

Advocates Guide To California's Coordinated Care Initiative

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About This Guide

This Guide is designed for advocates and individuals who provide assistance to dual eligibles and seniors and persons with disabilities. Justice in Aging and Disability Rights Education and Defense Fund (DREDF) strive to make the information in this Guide as accurate as possible as of the publication date (June 16, 2015). However, many of the details about the Coordinated Care Initiative (CCI) are still evolving. To get the most up-to-date information on the CCI and sign-up for alerts, Justice in Aging webinars, and other trainings, please visit our website <http://dualsdemoadvocacy.org/california> or email Shelby Minister, sminister@justiceinaging.org. You can also subscribe to the California Department of Health Care Service's official listserv to receive program updates at www.calduals.org.

Justice in Aging advocates for the rights of low-income seniors and persons with disabilities to access healthcare. Justice in Aging cannot represent individuals in their claims for benefits, but can provide technical assistance and advice to advocates. DREDF also does not provide individual representation on benefit eligibility or amounts. DREDF staff gives information and referrals for individual benefits assistance, and technical assistance on disability civil rights to legal service advocates. DREDF is also tracking failures to comply with federal and state disability rights laws and provide reasonable accommodations to benefit applicants and enrollees. For more information about other organizations that assist consumers, see Appendix A.

This is version 4 of the Guide. The CCI has undergone significant changes from the last publication of this Guide. Prior versions are outdated and should be discarded.

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Executive Summary

Implementation of the Coordinated Care Initiative (CCI) is now underway in Los Angeles, Orange, Riverside, San Diego, San Bernardino, San Mateo, and Santa Clara counties. There have been significant changes to the CCI since the release of the third version of the Advocate's Guide to California's Coordinated Care Initiative in June 2014. Version Four of the Guide includes these important changes and provides the most recent information on the CCI. If you have a saved or printed Version Three, please replace it with Version Four because the former contains outdated information.

Justice in Aging provides regular updates to advocates on the CCI through an Advocates Alert. To sign up for these updates, please contact sminister@justiceinaging.org. Justice in Aging also maintains a CCI "fix list" documenting the problems brought to Justice in Aging's attention during the implementation of the CCI. The CCI Fix List is available at <http://dualsdemoadvocacy.org/california/cci-fix-list>.

Acknowledgments

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This Guide is also supported in part by a grant from The California Health Care Foundation and The California Wellness Foundation (TCWF). Created in 1992 as a private independent foundation, TCWF's mission is to improve the health of the people of California by making grants for health promotion, wellness education and disease prevention.

Glossary

BH = behavioral health. This includes mental health services and substance use disorder (SUD) services.

CBAS = Community-Based Adult Services. Formerly, CBAS was called Adult Day Health Care. CBAS is a Medi-Cal benefit offered to eligible seniors and persons with disabilities to help individuals continue living in the community. Services are provided at CBAS centers. Services include, for example, nursing services, mental health services, nutritional counseling, and occupational, speech, and physical therapies.

CCI = Coordinated Care Initiative.

CMS = Centers for Medicare and Medicaid Services. The federal agency within the United States Department of Health and Human Services that administers Medicare and Medicaid.

COHS = County Organized Health System. A local county public agency that contracts with DHCS to administer Medi-Cal benefits for its county (counties). For the purposes of the CCI, Orange County and San Mateo County are COHS counties.

CPO services = Care Plan Option services. These are home and community based-like services that Cal MediConnect plans have the option to offer to beneficiaries under a Cal MediConnect plan.

DD Waiver = Developmentally Disabled waiver. This is a home and community-based services waiver for individuals with developmental disabilities who are Regional Center consumers.

DHCS = Department of Health Care Services, the California state department that is the single state agency responsible for overseeing administration of the Medi-Cal program.

DME = durable medical equipment.

DMHC = Department of Managed Health Care. The California state agency that is responsible for overseeing managed care plans.

D-SNP = Dual-Eligible Special Needs Plan. A Medicare Advantage plan limited to serving dual eligible beneficiaries.

FFS = fee-for-service. Payment system whereby each health care services provider bills for each service provided, as compared to managed care, which usually involves prospective payment based on capitated rates. Prior to the CCI, fee for service was the default payment model where a provider is paid directly from Medicare or Medi-Cal rather than contracting with a health plan.

HCBS = home and community-based services that provide assistance with daily activities that generally help beneficiaries remain in their homes (includes waivers such as In-Home Operations waiver, Nursing Facility/Acute Hospital waiver, Assisted Living waiver, DD waiver, MSSP).

HICAP = Health Insurance Counseling and Advocacy Program. Provides free and objective counseling about Medicare and Cal MediConnect.

ICF/DD = Intermediate care facility/developmentally disabled. A long-term care facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to residents with developmental disabilities.

IHO Waiver = In-Home Operations Waiver. A home and community-based services waiver limited to people who require nursing facility or subacute levels of care who have been receiving services in an acute hospital for 36 months or more, and have a need for physician-ordered services that exceed what can be provided under the NF/AH waiver.

IHSS = In-Home Supportive Services. The IHSS program provides services that allow a beneficiary to remain safely in the home rather than in a nursing facility or other institution. Some of the services offered through IHSS include housecleaning, shopping, meal preparation, laundry, personal care services, accompaniment to medical appointments, and protective supervision for the mentally impaired.

LTSS = long-term services and supports. Under the CCI, LTSS is an umbrella term that includes four specific programs: In-Home Supportive Services, Community-Based Adult Services, Multi-Purpose Senior Services Program, and Long-Term Care (nursing facility care).

MOU = Memorandum of Understanding. For the purposes of this Guide, the MOU generally refers to the agreement entered into between DHCS and CMS authorizing Cal MediConnect.

MSSP = Multi-Purpose Senior Services Program. A program that provides social and health care management to frail elderly individuals. It allows individuals, who without the program would be placed in a nursing facility or other institution, to remain living in their community.

NF/AH Waiver = Nursing Facility/Acute Hospital waiver. A home and community-based services waiver available to Medi-Cal beneficiaries who meet one of three levels of care: nursing facility level A or level B; nursing facility subacute; or acute hospital.

SNF = skilled nursing facility.

SOC = share of cost. Individuals who have higher incomes can still receive Medi-Cal by paying a share of the cost of the services they receive. Once a beneficiary's healthcare expenses reach a specified amount each month, Medi-Cal will pay for any additional accrued expenses in that month.

SPDs = seniors and persons with disabilities. SPDs are a defined population under Medi-Cal referring specifically to people who have Medi-Cal because they are age 65 or older or have a disability, but who do not have Medicare, i.e., NOT dually eligible.

Introduction

The Coordinated Care Initiative (CCI) is a new program that, in the seven counties in which it is being implemented, changes the way that California's dually eligible individuals – i.e., those who have both Medi-Cal and Medicare, “duals” or “Medi-Medis” – and seniors and persons with disabilities with Medi-Cal only (“SPDs”) get their health care. Anyone who represents or works with duals and SPDs in these seven counties should be familiar with the CCI. An understanding of the program and its rules is the best way to make sure that at-risk Californians do not lose access to vital health services. This Guide is intended to assist advocates in understanding the CCI. It includes a description of what the CCI is, whom the CCI impacts and how beneficiaries are affected, why it is being implemented, and when and where the CCI is occurring.

What is the CCI?

The CCI is a program intended to integrate and coordinate the delivery of health benefits, including behavioral health benefits, and long-term services and supports (LTSS) to dual eligibles and SPDs¹ living in seven² California counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.³

The CCI involves three distinct changes:

- 1 SPDs refer to a specifically defined population of individuals who qualify for Medi-Cal only (not Medicare) based on age or disability.
- 2 Originally, eight counties were slated to implement the CCI. On November 13, 2014, DHCS announced that Alameda County would not move forward with the CCI.
- 3 On June 27, 2012, the California Legislature passed, and the Governor signed, two pieces of legislation creating the CCI: SB 1008 (Chapter 33, Statutes of 2012) and SB 1036 (Chapter 45, Statutes of 2012). On June 17, 2013, the California Legislature passed SB 94, which amends portions of the CCI legislation.

Mandatory Enrollment in Medi-Cal Managed Care⁴

The CCI expands mandatory enrollment into Medi-Cal managed care. In 2011, California began mandatory enrollment of SPDs into Medi-Cal managed care. At that time, certain populations were excluded from mandatory enrollment, including individuals living in nursing facilities, individuals with a share of cost, and dual eligibles.⁵ The CCI now requires these previously excluded groups of individuals living in the seven CCI counties to enroll in a managed care plan to receive their Medi-Cal benefit. Enrollment is mandatory.⁶ If a beneficiary fails to choose a plan, the State will choose a plan for the beneficiary.⁷

LTSS Integration⁸

Long-term services and supports (LTSS) historically have not been included in the managed care benefit package.⁹ Under the CCI, LTSS, including nursing

- 4 WIC §§ 14182; 14182.16; 14182.17. California received federal approval on March 19, 2014, to move forward with mandatory enrollment of dual eligibles and other SPDs into Medi-Cal managed care through an amendment to California's Bridge to Reform 1115 waiver. The waiver approval letter and amended special terms and conditions are available at www.calduals.org/dhcs-cci-amendment-to-1115-waiver.
- 5 In County Organized Health System (COHS) counties, all individuals receiving Medi-Cal have always been mandatorily enrolled in Medi-Cal managed care, including duals, share of cost, and nursing facility residents.
- 6 For a description of the few limited exceptions to mandatory enrollment in Medi-Cal managed care, see page 12.
- 7 The State will primarily use a beneficiary's provider history to select a plan. WIC § 14182(b)(6). See also 1115 waiver Special Terms and Conditions, p. 99, available at www.calduals.org/wp-content/uploads/2014/03/CA-Bridge-Amendment_STCs_CMS-approved-3_19_14.pdf.
- 8 WIC § 14186. California received federal approval to integrate LTSS into managed care plans on March 19, 2014, through an amendment to California's Bridge to Reform 1115 waiver. The waiver approval letter and amended special terms and conditions are available at www.calduals.org/dhcs-cci-amendment-to-1115-waiver.
- 9 Community-Based Adult Services (CBAS) was transitioned into Medi-Cal managed care in 2012, as a result of the settlement of the *Darling v. Douglas* lawsuit. More information about CBAS

facility care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and the Multi-Purpose Senior Services Program (MSSP) are provided through managed care plans. This change impacts both those beneficiaries who are new to Medi-Cal managed care as well as those who are already enrolled in Medi-Cal managed care, since it is the first time that many will receive LTSS through their Medi-Cal managed care plan.¹⁰

Passive Enrollment

"Opt In" versus "Opt Out" versus "Disenroll"

Most dual eligible beneficiaries will receive notices about enrollment into Cal MediConnect. If a beneficiary does not make a choice, she will automatically (or passively) be enrolled into a Cal MediConnect plan.

A beneficiary has the choice to **opt in** or **opt out** of Cal MediConnect prior to her effective date of coverage in the program.

After a beneficiary's effective coverage begins in a Cal MediConnect plan, she will have to **disenroll** from the program to change how she receives her Medicare benefit.

and the *Darling* settlement is available on DHCS's website (www.dhcs.ca.gov/services/medi-cal/pages/adhc/adhc.aspx); and the websites of the California Association for Adult Services (CAADS) (www.caads.org/), and Disability Rights California (www.disabilityrightsca.org/advocacy/Darling-v-Douglas/index.html).

- 10 Individuals residing in COHS counties already receive nursing facility care and CBAS through their Medi-Cal managed care plan. The CCI will now require the COHS-county managed care plans to provide IHSS and MSSP services as well. Likewise, some beneficiaries already receive CBAS through managed care. The only change for these beneficiaries will be the inclusion of the other LTSS into their managed care plan.

Cal MediConnect¹¹

The CCI creates a new type of managed care program, known as Cal MediConnect, which combines a dual eligible's Medi-Cal and Medicare benefits into one integrated managed care plan.¹² Cal MediConnect is a three-year demonstration program. If the program is successful after the demonstration period, the State plans on implementing the program statewide. Cal MediConnect impacts dual eligible beneficiaries, not SPDs or individuals with Medicare only. The Cal MediConnect plans in the seven CCI counties entered into three-way contracts with the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). The three-way contracts outline the plans' responsibilities under the Cal MediConnect program.¹³ Cal MediConnect health plans are paid a monthly fee for each individual enrollee, called a "capitated" rate, and are responsible for providing a package of Medicare and Medi-Cal services in exchange for that rate.¹⁴

Cal MediConnect plans provide Medi-Cal and

- 11 WIC § 14132.275. California received federal approval of Cal MediConnect through the Memorandum of Understanding entered into between DHCS and CMS on March 27, 2013 [hereinafter "MOU"]. The MOU is available online at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf.
- 12 Cal MediConnect is not the first example of integrated care for dual eligibles. The Program for All-Inclusive Care for the Elderly (PACE) has been using an integrated care model for many years; see p.14 for more information about the PACE option.
- 13 A template of the three-way contract is available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CACContractwithoutSub.pdf>.
- 14 The rate paid to the health plans is a combination of a Medicare rate and a Medi-Cal rate. The amount paid by each program starts with a 'baseline' that then is adjusted to the acuity of the enrolled population and reduced by a predetermined savings percentage. MOU pp. 45-52. A summary of the Medicare rates for 2014 is available at www.calduals.org/wp-content/uploads/2014/04/4-22-14-CA-MediConnect-Rate-Report-clean.pdf and the Medi-Cal portion of the Cal MediConnect rates for 2014 is available at www.calduals.org/wp-content/uploads/2014/01/CCI-Medi-Cal-rates1-23.pdf.

Medicare services using a network of contracted providers (primary care physicians, hospitals, pharmacies, LTSS providers, etc.). A member of a Cal MediConnect plan can only get services from providers who are within the plan's network, and can only get those services that have been approved by the plan.¹⁵ This is in contrast to a dual eligible with traditional, fee-for-service Medicare and Medi-Cal who can see any doctor or other provider who accepts Medicare or Medi-Cal.

Most dual eligibles will be passively enrolled into Cal MediConnect. This means that if a dual eligible does not “opt out” of Cal MediConnect after receiving notices about enrollment, or does not affirmatively choose a particular Cal MediConnect plan, the individual will automatically be placed in a Cal MediConnect plan chosen by the State.¹⁶

Enrollment in Cal MediConnect is voluntary. An individual in Cal MediConnect has the right to change plans or disenroll at any time. The dual eligible does not have to cite a reason to opt out or disenroll from Cal MediConnect. Disenrollment becomes effective the first day of the month following disenrollment.¹⁷ If a dual eligible opts out or disenrolls from Cal MediConnect, she will receive her Medicare benefits through Medicare fee-for-service, or, if she chooses, a Medicare Advantage plan.¹⁸ A dual eligible who decides not to enroll in a Cal MediConnect plan must still be enrolled in a Medi-Cal managed care plan for her Medi-Cal benefit.¹⁹

If a dual eligible opts out or disenrolls from Cal MediConnect, she will not again be subject to passive enrollment into the program throughout the three-year

life of the demonstration.²⁰

Remember, while dual eligibles are free to opt out or disenroll from Cal MediConnect for their Medicare benefit, enrollment into managed care for their Medi-Cal benefit is mandatory.

Frequently Asked Questions

What is passive enrollment?

Passive enrollment is the process by which individuals are enrolled into a Cal MediConnect plan. If a beneficiary receives a notice and does not act affirmatively by either opting out of Cal MediConnect or choosing a plan, the beneficiary is automatically enrolled into a Cal MediConnect plan chosen for her by DHCS. In other words, if a beneficiary does nothing, she is automatically enrolled in Cal MediConnect.

Beneficiaries can always enroll in Cal MediConnect at any time. They, however, cannot opt out of the program until they receive their passive enrollment notices. The passive enrollment timeline differs from county to county. After passive enrollment ends, dual eligibles will not be subject to passive enrollment again, but will continue to have the opportunity to voluntarily enroll in Cal MediConnect by contacting Health Care Options, the state's enrollment broker (or the health plan directly in the COHS counties).

Individuals who only have to select a Medi-Cal plan will also be passively enrolled into a Medi-Cal plan. If a beneficiary does not make a plan selection, the state will automatically enroll the beneficiary into a plan chosen by the state.

15 Beneficiaries have continuity of care rights when transitioning into the CCI. See p.34 for more information about continuity of care.

16 An individual is placed in a default plan based on a hierarchical logic. See three-way contract, § 2.3.1.5.3.1, p. 25.

17 MOU p. 64. See also three-way contract § 2.3.2, pp. 27-29, for disenrollment triggers.

18 Duals will also have the option to enroll in PACE if eligible. See p.14 for more information about the PACE option.

19 Beneficiaries living in COHS counties are already enrolled in Medi-Cal managed care. The only change for them is full integration of LTSS into their Medi-Cal benefit package.

20 See “Medicare Medicaid Plan Enrollment and Disenrollment Guidance,” dated June 14, 2013, p. 17, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf.

Can a beneficiary disenroll from Cal MediConnect after being enrolled?

Yes. A beneficiary can disenroll from Cal MediConnect at any time for any reason. Disenrollment becomes effective the first day of the month following the disenrollment request. Disenrollment can happen in several ways. The individual can call Health Care Options, the enrollment broker and disenroll. If she does nothing more, she will receive her Medicare Part A and B benefits through fee-for-service and she will be auto-enrolled in a Part D plan. A beneficiary will also be disenrolled if she chooses to enroll in a Medicare Advantage Plan or if she chooses to change her Part D coverage by enrolling in a Prescription Drug Plan (PDP).²¹ However, disenrollment will only apply to her Medicare benefit. A beneficiary still has to be enrolled in a managed care plan for her Medi-Cal benefit.

²¹ Three-way contract, § 2.3.2, pp. 27-29.

Authority for the CCI

The authority for the CCI is contained in a myriad of sources, including enacting legislation, statute, memorandum of understanding, contracts, and policy documents.

Enacting Legislation

- [Senate Bill 1008](#), June, 27, 2012
- [Senate Bill 1036](#), June 27, 2012
- [Senate Bill 94](#), amending SB 1008, June 17, 2013
- [Senate Bill 857](#), amending SB 1008, June 12, 2014

Statutory Authority

- SB 1008 amended or added sections to the Welfare and Institutions Code including sections 14132.275, 14132.276, 14182, 14182.16, 14182.17, 14183.6, 14301.1, and 14301.2.
- SB 1036 amended and added sections to the Welfare and Institutions Code including sections 6253.2, 6531.5, 10101.1, 12306, 12306.1, 12300.5, 12300.6, 12300.7, 12302.6, 12306.15, 12330, 14186.35, and 14186.36.

CMS Waiver Authority

- [California's Bridge to Reform Demonstration 1115 Waiver Amendment](#) – Pursuant to Section 1115 of the Social Security Act, CMS has authority to grant waivers of certain requirements under the Medicaid State Plan provisions to allow states to develop and test new service delivery and payment systems. To move forward with the changes under the CCI, California submitted an amendment to its 1115 waiver on June 18, 2013, which was approved by CMS on March 19, 2014.

Cal MediConnect Specific Sources

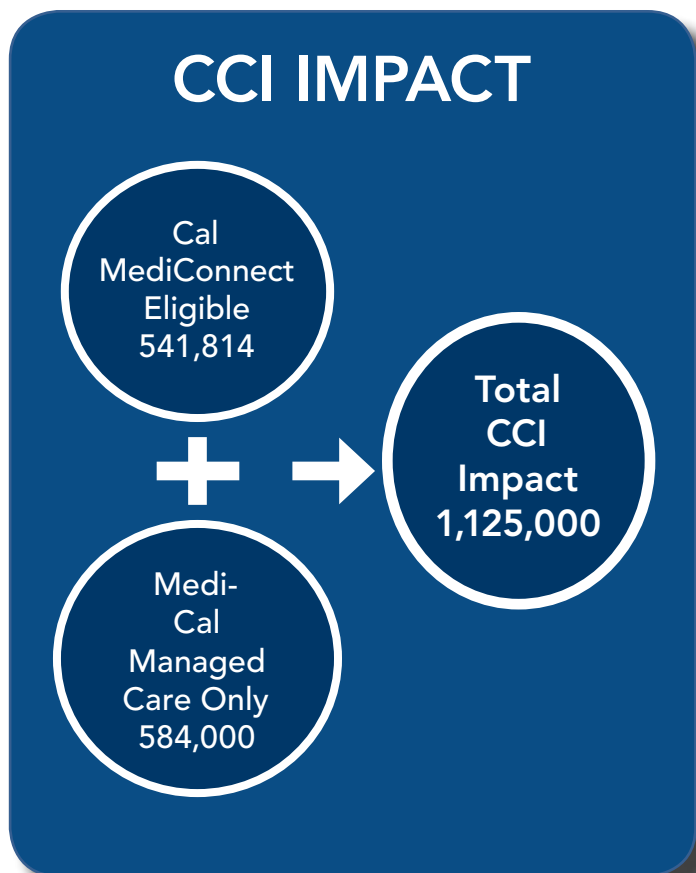
- [Memorandum of Understanding](#) – an agreement between CMS and DHCS signed March 27, 2013, outlining the parameters of the Cal MediConnect program.
- [Three-Way Contracts](#) – contracts entered into between CMS, DHCS, and the Cal MediConnect plans setting forth the obligations of each of the parties under the Cal MediConnect program.
- [Dual All Plan Letters](#) – guidance issued by DHCS to the Cal MediConnect plans.
- [CMS Policy](#) – CMS has issued both national and state-specific guidance for the duals demonstration including, for example, enrollment guidance, the member handbook, and marketing guidance.
- [DHCS Policy](#) – DHCS has issued policy documents and fact sheets on different areas of the program including, for example CPO Services, transportation benefit, and reporting requirements.

Whom Does the CCI Impact and How?

The CCI impacts dual eligibles and SPDs in the seven CCI counties. Individuals who only qualify for Medicare and have no Medi-Cal coverage are not impacted by the CCI. Dual eligibles and SPDs are impacted differently under the CCI. We have provided a pull-out table on page 19, which provides a summary of how dual eligibles and SPDs are affected, including:

1. Who will be mandatorily enrolled in Medi-Cal managed care;
2. Who will have LTSS integrated into the Medi-Cal Managed Care benefit package;
3. Who will be passively enrolled into Cal MediConnect; and
4. Who can participate in Cal MediConnect, but will not be passively enrolled.

The CCI impacts over one million duals and SPDs in the seven CCI counties.



Medi-Cal Managed Care

Most SPDs and duals will be mandatorily enrolled in some form of Medi-Cal managed care. There are few exceptions to mandatory enrollment in Medi-Cal managed care. These exceptions include beneficiaries under age 21, individuals living in certain rural zip codes²², beneficiaries with other health coverage in certain counties, individuals living in a veterans' home, and residents of an Intermediate Care Facility for the Developmentally Disabled (ICF-DD) in certain counties.²³ The table on page 19 outlines these exceptions in detail.

Cal MediConnect

There are many more exceptions to participation in Cal MediConnect. In general, most dual eligibles will be passively enrolled into Cal MediConnect. However, certain dual eligible beneficiaries are not permitted to participate in Cal MediConnect, including, for example, beneficiaries under age 21, beneficiaries in certain rural zip codes, beneficiaries who do not routinely meet their Medi-Cal share of cost, beneficiaries with developmental disabilities receiving services through a Regional Center, and beneficiaries with End Stage Renal Disease in certain counties.²⁴

There are also dual eligible beneficiaries who can participate in Cal MediConnect if they choose, but who will not be passively enrolled into the program. For example, individuals enrolled in a Kaiser plan and individuals living in certain rural zip codes in San Bernardino County will not be passively enrolled into Cal MediConnect, but can voluntarily enroll into the program.²⁵ Individuals enrolled in a Medicare

22 Only one health plan is available in these rural zip codes. Except in County Organized Health System (COHS) counties, federal law prohibits mandatory enrollment into Medi-Cal managed care if there is only one health plan available. 42 USC § 1396u-2(a)(1)(A)(i)(I); 42 USC § 1396u-2(a)(3)(A); see also CMS "2014 Capitated Financial Alignment Demonstration Timeline" (p. 5), available at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_PlanGuidance01092013.pdf.

23 WIC § 14182.16(c)(1).

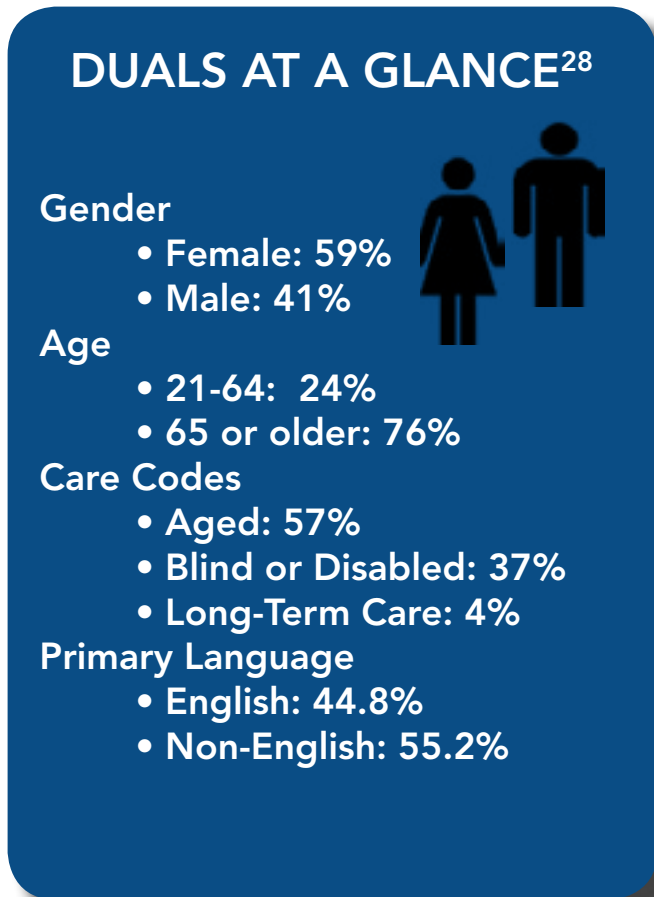
24 WIC § 14132.275(l)(3)(A); MOU pp. 8-9.

25 MOU p. 9.

Advantage plan or in a D-SNP not operated by a Cal MediConnect plan will not be subject to passive enrollment, but can opt-in to the program if they disenroll from their Medicare Advantage or D-SNP plan.²⁶ Likewise, individuals who are enrolled in PACE or in Home and Community-Based Services (HCBS) waivers will not be passively enrolled into Cal MediConnect, but can choose to enroll if they disenroll from PACE or their waiver.²⁷ The table on page 19 shows these different exceptions in detail.

Approximately 542,000 beneficiaries in the seven counties are eligible for passive enrollment in Cal MediConnect.²⁸ Of those eligible for passive enrollment, only 453,000 can be enrolled. This is because Los Angeles County has a limit on how many beneficiaries can enroll in Cal MediConnect. Of the 288,000 duals who are eligible for passive enrollment residing in Los Angeles County, only 200,000 can be enrolled.²⁹ The table below lists the approximate number of dual eligibles subject to passive enrollment in each county.

Remember that dual eligibles who are not passively enrolled into Cal MediConnect or who are not able to participate in Cal MediConnect will still be mandatorily enrolled into Medi-Cal managed care for their Medi-Cal benefit.³⁰



26 Individuals enrolled in a Medicare Advantage plan, FIDE-SNP, or a D-SNP plan not operated by a Cal MediConnect plan will not be subject to passive enrollment into Cal MediConnect plans. Individuals enrolled in a D-SNP operated by a Cal MediConnect plan will be subject to passive enrollment into Cal MediConnects plans. See [SB 857](#); § 14132.277. For more information on the D-SNP policy, refer to the All Plan Letters [14-007](#) and [14-014](#) and Justice in Aging’s county specific fact sheets available at <http://dualsdemoadvocacy.org/trainings-and-education-materials>.

27 MOU p. 9.

28 See “Medi-Cal’s Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden” (November 2012), available at www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf. Long-term care codes include dual eligibles residing in long-term care facilities and enrolled in Medi-Cal aid codes 13-Age Long-Term Care, 23-Blind Long-Term Care, and 63-Disabled Long-Term Care. *Id.* at 54. The estimates in these reports are superseded by a DHCS analysis conducted in May 2013, which reflects higher numbers of enrollment. This data was not made available by DHCS but is summarized in “Senate Budget & Senate Health Oversight Hearing on Coordinated Care Initiative – Background Paper,” February 6, 2014, available at <http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/02062014SBFR-HealthJointHearingAgendaCCI.pdf>.

29 MOU p. 8. The enrollment cap in LA County only applies to Cal MediConnect and not enrollment into Medi-Cal managed care.

30 In total, there are 584,000 individuals who either have to join a Medi-Cal managed care plan or will have LTSS added to their Medi-Cal plan in addition to those subject to passive enrollment into Cal MediConnect. This total includes dual eligibles who cannot participate in Cal MediConnect, dual eligibles not subject to passive enrollment in Cal MediConnect, non-dual beneficiaries who must join a Medi-Cal managed care plan under the CCI, and beneficiaries who will have LTSS integrated into their Medi-Cal managed care plan under the CCI. See “Medi-Cal’s Coordinated Care Initiative Population: Definitions and Estimated Counts,” available at www.dhcs.ca.gov/dataandstats/statistics/Documents/CCI%20Population%20Brief.pdf and http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2013_May_Estimate/May_2013_Medi-Cal_Estimate.pdf (PC Page 247). The estimates in this report

County	Duals Subject to Passive Enrollment in Cal MediConnect ³¹
Los Angeles	288,399 (200,000 cap)
Orange	65,537
Riverside	40,040
San Bernadino	41,930
San Diego	55,798
San Mateo	12,371
Santa Clara	37,739
GRAND TOTAL	541,814 (453,415 with cap)

DHCS maintains a monthly dashboard of individuals who have enrolled, disenrolled, and opted-out of the Cal MediConnect program available at <http://www.calduals.org/enrollment-data/>.³²

are superseded by a DHCS analysis conducted in May 2013, which reflects higher numbers of enrollment. This data was not made available by DHCS but is summarized in “Senate Budget & Senate Health Oversight Hearing on Coordinated Care Initiative – Background Paper,” Feb. 6, 2014, available at http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/02062014SBFR_HealthJointHearingAgendaCCI.pdf.

31 See “Medi-Cal’s Coordinated Care Initiative Population: Definitions and Estimated Counts” (p. 11), available at www.dhcs.ca.gov/dataandstats/statistics/Documents/CCI%20Population%20Brief.pdf. The estimates in this report are superseded by a DHCS analysis conducted in May 2013, which reflects higher numbers of enrollment. This data was not made available by DHCS but is summarized in “Senate Budget & Senate Health Oversight Hearing on Coordinated Care Initiative – Background Paper,” Feb. 6, 2014, available at http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/02062014SBFR_HealthJointHearingAgendaCCI.pdf.

32 As of May 1, 2015, 122,787 dual eligibles were enrolled

Frequently Asked Questions

Are people who only qualify Medicare - and not for Medi-Cal - affected by the CCI?

No. Beneficiaries who only have Medicare coverage, and not Medi-Cal, are not affected by the CCI.

What is PACE and how does the CCI interact with PACE?

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program available to individuals age 55 or older who meet the level of care requirement for a skilled nursing facility but who can live safely in the community with PACE services. PACE provides its members with both Medicare and Medi-Cal services. PACE uses an interdisciplinary team to coordinate the care of each participant.³³

PACE programs in California have a long history of providing integrated, coordinated care to older adults - in fact, the PACE model of care was originally developed in the 1970s by On Lok in San Francisco.³⁴ Beneficiaries who meet the PACE eligibility criteria may find that it is a well-tested alternative to Cal MediConnect. As a community-based program, PACE is only available in certain zip codes in six of the seven CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara).³⁵

PACE remains an enrollment option for dual eligibles. In addition, if a dual eligible beneficiary is already enrolled in PACE, that individual is not subject to passive enrollment in Cal MediConnect. If the

in Cal MediConnect. See Cal MediConnect Monthly Enrollment Dashboard (May 1, 2015) available at www.calduals.org/wp-content/uploads/2015/05/CMC-Enrollment-Dashboard-May-2015.pdf. As of January 1, 2015, 608,000 duals and SPDs were enrolled in Medi-Cal plans. See Senate Overview of the 2015-16 Budget, p. 3-7, available at http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/overview/2015Overview2015_16Budget.pdf.

33 See www.dhcs.ca.gov/provgovpart/Pages/PACE.aspx.

34 See “About PACE,” available at www.onlok.org/About/AboutPACE.aspx.

35 For a list of PACE plans in California and the geographic areas they serve, see www.dhcs.ca.gov/individuals/Pages/PACEPlans.aspx.

beneficiary wishes to enroll in Cal MediConnect, she must disenroll from PACE. The PACE participant will not be mandatorily enrolled in Medi-Cal managed care, since PACE is already a managed care plan that includes Medi-Cal benefits.

If a dual eligible beneficiary wishes to enroll in PACE rather than a Cal MediConnect plan, a 60-day clock starts when the individual applies for PACE. During that time, the PACE assessment process must be completed. If the beneficiary is found eligible for PACE, the local PACE plan will complete the enrollment process. If the beneficiary is found ineligible for PACE, she will be enrolled into the back-up Medi-Cal managed care plan or the Cal MediConnect health plan previously selected.³⁶ For this reason, it is important that an individual who chooses PACE also carefully decide whether she wants to join Cal MediConnect as a backup, and, if so, decide on the plan that is best for her.³⁷

How does the 200,000 cap in Los Angeles County work?

The cap on enrollment of 200,000 in Los Angeles only applies to Cal MediConnect enrollment. If the cap is reached, individuals who want to enroll in Cal MediConnect will be placed on a waiting list. When a slot becomes available, the individual will be able to enroll in Cal MediConnect. Preference for enrollment will be given to individuals who affirmatively choose to enroll in Cal MediConnect over those who will be passively enrolled into the program.³⁸ Most likely the cap in Los Angeles will not be reached. As of the publication date of this Guide, approximately 55,000 dual eligibles were enrolled in Cal MediConnect plans in Los Angeles County.

36 See “The Coordinated Care Initiative and PACE,” available at www.calduals.org/wp-content/uploads/2012/08/PACECCI-5.8.13.pdf.

37 PACE referral data through August 31, 2014, is available at www.calduals.org/wp-content/uploads/2014/09/PACE-Dashboard-September-2014.pdf.

38 See draft LA Enrollment Strategy dated Feb. 18, 2014, available at www.calduals.org/wp-content/uploads/2014/02/REVISED-LA-Enrollment-Strategy-2.19.14-2.0.pdf.

How does enrollment work for Medi-Cal beneficiaries with a share of cost?

Dual eligibles who meet their Medi-Cal share of cost on a continuous basis will be passively enrolled into Cal MediConnect. Individuals residing in a nursing facility and those enrolled in MSSP are deemed to meet their share of cost continuously. Individuals living in the community who receive IHSS are deemed to meet their share of cost continuously if their share of cost is met the first day of the fifth and fourth months prior to passive enrollment.³⁹ For example, if an individual with share of cost receiving IHSS is scheduled to be passively enrolled into Cal MediConnect in August 2015, the State will review whether her share of cost was met in February and March of 2015. Individuals who are deemed not to meet their share of cost continuously cannot participate in Cal MediConnect, and should not receive notices regarding the program.

DHCS has verbally stated that individuals enrolled in Cal MediConnect who do not meet their share of cost in a single month will be disenrolled from Cal MediConnect effective the first of the following month. Those who are disenrolled due to failure to meet share of cost may reenroll in Cal MediConnect the following January 1st if they meet their share of cost as described above.⁴⁰

However, all Medi-Cal beneficiaries who have a share of cost – both share of cost continuously and not continuously certified – will be mandatorily enrolled in a Medi-Cal managed care plan once their share of cost is met in any given month.

What if a beneficiary loses Medi-Cal eligibility?

If a beneficiary loses Medi-Cal eligibility, she will be disenrolled from Cal MediConnect. As of the date of this Guide, health plans and DHCS were working on implementing a deeming period during which dual eligibles will remain enrolled in the Cal MediConnect plan for at least an additional month to

39 MOU p. 7.

40 DHCS has provided this guidance verbally, and it is subject to change. As of the date of this Guide, DHCS had not developed a written policy on disenrollment from Cal MediConnect when an individual no longer meets her share of cost.

provide beneficiaries with time to address their Medi-Cal eligibility before being disenrolled from their Cal MediConnect plan.⁴¹

Does a beneficiary on dialysis have to enroll in the CCI?

In most instances, beneficiaries with a diagnosis of End Stage Renal Disease (ESRD) at the time of their passive enrollment date are not able to participate in Cal MediConnect. They should not receive notices regarding Cal MediConnect, but they still have to enroll in Medi-Cal managed care for their Medi-Cal benefit and will receive notices telling them about their Medi-Cal managed care choices. However, if a beneficiary with an ESRD diagnosis lives in a COHS county (San Mateo and Orange), she will be passively enrolled into Cal MediConnect. Also, if a beneficiary is enrolled in a healthcare plan that is operated by a Cal MediConnect plan sponsor (for example, an individual in LA Care's Medi-Cal plan), she is subject to passive enrollment into Cal MediConnect.⁴²

A beneficiary who is diagnosed with ESRD after being enrolled in Cal MediConnect will stay in Cal MediConnect unless she decides to disenroll. If she decides to disenroll, she still has to be enrolled in Medi-Cal managed care for her Medi-Cal benefit.

Does a beneficiary who receives services from a Regional Center have to enroll in the CCI?

Beneficiaries who have a developmental disability and receive services through the Developmentally Disabled (DD) waiver, Regional Center, or state developmental center are not able to participate in Cal MediConnect and should not receive notices about Cal MediConnect. However, these individuals are still required to enroll in Medi-Cal managed care plans to receive their Medi-Cal benefit.⁴³

41 The Health Plan of San Mateo started a deeming period on June 1, 2015, of two months. Other counties are scheduled to begin a one-month deeming period in July 2015.

42 MOU p. 8.

43 The Health Plan of San Mateo has proposed legislation, [AB 461](#), that would provide individuals receiving services through a regional center the option to voluntarily enroll in San Mateo's Cal MediConnect plan.

What happens to a dual eligible who opts out or disenrolls from Cal MediConnect?

When a dual eligible is enrolled in Cal MediConnect, she receives both her Medicare and Medi-Cal benefits through one integrated managed care plan. If she decides to opt out of or disenroll from Cal MediConnect, she can choose how she wants to receive her Medicare benefit. For example, she can choose fee-for-service Medicare, Medicare Advantage, or PACE.

Remember, if she opts out of or disenrolls from Cal MediConnect, she still has to choose a Medi-Cal managed care plan to receive her Medi-Cal benefit. Keep in mind that beneficiaries living in COHS counties are already enrolled in Medi-Cal managed care. They do not have to choose a Medi-Cal managed care plan. The only change for them if they decide to opt out of Cal MediConnect is the full integration of LTSS into their Medi-Cal benefit package.

Dual eligibles who decide not to participate in Cal MediConnect do not lose any benefits to which they are entitled under Medi-Cal and Medicare. They, however, will not receive the additional benefits available under Cal MediConnect, including the additional transportation benefit or vision benefit (see page 26).

What about Part D?

The Cal MediConnect passive enrollment process triggers a confusing notice cycle.

A dual eligible who opts out of Cal MediConnect prior to her effective date of Cal MediConnect coverage will stay in her current Part D Medicare prescription drug plan. Technically, individuals are enrolled into Cal MediConnect plans 60 days prior to the effective coverage date. This mechanism allows DHCS and CMS to share beneficiary data with Cal MediConnect plans, so plans are prepared to provide services on the first date of effective coverage. For example, an individual subject to passive enrollment into a Cal MediConnect plan in July 2015 is technically enrolled in the program on May 1 with effective coverage starting July 1.

When an individual is technically enrolled into the Cal MediConnect plan at the 60-day mark, this triggers the automatic disenrollment of the dual eligible from her Part D plan. This is because a Cal MediConnect plan

becomes the dual eligible's Part D plan. Accordingly, seven to ten days after the dual eligible receives her 60-day Cal MediConnect notice, she will receive a notice from her Part D plan informing her that she will be disenrolled from her Part D plan.⁴⁴ If she wants to keep her Part D plan and makes this choice clear through contacting either her Part D plan, Medicare, or the state's enrollment broker, this choice effectuates an opt-out of Cal MediConnect, and she will automatically be reenrolled into her Part D plan. She will still need to enroll in a Medi-Cal managed care plan to receive her Medi-Cal benefit.

Note that an individual will not experience a gap in her Part D coverage. Her disenrollment from the Part D plan does not take effect until her Cal MediConnect coverage is effective.

A dual eligible who decides to disenroll from Cal MediConnect after her effective date of coverage will have to choose a new Part D plan. If she does not choose a Part D plan, she will be passively enrolled into a Part D plan by CMS. Passive enrollment into a Part D benchmark plan is random; it cannot be assumed that she will be re-enrolled in her old Part D plan. During the period of time after disenrollment from the Cal MediConnect plan but prior to assignment to a new Part D plan, the beneficiary will receive drug coverage through the Limited Income Net Program (LI NET).⁴⁵

What if a beneficiary is enrolled in a Kaiser plan?

Individuals enrolled in a Kaiser plan⁴⁶ should not receive notices regarding Cal MediConnect and should not be passively enrolled into Cal MediConnect. However, individuals enrolled in a Kaiser Medicare plan

still have to enroll in a Medi-Cal managed care plan for their Medi-Cal benefit. In general, individuals who only have to choose a Medi-Cal managed care plan will receive notices by birth month, which began in August 2014 (see p. 29). If a beneficiary enrolled in Kaiser would like to enroll in Cal MediConnect, she would have to disenroll from her Kaiser Medicare plan and choose a Cal MediConnect plan.⁴⁷

How does the CCI affect people currently in waivers?

Individuals who are currently in an HCBS waiver (e.g., Assisted Living, NF/AH, IHO waiver, DD waiver) are not able to participate in Cal MediConnect. They should not receive notices about Cal MediConnect and can only enroll in Cal MediConnect if they disenroll from their waiver. Individuals who are on waiver waiting lists will be passively enrolled into Cal MediConnect unless they opt out. They do not lose their spot on the waiver waiting list by enrolling in Cal MediConnect. If a waiver slot opens, they can disenroll from Cal MediConnect and join the waiver.

NOTE: Individuals who are in waivers still must enroll in Medi-Cal managed care. They will remain in the waiver programs. The waiver provider, not the plans, will provide the waiver services. The Medi-Cal managed care plan is responsible for coordinating services with the waiver providers.⁴⁸

Does institutional deeming still apply to MSSP after it becomes a Cal MediConnect benefit?

Yes. Institutional deeming eligibility rules and requirements will stay the same.

Institutional deeming is one means by which DHCS calculates income and resources for eligibility for Medi-Cal services. Under institutional deeming, DHCS will review an individual's income and resources as if the individual lives in an institution rather than in the home (where a spouse's or parent's income and resources

⁴⁴ Beneficiaries receive a Part D insert with their 60-day notice alerting them to disenrollment from their Part D plan; a sample is available at www.calduals.org/wp-content/uploads/2014/10/CMS_6004035_ENG_0514.pdf. A sample of the Part D Plan disenrollment notice is available at www.calduals.org/wp-content/uploads/2014/10/Medicare-Part-D-Disenrollment-Notice.pdf.

⁴⁵ LI NET ensures that low-income beneficiaries do not lose access to their prescription drug coverage. For more information, visit www.humana.com/pharmacy/pharmacists/linet.

⁴⁶ This exception applies to both Medicare and Medi-Cal Kaiser plans.

⁴⁷ Kaiser enrollees are not subject to passive enrollment in Cal MediConnect. MOU p. 9.

⁴⁸ See "Select 1915(c) waivers and the Coordinated Care Initiative," available at www.calduals.org/wp-content/uploads/2013/08/FAQ-Waiver-05_02_2013-final.pdf.

would normally be counted).

Does institutional deeming still apply if an individual is not in an HCBS waiver?

Yes. Institutional deeming eligibility rules and requirements will still apply, but only if the managed care plan decides that the beneficiary needs “Care Plan Option” (CPO) services. CPO services are like HCBS waiver services, but they are services that Cal MediConnect plans can, but are not required, to offer. See page 25 for more information about CPO services.

My client signed up for a Medigap plan, or some other extra health insurance program, in order to qualify for the Aged & Disabled Medi-Cal program. How does the CCI affect her?

People who have “other health coverage”—including a Medigap plan or other private health insurance—are excluded from both Cal MediConnect and Medi-Cal managed care and should not receive CCI notices.⁴⁹ In order to enroll in Cal MediConnect, the beneficiary would have to drop the other health coverage.

Some people use payments for other health coverage to reduce countable income and qualify for Medi-Cal. Advocates should discourage these individuals from dropping their other health coverage, since it could cause them to lose their Medi-Cal eligibility entirely.

Many beneficiaries who have other health coverage do not have the proof of coverage documented in the Medi-Cal system and consequently erroneously receive notices about enrollment in Cal MediConnect or Medi-Cal managed care plans. Other health coverage can be added to a beneficiary’s record online at http://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx

What happens if my client decides to stay in her Medicare Advantage plan, but there is no matching Medi-Cal plan?

It has been DHCS policy that individuals who are in Medicare Advantage cannot enroll in Medi-Cal managed care for their Medi-Cal benefit unless the Medi-Cal managed care plan is operated by the same company that operates their Medicare Advantage plan. This is called a “matching” plan.⁵⁰ Instead, the beneficiary would remain in FFS Medi-Cal. This “matching” policy does not apply to the CCI.⁵¹ For example, an individual who is enrolled in UnitedHealthcare for Medicare Advantage still has to enroll in a Medi-Cal managed care plan despite the fact that UnitedHealthcare does not offer a Medi-Cal managed care plan.

⁴⁹ Exception: Beneficiaries living in COHS counties with other health insurance must enroll in a Medi-Cal managed care plan.

⁵⁰ A list of Medicare Advantage plans and their matching Medi-Cal plans for 2013 is available at www.dhcs.ca.gov/provgovpart/Documents/2013_MMCD_MASNP_MTCH_PLANS.pdf.

⁵¹ 1115 waiver Standard Terms and Conditions, p. 97.

CCI Eligibility Chart

Eligibility rules for Medi-Cal managed care, integrated LTSS, and Cal MediConnect get very complicated very quickly. The chart below goes into detail about how different groups of people are affected. Generally speaking in the CCI counties:

- Most SPDs will be mandatorily enrolled into Medi-Cal Managed Care, and LTSS will be integrated into the Medi-Cal managed care plan.
- SPDs are not impacted by Cal MediConnect.
- Most dual eligible beneficiaries are subject to passive enrollment into Cal MediConnect.
- If a dual is not enrolled in Cal MediConnect, the dual nevertheless has to be enrolled in a Medi-Cal managed care plan.

	Required to enroll in managed care for Medi-Cal		LTSS will be integrated into Medi-Cal managed care plan		Eligible to enroll in Cal MediConnect	Will be passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
Beneficiary						
Under age 21	No	No	No	No	No	No
American Indian Medi-Cal beneficiaries	Yes ⁵²	Yes	Yes	Yes	Yes	Yes
Beneficiary Diagnosis						
Prior End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	No ⁵³	No ⁵³
Subsequent End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	Yes	Already Enrolled ⁵⁴

52 American Indian beneficiaries are mandatorily enrolled, but can disenroll at any time. To opt out entirely from a managed care plan, American Indian beneficiaries first must opt out of Cal MediConnect and then submit a Non-Medical Exemption Request form available at www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/content/en/forms/MU_0003382.pdf to opt out of Medi-Cal managed care.

53 Except in COHS counties or where a beneficiary receives ESRD services from a provider operated by a Cal MediConnect plan.

54 An individual who is diagnosed with ESRD after being enrolled into Cal MediConnect will stay in Cal MediConnect unless she chooses to disenroll.

	Required to enroll in managed care for Medi-Cal		LTSS will be integrated into Medi-Cal managed care plan		Eligible to enroll in Cal MediConnect	Will be passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
Beneficiaries with HIV/AIDS	Yes ⁵⁵	Yes ⁵⁵	Yes	Yes	Yes	Yes
Beneficiary Residence						
Live in certain zip codes in Los Angeles, Riverside, and San Bernardino Counties ⁵⁶	No	No	No	No	No	No
Resident of certain zip codes in San Bernardino County ⁵⁷	No ⁵⁸	No ⁵⁸	No ⁵⁸	No ⁵⁸	Yes	No
Resident of Veterans Home	No	No	No	No	No	No
Resident of ICF-DD	No ⁵⁹	No ⁵⁹	No ⁵⁹	No ⁵⁹	No	No
Share of Cost						
Share of Cost living in a nursing home	Yes	Yes	Yes	Yes	Yes	Yes
Share of Cost enrolled in MSSP	Yes	Yes	Yes	Yes	Yes	Yes

55 Beneficiaries with HIV/AIDS are mandatorily enrolled, but can disenroll at any time. To opt out entirely from a managed care plan, beneficiaries with HIV/AIDS first must opt out of Cal MediConnect and then submit a Non-Medical Exemption Request form available at www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/content/en/forms/MU_0003382.pdf to opt out of Medi-Cal managed care.

56 LA County: 90704; Riverside: 92225, 92226; 92239; and San Bernardino: 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, and 93558.

57 Zip codes: 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304, 92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92326, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, and 92398.

58 These individuals can voluntarily enroll in Medi-Cal managed care.

59 Exception: Residents of an ICF-DD in San Mateo and Orange County (COHS counties) will be mandatorily enrolled in Medi-Cal managed care.

	Required to enroll in managed care for Medi-Cal		LTSS will be integrated into Medi-Cal managed care plan		Eligible to enroll in Cal MediConnect	Will be passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
Share of Cost enrolled in IHSS and meets SOC ⁶⁰	Yes	Yes	Yes	Yes	Yes	Yes
Share of Cost not regularly met	Yes	Yes	Yes	Yes	No	No
Beneficiary enrolled in Medicare Advantage or other health care plan						
Enrolled in Medicare Advantage (except a D-SNP)	N/A	Yes ⁶¹	N/A	Yes	Yes	Yes
Enrolled in D-SNP that is a sponsor of a CMC plan	N/A	Yes	N/A	Yes	Yes	Yes
Enrolled in a D-SNP NOT a sponsor operated by a CMC plan	N/A	Yes	N/A	Yes	Yes	No
Enrolled in PACE	No	No	No	No	Yes ⁶²	No
Enrolled in AIDS Healthcare Foundation	No	No	No	No	Yes ⁶³	No
Beneficiaries enrolled in Kaiser	Yes	Yes	Yes	Yes	Yes ⁶⁴	No

⁶⁰ Share of cost must be met the 1st day of the 5th and 4th months prior to the passive enrollment date.

⁶¹ If a beneficiary stays in their Medicare Advantage plan, the beneficiary will still have to choose a Medi-Cal managed care plan even if there is no “matching” plan. See FAQ p. 18.

⁶² PACE enrollees will have to disenroll from PACE in order to enroll in Cal MediConnect.

⁶³ Enrollees will have to disenroll from AIDS Healthcare Foundation in order to enroll in Cal MediConnect.

⁶⁴ Beneficiaries enrolled in Kaiser have the choice to join Cal MediConnect, but they will not receive a notice about Cal MediConnect.

	Required to enroll in managed care for Medi-Cal		LTSS will be integrated into Medi-Cal managed care plan		Eligible to enroll in Cal MediConnect	Will be passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
MSSP Enrollees	Yes	Yes	Yes	Yes	Yes	Yes
Beneficiary with "Other Health Insurance"	No ⁶⁵	No	No	No	No	No
Beneficiary enrolled in waiver or on waiver waiting list						
DDS waiver or receiving services from a regional center or State developmental center	Yes	Yes	Yes	Yes	No	No
Enrollees in NF/AH, HIV/AIDS, assisted living, or IHO waiver	Yes ⁶⁶	Yes	Yes	Yes	Yes ⁶⁷	No
Beneficiaries on waiver waiting lists	Yes	Yes	Yes	Yes	Yes ⁶⁸	Yes
Miscellaneous						
Partial Dual Eligibles ⁶⁹	Yes	Yes	Yes	Yes	No	No

⁶⁵ Exception: Beneficiaries living in COHS counties with other health insurance must enroll in Medi-Cal managed care.

⁶⁶ Beneficiaries will remain in waivers, and plans will coordinate with waiver providers.

⁶⁷ Beneficiaries in waivers will have to disenroll from the waiver to participate in Cal MediConnect.

⁶⁸ Beneficiaries who obtain a waiver after being enrolled in Cal MediConnect can disenroll from Cal MediConnect and enter the waiver.

⁶⁹ For purposes of the CCI, California defines a partial dual eligible as an individual 21 years of age or older who is enrolled for benefits under Medicare Part A (42 U.S.C. § 1395c et seq.), but not Medicare Part B (42 U.S.C. § 1395j et seq.), or who is eligible for Medicare Part B (42 U.S.C. § 1395j et seq.), but not Medicare Part A (42 U.S.C. § 1395c et seq.), and is eligible for medical assistance under the Medi-Cal State Plan. WIC § 14182.15(b)(6). This definition is different from that commonly used by CMS.

	Required to enroll in managed care for Medi-Cal		LTSS will be integrated into Medi-Cal managed care plan		Eligible to enroll in Cal MediConnect	Will be passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
Beneficiaries with a MER	No	No	No	No		
Duals Who Opt Out of Cal MediConnect		Yes		Yes		

Covered Benefits

Medi-Cal Managed Care Benefits

Beneficiaries who are not eligible for Cal MediConnect or who opt out of Cal MediConnect receive their Medi-Cal benefit, including nursing facility care, In-Home Support Services (IHSS), Multi-Purpose Senior Services (MSSP), and Community Based Adult Services (CBAS), through managed care. Medi-Cal managed care plans are also responsible for Medicare cost sharing for duals as Medi-Cal fee-for-service is today and for those services not covered by Medicare (e.g., incontinence supplies).⁷⁰

For dual eligibles who decide not to participate in Cal MediConnect, the Medi-Cal managed care plan is responsible for paying Medicare cost sharing. A beneficiary does not need to see a Medicare provider who is in the beneficiary's Medi-Cal managed care plan's network for the Medi-Cal plan to pay the cost sharing. In other words, the Medicare provider will be paid by the Medi-Cal plan just like the provider would have previously been paid by the state for cost sharing. The provider does not have to have a contract with the Medi-Cal plan to receive payment. Medicare providers are often turning away patients who are enrolled just in a Medi-Cal plan or providers are attempting to bill patients for the cost sharing. Balance billing dual eligibles is illegal under both federal and state law. For more information, please refer to fact sheets available on calduals.org or Justice in Aging's website.

Cal MediConnect Benefits

Required Benefits

Cal MediConnect plans are required to provide individual members with all needed Medi-Cal and Medicare services. These include:

- Medicare Part A (hospital coverage) and Part B (outpatient coverage)
- Medicare Part D prescription drug coverage
- All required Medi-Cal services
 - Including long-term services and supports: nursing facility care; IHSS; CBAS, MSSP.
- Preventive, restorative, and emergency vision benefits
- Non-emergency medical transportation
- Care coordination

As outlined above, Cal MediConnect plans are required to provide care coordination.⁷¹ Plans must coordinate a beneficiary's care in a person-centered manner by following the beneficiary's direction and providing the beneficiary with services in the least restrictive setting. Plans are responsible for coordinating care among the many different types of service providers including medical and LTSS, with a focus on providing smooth transitions between care settings. Plans must evaluate beneficiaries for behavioral health needs and coordinate services with county service providers. In order to accomplish effective care coordination, the health plans are required to conduct a health risk assessment with every member, develop individualized care plans with beneficiaries, and provide each beneficiary with an interdisciplinary care team, as necessary.⁷²

This level of care coordination is new for most

70 See "Medicare and Medi-Cal Payments & Services," Feb. 2014, available at www.calduals.org/wp-content/uploads/2014/02/PaymentsunderCCI-14-02-13.pdf.

71 MOU pp. 68-79. Care coordination standards were developed through the stakeholder process and are available here www.calduals.org/2013/02/20/cc_standards/ and here www.calduals.org/implementation/bh-coordination/.

72 See the Dual Plan Letter on Interdisciplinary Care Team and Individual Care Plan guidance (March 9, 2015), available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2015/DPL15-001.pdf.

plans, and many of the details about what the Cal MediConnect care coordination benefit entails are not yet clear despite enrollment having started.

Care Plan Option Services

Cal MediConnect plans may, but are not required to, provide additional services that go beyond the benefits listed above and which might help members avoid institutionalization or emergency room visits, including additional HCBS and behavioral health services.⁷³ These services may include, for example, supplemental home care services, home delivered meals, respite care, environmental adaptations, and counseling.⁷⁴ These are called “Care Plan Option” services (CPO services). Historically, plans have not provided CPO services. Plans are required to have policies and procedures governing the provision of these services.⁷⁵

Carved Out Benefits

Cal MediConnect plans are required to provide their members with all mental health and substance abuse services currently covered by Medicare and Medi-Cal.⁷⁶ However, some Medi-Cal funded services are

“carved out” and are not included in the capitated rates paid to Cal MediConnect plans.⁷⁷ These include specialty mental health services and Medi-Cal mental health drug services.⁷⁸ County agencies continue to remain responsible for financing and administering these services, but Cal MediConnect plans and county agencies have written agreements regarding coordination of these services.⁷⁹ In other words, the plans are responsible for coordinating these carved out mental health benefits so that the beneficiary receives seamless services.

On June 18, 2013, the California Legislature approved a partial restoration of the adult dental benefit eliminated in 2009. All Medi-Cal beneficiaries, including those enrolled in Cal MediConnect plans, started receiving preventive and denture services beginning May 1, 2014.⁸⁰ The dental benefit is provided through Denti-Cal. The Cal MediConnect plans are not responsible for providing or coordinating the dental benefit. Some Cal MediConnect plans have opted to provide a supplemental dental benefit in addition to the dental benefit provided for under Medi-Cal. The supplemental dental benefit and its provision differs from plan to plan.⁸¹

73 CMS has issued guidance encouraging the states to provide enhanced home and community-based services to meet the states’ obligation to provide services in the most integrated setting possible pursuant to the Americans with Disabilities Act and *Olmstead v. L.C.*, 527 U.S. 581 (1999). See “Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs,” available at www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf.

74 MOU pp. 93-94.

75 See “Policy for Cal MediConnect: Care Plan Option services (CPO services)” (June 3, 2013), available at www.calduals.org/wp-content/uploads/2013/06/Demo-CPO-services-Paper-6.3.13.pdf; “Interaction of Waiver Programs with the Coordinated Care Initiative” (June 3, 2013), available at www.calduals.org/wp-content/uploads/2013/06/DRAFT-HCBS-Flow-charts-6.3.13.pdf; “Home and Community Based Services under Cal MediConnect: Questions and Answers,” available at www.calduals.org/wp-content/uploads/2013/06/Question-Answer-from-HBCS-comments-6.3.13.pdf; All Plan Letter on Care Plan Option Services, available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-006.pdf.

76 Pursuant to [SBX1](#) 1 § 28, effective January 1, 2014, all Medi-Cal recipients are eligible for a new mental health benefit that

does not rise to the level of specialty mental health benefits which are provided by the county, but includes benefits beyond those that are provided by a primary care physician (e.g., individual therapy and medication management). Managed care plans are responsible for delivering these benefits.

77 This is also the case for Medi-Cal managed care plans.

78 Examples of these specialty services include intensive day treatment, crisis intervention, day rehab, and methadone treatment. MOU p. 74.

79 See DHCS, “The Coordinated Care Initiative and Behavioral Health Services: Frequently Asked Questions,” available at www.calduals.org/wp-content/uploads/2013/03/FAQ-BH.pdf.

80 See AB 82, available at www.leginfo.ca.gov/pub/13-14/bill_asm/ab_0051-0100/ab_82_bill_20130614_amended_sen_v96.pdf.

81 For more information on the Cal MediConnect dental supplement, see Justice in Aging’s fact sheets available at <http://dualsdemoadvocacy.org/trainings-and-education-materials>.

Frequently Asked Questions

How does the CCI affect IHSS?

Initially, not much. The CCI legislation requires that counties continue to assess and authorize IHSS as they always have, and IHSS consumers still have the right to self-direct their care, including hiring, firing and supervising IHSS home care providers. Medi-Cal beneficiaries still have the same ability to access the state fair hearing appeals process to dispute decisions about IHSS services.

Because IHSS is now a Medi-Cal managed care benefit, however, the plans have become involved in IHSS. Plans are required to have agreements with county IHSS offices and Public Authorities. The plans and counties share information about IHSS consumers' needs.⁸² A plan could, if it chooses, authorize additional personal care hours beyond the limits allowed by the current IHSS program through Care Plan Option services.⁸³ In other words, plans have the discretion to increase supplemental personal care attendant hours by providing CPO services, but plans cannot decrease IHSS.

In the long run, however, there could be changes for IHSS. When the transition to managed care is finished, IHSS providers will engage in collective bargaining with a new statewide California IHSS Authority, rather than local Public Authorities.⁸⁴ A new universal assessment tool for all LTSS, including IHSS, could result in changes to hours, authorizations, and increased plan

involvement generally.⁸⁵ IHSS appeals could be altered as a result of the new assessment tool or integrated appeals process.⁸⁶

How does the CCI affect Multipurpose Senior Services Programs (MSSP)?

Initially, MSSP remains the same under Cal MediConnect. Plans are required to contract with MSSP organizations in the seven CCI counties and pay MSSP providers the same rate they received prior to the CCI for the first 19 months of the demonstration. After 19 months, plans will have to continue to provide the services currently offered at MSSP sites, but will not be required to contract with MSSP organizations to provide those services.^{87,88} For the first 19 months, MSSP providers remain responsible for processing complaints, appeals, and grievances regarding MSSP services.⁸⁹

What does the Cal MediConnect vision benefits include?

Under Cal MediConnect, plans must provide preventive, restorative, and emergency vision services. The specific benefits are outlined in the three-way contracts between the State, CMS, and the plans. The vision benefit includes an annual eye exam and \$100 toward the cost of eyeglasses or contact lenses every two

82 Sharing mechanisms between the counties and plans will comply with state and federal privacy laws. MOU p. 76.

83 Since the plan would still get the same capitated rate, however, plans would only have a financial incentive to provide extra personal care hours in situations where those extra hours would reduce the likelihood of emergency room visits or nursing facility stays.

84 After this transition, counties may determine whether local public authorities will continue the following duties: obtaining Department of Justice background checks, conducting new IHSS provider orientations, and maintaining a registry of eligible providers. See DHCS "In-Home Supportive Services and the Coordinated Care Initiative: Frequently Asked Questions," available at http://www.calduals.org/wp-content/uploads/2015/01/FAQ-IHSS_1.27.15.pdf. WIC §14186.35.

85 WIC § 14186.36(a) (stating the universal assessment process "may inform future decisions about whether to amend existing law regarding the assessment processes that currently apply to LTSS programs, including IHSS"). A universal assessment stakeholder workgroup has been established and is meeting regularly to develop the new tool. See www.cdss.ca.gov/agedblinddisabled/PG3340.htm.

86 WIC §14186.36(c)(2)(A)(iv); MOU p. 101 (noting that the State may seek additional input to consider aligning IHSS appeals with the integrated Medicare/Medi-Cal appeals process).

87 WIC § 14186(b)(7)(A); MOU p. 85.

88 MSSP providers have proposed legislation in 2015 to extend the period of time plans must contract with MSSP providers beyond 19 months. At the time of publication of this manual, the legislation was pending.

89 See All Plan Letter, APL 15-002, dated January 22, 2015, available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-002.pdf.

years.⁹⁰

What does the Cal MediConnect transportation benefit include?

The Cal MediConnect plans provide an additional transportation benefit to beneficiaries to travel to medical services. Currently, Medi-Cal pays for transportation to medical appointments for those beneficiaries who cannot travel by car or public transportation. The Cal MediConnect transportation benefit provides 30 one-way trips to medical services over a twelve-month period to beneficiaries who can travel by car or public transportation.⁹¹ This benefit is often referred to as a “taxi voucher” program.⁹²

If a dual eligible beneficiary opts out of Cal MediConnect and is enrolled only in a Medi-Cal plan, is she assigned a Medi-Cal primary care doctor?

No. In general, dual eligibles enrolled in just a Medi-Cal plan should not be assigned a primary care physician (PCP) by the Medi-Cal plan.⁹³ A PCP is only assigned if the beneficiary requests one or if assignment is deemed necessary through the health risk assessment. Some beneficiaries have been erroneously assigned a PCP. If this occurs, the beneficiary should contact the Medi-Cal plan and have the assignment removed.

Do beneficiaries enrolled just in a Medi-Cal plan for their LTSS receive care coordination?

Medi-Cal plans are required to provide care coordination to beneficiaries enrolled in Medi-Cal plans. The extent of coordination depends on whether the

enrollee is an SPD or a dual.⁹⁴

Purpose of the CCI

The stated goals of the CCI, according to DHCS, are to improve access to care by providing the right care at the right time at the right place, with an emphasis on person-centered care and providing services that promote independence in the community.⁹⁵ The CCI is intended to result in cost savings for both California and the federal government.⁹⁶

Frequently Asked Questions

Will beneficiaries get better or worse care under Cal MediConnect?

This is a “demonstration” project; we don’t know for sure what the outcome will be. Plans are required to provide all needed Medi-Cal and Medicare benefits. The State hopes that by integrating Medicare and Medi-Cal funding and program rules, the plans will have an incentive to provide high-quality care to improve health and reduce costly emergency, hospital and nursing home treatment. For people who are enrolled in Medi-Cal managed care and not Cal MediConnect, however, some of these incentives do not exist. Furthermore, while Cal MediConnect plans have an incentive to avoid costly acute care, they may not have any incentive to provide additional services that are not part of the required

90 Three-way contract p. 188.

91 Three-way contract p. 188.

92 As of the date of this Guide, there is no formal written policy on the transportation benefit. A transportation fact sheet is available at www.calduals.org/wp-content/uploads/2014/01/NEMTvsNMT-12.30.13_finalclean.pdf.

93 See All Plan Letter 14-015, “Primary Care Provider Assignment in Medi-Cal Managed Care for Dual Eligibles” dated November 24, 2014, available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2014/APL14-015.pdf.

94 See All Plan Letter 14-010, “Care Coordination Requirements for Managed Long Term Services and Supports” dated September 10, 2014, available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/APL2014/APL14-010.pdf.

95 WIC § 14132.275(f). MOU p. 2. See DHCS, “What are the goals of California’s Cal MediConnect program,” available at www.calduals.org/background/faq/#goals.

96 To achieve savings, plans will receive a rate reduced by the amount that the State and CMS anticipate saving each year. Savings are intended to be accomplished by reductions in utilization of high-cost services like avoidable hospitalizations and unnecessary long-term nursing home placements rather than reductions to payment rates to providers or to home and community-based services. WIC § 14132.275(o)(2). The State predicts that plans will have the incentive to provide less costly, but more effective treatment in order to reduce higher cost services.

benefit package and that promote successful community living, but do not directly or immediately prevent institutionalization.

How do beneficiaries know if Cal MediConnect plans are doing a good job?

Prior to the start of Cal MediConnect, plans had to pass readiness reviews by DHCS and CMS.⁹⁷ The State also developed metrics for evaluating the quality of Cal MediConnect plans.⁹⁸ The plans' rates are reduced by quality withholds at the beginning of each year.⁹⁹ If a plan meets specific quality standards, the plans will be reimbursed the amount withheld. It will likely be some time before information about plan quality is available to beneficiaries.¹⁰⁰ It is always a good thing to check a plan's local reputation and experience with particular populations and services. Plans also have to report complaints and the resolution of those complaints to DHCS and CMS so these agencies can further monitor

97 See Cal MediConnect Readiness Review Tool, available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf.

98 See draft "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: California-Specific Reporting Requirements" (Mar. 6, 2014), available at http://dualsdemoadvocacy.org/wp-content/uploads/2014/04/Revised-Draft-CA-Reporting-Requirements_030614.pdf.

99 MOU pp. 52-54.

100 Some of the plans selected for Cal MediConnect have performed poorly in the past according to the limited available quality measurements. For more details about measuring quality, see NSCLC, "Assessing the Quality of California Dual Eligible Demonstration Health Plans" (May 2012), available at www.nsclc.org/wp-content/uploads/2012/05/Plan-Ratings-Report-May-2012.pdf; and generally, NSCLC and DREDF, "Identifying and Selecting Long-Term Services and Supports Outcome Measures" (January 2013), available at www.nsclc.org/wp-content/uploads/2013/02/Guide-LTSS-Outcome-Measures-Final.pdf. See also, "Demonstrations to Improve the Coordination of Medicare and Medicaid for Dually Eligible Beneficiaries: What Prior Experience Did Health Plans and States Have with Capitated Arrangements?" (April 21, 2015), available at http://kff.org/medicare/report/demonstrations-to-improve-the-coordination-of-medicare-and-medicare-for-dually-eligible-beneficiaries/?utm_campaign=KFF:%20General&utm_content=14249003&utm_medium=social&utm_source=twitter.

the quality of plans.¹⁰¹

The Cal MediConnect program is also being examined through a number of formal evaluations:

- CMS has contracted with RTI International to conduct a multi-year evaluation of the Cal MediConnect program.¹⁰²
- The SCAN Foundation is funding an evaluation of Cal MediConnect that is being conducted jointly by the UCSF Community Living Policy Center and the UC Berkeley Health Research Action Center. This three-year evaluation will document the impact of Cal MediConnect on dual eligible beneficiaries' experiences with care through focus groups with beneficiaries, telephone surveys, and interviews with health care and social service providers.
- DHCS and The SCAN Foundation are working together to conduct rapid cycle polling through telephone surveys with beneficiaries. The telephone surveys will target both beneficiaries who have opted out of Cal MediConnect and beneficiaries who are enrolled in Cal MediConnect plans to document their experiences. The first round of surveys is scheduled to take place starting in May through July 2015. The second round of surveys will be conducted in October and November 2015.

CCI Timeline and Enrollment

The CCI commenced on April 1, 2014.¹⁰³ However,

101 See Dual Plan Letter 14-001 on Complaint and Resolution Tracking, available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2014/DPL14-001.pdf.

102 RTI has developed an evaluation plan available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAEvalPlan.pdf.

103 Under the MOU, the CCI was scheduled to begin on October 1, 2013. MOU p. 1. On May 6, 2013, DHCS announced that Cal MediConnect would begin no earlier than January 2014. On August 14, 2013, DHCS announced that the CCI would begin no sooner than April 1, 2014. The timeline for implementation continues to change. The most current timeline is dated April 2, 2014, and is available

not all counties and not all changes under the CCI began in April. Although all three changes were originally intended to begin at the same time, the roll out of Cal MediConnect and the other changes under the CCI have been "delinked" and are moving forward on different timelines.

Cal MediConnect Enrollment

The actual timeline and phasing of enrollment varies by county and depends on several factors including whether the beneficiary is already in Medi-Cal managed care, in a D-SNP, receiving MSSP services, or was reassigned to a Part D plan in 2014 or 2015. It is important to review the CCI enrollment chart in Appendix B to learn the timeline in your county.

San Mateo County started passive enrollment into Cal MediConnect on April 1, 2014. San Bernardino, Riverside, and San Diego counties started passive enrollment on May 1, 2014. Los Angeles County started passive enrollment on July 1, 2014, and Santa Clara County started passive enrollment on January 1, 2015. Orange County begins passive enrollment in August 2015.¹⁰⁴ In general, individuals are passively enrolled by birth month, with some exceptions, over a twelve-month period. Individuals who are already enrolled in a Medi-Cal managed care plan are subject to Cal MediConnect passive enrollment in the first month that passive enrollment begins in a beneficiary's respective county. In all counties, individuals who are enrolled in a D-SNP operated by a CMC plan and those reassigned to a Part D Plan in 2014 were not subject to passive enrollment until January 2015 or January 2016 (depending on county). Alameda County is no longer moving forward with the CCI.

After passive enrollment in each county ends, new

at www.calduals.org/wp-content/uploads/2014/04/CCI-enrollment-by-County-4.2.14.pdf.

104 Orange County is moving forward with Cal MediConnect on August 1, 2015. Orange County's implementation was delayed as a result of a Medicare audit in November 2013 that resulted in sanctions against Cal Optima. In response to the Medicare audit, DHCS and DMHC also conducted an audit of Cal Optima's Medi-Cal program. CMS lifted Cal Optima's sanction on February 5, 2015. In Santa Clara County, the Santa Clara Family Health Plan began using a new system that was not sufficiently tested to proceed with Cal MediConnect prior to January 2015.

dual eligibles (e.g. those that obtain Medicare or Medi-Cal, or those who move into a CCI county) will not be subject to passive enrollment. These dual eligibles will have the option to enroll in Cal MediConnect voluntarily. These dual eligibles will still have to enroll in a Medi-Cal plan and will receive notices about enrollment in a Medi-Cal plan if they are not already enrolled in one. If a beneficiary does not choose a plan, she will be assigned to one.

Medi-Cal Managed Care and LTSS Only Enrollment

Individuals who are excluded from Cal MediConnect (e.g., duals with share of cost not continuously certified, beneficiaries receiving services at a regional center, etc.), duals not subject to passive enrollment in Cal MediConnect (e.g. those in HCBS waivers, Kaiser members, etc.) and SPDs not already enrolled in Medi-Cal managed care are enrolled in Medi-Cal managed care plans on a different timeline than Cal MediConnect. Generally, these individuals are enrolled by birth month over a 12-month period, which started in August 2014 in most counties. Again, refer to the enrollment chart in Appendix B for the enrollment timeline for those individuals who must choose a Medi-Cal managed care plan.

SPDs and dual eligibles already in managed care who are excluded from Cal MediConnect or not subject to passive enrollment into Cal MediConnect have LTSS added to their Medi-Cal managed care benefit package. The month in which LTSS benefits are added differs depending on county and whether the beneficiary is a dual eligible or SPD.

Frequently Asked Questions

What does phasing in by birth month mean?

A beneficiary is passively enrolled in the CCI on the first day of the month of her birthday. For example, if a beneficiary is born on April 10th, she will be enrolled on April 1st. She will receive her first notice in January, her second notice in February, and her final 30-day notice in March.

What is Part D reassignment and how does it impact

Cal MediConnect enrollment?

Each year, CMS reassigns some low-income beneficiaries who had previously been auto-enrolled in Part D prescription drug plans. If their assigned plans will start charging more than the Low Income Subsidy (LIS) benchmarks and the beneficiaries do not affirmatively choose a new plan, CMS will reassign them to a new Part D plan to prevent them from incurring premium costs. CMS also reassigns beneficiaries from Part D prescription drug plans and Medicare Advantage plans that are terminating. These beneficiaries are reassigned to a prescription drug plan that is below the LIS benchmark. CMS does not reassign beneficiaries who have voluntarily elected a plan, referred to as "choosers," unless their drug plan is terminating and would leave them with no Part D coverage.

Under Cal MediConnect, the beneficiaries who were reassigned to a Part D plan in 2014 were passively enrolled into Cal MediConnect on January 1, 2015. Beneficiaries in Orange County who were reassigned to a Part D plan in 2015 will be passively enrolled into Cal MediConnect on January 1, 2016.

Notices

Because the CCI impacts populations differently, different notices are sent to each population. As a general rule, beneficiaries who have to choose a health plan receive three notices regarding the change in the delivery of their health care services. The first notice is sent 90 days prior to enrollment. The second notice is sent 60 days in advance and the third notice is sent 30 days in advance. Notices are supposed to be written at a sixth grade reading level and are made available in different languages and alternative formats.¹⁰⁵

Medi-Cal Managed Care Notices

The CCI also affects beneficiaries who need to enroll in Medi-Cal managed care but who are not eligible for Cal MediConnect or not subject to passive enrollment into Cal MediConnect.¹⁰⁶ These beneficiaries receive

notices that are different than those for people who are eligible for Cal MediConnect. This "Medi-Cal managed care only" group of beneficiaries includes three populations:

1. **Medi-Cal beneficiaries (including duals who are not able to participate in Cal MediConnect or not subject to passive enrollment in Cal MediConnect) who are already enrolled in Medi-Cal managed care and who will now start receiving LTSS through managed care.** These beneficiaries receive one notice 30 to 45 days in advance of the transition explaining that their LTSS will now be delivered through managed care. This notice comes from their Medi-Cal managed care plan. The plan also sends an addendum to their evidence of coverage.
2. **Medi-Cal beneficiaries who do not have Medicare and who were previously excluded from Medi-Cal managed care.** This category includes, for example, Medi-Cal-only residents in long-term care facilities or Medi-Cal-only recipients with share-of-cost. These beneficiaries receive three notices. The first notice, sent 90 days prior to enrollment, informs beneficiaries of the change occurring. With the 60-day notice, they receive a choice booklet explaining the changes and explaining factors to consider when selecting a health plan. They receive a final 30-day notice reminding them that they will be mandatorily enrolled in managed care and reiterating that they have the option to choose a plan. The 60-day and 30-day notices already include the name of the default plan chosen by the State. If beneficiaries fail to affirmatively choose a plan, they are placed in this default plan.
3. **Dual eligible beneficiaries who are excluded from Cal MediConnect or not subject to passive enrollment in Cal MediConnect and are not already enrolled in Medi-Cal managed care.** These include, for example, duals living in certain rural zip codes or duals enrolled in an HCBS waiver. Beneficiaries in this group receive the same three notices as

[pdf.](#)

¹⁰⁵ WIC §§ 14182(b)(4); 14182.17(d)(1)(A); MOU p. 64.

¹⁰⁶ DHCS released draft notices for these populations. For Justice in Aging's comments on notices, see <http://dualsdemoadvocacy.org/wp-content/uploads/2013/02/Comments-MLTSS-Notice-Materials-NSCLC-DRC-032213.pdf>.

outlined above.

Samples of the Medi-Cal managed care notices are found in Appendix C.

Cal MediConnect Notices

DHCS sends three notices to all dual eligibles who are subject to passive enrollment in two-plan and GMC counties. Dual eligibles living in COHS counties (Orange and San Mateo) receive three notices from the county organized health plan. For duals living in the two-plan and GMC counties, the first notice is sent 90 days prior to enrollment; the second 60 days prior to enrollment, and the third 30 days prior to enrollment.¹⁰⁷¹⁰⁸ These notices explain beneficiaries' options to choose a particular plan or to opt out from enrollment in Cal MediConnect by keeping their Medicare the same. The 60-day and 30-day notices include the name of the default plan chosen by the State. However, beneficiaries still have the option of choosing another plan or they can choose to opt out of Cal MediConnect. A Cal MediConnect Guidebook and Choice Form follow the 60-day notice. To opt out of Cal MediConnect or keep Medicare the same, the beneficiary must choose a Medi-Cal managed care plan only. Samples of the current notices and choice form are found in Appendix C.

Individuals who are not subject to passive enrollment into Cal MediConnect should not receive notices about Cal MediConnect.

Frequently Asked Questions

Can a beneficiary opt out of Cal MediConnect prior to receiving a notice of passive enrollment?

No. A beneficiary cannot opt out of Cal MediConnect until she receives a notice about passive enrollment into the program. Once the beneficiary receives the 90-day notice, she can opt out of the program. If a beneficiary decides to opt out, she should not receive further notices about passive enrollment into

Cal MediConnect. She should receive a confirmation of her decision to opt out of Cal MediConnect approximately 10 days after she communicates her decision to the enrollment broker. When the beneficiary opts out of Cal MediConnect, she still must choose a Medi-Cal managed care plan if she is not already enrolled in a plan.

If you believe your client received a notice in error, contact the CCI Ombudsman at (855) 501-3077.

107 MOU pp. 63-64.

108 Some dual eligibles living in Los Angeles County will also receive a one-time voluntary notice explaining they can voluntarily enroll in Cal MediConnect.

Cal MediConnect Plans

The following table includes the plans approved for Cal MediConnect.¹⁰⁹ Beneficiaries who are enrolled in Cal MediConnect have the right to change plans at any time. The plan change becomes effective the first day of the next month.

County	Duals Demo Health Plans
Los Angeles ¹¹⁰	Care1st
	CareMore
	Health Net
	LA Care ¹¹¹
	Molina
Orange (COHS)	CalOptima
San Diego (GMC)	Care 1 st
	Community Health Group
	Health Net
	Molina Health Care
San Mateo (COHS)	Health Plan of San Mateo

County	Duals Demo Health Plans
Riverside & San Bernardino (two-plan)	Inland Empire Health Plan
	Molina Health Care
Santa Clara (two-plan)	Anthem Blue Cross
	Santa Clara Family Health Plan

Marketing Rules

CCI plans must adhere to Medicare marketing guidelines issued by CMS¹¹² and California-specific guidelines set forth by the State.¹¹³ These marketing rules require plans to provide beneficiaries with specific information such as a welcome letter, formulary, pharmacy/provider directory, ID card, and member handbook. The rules also prohibit plans from certain practices such as door-to-door solicitation, approaching beneficiaries in common areas, and soliciting individuals through telephonic or electronic contact (i.e. no “cold calls”). Advocates should report plans that engage in prohibited marketing activities to CMS, DHCS, and the Department of Managed Health Care (DMHC).

- 109 This table lists Cal MediConnect plans in the seven demonstration counties. The Medi-Cal managed care plans are essentially the same as the Cal MediConnect plans with a few variations. See DHCS “Medi-Cal Managed Care Counties,” available at www.dhcs.ca.gov/individuals/pages/mmedhealthplandir.aspx.
- 110 On February 4, 2014, DHCS announced that five health plans will act as Cal MediConnect plans in LA County. Previously, only L.A. Care and Health Net were acting as Cal MediConnect plans. See press release dated Feb. 14, 2014, available at www.calduals.org/2014/02/04/coordinated-care-initiative-update-february-4-2014.
- 111 L.A. Care received a Medicare low-performing icon (LPI) as a result of receiving low star rating for three consecutive years. As a result, L.A. Care could not accept passive enrollment into its Cal MediConnect plan until it removed the icon. However, starting in July 2014, L.A. Care was permitted to accept passive enrollment of beneficiaries into its Cal MediConnect plan who were already enrolled in the L.A. Care Medi-Cal plan. L.A. Care’s LPI was removed in September 2014 and was able to start passive enrollment in December 2014.

Marketing concerns specifically regarding the Cal MediConnect plans should be forwarded to medicaremedicaidcoordination@cms.hhs.gov.

General questions/concerns about Medicare Advantage marketing violations can be emailed to marketing@cms.hhs.gov.

- 112 See CMS, “Medicare Marketing Guidelines,” available at www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html; CMS also released marketing guidance specific to Cal MediConnect available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2015MarketingGuidanceCA.pdf.
- 113 Knox Keene Act (KKA), HSC §§ 1359-1366.4.

Factors a Beneficiary Should Consider in Deciding to Enroll or Opt Out of Cal MediConnect

Dual eligible beneficiaries should seek independent enrollment counseling to help them decide whether to opt in or opt out of Cal MediConnect. If a beneficiary decides she wants to participate in Cal MediConnect, she then must choose which Cal MediConnect plan meets her needs.¹¹⁴

1. **Current providers.** The first and most important question to ask is which, if any, of the Cal MediConnect managed care plans have networks that include the individual's current medical providers. Beneficiaries with complex conditions should think about all of their regular providers, not just their primary care provider. Relevant providers might include specialists (e.g., oncologist, pulmonologist, cardiologist), mental health providers, durable medical equipment providers (e.g., wheelchair servicer), hospitals, etc.

To help beneficiaries determine if their providers are part of a plan's network, provider directories are available on each plan's website. The State's enrollment broker, Health Care Options, can also provide limited information on whether a particular primary care doctor is in a plan's network. The HICAPs can also assist beneficiaries in determining whether their providers are in a plan's network.

2. **Prescription drugs.** Beneficiaries should also review plan formularies to determine whether the Cal MediConnect plans cover the prescription drugs they currently take. Plan formularies are also available on each plan's website.
3. **Care coordination and additional services.** A beneficiary should also consider the additional benefits that are available under Cal MediConnect. Cal MediConnect plans provide care coordination services as well as a

transportation and vision benefit, which are currently not covered by Medi-Cal or Medicare fee-for-service.¹¹⁵

Over one million beneficiaries will be impacted by the CCI. Beneficiaries face several decisions about their healthcare and require assistance throughout this process. Dual eligibles have to decide whether they want to opt into or opt out of Cal MediConnect. If they opt into Cal MediConnect, they have to choose a Cal MediConnect plan. If they decide to opt out or disenroll, they still need assistance with choosing the best Medi-Cal managed care plan. Likewise, individuals who will not participate in Cal MediConnect will need assistance with choosing the best Medi-Cal managed care plan.

Frequently Asked Questions

Who processes enrollments?

In two-plan counties and in San Diego County, Health Care Options serves as the independent enrollment broker.¹¹⁶ In COHS counties (San Mateo and Orange), the COHS plan processes enrollments. Health Care Options (HCO) has a dedicated call center for the CCI with its own phone number separate from the Medi-Cal Health Care Options center. The CCI-specific HCO call center number is 1-844-580-7272.

Who can make an enrollment decision?

In most circumstances, the beneficiary is only individual able to make an enrollment decision by either

¹¹⁴ Dual eligibles living in a COHS county will only have one Cal MediConnect plan choice

¹¹⁵ Some Medicare Advantage plans also provide dental, vision, and transportation benefits. Beneficiaries should compare benefits available under their Medicare Advantage plan to the benefits offered in the Cal MediConnect plans when making a decision.

¹¹⁶ See www.healthcareoptions.dhcs.ca.gov.

contacting Health Care Options (or the health plan in COHS counties) or by mailing in a completed choice form.

There are, however, circumstances when a beneficiary is unable to make an enrollment decision on his or her own behalf. Under state law and guidance, the following individuals can make an enrollment decision on the beneficiary's behalf:

1. A conservator/guardian appointed by the court
2. A designated Power of Attorney
3. An Authorized Representative – a beneficiary files an Authorized Representative form with the county Medi-Cal office.
4. An Enrollment Assistant – a family member, friend, or advocate acting in the beneficiary's best interest. The Enrollment Assistant must attest to his or her authority to make an enrollment decision on the beneficiary's behalf and cannot have a conflict of interest in making such decision.

Can beneficiaries receive enrollment counseling?

The primary source of enrollment counseling is the Health Insurance Counseling and Advocacy Program (HICAP) in each county. See Appendix A for more information. Other community-based organizations may also be prepared to assist individuals. Health Care Options should provide more general information about choices and, for dual eligibles, 1-800-Medicare will remain a resource for basic Medicare questions.

Continuity of Care¹¹⁷

Continuity of Care: Cal MediConnect

Beneficiaries who are enrolled in Cal MediConnect are able to keep seeing their current providers and maintain their service authorizations for up to six months for Medicare services and up to 12 months for Medi-Cal services.¹¹⁸ In order to qualify for continuity

of care, the following conditions must be met:¹¹⁹

- An existing relationship with the provider prior to enrollment in Cal MediConnect. An existing relationship is established if the beneficiary has seen their primary care physician once and a specialist twice within the 12 months preceding plan enrollment for a non-emergency visit. A pre-existing relationship is established through Medicare and Medi-Cal utilization data. If the plan cannot confirm a relationship through utilization data, the plan will request proof of the relationship from the member.
- The out-of-network provider will accept either the plan reimbursement rate or the applicable Medi-Cal or Medicare reimbursement rate, whichever is higher.
- The out-of-network provider would not otherwise be excluded from the plan's network due to quality of care issues or failure to meet federal or state requirements.¹²⁰

If these continuity of care requirements are met, the plan should provide the beneficiary with services from the out-of-network provider without interruption for a time-limited period.¹²¹ Beneficiaries and their providers can request continuity of care, and the plan must process continuity of care requests within three days if there is a risk of harm to the beneficiary.¹²²

Individuals living in nursing facilities at the time of

receive services from out-of-network Medicare provider).

119 WIC § 14132.275(k)(2)(A) (Medicare continuity of care); WIC § 14182.17(d)(5)(G) (Medi-Cal continuity of care); MOU p. 95-96. See also, HSC § 1373.96 (requiring plans to provide completion of covered services by non-participating providers); WIC § 14132.276(k)(14)(requiring Cal MediConnect plans to comply with HSC § 1373.96).

120 WIC § 14132.276(b)(13); Duals Plan Letter 15-003, dated March 27, 2015, available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/DPL2015/DPL15-003.pdf>.

121 See WIC § 14132.275 (k)(2)(B) (requiring the State to develop a process that notifies providers and beneficiaries of availability of continuity of services and ensures "that the beneficiary continues to receive services without interruption."

122 Dual Plan Letter, 15-003.

117 For a comprehensive summary of continuity of care rights in Medi-Cal, see NHeLP's "Continuity of Care in Medi-Cal," Sep. 30, 2013, available at www.healthlaw.org/issues/medicaid/managed-care/continuity-of-care-in-medi-cal/#.U0doha1dX2Q.

118 WIC § 14132.275(k)(2)(A)(ii-iii) (criteria for continuing to

enrollment into Cal MediConnect can continue to live in that nursing facility for the length of the demonstration even if the nursing facility is not part of the Cal MediConnect plan's network.¹²³

In the event a beneficiary enrolled in a Cal MediConnect plan visits an out-of-network provider without having first requested continuity of care from the plan, the provider can seek retroactive payment for services rendered as long as the continuity of care criteria are met and the request for payment is made within 30 days of services rendered.¹²⁴

For beneficiaries enrolled in a Cal MediConnect plan that contracts with Independent Physician Associations (IPAs) or Preferred Provider Groups (PPGs), beneficiaries must see providers within the IPA/PPG network. If a provider is within the plan's network but not within the IPA/PPG network, beneficiaries will have to switch to an IPA/PPG provider after the continuity of care period has expired.¹²⁵

These continuity of care rights do not extend to IHSS, durable medical equipment, medical supplies, transportation, or other ancillary services providers. Because IHSS recipients continue to have the right to hire, fire, and supervise their home care providers,¹²⁶ however, enrollment in Cal MediConnect should not disrupt an IHSS recipient's access to his chosen provider.

For prescription drugs, Cal MediConnect plans must also follow the Medicare Part D rules on transitions.¹²⁷ These include a one-time fill—a 30 day supply unless a lesser amount is prescribed—of any ongoing medication within the first 90 days of plan membership, even if the drug is not on the Cal MediConnect plan's formulary or is subject to utilization management controls.¹²⁸

123 Duals Plan Letter 15-003, p. 7.

124 Duals Plan Letter 15-003, p. 4. Advocates are attempting to extend retroactive payment beyond 30 days. As of the date of this manual, DHCS was considering this proposal.

125 Dual Plan Letter 15-003, pp. 3-4. Advocates are attempting to define continuity of care at the prime plan level rather than the IPA/PPG level so that beneficiaries have access to the full network of plan providers.

126 WIC § 14186.35(a)(2).

127 WIC § 14132.275(j)(1)(A)(iv).

128 For more information about Medicare prescription drug transition rights, see generally Justice in Aging, "2015

Of course, dual eligibles can choose to maintain relationships with Medicare providers by either staying in FFS Medicare or in their preferred Medicare Advantage plan. Individuals who enroll in Cal MediConnect also have the right to disenroll from the program at any time and return to FFS Medicare or a Medicare Advantage plan.¹²⁹

Continuity of Care: Medi-Cal Managed Care¹³⁰

On the Medi-Cal side, there are two different types of continuity of care rights. First, as described above, a beneficiary who is enrolled in Medi-Cal managed care can continue to see an out-of-network provider of Medi-Cal services for up to 12 months, if the applicable criteria are met (the beneficiary has an ongoing relationship with the provider; the provider will accept the plan rate or Medi-Cal FFS rate, if higher; and the provider is otherwise qualified). An SPD also can receive services, like a scheduled surgery as part of a documented course of treatment, that are set to occur within 180 days of enrollment.¹³¹ Like Cal MediConnect protections, nursing facility residents enrolled only in a Medi-Cal managed care plan have the right to continue residing in an out-of-network facility as long as they were residing in the facility at the time of enrollment into the Medi-Cal plan.¹³²

Second, an SPD in a two-plan or GMC county who would otherwise be subject to enrollment in Medi-

Transition Rights to Medications Under Medicare Part D," available at <http://justiceinaging.org/wp-content/uploads/2015/05/Transition-2015.pdf>, and Chapters 6 and 14 of the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

129 WIC § 14132.275(k)(1)(B) (right to opt out); MOU p. 11 (no lock-in).

130 DHCS launched a webpage dedicated to continuity of care for Medi-Cal managed care available at www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx.

131 HSC § 1373.96.

132 See All Plan Letter, 15-004, "Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect" dated February 12, 2015, available at http://www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/content/en/forms/MU_0003383.pdf.

Cal managed care under the CCI may file a Medical Exemption Request (MER) to avoid enrolling in Medi-Cal managed care altogether, instead staying in FFS Medi-Cal.¹³³ A MER is available to beneficiaries with complex medical conditions, such as cancer, a pending organ transplant, multiple sclerosis, cardiomyopathy, or a complex and/or progressive disorder that requires medical supervision or to beneficiaries receiving complex medical treatment that cannot be interrupted.¹³⁴ To file a MER, a beneficiary and her doctor must fill out a form and submit it to Health Care Options.¹³⁵ We recommend that beneficiaries enlist the assistance of an advocate in the MER process.¹³⁶ An approved MER is still temporary, exempting beneficiaries from managed care for up to 12 months, though at the end of that time beneficiaries can file for a renewal of a MER. Once the beneficiary's condition is stabilized, as determined by the beneficiary's treating FFS physician, she will be required to enroll in Medi-Cal managed care. If a MER is denied, a beneficiary can request a state fair hearing (see Appeal Rights below). People with HIV/AIDS and Native Americans may disenroll from Medi-Cal managed care at any time.¹³⁷ To do so, they should file a MER, which ought to be approved automatically.

Remember that the plans determine whether a beneficiary can continue to see out-of-network providers, whereas DHCS decides whether a beneficiary should be granted a Medical Exemption Request. Continuity of care protections are in place for beneficiaries who transition to Medi-Cal managed care

after a MER period expires.¹³⁸

Frequently Asked Questions

When is a MER available?

A MER is only available to individuals who have Medi-Cal only (an SPD) or where Medi-Cal is the primary payer of medical services. The MER is not available to dual eligible beneficiaries. The MER process does not apply to Cal MediConnect because a beneficiary has the right to opt out of or disenroll from Cal MediConnect at any time for her Medicare benefits.

Do continuity of care provisions affect carved-out benefits?

No. Enrollment into managed care does not impact the way a beneficiary receives carved-out benefits.

Beneficiaries' Right to Receive Materials and Services in Their Own Language

In accordance with federal law,¹³⁹ all plans participating in Cal MediConnect must ensure that communication and services are accessible to

133 WIC § 14182.16(c)(1)(D).

134 22 CCR § 53887.

135 The form is available online at www.healthcareoptions.dhcs.ca.gov/HCOCS/Enrollment/Exception_to_Plan_Enrollment_Forms.aspx.

136 Seniors and persons with disabilities who were already subject to mandatory managed Medi-Cal have encountered extraordinary difficulties in getting MERs approved, and in fact beneficiaries have filed a lawsuit against the State in an attempt to remove these roadblocks. See *Saavedra v. Douglas*, No. BS 140896, Cal. Super. Ct. (filed Dec. 21, 2012).

137 WIC § 14182.16(c)(2) (allowing beneficiary with diagnosis of HIV/AIDS to opt out of managed care enrollment at the beginning of any month).

138 See All Plan Letter, 15-001, providing Medi-Cal plans with guidance on the continuity of care rights beneficiaries have transitioning into a plan after a MER has been requested, available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-001.pdf>.

139 See generally Title VI of the Civil Rights Act, 42 U.S.C. § 2000d (barring discrimination under a program receiving federal financial assistance); *Lau v. Nichols*, 414 U.S. 563, 566 (1974) (applying Title VI to prohibit discrimination based on language and requiring local government to ensure meaningful opportunity to participate in federally funded program). For more guidance on the federal rules, see the U.S. Department of Health and Human Services (HHS) guidance on Title VI for health and social service providers, www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html, as well as the National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care, 65 FR §§ 80865-79.

those with limited English proficiency.¹⁴⁰ The MOU requires plans to provide translated written materials in languages spoken by at least 3,000 beneficiaries in a county.¹⁴¹ Services and materials must also be provided in alternative formats that are culturally, linguistically, cognitively, and physically appropriate including, for example, assistive listening systems and sign language interpreters.

Oral interpretation services must be provided in all languages without charge by plan call centers and all plan providers.

If your limited English proficient clients are unable to get needed oral interpretation or written translations, contact Justice in Aging.

Accessibility and Americans with Disabilities Act (ADA)/Section 504 Requirements

The MOU requires every participating plan to certify “that it intends to fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the ADA and the Rehabilitation Act of 1973.”¹⁴² In addition to the MOU, the Affordable Care Act (ACA) explicitly incorporates the requirements of the ADA and Rehabilitation Act.¹⁴³

140 WIC § 14182(b)(12) (requiring limited English proficient (LEP) access and compliance with applicable cultural and linguistic requirements); MOU p. 15, ¶ 5 (requiring that benefits be provided in a manner that is sensitive to language and culture); p. 15 ¶ 6 (requiring participating plans and providers to provide interpreters for those who do not speak English), p. 16 (requiring enrollment and other plan materials to be accessible to LEP individuals per federal guidelines).

141 MOU p. 32 (threshold languages). Depending on the county, these languages may include English, Spanish, Vietnamese, Chinese, Korean, Farsi, Tagalog, Russian, Armenian, Khmer, Arabic, and Hmong.

142 MOU p. 62.

143 The ACA’s non-discrimination provision in § 1557 broadly states that “an individual shall not [on grounds prohibited in a series of listed civil rights laws, including the ADA and Section 504] be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance.” Since regulations have not yet

The three federal laws address disability discrimination and together require health care providers to provide physical and programmatic access to people with disabilities. Discrimination includes the failure to make reasonable modifications in policies, ensure effective communication, provide auxiliary aids and services, provide materials in an accessible format, or take steps to remove architectural barriers, because such failures effectively prevent people with disabilities from enjoying goods and services offered to the public. In the health care context, this means that a health care organization must modify its policies, practices, and procedures when necessary to enable people with disabilities to gain full and equal access to its services, unless a requested modification constitutes a fundamental alteration of the health care service itself. For example, an office would have to provide assistance to patients who needed help with undressing or transfers if a patient with a mobility impairment required such assistance to receive a proper examination.

Health care entities must also provide auxiliary aids and services such as sign language interpreters, assistive listening devices, and written medical information in such alternative formats as Braille and large-font print, unless the provider can establish that doing so would fundamentally alter the nature of the health care service or constitute an undue burden.¹⁴⁴

Finally, health care entities are required to remove architectural barriers such as steps, narrow doorways, and inaccessible toilets in existing facilities if doing so is “readily achievable.” Health care facilities that are newly constructed or that undertake alterations to existing facilities must ensure that the new construction or alteration meets the higher standard of being readily accessible. Participating plans have these same obligations given their overarching role in developing and coordinating accessibility within their provider networks, and in light of their own financial and administrative resources.

Each plan participating in the CCI is required to

been issued under § 1557, its requirements will not be independently addressed in this Guide.

144 42 U.S.C. § 12182(b)(2)(A)(iii); C.F.R. § 36.302. “Undue burden” is defined as “causing significant difficulty or expense.”

provide staff training on disability discrimination and disability cultural competency, and should be prepared to deal with a network provider or plan representative's failure to provide effective reasonable accommodations or policy modifications. The three-way contracts have some specific references to accessibility for beneficiaries with disabilities. For example, the adequacy of the geographic location of the plan's providers is supposed to take into account "distance, travel time, the means of transportation, and whether the location provides physical access for enrollees with disabilities."¹⁴⁵ Plans are required to have "written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit enrollees with disabilities from obtaining all covered services from the contractor."¹⁴⁶ The three-way contract goes into some detail with regard to the plan's obligation to provide services that include flexibility in scheduling, interpreters and translators for deaf and hard-of-hearing individuals, and a range of examples of specific alternative formats.^{147,148} In practice, however, the transition from written policies to actual practice can be elusive. Advocates should contact Disability Rights Education and Defense Fund or Disability Rights California if a plan or government agency fails to respond appropriately to accessibility complaints.¹⁴⁸

Appeal Rights

Generally, beneficiaries have the right to appeal decisions that deny, terminate, or reduce services made by a Medi-Cal managed care plan, a Cal MediConnect plan, DHCS, or other governmental agencies or contractors.¹⁴⁹ Notices about these decisions, and appeal

procedures and hearings, should be understandable and accessible, including to people with disabilities and those who are limited English proficient. Notices should include specific information, including the decision made, the facts and law relied upon, the right to appeal and how to appeal.¹⁵⁰ Plans also have an internal grievance and complaint process that beneficiaries should follow when they are unhappy with the quality of their services or with someone from the health plan. The internal grievance and complaint process should also be accessible to people with disabilities and those who are limited English proficient.

Following the rules and timelines is important to succeeding in an appeal or grievance. If possible, a beneficiary should get help from an experienced advocate when filing an appeal or grievance (though this is not required). The CCI Ombudsman is available to assist beneficiaries with appeals and grievances.

Medi-Cal Managed Care

If a Medi-Cal managed care plan denies, reduces or terminates services, a beneficiary has appeal rights. A beneficiary can file both an internal appeal with the health plan and request a state fair hearing (the same process as in FFS Medi-Cal).¹⁵¹ Generally, advocates recommend filing both an internal appeal and a request for a fair hearing at the same time, and then

for Medi-Cal or Medicare, but those eligibility issues are beyond the scope of this Guide. If you have questions about eligibility for Medi-Cal, Medicare, or the Part D Low Income Subsidy, please consult the sources cited in this section, or contact Justice in Aging.

145 Three-way contract § 2.11.1.2, p. 72.

146 Three-way contract § 2.22.1.2, p. 72.

147 Three-way contract § 2.11.1.2.3, pp. 72-73.

148 Appendix B of the three-way contract includes Enrollee Rights and includes "access to" primary and specialty provider networks that can meet a beneficiary's physical access, communication, and scheduling needs. Beneficiaries also have the right to accessible information on their Medi-Cal and Medicare appeal rights, as well as all program services and health care options before and after enrollment and at the time information is need to make and informed choice. See Three-way contract, Appendix B, pp. 189-91.

149 Beneficiaries also have the right to appeal denials of eligibility

150 WIC § 14182.17(d)(7); MOU p. 82. See also *Goldberg v. Kelly*, 397 U.S. 254 (1970) (landmark Supreme Court case applying due process clause of the U.S. Constitution to public benefits).

151 For information about Medi-Cal notices, appeals and fair hearings, including citations to applicable state and federal law, see the National Health Law Program's Overview of the Medi-Cal Program (2008), particularly Chapter 19: Notice, Appeals and Fair Hearings, at <http://healthconsumer.org/Medi-CalOverview2008Ch19.pdf>, and Chapter 20: Medi-Cal Managed Care, <http://healthconsumer.org/Medi-CalOverview2008Ch20.pdf>. The Health Consumer Center also has county-specific consumer brochures explaining the process for filing an appeal with a Medi-Cal managed care plan, online at <http://healthconsumer.org/searchbrochures.php>.

withdrawing or postponing the fair hearing if the plan favorably resolves the internal appeal. The appeal may result in more information from the plan about the issue as well as quicker resolution of the dispute, while the request for a state fair hearing maximizes the beneficiary's due process rights. However, a request for a state fair hearing can preclude the right to an Independent Medical Review (described below).

Whether a beneficiary files an internal plan appeal or requests a state fair hearing, if that request is made within 10 days of a notice of action reducing or terminating ongoing services, the plan must continue to provide the service to the beneficiary.¹⁵² This protection is also known as an “aid paid pending” appeal. In any case, a request for a fair hearing must be made within 90 days of the notice of action unless there is a good reason that the deadline was missed (e.g., the notice was not received).

Make sure to request an appeal within 10 days of receiving a notice and to ask for “aid paid pending” when filing the appeal!

To file an internal plan appeal, the beneficiary should follow the managed care plan's internal appeal process. If the plan's initial response does not favorably resolve the issue, the beneficiary then may file the appeal with the Department of Managed Health Care (DMHC) for an external review of the decision.

There are two options at the external review stage: either requesting an Independent Medical Review (IMR) by an external medical expert if the denial involves a medical judgment, or filing a complaint with DMHC for all other issues.¹⁵³ The IMR is available if the beneficiary has already used the internal plan appeal process and was denied, or received no answer within 30 days. An IMR can be requested in cases where the plan finds that the service is not medically necessary; the plan refuses to pay for out-of-network emergency or urgent care; or the plan says that the treatment requested

is experimental or investigational.¹⁵⁴ An IMR must be requested within six months of the plan's written response to an appeal. A beneficiary cannot get an IMR if she has already requested a state fair hearing decision. However, a beneficiary can ask for a state fair hearing after an IMR if she does not receive a favorable decision, as long as the request for a fair hearing is still within 90 days of the original decision denying, reducing, or terminating services.

Cal MediConnect

For at least the first year, Cal MediConnect enrollees wishing to appeal a decision by a plan to deny, reduce, or terminate services has different options depending on whether the service is a Medicare benefit (e.g., inpatient and outpatient medical treatment, shorter-term SNF stays, most prescription drugs) or a Medi-Cal benefit. Regardless of the type of service, however, the Cal MediConnect plans must have a grievance and appeal processes that complies with state and federal law,¹⁵⁴ and they are required to provide their members notice of appeal rights when services are denied, reduced, or otherwise amended.¹⁵⁶

For Medi-Cal covered services, the appeals process is the same as that described on page 38 above for Medi-Cal managed care. “Beneficiaries are allowed to seek a state fair hearing at any time,”¹⁵⁷ although they are “encouraged” to appeal first through the plan's member services or navigation office. Initial requests for a state fair hearing must be filed within 90 days of receiving a notice of action. Plans cannot put any requirements on appeals and grievances that are stricter for Medi-Cal services than the current requirements in the FFS Medi-Cal system.¹⁵⁸

¹⁵⁴ HSC §§ 1374.30-1374.35.

¹⁵⁵ See WIC § 14450; HSC § 1368 and 1368.01 (grievance process required for managed care plans).

¹⁵⁶ MOU p. 82. An integrated appeals notice is available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html. A model denial notice is available at www.calduals.org/wp-content/uploads/2014/09/IntegratedDenialNotice_CA_04.11.14.pdf.

¹⁵⁷ MOU p. 99.

¹⁵⁸ MOU p. 82.

¹⁵² HSC §1368(a)(6); 22 CCR § 51014.2(a).

¹⁵³ The forms for both of these are available at www.dmh.ca.gov/dmhc_consumer/pc/pc_forms.aspx.

For Medicare-covered hospital and outpatient benefits, the current Medicare Advantage process is followed: 1) initial appeals must be filed within 90 days, and will be sent to the plan for a redetermination of its initial decision; 2) if the plan upholds its initial denial, the second level of appeal is a Medicare Independent Review Entity (IRE); 3) the third level of appeal is the Office of Medicare Hearings and Appeals; and so forth.¹⁵⁹ For Medicare-covered benefits, there is no state fair hearing option, but aid paid pending is available through the internal plan appeal process as long as the appeal is made within ten days.¹⁶⁰

Appeals for Part D-covered prescription drugs follow existing Medicare rules. This means that if coverage for a particular drug is denied at the pharmacy, the individual must either meet a prior authorization requirement or file a request for an “exception” with the Cal MediConnect plan. If the plan denies the request for an exception, then the appeals process can begin.¹⁶¹ Appeals regarding drugs that are NOT covered by Medicare Part D (for instance, over-the-counter drugs, or drugs for weight loss or gain) follow the usual Medi-Cal rules.

With regard to overlapping services covered by both Medicare and Medi-Cal (e.g., home health services, durable medical equipment, and other skilled service), an appeals process was supposed to be spelled out in the three-way contracts with CMS, the plan, and DHCS.¹⁶² Unfortunately, the three-way contracts are silent on appeals for overlapping services and the process has yet to be formalized. At a minimum, the appeals

process includes the right to a state fair hearing.¹⁶³

In addition to appeals of denial or reduction in services, each plan also has an internal grievance process; the plan must either track and resolve these grievances or reroute them to the appropriate coverage determination or appeals processes.¹⁶⁴ Information about the grievance process must be provided to members. For Medicare benefits, the internal plan grievance procedures are to be used in all cases that do not involve an “organization determination.” For instance, disputes about hours of service, location of facilities, or courtesy of personnel would go through the plan grievance process.

Eventually, California and CMS are supposed to work together to create an integrated grievance and appeals system for Cal MediConnect that combines the Medicare and Medi-Cal processes into one. This integrated system has not yet been designed or implemented.

In-Home Supportive Services and Behavioral Health

As described above on p.25, IHSS and behavioral health will continue to be authorized by the counties and the appeals process remains as it is in FFS Medi-Cal. An IHSS beneficiary can request a reassessment or challenge her hours assessment by filing a request for fair hearing.¹⁶⁵

Care Plan Option Services

As described on p. 25, plans are not required to provide Care Plan Option services. If plans do decide to provide such services, according to DHCS, they are not subject to the Medi-Cal or Medicare formal grievance and appeals processes. Instead, plans are required to create an internal grievance procedure to record and

159 MOU pp. 99-100. For more information about Medicare managed care appeals, see the CMS page on Medicare Managed Care Appeals & Grievances, which includes a link to Chapter 13 of the Medicare Managed Care Manual, “Medicare Managed Care Beneficiary Grievances, Organizational Determinations, and Appeals,” as well as a helpful flowchart of the appeals process. See www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index.html?redirect=/mmcag/. See also, Medicare Rights Center www.medicarerights.org/fliers/Rights-and-Appeals/OM-Post-Service-General-Appeals-Packet.pdf?nrd=1.

160 Three-way contract p. 98.

161 More details about Medicare Part D exceptions and appeals is available at www.medicare.gov/claims-and-appeals/file-an-appeal/prescription-plan/prescription-drug-coverage-appeals.html.

162 MOU pp. 99-100.

163 MOU p. 100.

164 MOU p. 98.

165 WIC § 14186.35(b)(2) (preserving right to appeal); WIC § 14186.35(b)(4) (preserving right to request reassessment). For information about IHSS services, assessments and appeals, see Disability Rights California’s manual, In-Home Supportive Services: Nuts and Bolts, available at www.disabilityrightscalifornia.org/pubs/PublicationsIHSSNutsandBolts.htm. Note that the information in this manual is current as of its May 2008 publication date.

address complaints.¹⁶⁶ The internal grievance procedure differs from plan to plan.

Frequently Asked Questions

Who can help beneficiaries with appeals?

The State applied for and was awarded funding from CMS to develop an independent ombudsman program that assists individuals enrolled in Cal MediConnect plans with appeals and other issues they may face in a Cal MediConnect plan. The CCI ombudsman is managed through non-profit legal services programs in the seven CCI counties. In addition to helping with appeals, the ombudsman is responsible for tracking reported problems and providing feedback to the State and CMS on systemic issues arising out of Cal MediConnect.

While the independent ombudsman is funded only to provide assistance to dual eligibles impacted by Cal MediConnect, the selected Ombudsman program made it clear that it serves both Cal MediConnect dual eligibles and individuals impacted by the CCI generally.¹⁶⁷ See Appendix A for the ombudsman contact information and additional resources available to consumers.

Medi-Cal and Medicare Refresher

Medicare

Medicare is a federally funded program for people who are age 65 and over or others who qualify because of disability or because of End-Stage Renal Disease (ESRD).¹⁶⁸ Medicare Parts A and B (also called

“traditional” or “fee-for-service” Medicare) pay for medical services such as doctor visits, hospital stays and laboratory work typically through a FFS model. Traditional Medicare insurance has no restriction on where you go to see a doctor (freedom of choice), and doctors likewise have freedom to choose which patients they see.¹⁶⁹ Medicare Part C is the managed care alternative to traditional Medicare; Medicare Part D pays for prescription drugs.

Usually, Medicare pays 80% of the cost of health services, and the beneficiary pays the remaining 20%. For duals, Medicare is the primary health insurance program that pays for needed care. Medi-Cal then fills in the gaps in Medicare coverage. For example, Medi-Cal pays the Medicare Part B premium. Medi-Cal also pays the cost sharing for any Medicare deductibles, coinsurance, and copayments charged. For dual eligibles, the State agrees to reimburse Medicare doctors for services provided to duals up to the reimbursement limit that Medi-Cal would have paid for the same services. As part of health reform, for 2013 and 2014 only, the Medi-Cal rate must equal the Medicare rate for primary care doctors, so Medi-Cal must pay the full cost sharing for those doctors. For other providers, however, Medi-Cal reimbursement rates are usually less than 80% of the Medicare reimbursement rates. This means that many providers who treat dual eligibles only get paid 80% of the standard Medicare rate for the service. Federal rules do not allow Medicare providers to “balance bill” duals; in other words, they cannot require that a dual eligible patient pay the remaining 20%.¹⁷⁰ They can, however, decide not to accept a dual eligible patient.

Medicare offers private health plans, called Medicare Advantage, as an alternative to original Medicare. Once a beneficiary enrolls in a Medicare Advantage plan, she receives all Part A and Part B benefits through the plan, and usually Part D prescription drug coverage as well. Medicare Advantage plans include HMOs,

166 See “Policy for Cal MediConnect: Care Plan Option services (CPO services)” (June 3, 2013), available at www.calduals.org/wp-content/uploads/2013/06/Demo-CPO-services-Paper-6.3.13.pdf.

167 The Legal Aid Society of San Diego was awarded the ombudsman funding and entered into subcontracts with legal services providers in the other six CCI counties to provide local assistance.

168 For a more detailed description for advocates of the Medicare Program, consult the Center for Medicare Advocacy’s Medicare Handbook, or go to their website, www.medicareadvocacy.org. The Medicare website for the general

public is www.medicare.gov is very helpful, and advocates may find additional useful material at www.cms.gov/Medicare/Medicare.html.

169 42 U.S.C. § 1395 (prohibiting federal interference in the manner in which medical services are provided).

170 See www.cms.gov/MLN Matters Articles/downloads/SE1128.pdf.

PPOs, private fee-for-service plans, Medicare medical savings account plans, and special needs plans (SNPs). SNPs are a type of Medicare Advantage plan that limits membership to people with specific diseases or characteristics.¹⁷¹ Some SNPs serve individuals with particular chronic conditions (C-SNPs) or those requiring an institutional level of care (I-SNPs). The majority of SNPs, however, are designed to serve dual eligibles (D-SNPs). Some D-SNP sponsors also have Medi-Cal contracts in the same county where they operate, while others do not. In all cases, D-SNPs are required to provide some coordination of Medicare and Medi-Cal benefits.

Medi-Cal

Medi-Cal is California's state Medicaid program, funded in part by the state and in part by the federal government.¹⁷² It provides health insurance coverage to low-income families with children, seniors, persons with disabilities, pregnant women, and other individuals with specific medical conditions. Medi-Cal helps pay for doctor visits, hospital stays, prescription drugs, limited vision and dental services, durable medical equipment, medical transportation, long-term services and supports and other medical services. If an individual is eligible for both Medicare and Medi-Cal, Medicare acts as the primary payor for services, and Medi-Cal pays for the portion Medicare does not cover (see above Medicare summary). California, like many states, has two delivery systems for its Medi-Cal program, fee-for-service and managed care.

Fee-For-Service

Under FFS, healthcare providers are paid for each service they provide to a beneficiary. For example, a

provider will receive reimbursement from DHCS for an office visit, test, or procedure. Beneficiaries with FFS Medi-Cal can see any provider who accepts Medi-Cal.

Medi-Cal Managed Care

Under Medi-Cal managed care, a beneficiary is enrolled in a plan to receive her Medi-Cal benefits. The plan is paid a single rate from DHCS to deliver a beneficiary's health care services. Plans contract with providers including, for example, doctors, specialists, hospitals, and pharmacies to develop a "network." Individuals enrolled in a managed care plan can generally only see providers that are within the plan's network. Dual eligibles primarily use Medi-Cal managed care providers for their long-term services and supports because their medical care is generally covered by Medicare.

Over the last decade, California has been moving most populations eligible for Medi-Cal benefits from fee-for-service into managed care. Today, approximately 4.5 million Medi-Cal beneficiaries residing in 30 counties receive their medical services through health plans mirroring traditional health maintenance organizations (HMOs). The movement of SPDs into managed care began in 2011 in 16 California counties.¹⁷³ DHCS is expanding Medi-Cal managed care for SPDs into rural counties. This expansion started in 2013 and is set to conclude in 2014.¹⁷⁴

California has adopted three models of managed care:¹⁷⁵

1. Two-Plan Model. In two-plan counties, there is generally a Local Initiative plan and a Commercial plan. The Local Initiative plans are nonprofit health plans designed with input from local government and community stakeholders. These plans are usually the county health system, including the county hospitals. The Commercial

171 CMS, Medicare Managed Care Manual, Chapter 16-B: Special Needs Plans (May 20, 2011), www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf.

172 For a detailed guide to the Medi-Cal program, see the National Health Law Program's Overview of the Medi-Cal Program (July 2008), available at www.healthconsumer.org/publications.htm#manuals. Please note that this manual is up to date only through the date of publication. For more information generally about Medi-Cal and health reform, go to <http://healthconsumer.org/index.php?id=pubs>. For more information about Medi-Cal and planning for long term care, go to www.canhr.org/medcal/.

173 For more information regarding the SPD transition into Medi-Cal Managed Care www.chcf.org/-/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FirstLookMandatoryEnrollmentSPD.pdf.

174 See www.dhcs.ca.gov/provgovpart/Pages/Medi-CalManagedCareExpansion.aspx.

175 See www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf.

plans are private insurance plans with a state contract to provide Medi-Cal. A beneficiary is given the option to choose the plan that best meets her health care needs. Four of the counties affected by the CCI—Los Angeles, Riverside, San Bernardino and Santa Clara—are two-plan counties.

2. County Organized Health Systems (COHS). Under this model, there is one health plan in the county created by the County Board of Supervisors with input from the community. These plans are managed by the individual counties. All Medi-Cal beneficiaries (including duals) residing in a COHS county have the same managed care plan for their Medi-Cal. Two of the counties affected by the CCI—San Mateo and Orange—are COHS counties.
3. Geographic Managed Care (GMC). Under this model, the State contracts with several commercial plans to provide Medi-Cal services. Beneficiaries can choose among these plans. Only one CCI county, San Diego, uses the GMC model.

Certain groups were excluded from Medi-Cal managed care enrollment in 2011, including dual eligible beneficiaries, share of cost beneficiaries, and individuals receiving nursing facility care. These groups continued to receive services through Medi-Cal fee-for-service. The CCI changes this.

Appendix A - Resources

Contact Information for Plans

County	Cal MediConnect Plans	Contact Information
Los Angeles	Care1st Cal MediConnect Plan	1-855-905-3825 (TTY: 711) www.care1st.com/ca/calmediconnect
	CareMore Cal MediConnect Plan	1-888-350-3447 (TTY: 711) www.duals.caremore.com
	Health Net Cal MediConnect	1-888-788-5395 (TTY: 1-888-788-6383) www.healthnet.com
	L.A. Care Cal MediConnect	1-888-522-1298 (TTY: 1-888-212-4460) www.calmediconnectla.org
	Molina Dual Options	1-855-665-4627 (TTY: 711) www.molinahealthcare.com
Orange	CalOptima One Care Connect	1-855-705-8823 (TTY: 1-800-735-2929) www.caloptima.org
San Diego	Care1st Cal MediConnect Plan	1-855-905-3825 (TTY: 1-800-735-2929) www.care1st.com
	CommuniCare Advantage	1-800-224-7766 (TTY: 1-800-735-2929) www.chgsd.com
	Health Net Cal MediConnect	1-888-788-5805 (TTY: 1-888-788-6383) www.healthnet.com
	Molina Dual Options	1-855-665-4627 (TTY: 1-800-479-3310) www.molinahealthcare.com
San Mateo	Care Advantage Cal MediConnect	1-866-880-0606 (TTY: 1-800-735-2929) www.hpsm.org
Riverside & San Bernardino	IEHP DualChoice	1-877-273-4347 (TTY: 1-800-718-4347) www.iehp.org
	Molina Dual Options	1-855-665-4627 (TTY: 1-800-479-3310) www.molinahealthcare.com
Santa Clara	Anthem Blue Cross	1-888-350-3532 (TTY: 711) www.anthem.com
	Santa Clara Family Health Plan	1-800-260-2055 (TTY: 1-800-735-2929) www.scfhp.com

PACE Contact Information

County	PACE Plan	Contact Information
Los Angeles	Altamed Senior BuenaCare PACE	1-877-462-2582 www.altamed.org/seniorservices#BuenaCare
	Brandman Centers for Senior Care	1-818-774-3065 www.brandmanseniorcare.org/
Orange	Cal Optima	1-855-785-2584 www.caloptima.org/en/Members/PACE.aspx
Riverside/San Bernardino	InnovAge PACE	1-888-992-4464 www.myinnovage.org/ProgramsandServices/InnovAgePACE.aspx
San Diego	St. Paul's PACE	1-619-677-3800 www.stpaulspace.org/
	San Diego PACE	1-619-662-4100 www.syhc.org/sdpacer/
Santa Clara	On Lok Lifeways	1-888-886-6565 www.onlok.org

Consumer Assistance

Resource	Assistance Provided	County	Contact Information
CCI Ombudsman	Assistance with Cal MediConnect enrollment, appeals, and grievances	All CCI counties	855-501-3077 www.calduals.org/terms-and-conditions/ombudsman-resources
HICAP	Free information and counseling about Medicare for individual beneficiaries.	Los Angeles	Center for Health Care Rights 213-383-4519
		Orange	Council on Aging - Orange County 714-560-0424 www.coaoc.org
		Riverside/San Bernardino	909-256-8369 www.hicapsbc.org
		San Diego	858-565-8772 www.seniorlaw-sd.org
		San Mateo	Self Help for the Elderly 650-627-9350 www.selfhelpelderly.org
		Santa Clara	Council on Aging 408-296-8290 www.careaccess.org
Disability Rights California	Advocate, educate, investigate and litigate to advance and protect the rights of Californians with disabilities.	Statewide	1-800-776-5746 (TTY: 1-800-719-5798) www.disabilityrightscalifornia.org
Health Consumer Alliance	Assist consumers in obtaining essential health care.	Statewide	www.healthconsumer.org
LawHelpCA	Helping Californians find legal aid and self-help resources	Statewide	www.lawhelpca.org

State and Federal Guidance

DHCS	www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareIntiative.aspx www.dhcs.ca.gov/Pages/DualsDemonstration.aspx www.calduals.org/
Health Care Options	1-844-580-7272 (TTY: 1-800-430-7077) www.healthcareoptions.dhcs.ca.gov
CCI Independent Ombudsman	1-855-501-3077 www.calduals.org/terms-and-conditions/ombudsman-resources
Department Of Managed Health Care Help Center	1-888-466-2219 (TTY: 1-877-688-9891)
Medi-Cal Managed Care Ombudsman	1-888-452-8609
Office Of The Patient Advocate	http://www.opa.ca.gov/Pages/Home.aspx
State Fair Hearing Requests	1-800-952-5253
Medicare Medicaid Coordination Office	www.cms.gov/Medicare-Medicaid-Coordination/Medicare-Medicaid-Coordination.html
Medicare	1-800-Medicare (TTY: 1-877-486-2048)

Opportunities for Systemic Advocacy

Advocates have many roles to fill with the implementation of the CCI. In addition to preparing to counsel individual beneficiaries, advocates can also influence the development of the CCI program. Below is a list of ways to get involved.

How to get involved	Contact Information
Join a regional coalition	Contact your local coalition listed here: http://www.thescanfoundation.org/our-goals/dual-integration/community-of-constituents
Participate in DHCS stakeholder calls and meetings	www.Calduals.org
Participate in plan stakeholder meetings	Each plan's website provides information about stakeholder meetings
Participate in beneficiary advocate coalitions and information sharing.	Contact Justice in Aging, Amber Cutler, acutler@justiceinaging.org , or Denny Chan, dchan@justiceinaging.org .

Appendix B – County Timelines¹⁷⁶

CCI Enrollment Timeline by County and Population

** Revised 11.20.14**

Cal MediConnect enrollment begins in April 2014 with passive enrollment in San Mateo; and "opt-in" in Riverside, San Bernardino, San Diego and Los Angeles counties.

Cal MediConnect (Passive enrollment)														MLTSS (Mandatory enrollment)											
Full Duals Only														Full Duals in Medi-Cal FFS ¹				Full Duals in Medi-Cal Managed Care				MSPP		Partial Duals/Medi-Cal only	
Start Date	Medi-Cal FFS and in Medi-Cal Managed Care (enrolled in one month) ²	Medi-Cal FFS and Medi-Cal FFS (enrolled by birth month) ³	Non-Medicaid HH and in Medi-Cal Managed Care (enrolled in one month) ⁴	LMC OSMP / Part D LIS (enrolled in one month)	Opt-out of CMC and in Medi-Cal FFS (enrolled by birth month)	Excluded from CMC (FSR, LSCs, waiver, etc.) and in Medi-Cal FFS (enrolled by birth month)	Full Duals in a CMC plan (OSMP only) (enrolled in one month)	In a new CMC (OSMP) plan (all day MA plan sponsored by July health plan (enrolled by birth month) ⁵	Full Duals in Medi-Cal managed care plan (benefit added in one month) ⁶	Excluded from CMC (FSR, LSC, waiver, etc.) and in Medi-Cal Managed Care (benefit added in one month) ⁷	MA (benefit or LIS) enrollees in Medi-Cal Managed Care (benefit added in one month) ⁸	MSPP (benefit added in Medi-Cal managed care or Medi-Cal FFS (enrolled in one month)	Medi-Cal Managed Care (benefit added in one month)	Medi-Cal FFS (enrolled by birth month) ⁹											
4/14	San Mateo		San Mateo						Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	San Mateo (Full Duals in MA plan or opted from CMC)													
5/14	Riverside, San Bernardino, and San Diego	Riverside, San Bernardino, and San Diego			Riverside, San Bernardino, and San Diego																				
7/14	Los Angeles	Los Angeles			Los Angeles				Santa Clara	Santa Clara	Santa Clara	San Mateo (Full Duals and Medi-Cal only)	Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara												
8/14					Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara									Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara											
10/14			Los Angeles, Riverside, San Bernardino, and San Diego									Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara													
1/15	Santa Clara	Santa Clara	Santa Clara	Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara	Santa Clara		Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara	Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara																	
7/15									Orange	Orange	Orange	Orange	Orange												
8/15 ⁸	Orange		Orange																						
1/16				Orange																					

1. Enrollees already in a Medi-Cal managed Care plan will receive one notice prior to the change in benefit.

2. There are no FFS Medi-Cal Enrollees in Orange and San Mateo counties.

3. Enrollees with April and May birthdates will be enrolled in May 2014, then follow enrollment schedule by birth month.

4. Enrollment in Orange County will proceed by birth month.

5. County FFS enrollment includes April County birthdates in Riverside, San Bernardino & San Diego; July County birthdates in Los Angeles; County birthdates in San Mateo. Enrollment will continue by birth month in February in those counties.

6. "Opt-in" Cal MediConnect enrollment in Orange County will begin in July 2015.

176 <http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf>.

Appendix C – Notices

The Coordinated Care Initiative notices are available on calduals.org and are available in the threshold languages. The notices are also available online in audio format. In addition to the notices in this Appendix, the calduals website also includes the Cal MediConnect and MLTSS choice form and booklet for each county, the opt out confirmation letter, and a template adverse notice of action.

Cal MediConnect 90-Day Notice

State of California

DHCS

Cal MediConnect
Your choice for complete care

Health and Human Services

W- [Barcode] XX/XX/XXXX

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

Important Information on Your Medicare and Medi-Cal

You are getting this letter because you have **BOTH** Medicare and Medi-Cal. The way you get your health care is changing. You will now have new choices to meet your health care needs.

Cal MediConnect is a new type of health plan.

Enrolling in a Cal MediConnect plan:

- Combines all of the Medicare or Medi-Cal benefits and services you receive now into a single plan.
- Will not cost more than what you pay today for your Medicare and Medi-Cal benefits.
- Ensures Cal MediConnect doctors, specialists, and other approved providers will work together to get you the care you need.
- Gives additional transportation to medical services and vision benefits.

What are my choices?

This is the first letter telling you about your new choices. You will get a second letter with more information about your choices soon.

1. **Automatically enroll in the Cal MediConnect plan that we have chosen for you.**
To do this, you do not have to do anything. It will be automatic.
2. **If you do not want to be automatically enrolled** in the Cal MediConnect plan chosen for you, you **MUST** either contact Health Care Options at 1-844-580-7272 or in about a month we will send you the Plan Choices Form you can fill out and return to choose **one** of these options:



- Option A: **Enroll in a different Cal MediConnect Plan.**

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- Option B: **Keep your Medicare the way it is AND enroll in a Medi-Cal plan.**

Some may be eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE).

What should I do now?

- Talk about your choices with someone who knows about your health care needs, like your family or your doctors. Call the California Health Insurance Counseling & Advocacy Program for free health insurance counseling at 1-800-434-0222.
- Watch your mail for a packet from Health Care Options in about one month.

How can I get help or more information?

If you want to:	Contact:
<ul style="list-style-type: none"> • Talk to a health insurance counselor for free about these changes and your choices 	California Health Insurance Counseling & Advocacy Program (HICAP) 1-800-434-0222 TTY users should call 711
<ul style="list-style-type: none"> • Select a different Cal MediConnect plan, • Stay in regular Medicare, • Learn more about PACE, or • Get this letter in another language, large print, audio, or Braille 	Health Care Options 1-844-580-7272 TTY users should call 1-800-430-7077
<ul style="list-style-type: none"> • Ask questions about Medicare 	1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048
<ul style="list-style-type: none"> • Get help with Cal MediConnect plan problems and complaints 	Cal MediConnect Ombudsman 1-855-501-3077

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Cal MediConnect 60-Day Notice

State of California			
			Health and Human Services



▶ Z-  ◀

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information on Your Medicare and Medi-Cal

You are getting this **second letter** because you have **BOTH** Medicare and Medi-Cal. The way you get your health care is changing. You will keep the benefits and services you have now, but you will get them in a different way. Unless you choose a different option, in 60 days, you will be automatically enrolled in a new Cal MediConnect plan <Plan Name>.

If you do not want to be enrolled in the plan selected for you, you **must** take action.

**If you do not do anything, your coverage in Cal MediConnect
<Plan Name>
will become effective on 00/00/0000**

In the next few days, you will receive a Health Plan Guidebook and a Choice Book to help you better understand the Cal MediConnect program and the plan you have been assigned. Carefully review that information when you receive it.

What are my choices?

1. **Automatically enroll in the Cal MediConnect plan that we have chosen for you starting 00/00/0000.** To do this, you do not have to do anything. It will be automatic.
2. **If you do not want to be automatically enrolled** in the Cal MediConnect plan chosen for you, you **MUST** either contact Health Care Options at 1-844-580-7272 or fill out and return the Plan Choice Form by 00/00/0000 to choose from these options:
 - Option A: **Enroll in a different Cal MediConnect Plan.**
 - Option B: **Keep your Medicare the way it is AND enroll in a Medi-Cal plan.**

Z You can also find out if you are eligible to enroll in the Program of All-Inclusive Care for the Elderly (PACE).

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What do my choices mean?

1. Automatically enroll in the Cal MediConnect plan

<Plan Name>.

This plan:

- Has been chosen for you based on your past services and health care needs.
- Combines all of the Medicare and Medi-Cal benefits and services you receive now into a single plan.
- Gives additional transportation to medical services and vision benefits.
- Will not cost more than what you pay today for your Medicare and Medi-Cal benefits.
- Ensures Cal MediConnect doctors, specialists, and other approved providers will work together to get you the care you need.
 - If your doctor is not a part of the Cal MediConnect plan, you may have to choose a new doctor.
 - Other providers won't change, like those for Medi-Cal services such as In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing home care.

2. If you do not want to be automatically enrolled in the Cal MediConnect plan chosen for you, you **MUST choose from these options:**

Option A: Enroll in a different Cal MediConnect plan

- If you want all of the benefits of having a Cal MediConnect plan, but you don't want to be automatically enrolled in the one we have chosen for you, you may select a different one. You will receive a Health Plan Guidebook to help you make your choice.

Option B: Keep your Medicare the way it is now AND enroll in a Medi-Cal plan

- If you choose to stay with regular Medicare, you still must choose a Medi-Cal plan to receive your Medi-Cal benefits.
- You will receive Medi-Cal services like In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing facility care through the Medi-Cal plan, if you qualify for these services.

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Cal MediConnect 30-Day Notice

State of California			
			Health and Human Services





JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Final Notice: Important Reminder on Your Medicare and Medi-Cal

You are getting this **third and final letter** because you have **BOTH** Medicare and Medi-Cal. The way you get your health care is changing. You will keep the benefits and services you have now, but you will get them in a different way. In 30 days, you will be automatically enrolled in a new Cal MediConnect plan
<Plan Name>.

If you do not want to be enrolled in the plan selected for you, you **must** take action.

**If you do not do anything, your coverage in Cal MediConnect
<Plan Name>
will become effective on 00/00/0000**

What are my choices?

1. **Automatically enroll in the Cal MediConnect plan that we have chosen for you starting 00/0/0000.** To do this, you do not have to do anything. It will be automatic.
2. **If you do not want to be automatically enrolled** in the Cal MediConnect plan chosen for you, you **MUST** either contact Health Care Options at 1-844-580-7272 or fill out and return the Plan Choice Form by 00/00/0000 to choose from these options:
 - Option A: **Enroll in a different Cal MediConnect Plan.**
 - Option B: **Keep your Medicare the way it is AND enroll in a Medi-Cal plan.**

If eligible, enroll in the Program of All-Inclusive Care for the Elderly (PACE).

How does a Cal MediConnect plan help me?

Enrolling in a Cal MediConnect plan:

- Combines all of the Medicare or Medi-Cal benefits and services you receive now into a single plan.
- Will not cost more than what you pay today for your Medicare and Medi-Cal benefits.
- Ensures Cal MediConnect doctors, specialists, and other approved providers will work together to get you the care you need.
- Gives additional transportation to medical services and vision benefits.

How can I get help or more information?

If you want to:	Contact:
<ul style="list-style-type: none">• Talk to a health insurance counselor for free about these changes and your choices	California Health Insurance Counseling & Advocacy Program (HICAP) 1-800-434-0222 TTY users should call 711
<ul style="list-style-type: none">• Select a different Cal MediConnect plan,• Stay in regular Medicare,• Choose PACE, or• Get this letter in another language, large print, audio, or Braille	Health Care Options 1-844-580-7272 TTY users should call 1-800-430-7077
<ul style="list-style-type: none">• Ask questions for free about Medicare	1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048
<ul style="list-style-type: none">• Get free help with Cal MediConnect plan problems and complaints	Cal MediConnect Ombudsman 1-855-501-3077

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Cal MediConnect and Medicare Part D

When you join a Cal MediConnect plan, you will get health care and prescription drugs from your new plan. Your current Medicare Part D prescription drug plan will send you a letter telling you that your prescription drug plan will not cover your prescription drugs. You will not lose your prescription drug coverage.

Here is some more important information about the changes to your drug coverage.

- Soon, you will receive all of your Medi-Cal and Medicare benefits, **including Medicare Part D**, from the Cal MediConnect plan we tell you about in the other letter in this envelope.
- Your Cal MediConnect plan will become your new Medicare Part D plan, which means that coverage in your current prescription drug plan will end. You cannot keep your current Part D plan and be in a Cal MediConnect plan at the same time.
- You will continue to receive your prescription drug benefits from your current plan until your new prescription coverage from the Cal MediConnect plan starts. You will not lose your prescription drug coverage at any time.
- If you do not want to be in Cal MediConnect, you may keep your Medicare the same and stay in your current prescription drug plan. You will still have to select a Medi-Cal plan for your Medi-Cal benefits. You just need to let Health Care Options know your decision.


More information about your Cal MediConnect plan and other health care choices is included with this insert.

If you want to talk to a health insurance counselor for free about these changes and your choices, call the California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or TTY 711.


If you need this letter in another language or alternate format, like large print, audio, or Braille; or if you need help understanding this letter, please call Health Care Options Customer Service Monday–Friday, 8:00 a.m.–5:00 p.m. at 1-844-580-7272, or TTY: 1-800-430-7077 (for people who are deaf, hard of hearing, or speech impaired).


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MLTSS 90-Day Notice



State of California — Health and Human Services
Department of Health Care Services
P.O. Box 989009, West Sacramento, CA 95798-9850





JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information on Your Medi-Cal

You have both Medicare and Medi-Cal. You are receiving this letter because the way you get your **Medi-Cal** benefits is changing. You **must** now enroll in a Medi-Cal managed care plan to receive your Medi-Cal services, including Long Term Services and Supports. The reason for this change is to help make your Medi-Cal services work better together. This change does not affect your Medicare coverage or your ability to see your Medicare doctor.

Please read this letter carefully. We will send you more information and health plan enrollment materials in about one month.

How will this change affect me?


Your Medi-Cal plan will:

- Coordinate all of your Medi-Cal covered services, including Long Term Services and Supports.
- Pay for certain Medicare cost-sharing.
- Cover other benefits that are not covered by Medicare, such as some medical transportation, certain medical supplies, and certain prescription drugs.

What won't change about my healthcare?

Enrolling in a Medi-Cal plan:

- Does NOT change your Medicare.
- Does NOT change any of your Medi-Cal benefits.
- Does NOT change your Medi-Cal eligibility or cost you extra.



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What are Medi-Cal Long Term Services and Supports?

These are non-medical services that help you with your personal care and supportive service needs. If you do not get these services now, your Medi-Cal plan can help you get them in the future, if you qualify.

- **In-Home Supportive Services (IHSS)** are personal care services for people who need help to live safely in their homes. If you get IHSS now, your services will not change. You can keep your IHSS providers and you can still hire, fire, and manage your providers.
- **Community-Based Adult Services (CBAS)** centers provide daytime health care like nursing, therapy, activities and meals for people with certain chronic health conditions. If you get CBAS now, your services will not change.
- **Multipurpose Senior Services Program (MSSP)** provides social and health care coordination services for people age 65 and older. If you get MSSP now, you will still receive it through your current MSSP providers. Your Medi-Cal plan will work with them to better coordinate your care.
- **Nursing home care:** If you get care in a nursing home now, you do not have to change your nursing home. Your plan will work with your doctor and nursing home to better coordinate your care.

Can I keep my Medicare doctors after I enroll in a Medi-Cal plan?

Yes. Your Medicare doctors will not change.

Can I keep my Medi-Cal providers after I enroll in a Medi-Cal plan?

You will need to check with your Medi-Cal plan to determine if your providers work with the plan. Your Long Term Services and Supports providers, such as IHSS, CBAS, MSSP or nursing facilities, won't change. But you may have to change other Medi-Cal providers and vendors, such as durable medical equipment suppliers.

When do I need to enroll in a Medi-Cal plan?

You will be receiving more information about your choices for a Medi-Cal plan. If you do not make a choice, a plan will be chosen for you and you will be enrolled in a Medi-Cal plan starting 00/00/0000.

What should I do now?

- Talk about your choices with someone who knows about your health care and other needs, like your family, friends, your doctors, or your local Long Term Services and Supports providers.
- Watch your mail for a packet from Health Care Options in about one month.


For help or more information

If you have questions about Medicare, please call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.


If you want to select a different Medi-Cal plan, and/or get this letter in another language or alternate format – like large print, audio, or Braille, please call:


Health Care Options

Monday - Friday, 8 am - 5 pm
1-844-580-7272 • TTY: 1-800-430-7077
www.HealthCareOptions.dhcs.ca.gov



State of California — Health and Human Services
Department of Health Care Services
P.O. Box 989009, West Sacramento, CA 95798-9850





JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information on Your Medi-Cal

The Way You Get Your Medi-Cal Benefits is Changing on 00/00/0000

You have both Medicare and Medi-Cal. You are receiving this letter because the way you get your **Medi-Cal** benefits is changing. You **must** now enroll in a Medi-Cal managed care plan to receive your Medi-Cal services, including Long Term Services and Supports. The reason for this change is to help make your Medi-Cal services work better together. This change does not affect your Medicare coverage or your ability to see your Medicare doctor.


This is the **second letter** telling you about your options for choosing a Medi-Cal plan. Based upon your past services and health care needs, you have been assigned to the Medi-Cal plan named below. **Unless you make a different Medi-Cal plan choice, you will be enrolled in the plan below on**

MM/DD/YYYY: NAME OF PLAN

How will this change affect me?

Your Medi-Cal plan will:

- Coordinate all of your Medi-Cal covered services, including Long Term Services and Supports.
- Pay for certain Medicare cost-sharing.
- Cover other benefits that are not covered by Medicare, such as some medical transportation, certain medical supplies, and certain prescription drugs.



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What won't change about my healthcare?

Enrolling in a Medi-Cal plan:

- Does NOT change your Medicare.
- Does NOT change any of your Medi-Cal benefits.
- Does NOT change your Medi-Cal eligibility or cost you extra.

What are Medi-Cal Long Term Services and Supports?

These are non-medical services that help you with your personal care and supportive service needs. If you do not get these services now, your Medi-Cal plan can help you get them in the future, if you qualify.

- **In-Home Supportive Services (IHSS)** are personal care services for people who need help to live safely in their homes. If you get IHSS now, your services will not change. You can keep your IHSS providers and you can still hire, fire, and manage your providers.
- **Community-Based Adult Services (CBAS)** centers provide daytime health care like nursing, therapy, activities, and meals for people with certain chronic health conditions. If you get CBAS now, your services will not change.
- **Multipurpose Senior Services Program (MSSP)** provides social and health care coordination services for people age 65 and older. If you get MSSP now, you will still receive it through your current MSSP providers. Your Medi-Cal plan will work with them to better coordinate your care.
- **Nursing home care:** If you get care in a nursing home now, you do not have to change your nursing home. Your health plan will work with your doctor and nursing home to better coordinate your care.

Can I keep my Medicare doctors after I enroll in a Medi-Cal plan?

Yes. Your Medicare doctors will not change.

Can I keep my Medi-Cal providers after I enroll in a Medi-Cal plan?

You will need to check with your Medi-Cal plan to determine if your providers work with the plan. Your Long Term Services and Supports providers, such as IHSS, CBAS, MSSP or nursing facilities, won't change. But you may have to change other Medi-Cal providers and vendors, such as durable medical equipment suppliers.

Can I choose a different Medi-Cal plan?

Yes. You will soon get a packet of Medi-Cal plan information in the mail. Read the materials in this packet. This packet includes a Choice Book that has instructions on how to choose and enroll in a Medi-Cal plan in your county.

What should I do now?

- Expect a packet of Medi-Cal plan information in the mail.
- Review this information with your family or someone who knows about your health care and other needs.
- Talk to your health providers to see which Medi-Cal plans they work with.

To stay with the Medi-Cal plan listed above, you do not need to do anything.

To choose a different health plan, you can contact Health Care Options at 1-844-580-7272 to make a choice, or fill out, sign, and return the Medi-Cal Health Plan Choice Form by 00/00/0000.


For help or more information

If you have questions about Medicare, please call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.


If you want to select a different Medi-Cal plan, and/or get this letter in another language or alternate format – like large print, audio, or Braille, please call:


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Department of Health Care Services
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▶ ES3*  ◀

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XX/XX/XXXX

Important Final Reminder on Your Medi-Cal

The Way You Get Your Medi-Cal Benefits is Changing on 00/00/0000

You have both Medicare and Medi-Cal. You are receiving this letter because the way you get your **Medi-Cal** benefits is changing. You **must** now enroll in a Medi-Cal managed care plan to receive your Medi-Cal services, including Long Term Services and Supports. The reason for this change is to help make your Medi-Cal services work better together. This change does not affect your Medicare coverage or your ability to see your Medicare doctor.

This is the **FINAL letter** telling you about your options for choosing a Medi-Cal plan. Unless you choose a different Medi-Cal plan, your coverage in [Health Plan Name] will become effective on 00/00/0000.

We chose this plan for you based on your past services and health care needs, but you still have the right to choose a different Medi-Cal plan.

How will this change affect me?

Your Medi-Cal plan will:

- Coordinate all of your Medi-Cal covered services, including Long Term Services and Supports.
- Pay for certain Medicare cost-sharing,
- Cover other benefits that are not covered by Medicare, such as some medical transportation, certain medical supplies, and certain prescription drugs.

You should check to see if your Medi-Cal plan includes your Medi-Cal providers such as durable medical equipment suppliers. You will not have to change Long Term Services and Supports providers.

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What won't change about my healthcare?

Enrolling in a Medi-Cal plan:

- Does NOT change your Medicare.
- Does NOT change any of your Medi-Cal benefits.
- Does NOT change your Medi-Cal eligibility or cost you extra.

What are Medi-Cal Long Term Services and Supports?

These are non-medical services that help you with your personal care and supportive service needs. If you do not get these services now, your Medi-Cal plan can help you get them in the future, if you qualify.

- **In-Home Supportive Services (IHSS)** are personal care services for people who need help to live safely in their homes. If you get IHSS now, your services will not change. You can keep your IHSS providers and you can still hire, fire, and manage your providers.
- **Community-Based Adult Services (CBAS)** centers provide daytime health care like nursing, therapy, activities and meals for people with certain chronic health conditions. If you get CBAS now, your services will not change.
- **Multipurpose Senior Services Program (MSSP)** provides social and health care coordination services for people age 65 and older. If you get MSSP now, you will still receive it through your current MSSP providers. Your Medi-Cal plan will work with them to better coordinate your care.
- **Nursing home care:** If you get care in a nursing home now, you do not have to change your nursing home. Your plan will work with your doctor and nursing home to better coordinate your care.

What are my choices?

- **Stay in the Medi-Cal plan we have chosen for you.** If you decide that [Health Plan Name] is right for you, you do not need to do anything. You will be enrolled in a Medi-Cal plan starting 00/00/0000.
- **Choose a different Medi-Cal plan.** You may review the plans available in your county to see if one of those is better for you. We sent you a choice packet that gives you information about the plans you can choose.
 - You can contact Health Care Options at 1-844-580-7272 to make a choice, or fill out, sign, and return the Medi-Cal Health Plan Choice Form by 00/00/0000. If you need another copy of the choice packet, call Health Care Options.

For help or more information

If you have questions about Medicare, please call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

If you want to select a different Medi-Cal plan, and/or get this letter in another language or alternate format – like large print, audio, or Braille, please call:

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