Advocate's 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 SPDs. The National Senior Citizens Law Center (NSCLC) 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 (September 09, 2013). However, many of the details about the CCI are still in flux. To get an updated version of this Guide, as well as information about NSCLC webinars and other trainings, please email info@nsclc.org. You can also subscribe to the DHCS's official listserv to receive program updates at www.calduals.org. This is version 2 of the Guide. Changes from Version 1 are highlighted by ** and can be found on pages 7, 8, 16, 21, 22, 24, 25, 26, 27, 28, 29, and 40.

At NSCLC, we advocate for the rights of low-income seniors and persons with disabilities to access healthcare. We cannot represent individuals in their claims for benefits, but we can provide technical assistance and advice to advocates. DREDF also does not provide individual representation on benefit eligibility or amounts. Our staff gives information and referrals for individual benefits assistance, and technical assistance on disability civil rights to legal service advocates. We are 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 the Appendix.

Acknowledgments

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This Guide is also supported in part by a grant from 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.

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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.

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 under a Cal MediConnect plan.

DD Waiver = Developmentally Disabled waiver. Home and community-based services waiver that provides home and community-based services to 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. 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.

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 Nursing Facility/Acute Hospital 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 those with mental impairments who require it.

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 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 to remain living in their community who without the program would be placed in a nursing facility or other institution.

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 contributing to their healthcare 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 don't have Medicare, i.e., NOT dually eligible.

Introduction

The Coordinated Care Initiative (CCI) is a new program that, in the eight counties in which it will be 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")[1] get their health care. Anyone who represents or works with duals and SPDs in these eight counties should be familiar with the CCI. Preparation prior to enrollment 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 an advocate in understanding the CCI, including 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 supports and services to dual eligibles and SPDs living in eight California counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara.[2]

1 SPDs refer to a specifically defined population of individuals who receive Medi-Cal only (not Medicare) based on age or disability.

2 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.

The CCI involves three[3] distinct changes:

Mandatory Enrollment in Medi-Cal Managed Care[4]

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 eight demonstration counties to enroll in a Medi-Cal 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

3 The State refers to the CCI as having "two parts," the first of which includes both the mandatory enrollment of most duals into Medi-Cal managed care and the integration of LTSS into Medi-Cal managed care. The second part is Cal MediConnect, the optional "duals demonstration" project to integrate Medicare and Medi-Cal into a single health care plan. In order to spotlight all of the changes that are part of the CCI, this Guide refers to three distinct changes.

4 WIC §§ 14182; 14182.16; 14182.17. As of the date of this Guide, California has not received federal approval to move forward with mandatory enrollment of dual eligibles and other SPDs into Medi-Cal managed care. **DHCS submitted an amendment application to its Section 1115 Medicaid waiver to CMS for approval on 6/18/2013.

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 11.

plan for the beneficiary.[7]

LTSS Integration[8]

Long-term services and supports (LTSS) historically have not been included in the managed care benefit package.[9] Under the CCI, LTSS, such as nursing facility care and In-Home Supportive Services (IHSS), will be provided through Medi-Cal managed care plans. This change will impact both those beneficiaries who will be new to Medi-Cal managed care as well as those who are already enrolled in Medi-Cal managed care, since it will be the first time that many will receive LTSS through their Medi-Cal managed care plan.[10]

7 The State will primarily use a beneficiary's provider history to select a plan. WIC § 14182(b)(6).

8 WIC § 14186. As of the date of this Guide, California had not received federal approval to integrate LTSS into the Medi-Cal managed care benefit package. **DHCS submitted an amendment application to its Section 1115 Medicaid waiver to CMS for approval on 6/18/2013.

9 Community-Based Adult Services (CBAS) was transitioned into Medi-Cal managed care in 2012, as a result of the settlement of the *Darling* lawsuit. More information about CBAS and the *Darling* settlement is available on the websites of DHCS (www.dhcs.ca.gov/services/medi-cal/pages/adhc/adhc.aspx), 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 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 MediConnect[11]

The CCI creates a new type of managed care program, known as Cal MediConnect, which combines a dual eligible beneficiary'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 will impact dual eligible beneficiaries, not SPDs

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

A beneficiary has the choice to opt in or opt out of Cal MediConnect prior to being passively enrolled into the program.

After a beneficiary opts into Cal MediConnect or is by default passively enrolled into Cal MediConnect, she will have to disenroll from the program to change how she receives her Medicare benefit.

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. 13 for more information about the PACE option.

or individuals with Medicare only. Health care plans will enter into three-way contracts with the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). The health plan will be paid a monthly fee for each individual enrollee, also known as a "capitated" rate, and will be responsible for providing a package of Medicare and Medi-Cal services in exchange for that rate.[13]

Cal MediConnect plans will provide Medi-Cal and Medicare services using a network of contracted providers (primary care physicians, specialty providers, hospitals, pharmacies, LTSS providers, etc.). An individual who is 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.[14] A dual eligible beneficiary with traditional, fee-for-service Medicare and Medi-Cal can see any doctor who accepts Medicare or Medi-Cal, but a dual eligible beneficiary enrolled in Cal MediConnect generally can only see doctors in the managed care plan.

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

Enrollment in Cal MediConnect is optional. An individual in Cal MediConnect has the right to change plans or disenroll at any time. A beneficiary 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.[15] If a dual 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.[16] A dual who opts out of Cal MediConnect must still be enrolled in a Medi-Cal managed care plan for her Medi-Cal benefit.[17]

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 will be enrolled into Cal MediConnect. If a beneficiary receives

13 The rate paid to the health plans will be a combination of a Medicare rate and a Medi-Cal rate. The amount paid by each program will start with a 'baseline' that will then be adjusted to the acuity of the enrolled population and reduced by a predetermined savings percentage. MOU pp. 45-52.

14 Beneficiaries have continuity of care rights when transitioning into the CCI. See p. 32 for more information about continuity of care.

15 MOU p. 64.

16 Duals will also have the option to enroll in PACE if eligible. See p. 13 for more information about the PACE option.

17 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.

a notice and does not act affirmatively by either opting out of Cal MediConnect or choosing a plan, the beneficiary will be automatically enrolled into a Cal MediConnect plan chosen for her by DHCS. In other words, if a beneficiary does nothing, she will be automatically enrolled in Cal MediConnect.

Can a beneficiary disenroll from Cal MediConnect after being passively enrolled?

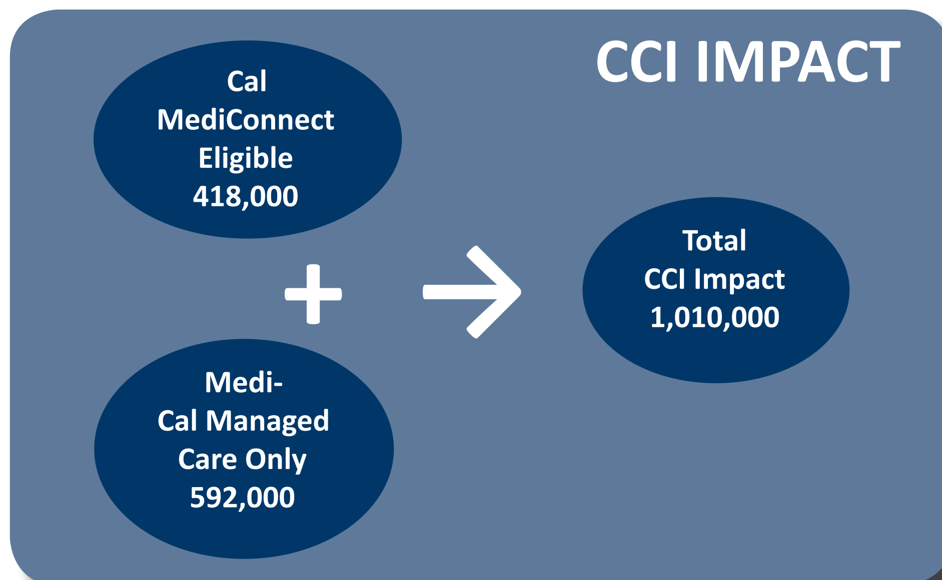
Yes. A beneficiary can disenroll from Cal MediConnect at any time for any reason. However, the disenrollment rights only apply to her Medicare benefit. A beneficiary will still have to be enrolled in managed care for her Medi-Cal benefit.

Who Does the CCI Impact and How?

The CCI will impact dual eligibles and SPDs in the CCI counties. Individuals with Medicare only will not be impacted by the CCI. Duals and SPDs will be impacted differently under the CCI. We have provided a pull-out table on page 17, which provides a summary of how duals and SPDs will be 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 will impact over one million duals and SPDs in the eight demonstration 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 codes,[18] beneficiaries with other health coverage in certain counties, individuals living in a veterans' home and residents of an ICF-DD in certain counties.[19] The table on page 17 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.[20]

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 Kaiser and individuals living in certain rural zip codes in San Bernardino County will not be passively enrolled into Cal MediConnect, but can opt-in to the program.[21] Individuals enrolled in a Medicare Advantage plan or in a D-SNP will not be subject to passive enrollment in 2014, but can opt-in to the program if they disenroll from their Medicare Advantage or

DUALS AT A GLANCE[24]

Gender
- **Female: 59%**
- **Male: 41%**

Age
- **21-64: 24%**
- **65 or older: 76%**

Care Codes
- **Aged: 57%**
- **Blind or Disabled: 37%**
- **Long-Term Care: 4%**

Primary Language
- **English: 44.8%**
- **Non-English: 55.2%**

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18 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 USCS § 1396u-2(a)(1)(A)(i)(I); 42 USCS § 1396u-2(a)(3)(A); See also, CMS "2014 Capitated Financial Alignment Demonstration Timeline" (p. 5), available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_PlanGuidance01092013.pdf.

19 WIC § 14182.16(c)(1).

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

21 MOU p. 9.

D-SNP plan.[22] Likewise, individuals who are enrolled in PACE or in HCBS waivers will not be passively enrolled into Cal MediConnect, but can choose to enroll if they disenroll from PACE or their waiver.[23] The table on page 17 shows these different exceptions in detail.

Approximately 418,000 beneficiaries in the eight counties will be eligible for passive enrollment in Cal MediConnect and will receive notices regarding enrollment in 2014.[24] Of those eligible for passive enrollment, only 395,000 can be enrolled. This is because Los Angeles County has a limit on how many beneficiaries can enroll in Cal MediConnect. Of the 223,000 duals who are eligible for passive enrollment residing in Los Angeles County, only 200,000 can be enrolled.[25] The table to the right lists the number of dual eligibles subject to passive enrollment in each county.

Remember that duals 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.[26]

County	Duals Subject to Passive Enrollment in Cal MediConnect[27]
Alameda	25,502
Los Angeles	223,084 (200,000 cap)
Orange	39,969
Riverside	24,395
San Bernardino	26,977
San Diego	41,710
San Mateo	3,701
Santa Clara	32,986
Grand Total	**418,324 (395,204 with cap)**

22 Under the MOU, individuals enrolled in Medicare Advantage or a D-SNP were subject to passive enrollment in Cal MediConnect beginning January 1, 2014. On June 17, 2013, the California Legislature passed SB 94, which states that individuals enrolled in a Medicare Advantage plan or D-SNP are not subject to passive enrollment in Cal MediConnect for 2014, creating a contradiction with the MOU. See SB 94 § 14132.277.

23 MOU p. 9.

24 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.

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

26 In total, there are 592,000 individuals who will have to join a Medi-Cal managed care plan under the CCI in addition to those subject to passive enrollment into Cal MediConnect. This total includes beneficiaries who cannot participate in Cal MediConnect, beneficiaries 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/mcestimates/Documents/2013_May_Estimate/May_2013_Medi-Cal_Estimate.pdf (PC Page 247).

27 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.

Frequently Asked Questions

Will people who have only Medicare be affected by the CCI?

No. People who have only Medicare, and not Medi-Cal, will not be 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. PACE provides its members with both Medicare and Medi-Cal services. PACE uses an interdisciplinary team to coordinate the care of each enrolled participant.[28]

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.[29] 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 four of the eight CCI counties (Alameda, Los Angeles, San Diego and Santa Clara).[30]

PACE will remain an enrollment option for dual eligibles. In addition, if a dual eligible beneficiary is already enrolled in PACE, that beneficiary will not be subject to passive enrollment in Cal MediConnect. If the beneficiary wishes to enroll in Cal MediConnect, the beneficiary 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.[31]

How will 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 are deemed to meet their share of cost continuously. Likewise, individuals 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

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

29 See "About PACE," available at www.onlok.org/About/AboutPACE.aspx.

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

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

enrollment. For example, if an individual with share of cost receiving IHSS is scheduled to be passively enrolled into Cal MediConnect in April 2014, the State will review whether her share of cost was met on November 1 and December 1 of 2013. Individuals who are not deemed to meet their share of cost 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. For those who are disenrolled due to failure to meet share of cost, they may reenroll in Cal MediConnect the following January 1st if they meet their share of cost as described above.[32]

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 Medi-Cal managed care.

Will 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 will not be able to participate in Cal MediConnect. They will not receive notices regarding Cal MediConnect, but they will still have to enroll in Medi-Cal managed care for their Medi-Cal benefit. 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 (for example, an individual in LA Care's D-SNP), she will have the option to enroll in Cal MediConnect, but will not be subject to passive enrollment.[33]

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 will still have to enroll in Medi-Cal managed care for her Medi-Cal benefit.

Will 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 will not be able to participate in Cal MediConnect and will not receive notices about Cal MediConnect. However, these individuals will still have to enroll in Medi-Cal managed care to receive their Medi-Cal benefit.

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

When a dual 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

32 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.

33 MOU p. 8.

Advantage or PACE.

Remember, with very few exceptions (see page 11), if she opts out or disenrolls from Cal MediConnect, she will still have 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 will not have to choose a Medi-Cal managed care plan. The only change for them if they decide to opt out of Cal MediConnect will be integration of LTSS into their Medi-Cal benefit package.

What about Part D?

For a beneficiary who opts out of Cal MediConnect prior to enrollment, she will stay in her current Part D Medicare prescription drug plan. For an individual who is enrolled in Cal MediConnect and wants to disenroll, not only will she have to choose how she receives her Medicare benefit, she will also 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.

What if a beneficiary is enrolled in a Kaiser plan?

Individuals enrolled in a Kaiser plan[34] will not receive notices regarding Cal MediConnect and will not be passively enrolled into Cal MediConnect. However, individuals enrolled in Kaiser will still have to enroll in a Medi-Cal managed care plan for their Medi-Cal benefit. If a beneficiary enrolled in Kaiser would like to enroll in Cal MediConnect, she would have to disenroll from Kaiser and choose a Cal MediConnect plan.

How will 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 will 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 will not lose their waiver spot on the waiting list by enrolling. 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. The beneficiaries will remain in the waiver programs. The waiver provider, not the plans, will provide the waiver services. The Medi-Cal managed care plan will be responsible for coordinating services with the waiver providers.

Will 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 would normally be counted).

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

Will 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. These are services that are like HCBS waiver services that Cal MediConnect plans can, but are not required, to offer. See page 21 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 will 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. 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.

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

Normally, 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. Instead, the beneficiary would remain in FFS Medi-Cal. This "matching" policy will not apply to the CCI.[35] For example, an individual who is enrolled in UnitedHealthcare for Medicare Advantage will still have to enroll in a Medi-Cal managed care plan despite the fact that UnitedHealthcare does not offer a Medi-Cal managed care plan.

35 **DHCS's application for an amendment to its 1115 waiver states, "dual eligibles enrolled in a Medicare Advantage plan may be mandatorily enrolled in a Medi-Cal managed care plan that is not operated by the same parent or organization for their Medi-Cal and Medicare wrap around benefits. This is applicable only in the eight authorized CCI counties."

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 will be passively enrolled into Cal MediConnect.
- If a dual is not enrolled in Cal MediConnect, the dual will nevertheless have 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[36]	Yes[36]	Yes	Yes	Yes	Yes
Beneficiary Diagnosis						
Prior End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	No[37]	No[37]
Subsequent End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	Yes	Already Enrolled[38]
Beneficiaries with HIV/AIDS	Yes[39]	Yes[39]	Yes	Yes	Yes	Yes

36 American Indian beneficiaries are mandatorily enrolled, but can disenroll at any time.

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

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

39 Beneficiaries with HIV/AIDS are mandatorily enrolled, but can disenroll at any time.

	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 Residence						
Live in certain zip codes in Los Angeles, Riverside, and San Bernardino Counties[40]	No	No	No	No	No	No
Resident of certain zip codes in San Bernardino County[41]	No[42]	No[42]	No[42]	No[42]	Yes[43]	No
Resident of Veterans Home	No	No	No	No	No	No
Resident of ICF-DD	No[44]	No[44]	No[44]	No[44]	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
Share of Cost enrolled in IHSS and meets SOC[45]	Yes	Yes	Yes	Yes	Yes	Yes
Share of Cost not regularly met	Yes	Yes	Yes	Yes	No	No

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

41 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.

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

43 Beneficiaries living in these zip codes will not be passively enrolled, but they will receive notices informing them that they can enroll in Cal MediConnect voluntarily.

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

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

	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 enrolled in Medicare Advantage or other health care plan						
Enrolled in Medicare Advantage	N/A	Yes[46]	N/A	Yes	Yes	No[47]
Enrolled in D-SNP	N/A	Yes	N/A	Yes	Yes	No[48]
Enrolled in PACE	No	No	No	No	Yes[49]	No
Enrolled in AIDS Healthcare Foundation	No	No	No	No	Yes[50]	No
Beneficiaries enrolled in Kaiser	Yes	Yes	Yes	Yes	Yes[51]	No
MSSP Enrollees	Yes	Yes	Yes	Yes	Yes	Yes
Beneficiary with "Other Health Insurance"	No[52]	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

46 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. 16.

47 Under the MOU, beneficiaries enrolled in Medicare Advantage are subject to passive enrollment. SB 94, passed on June 17, 2013, contradicts the MOU and states that for the calendar year 2014, Medicare Advantage enrollees will not be subject to passive enrollment in Cal MediConnect.

48 Under the MOU, beneficiaries enrolled in a D-SNP are subject to passive enrollment. SB 94, passed on June 17, 2013, contradicts the MOU and states that for the calendar year 2014, D-SNP enrollees will not be subject to passive enrollment in Cal MediConnect.

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

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

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

52 Exception: Beneficiaries living in COHS counties with other health insurance must enroll 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**
Enrollees in NF/AH, HIV/AIDS, assisted living, or IHO waiver	Yes[53]	Yes	Yes	Yes	Yes[54]	No
Beneficiaries on waiver waiting lists	Yes	Yes	Yes	Yes	Yes[55]	Yes
Miscellaneous						
Partial Dual Eligibles[56]	Yes	Yes	Yes	Yes	No	No
Beneficiaries with a MER	No	No	No	No	Yes	Yes
Duals Who Opt Out of Cal MediConnect		Yes		Yes		

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

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

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

56 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.

Covered Benefits

Medi-Cal Managed Care Benefits

Beneficiaries who are not eligible for Cal MediConnect or who opt out of Cal MediConnect will 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 will also be responsible for Medicare cost sharing as Medi-Cal fee-for-service is today.

Cal MediConnect 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 supports and services: nursing facility care; IHSS; CBAS, MSSP.
    - **Including dental, which will become a required Medi-Cal benefit starting May 2014.[57]
- Preventive, restorative, and emergency vision benefits.
- Non-emergency, accessible medical transportation.
- Care coordination.

Cal MediConnect plans may, but are not required to, provide additional services that go beyond the required benefits listed above and which might help members avoid institutionalization or emergency room visits, including additional HCBS and behavioral health services.[58] These services may include, for example, supplemental home care services, home delivered meals, respite care, environmental adaptations and counseling.[59] These are called "Care Plan Option" services ("CPO services"). Historically, plans have not provided CPO services. Prior to implementation of Cal MediConnect, plans will have to put in place policies and

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57 **On June 18, 2013, the California Legislature approved a partial restoration of the adult dental benefit eliminated in 2009. Medi-Cal beneficiaries will start receiving preventative and denture services beginning May 1, 2014. 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.

58 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.

59 MOU pp. 93-94.

procedures governing the provision of these services.[60]

Cal MediConnect plans will be required to provide their members with all mental health and substance abuse services currently covered by Medicare and Medi-Cal.[61] However, some Medi-Cal funded services are "carved out" and will not be included in the capitated rates paid to Cal MediConnect plans.[62] These include specialty mental health services and Medi-Cal drug services.[63] County agencies will continue financing and administering these services, but plans and county agencies will have written agreements. As outlined above, Cal MediConnect plans

60 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. **See also NSCLC's summary of CPO Services available at http://dualsdemoadvocacy.org/wp-content/uploads/2013/02/CPO-Summary.pdf

61 Pursuant to SBX1 1 § 28, beginning January 1, 2014, DHCS will offer a new mental health benefit to all Medi-Cal recipients that will provide non-specialty mental health services including, for example, therapy and medication management.

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

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

regarding coordination of these services.[64] In other words, the plans are responsiblefor coordinating these carved out benefits so that the beneficiary receives seamless services.

are required to provide care coordination.[65] 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 will be 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 will evaluate beneficiaries for behavioral health needs and coordinate services with county services. In order to accomplish effective care coordination, the health plans are required to develop individualized care plans with beneficiaries and provide each beneficiary with an interdisciplinary care team, as necessary. This level of care coordination is new for most plans and many of the details about what the Cal MediConnect care coordination benefit will offer are not yet clear.

Frequently Asked Questions

How will the CCI affect IHSS?

Initially, not much. The CCI legislation

64 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.

65 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/.

requires that counties continue to assess and authorize IHSS as they always have, and IHSS consumers will still have the right to self-direct their care, including hiring, firing and supervising IHSS home care providers. Medi-Cal beneficiaries will still have the same ability to access the state fair hearing appeals process to dispute decisions about IHSS provision.

Because IHSS will become a Medi-Cal managed care benefit, however, the plans will become involved in IHSS. Plans will be required to have agreements with county IHSS offices and Public Authorities. The plans and counties will share information about IHSS consumers' needs.[66] A plan could, if it chose, authorize additional personal care hours beyond the limits allowed by the current IHSS program.[67] 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 state-wide California IHSS Authority, rather than local Public Authorities.[68] A new universal assessment tool for all LTSS, including IHSS, could result in changes to hours, authorizations and increased plan involvement generally.[69] IHSS appeals could be altered as a result of the new assessment tool or integrated appeals process.[70]

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

Initially, MSSP will remain the same under Cal MediConnect. Up until March 31, 2015, or 19 months after enrollment commences (whichever is later), plans will be required to contract with all MSSP organizations in the eight demonstration counties and pay MSSP providers the same rate they currently receive. After March 31, 2015, 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

66 Sharing mechanisms between the counties and plans will comply with State and Federal privacy laws. MOU p. 76.

67 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.

68 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 www.calduals.org/wp-content/uploads/2012/09/FAQIHSS090512.pdf. WIC §14186.35.

69 WIC § 14186.36(a) (stating the a 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").

70 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).

provide those services.[71]

What will the Cal MediConnect vision benefits provide?

Under Cal MediConnect, plans must provide preventive, restorative, and emergency vision services. The specific benefits will be outlined in the three-way contracts between the State, CMS and the plans. As of the date of publication of this Guide, the three-way contracts had not been finalized.

Purposes 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.[72] The CCI is intended to result in cost savings for both California and the federal government.[73]

71 **WIC § 14186(b)(7)(A); MOU p. 85.

72 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.

73 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.

Frequently Asked Questions

Will beneficiaries get better or worse care under Cal MediConnect?

This is a "demonstration" project; we do not 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 but not Cal MediConnect, however, these incentives will not exist. Furthermore, while Cal MediConnect plans will 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 benefit package and that promote successful community living, but do not directly or immediately prevent institutionalization.

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

Prior to the start of Cal MediConnect, plans must pass readiness reviews by DHCS and CMS.[74] The state is also developing metrics for evaluating the quality of Cal MediConnect plans. The plans' rates will be reduced by quality withholds at the beginning of each year.[75] If the plan meets specific quality standards, the plans will be reimbursed

74 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.

75 MOU pp. 52-54.

the amount withheld. It will likely be some time before information about plan quality is available to beneficiaries.[76] It is always a good thing to check a plan's local reputation and experience with particular populations and services.

CCI Timeline and Enrollment

Under the CCI, coverage becomes effective at enrollment.

The CCI is now scheduled to commence no sooner than **April 1, 2014.[77] There are still many details about CCI policy that need to be worked out prior to enrollment.[78] As of the date this Guide was published, there were still several important steps that must happen before enrollment in the CCI can begin. The State must obtain approval of its 1115 waiver amendment from CMS authorizing the State to move forward with mandatory enrollment into Medi-Cal managed care and integration of LTSS into Medi-Cal managed care. CMS and the State must work with the plans to develop rates the plans will receive. Plans also must complete all required contracts with the State, providers and local entities, and plans must pass a readiness review as outlined in the California Readiness Review Tool.[79] Furthermore, the enrollment process for Los Angeles County must be finalized, notices and other materials have to be developed, and the State must secure funding for enrollment counseling and consumer assistance. Only after these steps are accomplished can enrollment in the CCI begin.

Cal MediConnect Enrollment

The actual timeline and phasing of enrollment varies by county. LA County is the only county under the MOU that is supposed to provide a three-month voluntary enrollment period now set to start no sooner than **April 1, 2014.[80] During this period, beneficiaries can voluntarily opt into Cal MediConnect. After the three-month voluntary enrollment

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76 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.

77 Under the MOU, the CCI was scheduled to begin on October 1, 2013. MOU p. 1. On May 6, 2013, DHCS announced that the CCI will begin no earlier than January 2014. **On August 14, 2013, DHCS again announced that the CCI will begin no sooner than April 1, 2014. With the change to **April 1, 2014, the timeline outlined in the MOU must be adjusted. As of the date of publication of this Guide, the new timeline for enrollment had not been finalized.

78 The Legislature passed SB 94 on June 17, 2013, that "delinks" the three components of the CCI, which means that each component of the CCI can be implemented separately and at different times. See www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0051-0100/sb_94_bill_20130618_enrolled.pdf.

79 www.calduals.org/2013/03/29/rrtool/

80 MOU p. 66.

period, passive enrollment in LA County will begin. Exactly how passive enrollment will work has not been decided for LA County. **DHCS has released an enrollment strategy for LA County, which stakeholders had an opportunity to comment on. However, the policy has not been finalized as of date of publication of this Guide.[81] Enrollment in LA County is capped at 200,000 beneficiaries.

In the remaining seven counties, passive enrollment into the CCI is currently set to begin no sooner than **April 1, 2014. In all counties except San Mateo County, passive enrollment will be phased in according to the month of the beneficiary's birth, with some exceptions. In San Mateo County, beneficiaries will be passively enrolled at one time beginning no sooner than **April 1, 2014. There are major exceptions to these general rules outlined in the MOU. For example, individuals enrolled in MSSP will be enrolled under a different schedule. DHCS is in the process of amending many of the enrollment rules outlined in the MOU. The following table outlines the general enrollment rules and exceptions outlined in the MOU.

Note: The enrollment guidance outlined in the following tables is likely to change due to the change in the enrollment start date from October 1, 2013, to **April 1, 2014. The Guide will be updated accordingly.

81 **The comment period for stakeholder review of the LA Enrollment Strategy closed on August 2, 2013.

Enrollment Process and Timeframe by County

	Alameda, Orange, Riverside, San Bernardino, San Diego, & Santa Clara	San Mateo	Los Angeles
Voluntary Enrollment Period	N/A	N/A	3 months
Passive Enrollment Begins	**4/1/14	**4/1/14	**7/1/14
Passive Enrollment Phased	Over 12 months	**Over one month	**Undecided
Phasing Method	1st day of birth month (with exceptions on next page)	**All at once	Undecided

Exceptions to Enrollment

The following table outlines exceptions to the enrollment processes and timeframes outlined in the previous table.

Exception outlined in MOU
Duals enrolled in MSSP
Duals currently enrolled in Medi-Cal Managed Care in Alameda and Santa Clara
In counties enrolling by birth month, individuals born in January
Duals that were reassigned effective 1/1/13 as part of the Part D reassignment process
Duals that would be reassigned effective 1/1/14 as part of the Part D reassignment process

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) and SPDs not already enrolled in Medi-Cal managed care will be enrolled in Medi-Cal managed care through the same enrollment process described for Cal MediConnect. SPDs already in managed care who will start receiving their LTSS benefit through managed care will be enrolled in Medi-Cal managed care on one date no sooner than **April 1, 2014.[82]

82 There is discussion that enrollment will occur on one date for this population, rather than by some phasing process. At the time this Guide was published, no policy was in place regarding enrollment for this population.

Frequently Asked Questions

What does phasing in by birth month mean?

A beneficiary will be 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. After the CCI has started, newly eligible beneficiaries will be enrolled in the month when they become eligible.

How will the 200,000 cap in LA County work?

Details regarding the 200,000 enrollee cap in Los Angeles County have not been finalized. DHCS has informally stated that if enrollment reaches 200,000, it will implement a waiting list and individuals will move into Cal MediConnect as spots become available. The cap only applies to enrollment in Cal

MediConnect. Mandatory enrollment in Medi-Cal managed care has no cap.

What is Part D reassignment?

Each year, CMS reassigns low-income beneficiaries from Part D prescription drug plans that will start charging more than the Low Income Subsidy (LIS) benchmarks. 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 that have voluntarily elected a plan, referred to as "choosers" unless their drug plan is terminating and would leave them with no Part D coverage.

**Based on the MOU, individuals who have been reassigned to a Part D plan in 2013 or 2014 would be enrolled at a different time than other beneficiaries. However, with the change in the start date of the CCI, this may no longer be the case.

Notices

Because the CCI will impact populations differently, different notices will be sent to each population. As a general rule, beneficiaries who will have to choose a health plan will receive three notices regarding the change in the delivery of their health care services. The first notice will be sent 90 days prior to enrollment. The second notice will be sent 60 days in advance and the third notice will be sent 30 days in advance. Notices are supposed to be written at a sixth grade reading level and will be provided in different languages and alternative formats.[83]

Medi-Cal Managed Care Notices

The CCI will affect beneficiaries who will need to enroll in Medi-Cal managed care but who are not eligible for Cal MediConnect.[84] These beneficiaries will 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 four populations:

1. **Medi-Cal beneficiaries who are already enrolled in Medi-Cal managed care without Medicare who will now start receiving LTSS through managed care.** These beneficiaries will receive one notice 60 days in advance of the transition explaining that their LTSS will now be delivered through managed care.
2. **Medi-Cal beneficiaries who do not have Medicare and who were previously excluded from Medi-Cal managed care.** For example, Medi-Cal only residents in long-term care facilities or Medi-Cal only recipients with share-of-cost. These beneficiaries will receive three

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

84 DHCS released draft notices for these populations. For NSCLC comments on notices, see dualsdemoadvocacy.org/wp-content/uploads/2013/02/Comments-MLTSS-Notice-Materials-NSCLC-DRC-032213.pdf.

notices. The first notice, sent 90 days prior to enrollment, will inform beneficiaries of the change occurring. With the 60-day notice, they will receive a choice booklet explaining the changes and providing factors to consider when selecting a health plan. They will also receive plan materials and a provider directory. They will receive a final 30-day notice reminding them that they will be mandatorily enrolled in managed care and that they will be given the option again to choose a plan. The 60-day and 30-day notices will already include the name of the default plan chosen by the State. If beneficiaries fail to affirmatively choose a plan, they will be placed in this default plan.

3. **Dual eligible beneficiaries who are excluded from Cal MediConnect and are not already enrolled in Medi-Cal managed care.** For example, duals living in certain rural zip codes, duals enrolled in an HCBS waiver, **or duals enrolled in a Medicare Advantage plan in 2014. Beneficiaries in this group will also receive three notices as outlined above.

4. **Medi-Cal beneficiaries who live in rural zip codes of San Bernardino County who have the option to enroll in Medi-Cal managed care.** These beneficiaries will receive one notice 60 days prior to the transition informing them that they can voluntarily enroll in a Medi-Cal managed care plan if they wish. This notice will include a choice booklet and provider directory.

Cal MediConnect Notices

DHCS will send 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) will receive three notices from the county organized health plan. For duals living in the two-plan and GMC counties, the first notice will be sent 90 days prior to enrollment; the second 60 days prior to enrollment, and the third 30 days prior to enrollment.[85] **These notices will provide beneficiaries with the choice to participate in Cal MediConnect. **If she chooses to participate, the notice will tell her how to choose a plan. **In the event that the beneficiary chooses not to participate in Cal MediConnect, the notice will explain that she must still choose a managed care plan for her Medi-Cal benefit. The 60-day and 30-day notices will already include the name of the default plan chosen by the State. However, beneficiaries will still have the option of choosing another plan.[86] Individuals who are not subject to passive enrollment into Cal MediConnect will not receive notices regarding Cal MediConnect.[87]

Frequently Asked Questions

What happens when a beneficiary decides not to participate in Cal MediConnect prior to receiving a notice of passive enrollment?

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85 MOU pp. 63-64.

86 **Except in COHS counties where only one plan operates.

87 Exception: individuals living in the 40 rural zip codes in San Bernardino County not subject to passive enrollment will receive a notice stating that they have the option to enroll in Cal MediConnect. MOU p. 67.

If a beneficiary decides to opt out of Cal MediConnect prior to receiving a notice of passive enrollment, she will not receive further notices of passive enrollment into Cal MediConnect. However, she will receive three notices in advance of her scheduled passive enrollment date informing her that she must enroll in a Medi-Cal managed care plan as described above. The notices will include the name of the health plan selected by the State, but she will have the option of selecting another plan (except in a COHS county where there is only one plan).

Cal MediConnect Plans

The following table includes the plans approved for Cal MediConnect.[88] Beneficiaries who are enrolled in Cal MediConnect will have the right to change plans at any time. The plan change will become effective the first day of the next month.

County	Duals Demo Health Plans
Alameda (two-plan)	Alameda Alliance for Health
	Anthem Blue Cross/Caremore
Los Angeles (two-plan)	L.A. Care Subcontracts: CareMore (Anthem Blue Cross); Care 1st; Kaiser
	Health Net
Orange (COHS)	CalOptima
San Diego (GMC)	Care 1st
	Community Health Group
	Health Net
	Molina Health Care
San Mateo (COHS)	Health Plan of San Mateo
Riverside & San Bernardino (two-plan)	Inland Empire Health Plan
	Molina Health Care
Santa Clara (two-plan)	Anthem Blue Cross
	Santa Clara Family Health Plan

88 This table lists Cal MediConnect plans in the eight 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 healthconsumer.org/ManagedCareCounties6-25-08.pdf.

Marketing Rules

CCI plans will have to adhere to Medicare marketing guidelines issued by CMS[89] and California-specific guidelines set forth by the State.[90] 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).

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 has to choose which Cal MediConnect plan meets her needs.

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. It is especially important for beneficiaries with complex conditions to 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, a provider directory for each plan will accompany the 60-day notice a beneficiary will receive. Beneficiaries will also be able to access the provider directory online.

2. **Prescription drugs**. Beneficiaries should also review plan formularies to determine whether the Cal MediConnect plans cover the prescription drugs they currently take.

3. **Care coordination and additional services**. A beneficiary should also consider the additional benefits that are available under Cal MediConnect. Cal MediConnect plans will provide care coordination services as well as some preventive, dental, and vision services, which are currently not

89 See CMS, "Medicare Marketing Guidelines," available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf; CMS is also releasing marketing guidance specific to Cal MediConnect. The draft guidance was issued on 5/21/13 for public comment. For updates on CMS marketing guidance for Cal MediConnect visit www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office.

90 Knox Keene Act (KKA), HSC §§ 1359-1366.4.

covered by Medi-Cal or Medicare fee-for-service.[91] Cal MediConnect will also cover non-emergency transportation to scheduled and unscheduled medical care appointments.

Over one million beneficiaries will be impacted by the CCI. Beneficiaries will be faced with making several decisions about their healthcare and will require assistance throughout this process. Dual eligibles will have to decide whether they want to opt into or opt-out of Cal MediConnect. If they opt into Cal MediConnect, they will have to choose a Cal MediConnect plan. If they decide to opt-out or disenroll they will 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.

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

Frequently Asked Questions

Who will process enrollments?

In two-plan counties and in San Diego County, Health Care Options will serve as an independent enrollment broker.[92] In COHS counties (San Mateo and Orange), the COHS plan will process enrollments.

Can beneficiaries receive enrollment counseling?

The primary source of enrollment counseling will be HICAPs in each county. See the Appendix for more information. Other community-based organizations may also be prepared to assist individuals. Health Care Options will be able to provide more general information about choices and, for duals, 1-800-Medicare will remain a resource for basic Medicare questions.

Continuity of Care

Continuity of Care: Cal MediConnect

Beneficiaries who are enrolled in Cal MediConnect will be able to keep seeing their current providers and maintain their service authorizations for up to 6 months for Medicare services[93] and up to 12 months for Medi-Cal services. In order to qualify for these continuity of care periods, the following

92 See www.healthcareoptions.dhcs.ca.gov.

93 WIC § 14132.275(k)(2)(A)(ii-iii) (criteria for continuing to receive services from out-of-network Medicare provider).

conditions must be met:[94]

- An existing relationship with the provider prior to enrollment in Cal MediConnect. An existing relationship is established if the beneficiary has seen the provider at least twice within the 12 months preceding the request.
- The out-of-network providers 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.[95]

If these continuity of care requirements are met, the plan should provide the beneficiary with services from the out-of-network providers without interruption for a time-limited period.[96] The State expects that these continuity of care protections will allow nursing home residents who are enrolled in Cal MediConnect to stay in their current facility for at least 12 months (after that time, those whose nursing facility does not have a contract with their plan would have to switch facilities or change plans). Each plan must have a dedicated liaison to coordinate continuity of care.[97]

These continuity of care rights do not extend to IHSS, durable medical equipment, medical supplies, transportation, or other ancillary services providers. However, because IHSS recipients continue to have the right to hire, fire, and supervise their home care providers,[98] enrollment in Cal MediConnect should not disrupt an IHSS recipient's access to his or her chosen provider.

For prescription drugs, Cal MediConnect plans must also follow the Medicare Part D rules on transitions.[99] 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.[100]

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.[101]

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94 WIC § 14132.275(k)(2)(A) (Medicare continuity of care); WIC s. 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).

95 WIC § 14132.276(b)(13).

96 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."

97 WIC § 14132.276(b)(20)(A).

98 WIC § 14186.35(a)(2).

99 WIC § 14132.275(j)(1)(A)(iv).

100 For more information about Medicare prescription drug transition rights, see generally NSCLC, "2013 Transition Rights to Medications Under Medicare Part D," available at www.nsclc.org/index.php/2013-transition-rights-to-medications-under-part-d/, and Chapters 6 and 14 of the Medicare Managed Care Manual.

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

Continuity of Care: Medi-Cal Managed Care

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 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). A beneficiary 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.[102]

Second, an individual in a two-plan or GMC county who would otherwise be subject to enrollment in Medi-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.[103] 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.[104] To file a MER, a beneficiary and her doctor must fill out a form and submit it to DHCS.[105] We recommend that beneficiaries enlist the assistance of an advocate in the MER process.[106] 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. People with HIV/AIDS and Native Americans may disenroll from Medi-Cal managed care at any time.[107] To do so, they should file a MER. If a MER is denied, a beneficiary should request a State Fair Hearing (see Appeal Rights below).

Remember that the plans decide whether a beneficiary can continue to see their out-of-network providers, whereas DHCS, through its enrollment broker, Health Care Options, decides whether a beneficiary should be granted a Medical Exemption Request.

Frequently Asked Questions

When is a MER available?

A MER is only available with regard to Medi-Cal managed care. 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.

102 HSC § 1373.96.

103 WIC § 14182.16(c)(1)(D).

104 22 CCR § 53887.

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

106 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).

107 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).

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,[108] all plans participating in Cal MediConnect must ensure that communication and services are accessible to those with limited English proficiency.[109] The MOU requires plans to provide translated written materials in languages spoken by at least 3,000 beneficiaries in a county.[110] 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 the National Senior Citizens Law Center.

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

The MOU requires every participating plan, which by definition includes subcontracted plan partners,[111] 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."[112] In addition to the ADA and the Rehabilitation Act, the Affordable Care Act (ACA) explicitly incorporates the requirements of the two

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108 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.

109 WIC § 14182(b)(12) (requiring 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).

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

111 MOU p. 31.

112 MOU p. 62.

older laws.[113]

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 remove architectural barriers, because such failures effectively prevent people with disabilities from enjoying public goods and services. 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.[114]

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 receive 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 reasonable accommodations or policy modification effectively. In practice, however, it may prove difficult to get a plan to respond appropriately to an accessibility complaint. Advocates should contact Disability Rights Education and Defense Fund or Disability Rights California with accessibility complaints.

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

114 42 U.S.C. § 12182(b)(2)(A)(iii); C.F.R. § 36.302. "Undue burden" is defined as "causing significant difficulty or expense."

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.[115] Notices about these decisions should be understandable and accessible, including to people with disabilities and those who are limited English proficient. They should include specific information, including the decision made, the facts and law relied upon, the right to appeal and how to appeal.[116] Plans also have an internal grievance and complaint process that beneficiaries should follow when they are unhappy with their services or with someone from the health plan.

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).

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).[117] Generally, advocates recommend filing both an internal appeal and a request for a fair hearing at the same time, and then 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 filing an internal plan appeal or requesting 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.[118] This is also known as "aid paid pending" an 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).

115 Beneficiaries also have the right to appeal denials of eligibility 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 NSCLC.

116 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).

117 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 healthconsumer.org/Medi-CalOverview2008Ch19.pdf, and Chapter 20: Medi-Cal Managed Care, 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 healthconsumer.org/searchbrochures.php.

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

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.[119] 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.[120] An IMR must be requested within six months of the plan's written response to a grievance. A beneficiary cannot get an IMR if she has already requested 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.

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

120 HSC §§ 1374.30-1374.35.

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 will have 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 grievance and appeal processes that comply with state and federal law,[121] and they must give their members notice of appeal rights when services are denied, reduced or otherwise amended.[122]

For Medi-Cal covered services, the appeals process is the same as that described on page 37 above for Medi-Cal managed care. "Beneficiaries will be allowed to seek a state fair hearing at any time,"[123] although they will be "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.[124]

For Medicare-covered hospital and outpatient benefits, the current Medicare Advantage process is followed: 1) initial

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

122 MOU p. 82.

123 MOU p. 99.

124 MOU p. 82.

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.[125] For Medicare-covered benefits, there is no state fair hearing option and the option for aid paid pending is not explicitly provided.

Appeals for Part D-covered prescription drugs will also 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.[126] Appeals regarding drugs that are NOT covered by Medicare Part D (for instance, over-the-counter drugs, or drugs for weight loss or gain) will 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), there will be an appeal process specified in the three-way contracts with CMS, the plan and DHCS.[127] The appeals process will include the right to a state fair hearing.[128] More details about appeals for overlapping services have not yet been made available.

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.[129] 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.

125 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/.

126 More details about Medicare Part D exceptions and appeals, and citations to applicable CMS publications, are available in NSCLC's guide, "Medicare Part D Exceptions and Appeals: A Practical Guide for Advocates" (April 2010), available at www.nsclc.org/wp-content/uploads/2011/07/Exceptions-Appeals-Guide-2010.pdf.

127 MOU pp. 99-100.

128 Id. at 100.

129 MOU p. 98.

In-Home Supportive Services and Behavioral Health

As described above on p. 22, 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.[130]

Care Plan Option Services

As described on p. 21, plans are not required to provide Care Plan Option services. If plans do decide to provide such services, according to DHCS, they will not be subject to the Medi-Cal grievance and appeals processes. Instead, plans are required to create an internal grievance procedure to record and address complaints.[131] The internal grievance procedure will differ from plan to plan.

Frequently Asked Questions

Who will help beneficiaries with appeals?

Beneficiaries should look to their local legal services, HICAP, and other consumer advocates for assistance. See the Appendix for more detail. The State has **applied for funding made available through CMS to develop an independent Ombudsman office that will assist individuals with appeals and other issues beneficiaries will face.[132] This program would also be responsible for tracking reported problems and would provide feedback to the State on systemic problems arising out of the CCI.

130 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.disabilityrightsca.org/pubs/PublicationsIHSSNutsandBolts.htm. Note that the information in this manual is current as of its May 2008 publication date.

131 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.

132 **The CMS Ombudsman funding opportunity is available at https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=18232. DHCS submitted its grant proposal to CMS on August 2, 2013. CMS is scheduled to announce whether California receives funding and if so, the amount of the award on September 13, 2013.

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).[133] 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.[134] 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%.[135] 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 will receive all Part A and Part B benefits through the plan, and usually Part D services as well. The Medicare Advantage plans include HMOs, 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.[136] Some SNPs serve

133 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.

134 42 U.S.C. § 1395 (prohibiting federal interference in the manner in which medical services are provided).

135 See, www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf.

136 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.

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.[137] 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 will help 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 will act as the primary payor for services and Medi-Cal will pay 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.

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.[138] DHCS plans to expand Medi-Cal managed care for SPDs into rural counties beginning in the fall of 2013.

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137 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 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 healthconsumer.org/index.php?id=pubs, For more information about Medi-Cal and planning for long term care, go to www.canhr.org/medcal.

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

California has adopted three models of managed care:[139]

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 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. Five of the counties affected by the CCI—Alameda, 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.

Conclusion

The implementation of the CCI changes the delivery of health care to over a million beneficiaries living in California. From providing input in the development of rules and regulations to providing outreach and education on-the-ground, advocates will play a critical role in ensuring beneficiaries maintain access to care through this significant period of change.

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

Appendix

Contact Information for Plans

County	Duals Demo Health Plans	Contact Information
Alameda	Alameda Alliance for Health	1-877-371-2222 (TTY: 1-510-747-4501) www.alamedaalliance.org
	Anthem Blue Cross/Caremore	1-888-350-3532 (TTY: 711) www.anthem.com
Los Angeles	L.A. Care	1-888-522-1298 (TTY: 1-888-212-4460) www.lacare.org
	Health Net	1-888-788-5395 (TTY: 1-888-788-6383) www.healthnet.com
Orange	CalOptima	1-877-412-2734 (TTY: 1-800-735-2929) www.caloptima.org
San Diego	Care 1st	1-855-905-3825 (TTY: 1-800-735-2929) www.care1st.com
	Community Health Group	1-800-224-7766 (TTY: 1-800-735-2929) www.chgsd.com
	Health Net	1-888-788-5395 (TTY: 1-888-788-6383) www.healthnet.com
	Molina Health	1-855-665-4621 (TTY: 1-800-479-3310) www.molinahealthcare.com
San Mateo	Health Plan of San Mateo	1-866-880-0606 (TTY: 1-800-735-2929) www.hpsm.org
Riverside & San Bernardino	Inland Empire Health Plan	1-877-273-4347 (TTY: 1-800-718-4347) www.iehp.org
	Molina Health Care	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

State and Federal Resources

DHCS
www.dhcs.ca.gov/provgovpart/Pages/CoordinatedCareIntiatiave.aspx
www.dhcs.ca.gov/Pages/DualsDemonstration.aspx

Harbage Consulting
www.calduals.org

Health Care Options
1-800-430-4263 (TTY: 1-800-430-7077)
www.healthcareoptions.dhcs.ca.gov

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
www.opa.ca.gov

HMO Help Center
1-888-466-2219

State Fair Hearing Requests
1-800-952-5253

Medicare
1-800-Medicare (TTY: 1-877-486-2048)

PACE Contact Information

County	PACE Plan	Contact Information
Alameda	Center for Elders' Independence	1-510-433-1150 www.cei.elders.org
	On Lok Lifeways	1-888-886-6565 www.onlok.org
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/
San Diego	St. Paul's PACE	1-619-677-3800 www.stpaulspace.org/
Santa Clara	On Lok Lifeways	1-888-886-6565 www.onlok.org

Opportunities for Systemic Advocacy

Advocates have many roles to fill with the implementation of the CCI. In addition to preparing to provide counsel to 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 collaborative	Contact the SCAN Foundation 562-308-2867
Participate in DHCS stakeholder calls and meetings	Calduals.org
Participate in plan stakeholder meetings	Each plan's website will have information about stakeholder meetings
Participate in beneficiary advocate coalitions and information sharing.	Contact NSCLC, Amber Cutler, acutler@nsclc.org, or Anna Rich, arich@nsclc.org.

State and Federal Resources

Resource	Assistance Provided	County	Contact Information
HICAP	Free information and counseling about Medicare for individual beneficiaries.	Alameda	Legal Assistance for Seniors 510-839-0393 lashicap.org/services/health-insurance-counseling-and-advocacy-program
		Los Angeles	Health Care Rights 213-383-4519 www.healthcarerights.org
		Orange	Council on Aging - Orange County 714-560-0424 www.coaoc.org
		Riverside/ SanBernardino	760-872-2043 (Riverside) 909-256-8369 (San Bernardino) 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.disabilityrightsca.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

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1444 Eye St., NW, Suite 1100 | Washington, DC 20005 | (202) 289-6976 | (202) 289-7224 Fax
3701 Wilshire Blvd., Suite 750 | Los Angeles, CA 90010-1938 | (213) 639-0930 | (213) 368-0774 Fax
1330 Broadway, Suite 525 | Oakland, CA 94612 | (510) 663-1055 | (510) 663-1051 Fax

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