or the LIHP's own complaint process to handle grievances and appeals that involve services, access to care, or customer service, but handle eligibility-related complaints through the county welfare department.[39] Still others handle all complaints and grievances through the LIHP itself.[40] Kern Medical Center Health Plan does not require applicants and enrollees to exhaust the internal grievance and appeals process before requesting a fair hearing.[41]

III. LIHP appeals and grievances data

In the first twelve months of the LIHPs, applicants and enrollees filed 1274 appeals (of which 53%, or 678, were resolved), and 1597 grievances (of which 86%, or 1373, were resolved).[42] During this time, the LIHPs had enrolled 552,553 unduplicated enrollees.[43] Statewide, there was an average of 4.79 appeals per 1000 enrollees, and 4.23 grievances per 1000 enrollees.[44] But these numbers hide the wide variation among LIHPs. For example, San Diego's appeals (804) alone comprised nearly two-thirds (63%) of appeals statewide; San Diego had 38.15 appeals per 1000 enrollees.[45] By

contrast, Los Angeles and Ventura had only about 0.3 appeals per 1000 enrollees. [46] Similarly, San Diego and Los Angeles's grievances together comprise 70% of grievances statewide; San Diego had 23.35 grievances per 1000 enrollees, but Los Angeles had only 4.54.[47]

Statewide, the grievances process seems more favorable to enrollees—89% of grievances were resolved in favor (in whole or part) of the enrollee, compared to only 38% of appeals.[48] But again, there was wide variation among LIHPs. While in San Francisco, all 12 appeals were resolved (in whole or part) in favor of the enrollee, in San Bernardino, only two out of 67 appeals were resolved (in whole or part) in the enrollee's favor. [49] In Contra Costa, only 26 of 79 grievances were resolved (in whole or part) in favor of the enrollee, while in San Diego, 482 of 483 grievances were resolved (in whole or part) in the enrollee's favor. [50] Only 15 appeals have gone to a fair hearing so far—all from San Diego. [51] Of those cases, none were resolved (in whole or part) in favor of the enrollee. [52]

LIHPs have 60 days to resolve grievances and 45 days to resolve appeals (plus an additional 45 days for cases that go to fair hearing).[53] Nevertheless, the average time to resolve appeals and grievances was roughly the same—21 days and 18 days, respectively.[54] Only three LIHPs—Contra Costa, San Diego, and San Mateo—exceeded the maximum time for resolving their appeals; those three LIHPs had 397 cases (30% of all appeals) resolved outside of the maximum timeframe.[55] Four LIHPs—Contra Costa, Orange, Riverside and San Diego—exceed the maximum time for resolving grievances, but the number of cases that were resolved outside of the maximum time were few (28 cases, or about 2% of all grievances).[56]

The overwhelming majority (86%) of appeals involved eligibility issues. [57] Then, 11% of appeals involved denials or limited authorizations of services, and 3% involved the LIHP's failure to provide services in a timely manner.[58] The subject of grievances varied widely: 36% involved customer service issues, 25% involved access to care, 12% quality of care, 6% coverage disputes, 1% medical necessity, and 20% other.[59] Note however, that there may be overlap between appeals on a LIHP's failure to provide services in a timely manner and grievances involving access to care. Similarly, appeals on denials or limited service authorizations could overlap with grievances on medical necessity or coverage disputes.

IV. Looking ahead to 2014 – implementing a seamless notice and appeals process for multiple coverage programs

The LIHPs are an early experiment in the kind of multi-program application process that will be required in 2014. By 2014, California is expected to fully implement a "no wrong

door" eligibility system, through which Californians can apply for health coverage through multiple programs—Exchange subsidies, the Medi-Cal expansion, traditional Medi-Cal, as well as Healthy Families and Basic Health, if applicable—in one place, using one "single streamlined application."[60] Several LIHPs have begun using combined health program applications that cover Medi-Cal, Healthy Families, County Health (section 17000) programs, and/or other coverage programs. These combined applications raise several important due process questions, the importance of which will be amplified as California moves to a single statewide program application in 2014.

1. Multiple Program Applications and Notices in the LIHPs

One due process question raised by the LIHPs is what information can be required on a combined application. Not all data elements will be relevant to all programs. For example, in the LIHPs, there is no asset test for eligibility, unlike most Medi-Cal and section 17000 programs. Many counties have nevertheless required applicants to provide asset information on a combined application that determines or screens for eligibility in a program with an asset test, even if the applicant is unlikely to be eligible for that program (because, e.g., she has no linkage to Medi-Cal). Some counties then deny applicants eligibility for ***all*** programs based on their submission of an "incomplete" application, or their "refusal to cooperate" in the application process (by refusing to provide asset information). With respect to the LIHPs, this practice has questionable legitimacy. It is clear that applicants are only eligible for a LIHP if they are "not otherwise eligible" for Medi-Cal and Healthy Families.[61] Thus, counties have some obligation to screen for or determine eligibility for those programs (which have asset limits) before determining whether a person is eligible for LIHP, and may exclude from the LIHP individuals who have a link to Medi-Cal.[62] The state has not clarified whether a person who clearly has no eligibility or linkage to Medi-Cal or Healthy Families may be denied LIHP eligibility based on her failure to provide asset information. While counties have some discretion to "develop eligibility income standards, methodologies and procedures" for their LIHPs,[63] allowing counties to deny eligibility to individuals based on factors that are not required eligibility criteria appears to violate applicants' civil rights.[64]

Another issue raised by combined applications is how individuals who are waiting for a Medi-Cal determination may access coverage. LIHPs may allow applicants who are potentially Medi-Cal eligible based on disability to enroll in the LIHP while their Medi-Cal eligibility determinations and appeals are pending.[65] Several counties have declined to implement this option, however, citing cash flow concerns. As a result, LIHP applicants who are waiting on an appeal of an adverse Medi-Cal eligibility determination may experience gaps in their coverage, or may be forced to pay out-of-pocket for services that should be covered by LIHP or Medi-Cal.

In addition, combined applications raise questions of notice. If one application is used to simultaneously determine that a person is not eligible for Medi-Cal, but is eligible for LIHP, the applicant should receive notice of both eligibility determinations. Ideally, such notice could be combined, such that the applicant does not receive multiple, apparently conflicting, notices, but still receives full information about her appeal rights if she believes that either decision was in error. For example, the CMSP counties use a combined application for their LIHP and CMSP (the county health program). Currently, however, the counties do not issue any notices when applicants are determined ineligible for the LIHP—applicants are "screened" for LIHP, and then either determined eligible, or assessed for CMSP eligibility, after which they received a notice regarding CMPS eligibility only.[66] As a result, applicants who are determined ineligible for LIHP never receive notice of that decision and had no information about how to appeal the determination if they believe it was incorrect. These counties are now working with the state to correct this problem.

2. Multiple Programs Notices and Appeals after 2014

In 2014, California will be required to use a single application to determine eligibility for coverage in Medi-Cal, Healthy Families, the Exchange, and Basic Health, if applicable.[67] In addition, the state must accept applications through multiple means and in multiple venues—including both the Exchange and county welfare offices.[68] The state must ensure that eligibility determinations are coordinated between programs.[69] California will have to take special care to ensure that applicants for coverage are screened for programs appropriately, while ensuring that no one is required to submit more information than is necessary to make an eligibility determination.[70]

Moreover, given the expanded coverage options available in 2014, California will have to take care to ensure that applicants for coverage do not experience any gaps. For example, federal regulations require that applicants who are eligible to enroll in subsidized Exchange coverage, but who also have potential Medi-Cal eligibility, be permitted to enroll in the Exchange while they wait for a final Medi-Cal eligibility determination.[71] California must make sure to fully implement these provisions, and also to guarantee that Medi-Cal applicants who have an eligibility appeal pending have the opportunity to remain in subsidized Exchange coverage until their appeals are finally determined, to minimize any gaps in coverage during the application process.

Finally, to ensure that notice and appeals processes are truly seamless in 2014, California will have to ensure that applicants for health coverage receive comprehensive—and comprehensible—notice. Thus, for example, when the Exchange finds an applicant eligible to purchase coverage with subsidies, the applicant must receive notice that clearly explains both that the person has been found eligible for subsidized coverage, ***and*** that the person has been found ineligible for other programs,

including Medi-Cal. The notice should also plainly set out how the applicant can appeal the determination of ineligibility if she believes that it is in error.

V. Conclusion

The LIHPs are unique program created to expand coverage to low-income Californians in the three years before the new programs created by Affordable Care Act—including the Medi-Cal Expansion, and subsidized coverage in the Exchange—go into effect in 2014. Although the LIHPs were created through an 1115 Medicaid waiver, the hearings and appeals processes for the LIHPs were developed specifically for the program, and do not perfectly align with existing federal Medicaid rules and Medi-Cal processes. When California implements its Medi-Cal Expansion program in 2014, however, the standard Medi-Cal notice and appeals processes will apply. While we anticipate that most LIHP enrollees will move into the Medi-Cal Expansion in 2014, some enrollees will instead become eligible for subsidized coverage in the Exchange.[72] As of this writing, CMS has not released guidance on the notice and appeals requirements for Exchanges, so we do not yet know what due process rules will apply in the Exchange. California has been leading the nation to implement the Affordable Care Act. While LIHP enrollees will be automatically transitioned into Medi-Cal Expansion or the Exchange, the state should take the opportunity to learn from its experience with the LIHPs to ensure that new applicants for coverage in Medi-Cal and the Exchange receive comprehensive notices at the time their eligibility is determined. A high number of LIHP grievances involving customer service issues, which may indicate that applicants and enrollees are not receiving the information they need or expect.[73] California must ensure that its application and notice systems are adequate to provide applicants with all the information they need as efficiently as possible in 2014.

Figure 1: Number of LIHP Appeals and Grievances between 7/1/11 and 6/30/12

	LIHP Start Date	# Appeals	Appeals per 1000 enrollees	# Appeals Resolved	# Appeals resolved favorably to enrollee (whole or part)	% Appeals resolved favorably to enrollee (whole or part)	# Grievances	Grievances per 1000 enrollees	# Grievances Resolved	# Grievances resolved favorably to enrollee (whole or part)	% Grievances resolved favorably to enrollee (whole or part)	# SFH Resolved	# SFH resolved favorably to enrollee (whole or part)	% SFH resolved favorably to enrollee (whole or part)	Average Time to Resolve Appeals (Days) (Requirement = 45 days)	Number of Appeals Expedited	Average Time to Resolve Grievances (Days) (Requirement = 60 days)
Alameda	7/1/2011	33	1.13	26	15	58%	69	2.36	65	58	89%	0		N/A	10.25	0	22.75
CMSP	1/1/2012	74	1.49	64	44	69%	31	0.63	31	31	100%	0		N/A	15.5	4	22.5
Contra Costa	7/1/2011	141	11	116	47	41%	79	6.16	79	26	33%	0		N/A	39.25	0	24
Kern	7/1/2011	25	3.74	25	12	48%	36	5.39	36	32	89%	0		N/A	15.75	0	17.25
Los Angeles	7/1/2011	37	0.27	32	13	41%	631	4.54	426	361	85%	0		N/A	19	0	39.5
Orange	7/1/2011	27	0.76	27	15	56%	27	0.76	27	22	81%	0		N/A	11.47	0	9.16
Riverside	1/1/2012	2	0.13	2	2	100%	113	7.43	108	105	97%	0		N/A	0	0	11
San Bernardino	1/1/2012	67	7.67	65	2	3%	15	1.72	15	11	73%	0		N/A	18.55	0	16
San Diego	7/1/2011	804	38.15	257	72	28%	492	23.35	483	482	100%	15	0	0%	43.33	0	6.08
San Francisco	7/1/2011	12	1.15	12	12	100%	65	6.21	64	61	95%	0		N/A	8	0	10.63
San Joaquin	6/1/2012	0	0	0	0	N/A	0	0	0	0	N/A	0		N/A	0	0	0
San Mateo	7/1/2011	17	2.21	17	12	71%	24	3.13	24	19	79%	0		N/A	85	0	28.3
Santa Clara	7/1/2011	32	3.91	32	12	38%	12	1.47	12	10	83%	0		N/A	13.75	0	1
Santa Cruz	1/1/2012	0	0	0	0	N/A	0	0	0	0	N/A	0		N/A	0	0	0
Ventura	7/1/2011	3	0.31	3	2	67%	3	0.31	3	3	100%	0		N/A	38	0	60
TOTAL (AVERAGE)		***1274***	***4.79***	***678***	***260***	***38%***	***1597***	***4.23***	***1373***	***1221***	***89%***	***15***	***0***	***0%***	***21.19***	***4***	***17.88***

Source: DEPARTMENT OF HEALTH CARE SERVICES LOW INCOME HEALTH PROGRAM, LOW INCOME HEALTH PROGRAM (LIHP) PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO (2012), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY7-Q4_App-Grv_Rpt.pdf

Figure 2: Subject of LIHP Appeals and Grievances between 7/1/11 and 6/30/12

	LIHP Start Date	Appeals						Grievances						
		Denial, reduction or termination of eligibility	Reduction, suspension, or termination of a previously authorized service	Denial or limited authorization of a requested LIHP service, including the type or level of service	Failure to provide LIHP services in a timely manner	Failure of the LIHP or the State to act within the timeframes for grievances and appeals	**Total Appeals**	Medical Necessity	Coverage Dispute	Quality of Care	Access to Care	Customer Service	Other	**Total Grievances**
Alameda	7/1/2011	31	0	2	0	0	**33**	0	5	21	13	28	2	**69**
CMSP	1/1/2012	0	0	74	0	0	**74**	5	7	11	2	6	0	**31**
Contra Costa	7/1/2011	150	0	0	0	0	**150**	0	0	46	6	27	0	**79**
Kern	7/1/2011	18	0	7	0	0	**25**	0	7	13	9	7	0	**36**
Los Angeles	7/1/2011	16	0	21	0	0	**37**	17	0	40	68	323	183	**631**
Orange	7/1/2011	0	0	0	27	0	**27**	1	3	12	7	1	3	**27**
Riverside	1/1/2012	0	0	0	0	0	**0**	0	3	29	49	28	4	**113**
San Bernardino	1/1/2012	67	0	0	0	0	**67**	0	0	11	0	4	0	**15**
San Diego	7/1/2011	795	0	10	0	0	**805**	0	53	3	217	126	93	**492**
San Francisco	7/1/2011	2	0	3	7	0	**12**	0	2	3	16	18	26	**65**
San Joaquin	6/1/2012	0	0	0	0	0	**0**	0	0	0	0	0	0	**0**
San Mateo	7/1/2011	12	0	5	0	0	**17**	0	6	0	10	8	0	**24**
Santa Clara	7/1/2011	10	0	22	0	0	**32**	0	2	5	3	1	1	**12**
Santa Cruz	1/1/2012	0	0	0	0	0	**0**	0	0	0	0	0	0	**0**
Ventura	7/1/2011	1	0	2	0	0	**3**	0	0	0	0	0	3	**3**
TOTAL		***1,102***	***0***	***146***	***34***	***0***	***1,282***	***23***	***88***	***194***	***400***	***577***	***315***	***1,597***
PERCENT OF TOTAL		***86%***	***0%***	***11%***	***3%***	***0%***		***1%***	***6%***	***12%***	***25%***	***36%***	***20%***	

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End Notes

[1] U.S. CONST. AMEND. XIV, § 1; *see also* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.200-431.250.
[2] *Goldberg v. Kelly*, 397 U.S. 254, 266 (1970).
[3] 42 C.F.R. §§ 431.206(b), 435.912, 435.919; CAL. CODE REGS. tit. 22, § 50179(a).
[4] 42. C.F.R. § 431.201; CAL. WELF. & INST. CODE § 11004(e); CAL. CODE REGS. tit. 22, §§ 50179 (Eligibility), 51014.1
(Services). Note, however, that notices are not limited to actions which are adverse to the applicant or beneficiary's interests. 42 C.F.R. §§ 431.201, 431.206(c)(2); CAL. CODE REGS. tit. 22, § 50179(a).
[5] 42 C.F.R. §§ 431.206(b), 431.210; CAL. CODE REGS. tit. 22, §§ 50179(c), 51014.1(c).
[6] 42 C.F.R. §§ 431.206(b), 431.210; CAL. CODE REGS. tit. 22, §§ 50179(c), 51014.1(c).
[7] 42 C.F.R. §§ 431.211, 431.213, 431.214; CAL. CODE REGS. tit. 22, §§ 50179(d), 51014.1(c).
[8] CAL. CODE REGS. tit. 22, § 50951.
[9] 42 C.F.R. § 431.221(d); CAL. WELF. & INST. CODE § 10951. However, the 90-day limit does not apply if the beneficiary receives no written notice or the notice is inadequate. *Morales v. McMahon*, 223 Cal. App. 3d 184 (1990).
[10] CAL. WELF. & INST. Code § 10952.
[11] 42 C.F.R. § 431.230; CAL. CODE REGS. tit. 22, § 51014.2.
[12] 42 C.F.R. §§ 431.230, 431.231(c), 431.231(d); CAL. CODE REGS. tit. 22, § 51014.2(a).
[13] 42 C.F.R. § 431.231.
[14] *Id.* § 431.231(c).
[15] *Id.* § 431.230; CAL. CODE REGS. tit. 22, §§ 51014.2(a), 51003(c)(1).
[16] 42 C.F.R. § 438.402(a); CAL. HEALTH & SAFETY CODE § 1368(a).
[17] 42 C.F.R. § 438.402(b)(2)(ii);
[18] CAL. CODE REGS. tit. 28, § § 1300.74.30; *see also* CAL. HEALTH & SAFETY CODE §§ 1374.30 - 1374.35.
[19] CAL. HEALTH & SAFETY CODE §§ 1368.01(b), 1374.30(f), 1374.31; CAL. CODE REGS. tit. 28, §§ 1300.68.01, 1300.74.30(d)(4).
[20] CAL. CODE REGS. tit. 28, § 1300.74.30(f)(3).
[21] CENTER FOR MEDICARE & MEDICAID SERVICES, SPECIAL TERMS AND CONDITIONS, AMENDED APRIL 1, 2012, CALIFORNIA BRIDGE TO REFORM DEMONSTRATION ¶ 76 [hereinafter STC], *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Publications/California%20STCs%20(3-30-12).pdf.
[22] *See* CAL. DEP'T OF HEALTH CARE SERV., CALIFORNIA BRIDGE TO REFORM DEMONSTRATION HEARINGS AND APPEALS PROCESS FOR LOW INCOME HEALTH PROGRAMS (LIHP) (2011) [hereinafter LIHP HEARINGS AND APPEALS PROCESS], *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Hearings-Appeals/Hearing-Appeals_Process_062911.pdf.
[23] Memorandum from the Department of Health Care Services Low Income Health Program Branch to New Local LIHPs, Primary Contacts (Sep. 6, 2011), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Deliverables/NewDeliverablesEmail-1_9-6-11.pdf.
[24] LIHP HEARINGS AND APPEALS PROCESS § II.B.
[25] *Id.* §§ I.A, I.C, II.
[26] *Id.* §§ I.B, II.A.

[27] *Id.* § V.D.1.
[28] *Id.* §§ V.C.1.d, V.C.1.e.
[29] *Id.* § V.A.
[30] *Id.* § V.D.2.a.
[31] *Id.* §§ V.G.1, 2. While CMS has adopted this rule for the LIHPs, states have applied a similar standard in traditional Medicaid Managed Care programs. NHeLP does not believe that the federal Medicaid laws and regulations permit states to discontinue services to enrollees in Medicaid managed care when their authorization period for services ends, and is challenging this practice in several states.
[32] *Id.* § V.G.3.
[33] California Bridge to Reform Demonstration, Hearings and Appeals Process for Low Income Health Programs (LIHP) § V.C.2, http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Hearings-Appeals/Hearing-Appeals_Process_062911.pdf.
[34] *Id.* § V.D.2.
[35] *Id.* §§ V.D.3- 4.
[36] *Id.* § III.B.
[37] *Id.* § V.F.1.
[38] For example, San Mateo County's Access and Care for Everyone program requires that applicants and enrollees file all appeals and grievances with the Health Plan of San Mateo. *See* SAN MATEO COUNTY ACE, PARTICIPANT HANDBOOK 2011-2012 at 40 (2011), *available at* http://www.hpsm.org/documents/ACE_Handbook_English.pdf.
[39] For example, Orange County's Medical Services Initiative directs eligibility appeals to the county, while LIHP deals with other complaints. *See* ORANGE COUNTY HEALTH CARE AGENCY, MSI MEMBER HANDBOOK (2011), *available at* http://www.ochealthinfo.com/docs/medical/msi/MSI-Patient-Handbook.pdf.
[40] For example, Los Angeles County's Healthy Way LA Program handles its own grievances and appeals. *See* HWLA PROGRAM, HEALTHY WAY LA MEMBER HANDBOOK: BENEFIT YEAR 2011-2012 at 18-22 (2011), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Deliv/LA/15.1MemberHandbook.pdf.
[41] KERN MEDICAL CENTER HEALTH PLAN, MEMBER HANDBOOK 2011-2012 at 21-22 (2011), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Deliv/Kern/15.1Handbook.pdf.
[42] Author's calculations based on CAL. DEP'T OF HEALTH CARE SERVS. LOW INCOME HEALTH PROG., LOW INCOME HEALTH PROGRAM (LIHP) PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO (2012) [hereinafter LIHP PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO], *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY7-Q4_App-Grv_Rpt.pdf. *See* Fig. 1.
[43] CAL. DEP'T OF HEALTH CARE SERVS. LOW INCOME HEALTH PROG., LIHP ENROLLMENT DATA DEMONSTRATION YEAR 7 QUARTER 4 at 6 (2012), *available at* http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/DY7-Q4_Enrl_Rpt.pdf.
[44] Author's calculations based on LIHP PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO. *See* Fig. 1.
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Id.*

[52] *Id.*
[53] LIHP HEARINGS AND APPEALS PROCESS § V.D.2, 1.
[54] Author's calculations based on LIHP PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO. *See* Fig. 1.
[55] LIHP PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO at 14, 44, 59.
[56] *Id.* at 14, 29, 34, 44.
[57] Author's calculations based on LIHP PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO. *See* Fig. 2.
[58] *Id.*
[59] *Id.*
[60] *See* Affordable Care Act §§ 1413(b)(1), 2201(b); 42 C.F.R. § 435.907(b).
[61] STC ¶ 58.
[62] *See, e.g.,* Draft Memorandum from Jalynne Callori, Chief, Low Income Health Program Division, Cal. Dep't of Health Care Servs., for All Local Low Income Health Programs (Aug. 22, 2012) (on file with author) (draft policy letter from the State to the LIHPs indicating that an individual determined to be eligible for Medi-Cal is not eligible for LIHP even if that individual refuses to access the Medi-Cal benefits; an individual determined to have linkage for Medi-Cal eligibility through the LIHP eligibility screening process who refuses to apply for Medi-Cal is not eligible for LIHP; and an individual determined not eligible for Medi-Cal on the basis of the applicant's non-responsiveness or failure to cooperate is not eligible for LIHP).
[63] STC ¶ 59.b.
[64] *See, e.g.,* 42 C.F.R. § 435.901 (requiring that Medicaid agencies' standards and methods for determining eligibility be consistent with the U.S. Constitution, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act, and the Americans with Disabilities Act); *Marchwinski v. Howard*, 113 F. Supp. 2d 1134 (E.D. Mich. 2000) (holding that suspicionless drug testing of applicants for public assistance is an unconstitutional search and seizure under the U.S. Constitution).
[65] Draft Memorandum from Jalynne Callori, Chief, Low Income Health Program Division, Cal. Dep't of Health Care Servs. for All Local Low Income Health Programs (Aug. 22, 2012) (on file with author).
[66] *See, e.g.,* County Medical Services Program Notice of Denial, http://www.cmspcounties.org/pdf_files/forms/CMSP239A-1205.pdf; County Medical Services Program Approval/ Denial of Benefits, http://www.cmspcounties.org/pdf_files/forms/CMSP239B-0609.pdf.
[67] 42 C.F.R. § 435.907(b); 45 C.F.R. § 155.405(a).
[68] 42 C.F.R. § 435.907(a); 45 C.F.R. §§ 155.302, 155.405(b).
[69] 42 C.F.R. §§ 435.911, 435.1200; 45 C.F.R. § 155.345.
[70] 42 C.F.R. § 435.907(e).
[71] 45 C.F.R. § 155.345(e).
[72] If California implements a Basic Health Program, most of these LIHP enrollees would move into a Basic Health Program instead of into the Exchange.
[73] Author's calculations based on LIHP PROGRAM PROGRESS REPORT: PROGRAM YEAR TWO. *See* Fig. 2.