Advocate's Guide to California's Coordinated Care Initiative

By Amber Cutler, Anna Rich and Silvia Yee

JUNE 2014 • VERSION 3

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 (June 27, 2014). However, many of the details about the CCI are still in flux. To get the most up-to-date information on the CCI and sign-up for alerts, NSCLC webinars, and other trainings, please visit our website www.dualsdemoadvocacy.org/california or email Jenni Choi at jchoi@nsclc.org. You can also subscribe to the DHCS's official listserv to receive program updates at www.calduals.org. This is Version Three of the Guide. The CCI has undergone significant changes from the last publication of this Guide. Prior versions are outdated and should be discarded.

NSCLC advocates for the rights of low-income seniors and persons with disabilities to access healthcare. NSCLC 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. DREDF staff gives information and referrals for individual benefits assistance, and technical assistance on disability civil rights to legal service advocates. DREDF is also tracking failures to comply with federal and state disability rights laws and provide reasonable accommodations to benefit applicants and enrollees. For more information about other organizations that assist consumers, see Appendix A.

Executive Summary

Implementation of the Coordinated Care Initiative (CCI) is now underway in Los Angeles, Riverside, San Diego, San Bernardino, and San Mateo counties. There have been significant changes to the CCI since the release of the second version of the Advocate's Guide to California's Coordinated Care Initiative in September 2013. Version Three of the Guide includes these important changes and provides the most recent information on the CCI. If you have saved or printed Version Two, please replace it with Version Three because the former contains outdated information.

The National Senior Citizens Law Center provides bi-weekly updates to advocates on the CCI. To sign up for these updates, contact info@calduals.org. NSCLC also maintains a CCI "fix-list" documenting the problems brought to the attention of NSCLC during the implementation of the CCI. The CCI Fix List is available at http://dualsdemoadvocacy.org/california/cci-fix-list.

Acknowledgments

The development of this Guide would not have been possible without the support of The SCAN Foundation and the California Wellness Foundation. The authors wish to thank our colleagues at Disability Rights California, National Health Law Program, Disability Rights Education and Defense Fund, and the National Senior Citizens Law Center, for their contributions and willingness to help in a variety of ways, in particular Nancy Arévalo, Mary Lou Breslin, Dan Brzovic, Georgia Burke, Denny Chan, Jenni Choi, Kimberly Lewis, Scott Parkin, Kevin Prindiville and Elizabeth Zirker. The authors also wish to thank the California Department of Health Care Services and The SCAN Foundation for their review and comments.

Supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

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.

Table of Contents

About This Guide 1
Executive Summary 2
Acknowledgments 2
Glossary 5
Introduction 7
What is the Coordinated Care Initiative (CCI)? 7
Mandatory Enrollment in Medi-Cal Managed Care 7
LTSS Integration 8
Cal MediConnect 8
Frequently Asked Questions 10
Who Does the CCI Impact and How? 12
Medi-Cal Managed Care 12
Cal MediConnect 13
Frequently Asked Questions 15
CCI Eligibility Chart 20
Covered Benefits 24
Medi-Cal Managed Care Benefits 24
Cal MediConnect Benefits 24
Frequently Asked Questions 26
Purposes of the CCI 27
Frequently Asked Questions 28
CCI Timeline and Enrollment 29
Cal MediConnect Enrollment 29
Medi-Cal managed care and LTSS-only enrollment 30
Frequently Asked Questions 30
Notices 31
Medi-Cal Managed Care Notices 31
Cal MediConnect Notices 32
Frequently Asked Questions 32
CalMediConnect Plans 33
Marketing Rules 34

Factors a Beneficiary Should Consider in Deciding to Enroll or Opt Out of Cal MediConnect 34

Frequently Asked Questions 35

Continuity of Care 35

Continuity of Care: Cal MediConnect *35*

Continuity of Care: Medi-Cal Managed Care *37*

Frequently Asked Questions 38

Beneficiaries' Right to Receive Materials and Services in Their Own Language 38

Accessibility and Americans with Disabilities Act (ADA)/Section 504 Requirements 39

Appeal Rights 40

Medi-Cal Managed Care *40*

Cal MediConnect *41*

In-Home Supportive Services and Behavioral Health *43*

Care Plan Option Services *43*

Frequently Asked Questions 43

Medi-Cal and Medicare Refresher 44

Medicare *44*

Medi-Cal *45*

Fee-For-Service 45

Medi-Cal Managed Care 45

Conclusion 46

Appendix A....47

Contact Information for Plans *47*

State and Federal Resources *48*

PACE Contact Information *49*

Consumer Assistance *50*

Opportunities for Systemic Advocacy *51*

Appendix B....52

CCI Enrollment Timelines *52*

Appendix C....53

Cal MediConnect 90-Day Notice *53*

Cal MediConnect 60-Day Notice....*55*

Cal MediConnect 30-Day Notice *62*

MLTSS 90-Day Notice....*64*

MLTSS 60-Day Notice *66*

MLTSS 30-Day Notice *69*

Glossary

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

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

CCI = Coordinated Care Initiative.

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

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

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

DD Waiver = Developmentally Disabled Waiver. Home and community-based services waiver for the developmentally disabled. 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 is 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. Provides 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 waiver).

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

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

IHO Waiver = In-Home Operations Waiver. A home and community-based services waiver limited to people who require nursing facility or subacute levels of care who have been receiving services in an acute hospital for 36 months or longer, 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 the mentally impaired.

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

MOU = Memorandum of Understanding. For the purposes of this Guide, the MOU 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 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, will change 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. An understanding of the program and its rules is the best way to make sure that at-risk Californians do not lose access to vital health services. This Guide is intended to assist an advocate in comprehending 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 services and supports (LTSS) to dual eligibles and SPDs[1] 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 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

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. California received federal approval on March 19, 2014, to move forward with mandatory enrollment of dual eligibles and other SPDs into Medi-Cal managed care through an amendment to California's Bridge to Reform 1115 waiver. The waiver approval letter and amended special terms and conditions are availalble at www.calduals.org/dhcs-cci-amendment-to-1115-waiver.

5 In County Organized Health System (COHS) counties, all individuals receiving Medi-Cal have always been mandatorily enrolled in Medi-Cal managed care, including duals, share of cost, and nursing facility residents.

6 For a description of the few limited exceptions to mandatory enrollment in Medi-Cal managed care, see page 20.

a plan, the State will choose a 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, including nursing facility care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and the Multipurpose Senior Services Program (MSSP), 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]

Cal MediConnect[11]

The CCI creates a new type of managed care program, known as Cal MediConnect, which combines a dual eligible's Medi-Cal and Medicare benefits into one integrated

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

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

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

7 The State will primarily use a beneficiary's provider history to select a plan. WIC § 14182(b)(6). See also 1115 waiver Special Terms and Conditions, p. 99, available at www.calduals.org/wp-content/uploads/2014/03/CA-Bridge-Amendment_STCs_CMS-approved-3_19_14.pdf

8 WIC § 14186; California received federal approval on March 19, 2014, to integrate LTSS into the Cal MediConnect and Medi-Cal managed care benefit package through an amendment to California's Bridge to Reform 1115 waiver. The waiver approval letter and amended special terms and conditions are availalble at www.calduals.org/dhcs-cci-amendment-to-1115-waiver.

9 Community-Based Adult Services (CBAS) was transitioned into Medi-Cal managed care in 2012, as a result of the settlement of the *Darling* lawsuit. More information about CBAS and the *Darling* settlement is available on DHCS's website (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.

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.

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 or individuals with Medicare only. The Cal MediConnect plans in the eight CCI counties entered into three-way contracts with the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). The three-way contracts outline the plans' responsibilities under the Cal MediConnect program.[13] Cal MediConnect health plans will be paid a monthly fee for each individual enrollee, called a "capitated" rate, and will be responsible for providing a package of Medicare and Medi-Cal services in exchange for that rate.[14]

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

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

Enrollment in Cal MediConnect is voluntary. An individual in Cal MediConnect has the right to change plans or disenroll at any time. The dual eligible does not have to cite a reason to opt out or disenroll from a Cal MediConnect Plan. Disenrollment becomes effective the first day of the month following disenrollment.[17]

If a dual eligible opts out or disenrolls from Cal MediConnect, she will receive her Medicare benefits through Medicare fee-for-service, or, if she chooses, a Medicare Advantage plan.[18] A dual eligible who

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. 15 for more information about the PACE option.

13 A template of the three-way contract is available at http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContractwithoutSub.pdf.

14 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. A summary of the Medi-Cal portion of the Cal MediConnect rates for 2014 is available at www.calduals.org/wp-content/uploads/2014/01/CCI-Medi-Cal-rates1-23.pdf.

15 Beneficiaries have continuity of care rights when transitioning into the CCI. See p. 35 for more information about continuity of care.

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

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

18 Duals will also have the option to enroll in PACE if eligible. See p. 15 for more information about the PACE option.

opts out of Cal MediConnect must still be enrolled in a Medi-Cal managed care plan for her Medi-Cal benefit.[19]

If a dual eligible opts out or disenrolls from Cal MediConnect, she will not again be passively enrolled in the program throughout the three-year life of the demonstration.

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 a Cal MediConnect plan. If a beneficiary receives a notice and does not act affirmatively by either opting out of Cal MediConnect or choosing a plan, the beneficiary 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. Disenrollment becomes effective the first day of the month following disenrollment.

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

Disenrollment can happen in several ways. The individual can call the enrollment broker and disenroll. If she does nothing more, she will receive her Medicare Part A and B benefits through fee-for-service, and she will be auto-enrolled in a Part D plan. A beneficiary will also be disenrolled if she chooses to change her Part D plan.[20] However, disenrollment will only apply to her Medicare benefit. A beneficiary will still have to be enrolled in a managed care plan for her Medi-Cal benefit.

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

Authority for the CCI

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

Enacting Legislation

- Senate Bill 1008, June 27, 2012
- Senate Bill 1036, June 27, 2012
- Senate Bill 94, amending, June 17, 2013
- Senate Bill 857, amending, June 12, 2014

Statutory Authority

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

CMS Waiver Authority

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

Cal MediConnect Specific Sources

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

Who Does the CCI Impact and How?

The CCI will impact dual eligibles and SPDs in the CCI counties. Individuals who only qualify for Medicare and have no Medi-Cal coverage will not be impacted by the CCI. Dual eligibles and SPDs will be impacted differently under the CCI. We have provided a pull-out table on page 20, which provides a summary of how dual eligibles 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.

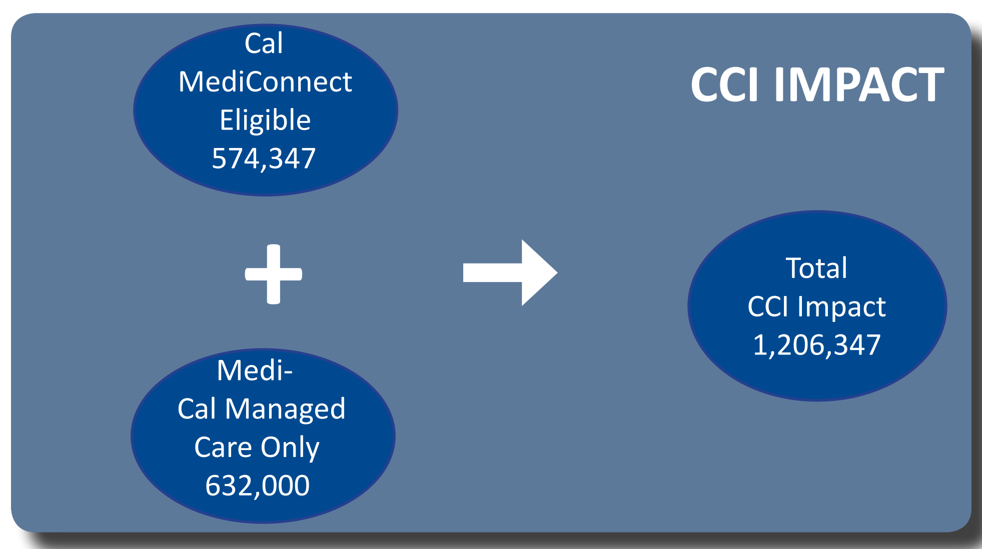
The CCI will impact over one million duals and SPDs in the eight CCI counties.

Medi-Cal Managed Care

Most SPDs and duals will be mandatorily enrolled in some form of Medi-Cal managed care. There are few exceptions to mandatory enrollment in Medi-Cal managed care. These exceptions include beneficiaries under age 21, individuals living in certain rural zip codes[21], beneficiaries with other health coverage in certain counties, individuals living in a veterans' home and residents of an Intermediate Care Facility for the Developmentally Disabled (ICF-DD) in certain counties.[22] The table on page 20 outlines these exceptions in detail.

21 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. 43 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 http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014_PlanGuidance01092013.pdf.

22 WIC § 14182.16(c)(1).



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 disabiliites receiving services through a Regional Center, and beneficiaries with End Stage Renal Disease in certain counties. [23]

There are also dual eligible beneficiaries who can participate in Cal MediConnect if they choose, but who will not be passively enrolled into the program. For example, individuals enrolled in a Kaiser plan and individuals living in certain rural zip codes in San Bernardino County will not be passively enrolled into Cal MediConnect, but can opt-in to the program.[24] Individuals enrolled in a Medicare Advantage plan or in a D-SNP not operated by a Cal MediConnect plan will not be subject to passive enrollment into Cal MediConnect if they are enrolled in these plans prior to December 31, 2014.[25] Likewise, individuals who are enrolled in PACE or in Home and Community-Based Services (HCBS) waivers will not be passively enrolled into Cal MediConnect, but can choose to enroll if they disenroll from PACE or their waiver. [26] The table on page 20 shows these different exceptions in detail.

DUALS AT A GLANCE[27]

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%**

Approximately 574,000 beneficiaries in the eight counties will be eligible for passive enrollment into Cal MediConnect.[27] Of

23 WIC § 14132.275(I)(3)(A); MOU pp. 8-9.

24 MOU p. 9.

25 Individuals enrolled in a Medicare Advantage plan, FIDE-SNP, or a D-SNP plan not operated by a Cal MediConnect plan will not be subject to passive enrollment into Cal MediConnect plans if they are enrolled in such plans as of December 31, 2014. Individuals enrolled in a D-SNP operated by a Cal MediConnect plan will be subject to passive enrollment into Cal MediConnect plans January 1, 2015. See SB 857; §14132.277.

26 MOU p. 9.

27 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

those eligible for passive enrollment, only 486,000 can be enrolled. This is because Los Angeles County has a limit on how many beneficiaries can enroll into Cal MediConnect. Of the 288,000 duals who are eligible for passive enrollment residing in Los Angeles County, only 200,000 can be enrolled.[28] The table to the right lists the number of dual eligibles subject to passive enrollment in each county.

Remember that dual eligibles who are not passively enrolled into Cal MediConnect or who are not able to participate in Cal MediConnect will still be mandatorily enrolled into Medi-Cal managed care for their Medi-Cal benefit.[29]

County	Duals Subject to Passive Enrollment in Cal MediConnect[30]
Alameda	32,533
Los Angeles	288,399 (200,000 cap)
Orange	65,537
Riverside	40,040
San Bernardino	41,930
San Diego	55,798
San Mateo	12,371
Santa Clara	37,739
Grand Total	574,387 (485,988 with cap)

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

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

29 In total, there are 632,000 individuals who will either have to join a Medi-Cal managed care plan or will have LTSS added to their Medi-Cal plan in addition to those subject to passive enrollment into Cal MediConnect. This total includes dual eligibles who cannot participate in Cal MediConnect, dual eligibles not subject to passive enrollment in Cal MediConnect, and non-dual beneficiaries who must join a 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). The estimates in this report are superseded by a DHCS analysis conducted in May 2013, which reflects higher numbers of enrollment. This data was not made available by DHCS but is summarized in "Senate Budget & Senate Health Oversight Hearing on Coordinated Care Initiative - Background Paper," Feb. 6, 2014, available at http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/FullC/02062014SBFR_HealthJointHearingAgendaCCI.pdf.

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

Frequently Asked Questions

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

No. Beneficiaries who only have Medicare coverage, 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 with PACE services. PACE provides its members with both Medicare and Medi-Cal services. PACE uses an interdisciplinary team to coordinate the care of each participant.[31]

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.[32] 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 seven of the eight CCI counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara).[33]

PACE will remain an enrollment option for dual eligibles. In addition, if a dual eligible beneficiary is already enrolled in PACE, that individual will not be subject to passive enrollment in Cal MediConnect. If the beneficiary wishes to enroll in Cal MediConnect, she must disenroll from PACE. The PACE participant will not be mandatorily enrolled in Medi-Cal managed care, since PACE is already a managed care plan that includes Medi-Cal benefits.

If a dual eligible beneficiary wishes to enroll in PACE rather than a Cal MediConnect plan, a 60-day clock starts when the individual applies for PACE. During that time, the PACE assessment process must be completed. If the beneficiary is found eligible for PACE, the local PACE plan will complete the enrollment process. If the beneficiary is found ineligible for PACE, she will be enrolled into the back-up Medi-Cal managed care plan or the Cal MediConnect health plan previously selected.[34] For this reason, it is important that an individual who chooses PACE also carefully decide whether she wants to join Cal MediConnect as a backup, and, if so, decide on the plan that is best for her.

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

The cap on enrollment of 200,000 in Los Angeles only applies to Cal MediConnect enrollment. If the cap is reached, individuals who want to enroll in Cal MediConnect will be placed on a waiting list. When a slot becomes available, the individual will be able to enroll in Cal

---

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

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

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

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

MediConnect. Preference for enrollment will be given to individuals who affirmatively choose to enroll in Cal MediConnect over those who will be passively enrolled into the program.[35]

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 and those enrolled in MSSP are deemed to meet their share of cost continuously. Individuals living in the community who receive IHSS are deemed to meet their share of cost continuously if their share of cost is met the first day of the fifth and fourth months prior to passive enrollment.[36] For example, if an individual with a share of cost receiving IHSS is scheduled to be passively enrolled into Cal MediConnect in August 2014, the State will review whether her share of cost was met in February and March of 2014. Individuals who are deemed not to meet their share of cost continuously cannot participate in Cal MediConnect, and should not receive notices regarding the program.

DHCS has verbally stated that individuals enrolled in Cal MediConnect who do not meet their share of cost in a single month will be disenrolled from Cal MediConnect effective the first of the following month. Those who are disenrolled due to failure to meet share of cost may reenroll in Cal MediConnect the following January 1st if they meet their share of cost as described above.[37]

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 should not receive notices regarding Cal MediConnect, but they will still have to enroll in Medi-Cal managed care for their Medi-Cal benefit and will receive notices telling them about their Medi-Cal managed care choices. However, if a beneficiary with an ESRD diagnosis lives in a COHS county (San Mateo and Orange), she will be passively enrolled into Cal MediConnect. Also, if a beneficiary is enrolled in a healthcare plan that is operated by a Cal MediConnect plan (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.[38]

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

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

36 MOU p. 7.

37 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.

38 MOU p. 8.

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 should not receive notices about Cal MediConnect. However, these individuals will still be required to enroll in Medi-Cal managed care plans to receive their Medi-Cal benefit.

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

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

Remember, with very few exceptions (see page 20), if she opts out of 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 full integration of LTSS into their Medi-Cal benefit package.

Dual eligibles who decide not to participate in Cal MediConnect will not lose any benefits to which they are entitled under Medi-Cal and Medicare. They, however, will not receive the additional benefits available under Cal MediConnect, including the additional medical transportation benefit or vision benefit (see page 24).

What about Part D?

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

A dual eligible who opts out of Cal MediConnect prior to her effective date of Cal MediConnect coverage, will stay in her current Part D Medicare prescription drug plan. Technically, individuals are enrolled into Cal MediConnect plans 60 days prior to the effective coverage date. This mechanism allows DHCS and CMS to share beneficiary data with Cal MediConnect plans, so plans are prepared to provide services on the first date of effective coverage. For example, an individual subject to passive enrollment into a Cal MediConnect plan in July 2014 will technically be enrolled in the program on May 1 with effective coverage starting July 1.

When an individual is technically enrolled into the Cal MediConnect plan at the 60-day mark, this triggers the automatic disenrollment of the dual eligible from her Part D plan. This is because a Cal MediConnect plan will become the dual eliglble's Part D plan. Accordingly, 7 to 10 days after the dual eligible receives her 60-day Cal MediConnect notice, she will receive a notice from her Part D plan, informing her that she will be disenrolled from her Part D plan. If she wants to keep her Part D plan , she should contact

the state's enrollment broker (or the plan in the COHS counties) to opt-out of Cal MediConnect. She will automatically be reenrolled into her Part D plan. She will still need to enroll in a Medi-Cal managed care plan to receive her Medi-Cal benefit.

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

A dual eligible who decides to disenroll from Cal MediConnect after her effective date of coverage into a Cal MediConnect plan will have to choose a new Part D plan. If she does not choose a Part D plan, she will be passively enrolled into a Part D plan by CMS. Passive enrollment into a Part D benchmark plan is random; it cannot be assumed that she will be re-enrolled in her old Part D plan.

What if a beneficiary is enrolled in a Kaiser plan?

Individuals enrolled in a Kaiser plan[39] should not receive notices regarding Cal MediConnect and will not be passively enrolled into Cal MediConnect. However, individuals enrolled in Kaiser Medicare plan will still have to enroll in a Medi-Cal managed care plan for their Medi-Cal benefit. In general, individuals who only have to choose a Medi-Cal managed care plan will receive notices by birth month starting in August (see p. 30). If a beneficiary enrolled in Kaisier would like to enroll in Cal MediConnect, she would have to disenroll from her Kaiser Medicare plan and choose a Cal MediConnect plan.[40]

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

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

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 should not receive notices about Cal MediConnect and can only enroll in Cal MediConnect if they disenroll from their waiver. Individuals who are on waiver waiting lists will be passively enrolled into Cal MediConnect unless they opt out. They will not lose their spot on the waiver waiting list by enrolling in Cal MediConnect. If a waiver slot opens, they can disenroll from Cal MediConnect and join the waiver.

NOTE: Individuals who are in waivers still must enroll in Medi-Cal managed care. They will remain in the waiver programs. The waiver provider, not the plans, will provide the waiver services. The Medi-Cal managed care plan will be responsible for coordinating services with the waiver providers.[41]

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

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

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).

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. CPO services are like HCBS waiver services, but they are services that Cal MediConnect plans can, but are not required, to offer. See page 25 for more information about CPO services.

My client signed up for a Medigap plan, or some other extra health insurance program, in order to qualify for the Aged & Disabled Medi-Cal program. How 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 and should not receive CCI notices.[42] 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?

It has been DHCS policy that individuals who are in Medicare Advantage cannot enroll in Medi-Cal managed care for their Medi-Cal benefit unless the Medi-Cal managed care plan is operated by the same company that operates their Medicare Advantage plan. This is called a "matching plan.[43] Instead, the beneficiary would remain in FFS Medi-Cal. This "matching" policy will ***not*** apply to the CCI.[44] 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.

42 Exception: Beneficiaries living in COHS counties with other health insurance must enroll in Medi-Cal managed care plan. § 14182.16 (c)(1)(A); § 14132.275 (l)(1)(C)(3)(A)(ii)

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

44 1115 waiver Standard Terms and Conditions, p. 97.

CCI Eligibility Chart

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

- Most SPDs will be mandatorily enrolled into Medi-Cal Managed Care, and LTSS will be integrated into the Medi-Cal managed care plan.
- SPDs are not impacted by Cal MediConnect.
- Most dual eligible beneficiaries will be subject to passive enrollment 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[45]	Yes[45]	Yes	Yes	Yes	Yes
Beneficiary Diagnosis						
Prior End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	No[46]	No[46]
Subsequent End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	Yes	Already Enrolled[47]
Beneficiaries with HIV/AIDS	Yes[48]	Yes[48]	Yes	Yes	Yes	Yes

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

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

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

48 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[49]	No	No	No	No	No	No
Resident of certain zip codes in San Bernardino County[50]	No[51]	No[51]	No[51]	No[51]	Yes	No
Resident of Veterans Home	No	No	No	No	No	No
Resident of ICF-DD	No[52]	No[52]	No[52]	No[52]	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[53]	Yes	Yes	Yes	Yes	Yes	Yes
Share of Cost	Yes	Yes	Yes	Yes	No	No

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

50 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.

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

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

53 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*
not regularly met						
Beneficiary enrolled in Medicare Advantage or other health care plan						
Enrolled in Medicare Advantage	N/A	Yes[54]	N/A	Yes	Yes	No
Enrolled in D-SNP that operates a CMC plan	N/A	Yes	N/A	Yes	Yes	Yes
Enrolled in a D-SNP NOT operated by a CMC plan	N/A	Yes	N/A	Yes	Yes	No
Enrolled in PACE	No	No	No	No	Yes[55]	No
Enrolled in AIDS Healthcare Foundation	No	No	No	No	Yes[56]	No
Beneficiaries enrolled in Kaiser	Yes	Yes	Yes	Yes	Yes[57]	No
MSSP Enrollees	Yes	Yes	Yes	Yes	Yes	Yes
Beneficiary with "Other Health Insurance"	No[58]	No	No	No	No	No

54 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. 19.

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

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

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

58 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*
DDS waiver or receiving services from a regional center or state developmental center	Yes	Yes	Yes	Yes	No	No
Enrollees in NF/AH, HIV/AIDS, assisted living, or IHO waiver	Yes[59]	Yes	Yes	Yes	Yes[60]	No
Beneficiaries on waiver waiting lists	Yes	Yes	Yes	Yes	Yes[61]	Yes
Miscellaneous						
Partial Dual Eligibles[62]	Yes	Yes	Yes	Yes	No	No
Beneficiaries with a MER	No	No	No	No		
Duals Who Opt Out of Cal MediConnect		Yes		Yes		

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

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

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

62 For purposes of the CCI, California defines a partial dual eligible as an individual 21 years of age or older who is enrolled for the 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

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 for duals as Medi-Cal fee-for-service is today and those services not covered by Medicare (e.g., incontinence supplies).[63]

Note: For dual eligibles who decide to stay in Medicare FFS or a Medicare Advantage plan rather than participating in Cal MediConnect, the Medi-Cal managed care plan is responsible for paying Medicare cost sharing. A beneficiary does not need to see a Medicare provider who is in the beneficiary's Medi-Cal managed care plan's network for the Medi-Cal plan to pay the cost sharing. In other words, the Medicare provider will be paid by the Medi-Cal plan, just like the provider would have previously been paid by the state for cost sharing. The provider does not have to have a contract with the Medi-Cal plan to receive payment.

assistance under the Medi-Cal State Plan. WIC § 14182.15(b)(6). This definition is different from that commonly used by CMS.

63 See "Medicare and Medi-Cal Payments & Services," Feb. 2014, available at www.calduals.org/wp-content/uploads/2014/02/PaymentsunderCCI-14-02-13.pdf. ; and see "What Medicare Doctors Needsd to Know: Payment of Medicare Deductible and Coinsurance", available at http://www.calduals.org/wp-content/uploads/2014/04/CrossOver-Claims-Fact-Sheet-FINAL_v2.pdf.

Cal MediConnect Benefits

Required Benefits

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

These include:

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

As outlined above, Cal MediConnect plans are required to provide care coordination.[64] 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 services 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

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

individualized care plans with beneficiaries and provide each beneficiary with an interdisciplinary care team, as necessary.[65]

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.

Care Plan Option Services

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.[66] These services may include, for example, supplemental home care services, home delivered meals, respite care, environmental adaptations and counseling.[67] 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 procedures governing the provision of these services.[68]

Carved Out Benefits

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.[69] However, some Medi-Cal funded services are "carved out" and will not be included in the capitated rates paid to Cal MediConnect plans.[70] These include specialty mental health services and Medi-Cal drug services.[71] County agencies will continue financing and administering these services, but plans and county agencies will have written agreements regarding coordination of these

65 See the All Plan Letter on Interdisciplinary Care Team and Individual Care Plan guidance (July 17, 2013), available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-004.pdf.

66 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.

67 MOU pp. 93-94.

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

69 Pursuant to SBX1 1 § 28, effective January 1, 2014, all Medi-Cal recipients are eligible for a new mental health benefit that does not rise to the level of specialty mental health benefits which are provided by the county, but are benefits beyond those that are provided by a primary care physician (e.g., individual therapy and medication management). Managed care plans are responsible for delivering these benefits.

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

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

services.[72] In other words, the plans are responsible for coordinating these carved out mental health benefits so that the beneficiary receives seamless services.

On June 18, 2013, the California Legislature approved a partial restoration of the adult dental benefit eliminated in 2009. All Medi-Cal beneficiaries, including those enrolled in Cal MediConnect plans, will start receiving preventive and denture services beginning May 1, 2014.[73] The dental benefit will be provided through Denti-Cal. The Cal MediConnect plans will not be responsible for providing or coordinating the dental benefit.

Frequently Asked Questions

How will the CCI affect IHSS?

Initially, not much. The CCI legislation requires that counties continue to assess and authorize IHSS as they always have, and IHSS consumers 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 services.

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.[74] A plan could, if it chose, authorize additional personal care hours beyond the limits allowed by the current IHSS program through Care Plan Option services.[75] In other words, plans have the discretion to increase supplemental personal care attendant hours by providing CPO services, but plans cannot decrease IHSS.

In the long run, however, there could be changes for IHSS. When the transition to managed care is finished, IHSS providers will engage in collective bargaining with a new statewide California IHSS Authority, rather than local Public Authorities.[76] A new universal assessment tool for all LTSS, including IHSS, could result in changes to hours, authorizations and increased plan involvement generally.[77] IHSS appeals

72 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.

73 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.

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

75 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.

76 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.

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

could be altered as a result of the new assessment tool or integrated appeals process.[78]

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 CCI counties and pay MSSP providers the same rate they currently receive. After 19 months, plans will have to continue to provide the services currently offered at MSSP sites, but will not be required to contract with MSSP organizations to provide those services.[79]

What will the Cal MediConnect vision benefits include?

Under Cal MediConnect, plans must provide preventive, restorative, and emergency vision services. The specific benefits are outlined in the three-way contracts between the State, CMS, and the plans. The vision benefit includes an annual eye exam and $100 toward the cost of eyeglasses or contact lenses every two years.[80]

agedblinddisabled/PG3340.htm.

78 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).

79 WIC § 14186(b)(7)(A); MOU p. 85.

80 Three-way contract p. 188.

What will the Cal MediConnect transportation benefit include?

The Cal MediConnect plans will provide an additional transportation benefit to beneficiaries to travel to medical services. Currently, Medi-Cal pays for transportation to medical appointments for those beneficiaries who cannot travel by car or public transportation. The Cal MediConnect transportation benefit will provide 30 one-way trips to medical services over a twelve-month period to beneficiaries who can travel by car or public transportation.[81] This benefit is often referred to as a "taxi voucher" program.[82]

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.[83] The CCI is intended to result in cost savings for both California and the federal government.[84]

81 Three-way contract p. 188.

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

83 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.

84 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

Frequently Asked Questions

Will beneficiaries get better or worse care under Cal MediConnect?

This is a "demonstration" project; we don't know for sure what the outcome will be. Plans are required to provide all needed Medi-Cal and Medicare benefits. The State hopes that by integrating Medicare and Medi-Cal funding and program rules, the plans will have an incentive to provide high-quality care to improve health and reduce costly emergency, hospital and nursing home treatment. For people who are enrolled in Medi-Cal managed care and not Cal MediConnect, however, 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.[85] The state is also developing metrics for evaluating the quality of Cal MediConnect plans.[86] The plans' rates will be reduced by quality withholds at the beginning of each year.[87] If a plan meets specific quality standards, the plans will be reimbursed the amount withheld. It will likely be some time before information about plan quality is available to beneficiaries.[88] It is always a good thing to check a plan's local reputation and experience with particular populations and services. Plans will also have to report complaints and the resolution of those complaints to DHCS and CMS so these agencies can further monitor the quality of plans.[89]

---

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.

85 See Cal MediConnect Readiness Review Tool, available at http://www.calduals.org/2013/03/29/rrtool/.

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

87 MOU pp. 52-54.

88 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.

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

CCI Timeline and Enrollment

The CCI commenced on April 1, 2014.[90] However, not all counties and not all changes under the CCI began in April. Although all three changes were originally intended to begin at the same time, the roll out of Cal MediConnect and the other changes under the CCI have been "delinked" and are moving forward on different timelines.

Cal MediConnect Enrollment

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

San Mateo County started passive enrollment into Cal MediConnect on April 1. San Bernardino, Riverside, and San Diego counties start passive enrollment on May 1, 2014. Los Angeles County starts passive enrollment on July 1, 2014, and Alameda, Orange, and Santa Clara Counties will not start passive enrollment into Cal MediConnect until January 2015, at earliest.[91] In general, individuals will be passively enrolled by birth month, with some exceptions, over a twelve-month period. Individuals who are already enrolled in a Medi-Cal managed care plan will be subject to Cal MediConnect passive enrollment in the first month that passive enrollment begins in a beneficiary's respective county. In all counties, individuals who are enrolled in a Medicare Advantage plan and those reassigned to a Part D Plan in 2014 will not be subject to passive enrollment until January 2015.

LA County is the only county under the MOU that provides a three-month voluntary enrollment period prior to the start of passive enrollment, which commenced on April 1, 2014.[92] During this period, beneficiaries can voluntarily opt into Cal MediConnect. After the three-month voluntary enrollment period, passive enrollment in LA County will begin. Most individuals in Los Angeles County will be subject to passive enrollment by birth month. However, there are exceptions. For example, the LA County enrollment strategy states that individuals who are best matched with LA Care will not be subject to passive enrollment until

90 Under the MOU, the CCI was scheduled to begin on October 1, 2013. MOU p. 1. On May 6, 2013, DHCS announced that Cal MediConnect would begin no earlier than January 2014. On August 14, 2013, DHCS announced that the CCI would begin no sooner than April 1, 2014. The timeline for implementation continues to change. The most current timeline is dated June 6, 2014, and is available at http://www.calduals.org/wp-content/uploads/2014/06/CCI-enrollment-by-County-6.6.14.pdf.

91 Implementation in Alameda, Orange, and Santa Clara is delayed for the following reasons. The reasons differ by county. Alameda County: Alameda Alliance does not currently have sufficient funds in its reserve as required by Knox Keene provisions. Orange County: a Medicare audit in November 2013 resulted in sanctions against Cal Optima. In response to the Medicare audit, DHCS and DMHC are also conducting an audit of Cal Optima's Medi-Cal program, which as of the date of this Guide was not concluded. The summary of the Medicare audit dated January 24, 2014, is available at https://www.caloptima.org/en/~/media/Files/CalOptimaOrg/CMSAuditInformation/2014-01-28_CMSAuditLetter.ashx. Santa Clara County: the Santa Clara Family Health Plan began using a new system that is not sufficiently tested to proceed with Cal MediConnect prior to January 2015.

92 MOU p. 66.

December 2014.[93] Enrollment in LA County is capped at 200,000 beneficiaries.

Medi-Cal managed care and LTSS-only enrollment

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

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

93 Under the MOU, the State was supposed to propose an enrollment approach within 30 days of the signing of the MOU. MOU p. 66. The most current draft of the LA enrollment strategy is dated February 18, 2014, and is available at www.calduals.org/wp-content/uploads/2014/02/REVISED-LA-Enrollment-Strategy-2.21.14.pdf.

Frequently Asked Questions

What does phasing in by birth month mean?

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

What is Part D reassignment, and how does it impact Cal MediConnect enrollment?

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.

Under Cal MediConnect, the beneficiaries who have been reassigned to a Part D plan in 2014 will be passively enrolled into Cal MediConnect on January 1, 2015.

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.[94]

Enrollment materials sent to beneficiaries who have to make a health plan choice will be sent in blue envelopes.

Managed 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 or not subject to passive enrollment into Cal MediConnect.[95] 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 three populations:

1. **Medi-Cal beneficiaries (including duals who will not be able to participate in Cal MediConnect or not subject to passive enrollment in Cal MediConnect) who are already enrolled in Medi-Cal managed care and who will now start receiving LTSS through managed care**. These beneficiaries will receive one notice 30 to 45 days in advance of the transition explaining that their LTSS will now be delivered through managed care. This notice will come from their Medi-Cal managed care plan. The plan will also send an addendum to their evidence of coverage.

2. **Medi-Cal beneficiaries who do not have Medicare and who were previously excluded from Medi-Cal managed care**. This category includes, for example, Medi-Cal only residents in long-term care facilities or Medi-Cal only recipients with share-of-cost. These beneficiaries will receive three 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 receive a final 30-day notice reminding them that they will be mandatorily enrolled in managed care and reiterating that they have the option to choose a plan. The 60-day and 30-day notices 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.

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

95 The MLTSS notices are available at http://dualsdemoadvocacy.org/advocacy-2 .

3. **Dual eligible beneficiaries who are excluded from Cal MediConnect or not subject to passive enrollment in Cal MediConnect and are not already enrolled in Medi-Cal managed care**. These include, for example, duals living in certain rural zip codes or duals enrolled in an HCBS waiver. Beneficiaries in this group will receive the same three notices as outlined above.

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

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.[96,97] These notices will explain beneficiaries' options to choose a particular plan or to opt out from enrollment in Cal MediConnect by keeping their Medicare the same. The 60-day and 30-day notices will include the name of the default plan chosen by the State. However, beneficiaries will still have the option of choosing another plan or they can choose to opt out of Cal MediConnect. A Cal MediConnect Guidebook and Choice Form will follow the 60-day notice. To opt-out of Cal MediConnect or keep Medicare the same, the beneficiary will choose a Medi-Cal managed care plan only. Samples of the current notices and choice form are found in Appendix C. Pursuant to beneficiary testing, DHCS is currently revising the Cal MediConnect notices.

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

Frequently Asked Questions

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

No. A beneficiary cannot opt out of Cal MediConnect until she receives a notice about passive enrollment into the program. Once the beneficiary receives the 90-day notice, she can opt out of the program. If a beneficiary decides to opt out, she should not receive further notices about passive enrollment into Cal MediConnect. She should receive a confirmation of her decision to opt-out of Cal MediConnect approximately 10 days after she communicates her decision to the enrollment broker. When the beneficiary opts out of Cal MediConnect, she still must choose a Medi-Cal managed care plan if she is not already enrolled in a plan.

If you believe your client received a notice in error, contact the Cal MediConnect ombudsman.

96 MOU pp. 63-64.

97 Dual eligibles living in Los Angeles County will also receive a one-time voluntary notice explaining they can voluntarily enroll in Cal MediConnect. Beneficiaries with October birthdays received this notice in April 2014. Beneficiaries with November and December birthdays received this notice in May 2014. Beneficiaries with later birthdays have not received this notice to date.

Cal MediConnect Plans

The following table includes the plans approved for Cal MediConnect.[98] 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
Los Angeles[99]	Care1st
	CareMore
	Health Net
	LA Care[100]
	Molina
Orange (COHS)	CalOptima
San Diego (GMC)	Care1st
	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

98 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 www.dhcs.ca.gov/individuals/pages/mmcdhealthplandir.aspx.

99 On February 4, 2014, DHCS announced that five health plans will act as Cal MediConnect plans. Previously, only L.A. Care and Health Net were acting as Cal MediConnect plans. See press release dated Feb. 14, 2014, available at www.calduals.org/2014/02/04/coordinated-care-initiative-update-february-4-2014.

100 L.A. Care received a Medicare low-performing icon as a result of receiving low star rating for three consectuive years. As a result, L.A. Care cannot accept passive enrollment into its Cal MediConnect plan until it removes the icon. However, starting in July 2014, L.A. Care will be permitted to accept passive enrollment of beneficiaries into its Cal MediConnect plan who are already enrolled in the L.A. Care Medi-Cal plan.

Marketing Rules

CCI plans must adhere to Medicare marketing guidelines issued by CMS[101] and California-specific guidelines set forth by the State.[102] 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 must choose which Cal MediConnect plan meets her needs.[103]

1. **Current providers.** The first and most important question to ask is which, if any, of the Cal MediConnect managed care plans have networks that include the individual's current medical providers. Beneficiaries with complex conditions should think about all of their regular providers, not just their primary care provider. Relevant providers might include specialists (e.g., oncologist, pulmonologist, cardiologist), mental health providers, durable medical equipment providers (e.g., wheelchair servicer), hospitals, etc. To help beneficiaries determine if their providers are part of a plan's network, provider directories are available on each plan's website. The state's enrollment broker, Health Care Options, can also provide limited information on whether a particular primary care doctor is in a plan's network. The HICAPs can also assist beneficiaries in determining whether their providers are in a plan's network.

2. **Prescription drugs.** Beneficiaries should also review plan formularies to determine whether the Cal MediConnect plans cover the prescription drugs they currently take. Plan formularies will also be available on each plan's website.

3. **Care coordination and additional services.** A beneficiary should also consider the additional benefits that are available under Cal MediConnect. Cal MediConnect plans will provide care coordination services as well as some preventive vision services, which are currently not covered by Medi-Cal or Medicare fee-for-service.[104] Cal MediConnect will also

101 See CMS, "Medicare Marketing Guidelines," available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c03.pdf; CMS has also issued specific California marketing guidelines available at http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CY2014FinalMarketingGuidanceforCAHPMS071013.pdf; and DHCS released an all plan letter dated March 1, 2013, on marketing and enrollment restrictions available at http://dualsdemoadvocacy.org/wp-content/uploads/2013/10/Dual-Eligible-Special-Needs-Plans-Marketing-and-Enrollment-Restrictions.pdf.

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

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

104 Some Medicare Advantage plans also provide dental and vision benefits. Beneficiaries should compare

cover non-emergency transportation to scheduled and unscheduled medical care appointments not currently covered by Medicare or Medi-Cal.

Over one million beneficiaries will be impacted by the CCI. Beneficiaries will face 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.

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.[105] In COHS counties (San Mateo and Orange), the COHS plan will process enrollments. Health Care Options has a dedicated call center for the CCI, with its own phone number separate from the Medi-Cal Health Care Options center.

benefits available under their Medicare Advantage plan to the benefits offered in the Cal MediConnect plans when making a decision.

105 See www.healthcareoptions.dhcs.ca.gov.

Can beneficiaries receive enrollment counseling?

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

Continuity of Care[106]

Continuity of Care: Cal MediConnect

Beneficiaries who enrolled in Cal MediConnect will be able to keep seeing their current providers and maintain their service authorizations for up to six months for Medicare services[107] and up to 12 months for Medi-Cal services. In order to qualify for continuity of care, the following conditions must be met:[108]

- An existing relationship with the

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

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

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

provider prior to enrollment in Cal MediConnect. An existing relationship is established if the beneficiary has seen her primary care physician once and a specialist twice within the 12 months preceding plan enrollment. A pre-existing relationship will be established through Medicare and Medi-Cal utilization data. If the plan cannot confirm a relationship through utilizaton data, the plan will request proof of the relationship from the member.

- The out-of-network provider will accept either the plan reimbursement rate or the applicable Medi-Cal or Medicare reimbursement rate, whichever is higher.

- The out-of-network provider would not otherwise be excluded from the plan's network due to quality of care issues or failure to meet federal or state requirements.[109]

If these continuity of care requirements are met, the plan should provide the beneficiary with services from the out-of-network provider without interruption for a time-limited period.[110]

109 WIC § 14132.276(b)(13); Duals Plan Letter 13-005, dated December 13, 2013, available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf.

110 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.")

Individuals living in nursing facilities at the time of enrollment into Cal MediConnect can continue to live in that nursing facility for the length of the demonstration even if the nursing facility is not part of the Cal MediConnect plan's network.[111]

These continuity of care rights do not extend to IHSS, durable medical equipment, medical supplies, transportation, or other ancillary services providers. Because IHSS recipients continue to have the right to hire, fire, and supervise their home care providers,[112] however, 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.[113] 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.[114]

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

111 Duals Plan Letter 13-005, p. 5.

112 WIC § 14186.35(a)(2).

113 WIC § 14132.275 (j)(1)(A)(iv).

114 For more information about Medicare prescription drug transition rights, see generally NSCLC, "2013 Transition Rights to Medicare 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, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

Medicare.[115]

Continuity of Care: Medi-Cal Managed Care[116]

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.[117] Unlike Cal MediConnect protections, however, nursing facility residents in a Medi-Cal managed care plan will only have a 12-month continuity of care period or "until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or a fair hearing process and implemented."[118]

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 manged care altogether, instead staying in FFS Medi-Cal.[119] 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.[120] To file a MER, a beneficiary and her doctor must fill out a form and submit it to Health Care Options.[121] We recommend that beneficiaries enlist the assistance of an advocate in the MER process.[122] An approved MER is still temporary, exempting beneficiaries from managed care for up to 12 months, though at the end of that time beneficiaries can file for a renewal of a MER. Once the beneficiary's condition is stabilized, as determined by the beneficiary's treating FFS physician, she will be required to enroll in Medi-Cal managed care. If a MER is denied, a beneficiary should request a State Fair Hearing (see Appeal Rights below). People with HIV/AIDS and Native Americans may disenroll from Medi-Cal managed care at any time.[123] To do so, they should file a MER, which ought to be approved automatically.

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

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

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

117 HSC § 1373.96.

118 1111 waiver, pp. 102-103.

119 WIC § 14182.16 (c)(1)(D).

120 22 CCR § 53887.

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

122 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).

123 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).

who transition to Medi-Cal managed care after a MER period expires.[124]

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.

Also, the MER is only available to individuals who have Medi-Cal only. The MER is not available to full dual eligible beneficiaries.

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,[125] all plans participating in Cal MediConnect must ensure that communication and services are accessible to those with limited English proficiency.[126] The MOU requires plans to provide translated written materials in languages spoken by at least 3,000 beneficiaries in a county.[127] 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.

124 See APL 13-013 Revised (Apr. 3, 2014), available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-013.pdf.

125 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 a 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.

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

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

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

The MOU requires every participating plan to certify "that it intends to fully comply with all state and Federal disability accessibility and civil rights laws, including but not limited to the ADA and Rehabilitation Act of 1973."[128] In addition to the MOU, the Affordable Care Act (ACA) explicitly incorporates the requirements of the ADA and Rehabilitation Act.[129]

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.[130]

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

128 MOU p. 62.

129 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 benefit 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.

130 42 USC § 12182 (b)(2)(A)(iii); CFR § 36.302. "Undue burden" is defined as "causing significant difficulty or expense."

modification effectively. The three-way contracts have some specific references to accessibility for beneficiaries with disabilities. For example, the adequacy of the geographic location of the plan's providers is supposed to take into account "distance, travel time, the means of transportation, and whether the location provides physical access for enrollees with disabilities."[131] Plans are required to have "written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit enrollees with disabilities from obtaining all covered services from the contractor."[132] The three-way contract goes into some detail with regard to the Plan's obligation to provide services that include flexibility in scheduling, interpreters and translators for deaf and hard-of-hearing individuals, and a range of examples of specific alternative formats.[133] In practice, however, the transition from written policies to actual practice can be elusive. Advocates should contact Disability Rights Education and Defense Fund or Disability Rights California if a plan or government agency fails to respond appropriately to accessibility complaints.[134]

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

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

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

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

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.[135] 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.[136] Plans also have an internal grievance and complaint process that beneficiares 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).[137] Generally, advocates recommend

135 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.

136 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).

137 For information about Medi-Cal notices, appeals and fair hearings, including citations to applicable state and federal law, see the National Health Law

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 a beneficiary files an internal plan appeal or requests a state fair hearing, if that request is made within 10 days of a notice of action reducing or terminating ongoing services, the plan must continue to provide the service to the beneficiary.[138] This is also known as an "aid paid pending" appeal. In any case, a request for a fair hearing must be made within 90 days of the notice of action unless there is a good reason that the deadline was missed (e.g., the notice was not received).

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

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

There are two options at the external review stage: either requesting an Independent Medical Review (IMR) by an external medical expert if the denial involves a medical judgment or filing a complaint with DMHC for all other issues.[139]

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

Cal MediConnect

For at least the first year, Cal MediConnect enrollees wishing to appeal a decision by a plan to deny, reduce, or terminate services 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

Program's Overview of the Medi-Cal Program (2008), particularly Chapter 19: Notice, Appeals and Fair Hearings, at http://healthconsumer.org/Medi-CalOverview2008Ch19.pdf, and Chapter 20: Medi-Cal Managed Care, http://healthconsumer.org/Medi-CalOverview2008Ch20.pdf. The Health Consumer Center also has county-specific consumer brochures explaining the process for filing an appeal with a Medi-Cal managed care plan, online at http://healthconsumer.org/searchbrochures.php

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

139 The forms for both of these are available at http://www.dmhc.ca.gov/FileaComplaint/ConsumerIndependentMedicalReviewComplaint.aspx.

140 HSC §§ 1374.30-1374.35.

however, the Cal MediConnect plans must have grievance and appeal processes that comply with state and federal law[141] and they must give their members notice of appeal rights when services are denied, reduced, or otherwise amended.[142]

For Medi-Cal covered services, the appeals process is the same as that described on pages 40 and 41 above for Medi-Cal managed care. "Beneficiaries will be allowed to seek a state fair hearing at any time,"[143] 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.[144]

For Medicare-covered hospital and outpatient benefits, the current Medicare Advantage process is followed: 1) initial appeals must be filed within 90 days, and will be sent to the plan for a redetermination of its initial decision; 2) if the plan upholds its initial denial, the second level of appeal is a Medicare Independent Review Entity (IRE); 3) the third level of appeal is the Office of Medicare Hearings and Appeals; and so forth.[145] For Medicare-covered only benefits, there is no state fair hearing option, but aid paid pending will be available through the internal plan appeal process as long as the appeal is made within ten days.[146]

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.[147] 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), an appeals process was supposed to be spelled out in the three-way contracts with CMS, the plan, and DHCS.[148]

Unfortunately, the three-way contracts are silent on appeals for overlapping services and the process has yet to be formalized. At a minimum, the appeals process will include the right to a state fair hearing.[149]

---

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

142 MOU p. 82. An integrated appeals notice is available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/California.html.

143 MOU p. 99.

144 MOU p. 82.

145 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 http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf.

146 Three-way contract p. 98.

147 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.

148 MOU pp. 99-100.

149 MOU p. 100.

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.[150] Information about the grievance process must be provided to members. For Medicare benefits, the internal plan grievance procedures are to be used in all cases that do not involve an "organization determination." For instance, disputes about hours of service, location of facilities, or courtesy of personnel would go through the plan grievance process.

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

In-Home Supportive Services and Behavioral Health

As described above on p. 24, 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.[151]

Care Plan Option Services

As described on p. 19, 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 or Medicare formal grievance and appeals processes. Instead, plans are required to create an internal grievance procedure to record and address complaints.[152] The internal grievance procedure will differ from plan to plan.

Frequently Asked Questions

Who will help beneficiaries with appeals?

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

While the independent ombudsman is funded only to provide assistance to dual eligibles impacted by Cal MediConnect, the selected Ombudsman program has made it clear that it will serve both Cal MediConnect dual eligibles and individuals impacted by the CCI generally.[153]

---

150 MOU p. 98.

151 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.

152 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.

153 The Legal Aid Society of San Diego was awarded the ombudsman funding and has entered into subcontracts with legal services providers in the other seven CCI

See Appendix A for the ombudsman contact information and additional resources available to consumers.

Medi-Cal and Medicare Refresher

Medicare

Medicare is a federally funded program for people who are age 65 and over or others who qualify because of disability or because of End-Stage Renal Disease (ESRD).[154] 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.[155] 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%.[156] 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 prescription drug coverage as well. 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.[157] Some SNPs serve individuals with particular chronic conditions (C-SNPs) or those requiring an

---

counties to provide local assistance.

154 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.

155 42 U.S.C. § 1395 (prohibiting federal interference in the manner in which medical services are provided).

156 See www.cms.gov/MLNMattersArticles/downloads/SE1128.pdf.

157 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.

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.[158] It provides health insurance coverage to low-income families with children, seniors, persons with disabilities, pregnant women, and other individuals with specific medical conditions. Medi-Cal helps pay for doctor visits, hospital stays, prescription drugs, limited vision and dental services, durable medical equipment, medical transportation, long-term services and supports and other medical services. If an individual is eligible for both Medicare and Medi-Cal, Medicare 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. Dual eligibles primarily use Medi-Cal managed care providers for their long-term services and supports because their medical care is generally covered by Medicare.

Over the last decade, California has been moving most populations eligible for Medi-Cal benefits from fee-for-service into managed care. Today, approximately 4.5 million Medi-Cal beneficiaries residing in 30 counties receive their medical services through health plans mirroring traditional health maintenance organizations (HMOs). The movement of SPDs into managed care began in 2011 in 16 California counties.[159] DHCS is expanding Medi-Cal managed care for SPDs into rural counties. This expansion started

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

159 For more information regarding the SPD transition into Medi-Cal Managed Care http://www.chcf.org/events/2013/briefing-spd-transition-managed-care.

in 2013 and is set to conclude in 2014.[160]

California has adopted three models of managed care:[161]

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.

160 See http://www.dhcs.ca.gov/provgovpart/Pages/Medi-CalManagedCareExpansion.aspx.

161 See http://www.dhcs.ca.gov/provgovpart/Documents/MMCDModelFactSheet.pdf.

Appendix A - Resources

Contact Information for Plans

County	Duals Demo Health Plans	Contact Information
Alameda	Alameda Alliance for Health	1-877-585-7526 (TTY: 1-800-735-2929) www.alamedaalliance.org
	Anthem Blue Cross	1-888-350-3532 (TTY: 711) www.anthem.com
Los Angeles	L.A. Care	1-888-522-1298 (TTY: 1-888-212-4460) www.calmediconnectla.org
	CareMore	1-888-350-3447 (TTY: 711) www.duals.caremore.com
	Care1st	1-855-905-3825 (TTY: 711) www.care1st.com
	Health Net	1-888-788-5395 (TTY: 711) www.healthnet.com
	Molina Health	1-855-665-4621 (TTY: 711) www.molinahealthcare.com
Orange	CalOptima	1-855-705-8823 (TTY: 1-800-735-2929) www.caloptima.org
San Diego	Care 1st	1-855-905-3825 (TTY: 711) www.care1st.com
	CommuniCare Advantage	1-800-224-7766 (TTY: 1-800-735-2929) www.chgsd.com
	Health Net	1-888-788-5805 (TTY: 711) www.healthnet.com
	Molina Health	1-855-665-4627 (TTY: 711) www.molinahealthcare.com
San Mateo	Care Advantage	1-866-880-0606 (TTY: 1-800-735-2929 or 711) 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: 711) 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
www.calduals.org

Health Care Options
1-800-580-7272 (TTY: 1-800-430-7077)
www.healthcareoptions.dhcs.ca.gov

Cal MediConnect Independent Ombudsman
1-855-501-3077
www.calduals.org/terms-and-conditions/ombudsman-resources

Department of Managed Health Care Help Center
1-888-466-2219 (TTY: 1-877-688-9891)

Medi-Cal Managed Care Ombudsman
1-888-452-8609

Office of the Patient Advocate
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/
Orange	Cal Optima	1-855-785-2584 www.caloptima.org/en/Members/PACE.aspx
Riverside/ San Bernardino	InnovAge PACE	1-888-992-4464 http://www.myinnovage.org/Programsand-Services/InnovAgePACE.aspx
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

Consumer Assistance

Resource	Assistance Provided	County	Contact Information
Cal MediConnect Ombudsman	Assistance with Cal MediConnect enrollment, appeals, and grievances.	All CCI counties	855-501-3077 www.calduals.org/terms-and-conditions/ombudsman-resources
HICAP	Free information and counseling about Medicare for individual beneficiaries.	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

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 beneficiary advocate coalitions and information sharing. Sign up for Bi-weekly Advocate's Alert by contacting info@calduals.org.	Contact NSCLC, Amber Cutler, acutler@nsclc.org, or Denny Chan, dchan@nsclc.org. Visit NSCLC's duals website for resources and information on the CCI. http://dualsdemoadvocacy.org/california/

Appendix B

CCI Enrollment Timeline by County and Population

**** Revised 6.6.14 pending DHCS proposed DSNP/MA policy****

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

	Cal MediConnect (Passive enrollment)				**MLTSS (Mandatory enrollment)**										
	Full Duals Only				**Full Duals in Medi-Cal FFS[2]**				**Full Duals in Medi-Cal Managed Care**			**MSSP**	**Partial Duals/Medi-Cal only**	
Start Date	Medicare FFS and in Medi-Cal Managed Care **(enrolled in one month)**	Medicare FFS and Medi-Cal FFS **(enrolled by birth month)[2]**	MSSP Benes eligible for Cal Medi-Connect **(enrolled in one month)**	CMC DSNP / Part D LIS Benes **(enrolled in one month)**	Opt out of CMC and in Medi-Cal FFS **(enrolled by birth month)**	Excluded from CMC (ESRD, 1915c waiver, etc.) and in Medi-Cal FFS **(enrolled by birth month)**	Full Duals in a CMC plan DSNP/ any LIS reassignees in Medi-Cal FFS **(enrolled in one month)**	In a non CMC DSNP plan or any MA plan sponsored by any health plan **(enrolled by birth month)[4]**	Full Duals in Medi-Cal managed care plan **(benefit added in one month)[1]**	Excluded from CMC (ESRD, 1915c waiver, etc.) and in Medi-Cal Managed Care **(benefit added in one month)[1]**	MA benes or LIS reassignees in Medi-Cal Managed Care **(benefit added in one month)[1]**	MSSP Beneficiaries in Medi-Cal managed care or Medi-Cal FFS **(enrolled in one month)**	Medi-Cal Managed Care **(benefit added in one month)**	Medi-Cal FFS **(enrolled by birth month)[2]**
4/14	San Mateo		San Mateo						Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo	Los Angeles, Riverside, San Bernardino, San Diego, and San Mateo.	San Mateo (Full Duals in MA plan or excluded from CMC)		
5/14	Riverside, San Bernardino, and San Diego	Riverside, San Bernardino, and San Diego[3]			Riverside, San Bernardino, and San Diego									
7/14	Los Angeles	Los Angeles			Los Angeles				Santa Clara	Santa Clara	Santa Clara	San Mateo (Partials and Medi-Cal only)	Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara	
8/14						Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara								Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara
10/14			Los Angeles, Riverside, San Bernardino, and San Diego					Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara				Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara		
1/15	Santa Clara, Alameda, and Orange	Santa Clara and Alameda	Alameda, Santa Clara and Orange	All Eight Counties	Alameda and Santa Clara	Alameda	All Eight Counties	Alameda	Alameda and Orange	Alameda and Orange	Alameda and Orange	Alameda and Orange	Alameda and Orange	Alameda

1. Enrollees already in a Medi-Cal managed Care plan will receive one notice prior to the change in benefit.
2. There are no FFS Medi-Cal Enrollees in Orange and San Mateo counties.
3. Enrollees with April and May birthdays will be enrolled in May 2014. Then follow enrollment schedule by birth month.
4. Those with Aug-Oct birthdays will be enrolled Oct 2014. Nov-July birthdays will be by birth month. There are no FFS Medi-Cal enrollees in Orange and San Mateo counties.

Appendix C

The Coordinated Care Initiative Notices are available on calduals.org and are available in the threshold languages. The notices are also available online in audio format. In addition the notices in this Appendix, the calduals website also includes the Cal MediConnect and MLTSS choice form and booklet for each county. Note: Cal MediConnect notices are currently being revised by DHCS and are subject to change.

Cal MediConnect 90-Day Notice

State of California | Health and Human Services

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information

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

What is a Cal MediConnect plan?

A Cal MediConnect plan is a Medicare/Medi-Cal plan that will manage your Medicare and Medi-Cal benefits. Enrolling in a Cal MediConnect plan means that you keep your Medicare and Medi-Cal benefits with no extra cost but you must use your Cal MediConnect providers. You can also get additional transportation and vision benefits.

What are my plan choices?

You will get more information about your health plan choices soon. You may choose a Cal MediConnect plan, or choose to stay with regular Medicare. If you choose to stay with regular Medicare, you must choose a Medi-Cal health plan for your Medi-Cal benefits. If you do not make a choice, we will choose one of the Cal MediConnect plans for you. You keep the benefits and services you have now, and the Cal MediConnect plan will work with your doctors and providers.

This is the first letter telling you about your new choices. You will get a second letter with more information about your choices soon. You may choose a Cal MediConnect plan in your county, or choose to stay with regular Medicare.

Your choices are:

1. **Enroll in a Cal MediConnect plan.** These health plans cover both Medicare and Medi-Cal services. If you join a Cal MediConnect plan you will receive In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing home care through the Cal MediConnect plan. They also cover vision care and transportation. The Cal MediConnect plan will work with you, your doctors and providers to ensure you get the care you need.
2. **Enroll in the Program of All-Inclusive Care for the Elderly (PACE).** If you are 55 or older and need a higher level of care in order to live at home, you may be able to join PACE. PACE provides all Medicare and Medi-Cal benefits plus some extra services to help seniors who have chronic conditions live at home.
3. **Enroll in a Medi-Cal health plan only. Your Medicare will stay the way it is now.** If you join a Medi-Cal health plan you keep your Medicare doctors and hospitals, and you will receive your Medi-Cal benefits like In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing home care through the Medi-Cal health plan.

How does a Cal MediConnect plan help me?

A Cal MediConnect plan helps you because your Medicare and Medi-Cal benefits work together and work better for you.

Your doctors, pharmacists, IHSS, CBAS, MSSP, and other providers work together to care for you and coordinates who assists you in getting the care and services that you need. This is called "care coordination."

What should I do now?

- Talk about your choices with someone who knows about your health care needs, like your family, your doctors, or your local senior center and/or Independent Living Center.
- Watch your mail for a packet from Health Care Options in about one month.
- If you want to talk to a health insurance counselor about your choices, call the **California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222.**
- If you need this letter in another language or alternate format, like large print, audio, or Braille; or if you need help understanding this letter, please call:

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

Cal MediConnect 60-Day Notice

State of California | Health and Human Services

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information

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

This is the second letter telling you about your new options. You may choose a Cal MediConnect plan, or choose to stay with regular Medicare. If you choose to stay with regular Medicare, you must choose a Medi-Cal health plan for your Medi-Cal benefits. If you do not make a choice, we will choose one of the Cal MediConnect plans for you.

Based upon your past services and health care needs, you have been assigned to the Cal MediConnect plan named below. Unless you choose to stay with regular Medicare, you do not need to do anything and your coverage in this plan will become effective on MM/DD/YYYY: [Health Plan Name]

How will this change affect me?

Enrolling in a Cal MediConnect plan will:

- Keep your Medicare or Medi-Cal benefits without any extra costs.
- Keep all of the services or benefits you receive now.
- Ensure that all of your doctors, specialists, and other providers will work together to get you the care you need.
- Give additional transportation and vision benefits.

MU_6003901_ENG1_0114

How does a Cal MediConnect plan help me?

The change is happening so your Medicare and Medi-Cal benefits work better together and work better for you.

Your choices include:

1. **Enrolling in a Cal MediConnect plan.** Cal MediConnect plans cover both Medicare and Medi-Cal services. If you join a Cal MediConnect plan, you will receive In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing home care through the Cal MediConnect plan. They also cover vision care and transportation. The Cal MediConnect plan will work with your doctors and providers to ensure you get the care you need.
2. **Enrolling in the Program of All-inclusive Care for the Elderly (PACE).** If you are 55 or older and need a higher level of care in order to live at home, you may be able to join PACE. PACE provides all Medicare and Medi-Cal benefits plus some extra services to help seniors who have chronic conditions live at home.
3. **Enrolling in a Medi-Cal health plan.** If you choose to stay with regular Medicare, you will not be assigned to a Cal MediConnect plan, but you must still choose a health plan in order to receive Medi-Cal. Joining a Medi-Cal plan will allow you to keep your Medicare doctors and hospitals and you will not lose any services. You will receive In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and nursing facility care through the plan.

What should I do now?

Review the three choices above and decide which is best for you. Use the Health Plan Guidebook and Choice Book that will come in the mail from Health Care Options to help you. Ask your doctors and other health care providers to see which plans they work with.

You do not need to do anything to join the Cal MediConnect plan below.

If you do not want to enroll in [Health Plan Name,]
you can contact Health Care Options to select a different Cal MediConnect plan or to stay in regular Medicare. Contact Health Care Options by

MM/DD/YYYY.

Call Health Care Options at the number below OR by filling out and mailing back the Choice Form with the enclosed envelope. This form is in your Choice Book that will come in the mail from Health Care Options.

For help or more information

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

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

If you want to select a different Cal MediConnect plan, stay in regular Medicare, or get this letter in another language or alternate format – like large print, audio, or Braille, please call Health Care Options Monday-Friday 8am-5pm at 1-844-580-7272 or TTY: 1-800-430-7077.

If you need further help, call the **Cal MediConnect Ombudsman** at 1-855-501-3077. This number will be operational starting 4/1/2014.

Frequently Asked Questions and Answers

1. What is the difference between Medicare and Medi-Cal?

Medicare and Medi-Cal are two separate programs that cover different services for eligible individuals. By joining a Cal MediConnect plan, your Medicare and Medi-Cal benefits work better together and work better for you.

- **Medicare** covers medical services like doctors, specialists, hospitals, and prescription drugs. Medicare also covers some medical equipment and home health.
- **Medi-Cal** covers any costs that Medicare doesn't pay for, including:
    a. Deductibles,
    b. IHSS, CBAS, MSSP, and nursing home care,
    c. Transportation to medical appointments,
    d. Medical equipment and supplies, like bandages or diapers.

2. What are the benefits of enrolling in a Cal MediConnect plan?

- You will get all of your Medicare and Medi-Cal benefits in one health plan, including doctors, hospitals, and prescription drugs.
- You will get one membership card and one phone number to call when you need help.
- You will get vision care and transportation to medical appointments.
- You can call a 24-hour nurse advice line for help.
- You can get a care coordinator. This person will answer your questions, help you find community services, assist you in making your medical appointments, and help you talk with your doctors.
- Your Cal MediConnect plan will ask you about your health care needs and work with you to create a personal care plan based on your goals.

3. How can I be sure my care continues after I join a Cal MediConnect plan?

Your new Cal MediConnect plan is required to ensure that you receive the quality care that you need. Your Cal MediConnect plan will contact you after you enroll to learn about your health care needs. They will work with you to make sure you get all the care you need.

If you have a scheduled treatment and are changing health plans, call your new Cal MediConnect plan right away. Tell the health plan about your upcoming treatment so they can work with you.

MU_6003901_ENG4_0114

- **If you see a doctor who is not a part of the health plan's network,** you can keep seeing this doctor for up to six months if the doctor agrees to your new health plan's, rates, and has no quality issues.
- **If you are in a Medi-Cal nursing home,** the Cal MediConnect plan will work with you and your care team so you get the care you need. You can stay in your nursing home.

4. What can I do if I join a Cal MediConnect or PACE plan and don't like it?

In any month, you can dis-enroll from Cal MediConnect or PACE and go back to the regular Medicare or a Medicare Advantage plan. To do this, call Health Care Options at 1-844-580-7272 (TTY: 1-800-430-7077), or tell your health plan that you want to leave the plan. The health plan can help you make this choice.

- Remember that you will still be enrolled in the health plan for your Medi-Cal benefits. Your dis-enrollment only affects how you get your Medicare benefits.

5. What are Long Term Services and Supports? How will they work in a health plan?

Long Term Services and Supports (LTSS) are Medi-Cal benefits that help you with on-going personal care needs. In a health plan, these services and supports will work like they do today.

Your health plan will work with your doctors and LTSS providers. If you do not get these services now, your health plan can help you get them in the future if they are medically needed.

- **In-Home Supportive Services (IHSS):** Personal care services for people who need help to live safely in their homes.
    - If you get IHSS, your services will not change. You can keep your IHSS providers and you can still hire, fire, and manage your providers. The county IHSS social worker will still assess your needs and approve your IHSS hours. Your rights to appeal will stay the same. If you want, your health plan can work with you and your IHSS providers to make sure you get the care you need.
- **Community-Based Adult Services (CBAS):** These are daytime health care services at centers that provide nursing, therapy, activities, and meals for people with certain chronic health conditions.
    - Where available, your health plan will work with you and your doctor if you need this service. If you get CBAS today, your services will not change.

- **Multipurpose Senior Services Program (MSSP):** These are social and health care coordination services for people age 65 and older.
  - ▶ If you get MSSP services, you will still receive it through your current MSSP providers. Your health plan will work with them to better coordinate your care.
- **Nursing home care:** Your health plan will work with your doctor and nursing home to give you the same services that you get now and to better coordinate your care.

6. I don't use any Medi-Cal Long Term Services and Supports benefits. Why must I join a health plan?

The reason for this choice is to better coordinate your Medi-Cal services. If you need Long Term Services and Supports, the health plan will help you. Also, in a health plan, you can get transportation to medical appointments and call a 24-hour nurse advice line for help. Medi-Cal health plans will pay any extra Medicare costs that the State pays today, like your deductibles.

Cal MediConnect and Medicare Part D

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

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

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

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

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

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

CMS_6004035_ENG1_0514

Cal MediConnect 30-Day Notice

State of California

Health and Human Services

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

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

You are getting this letter because you have **BOTH** Medicare and Medi-Cal. The way you get your health care is changing. This is the third and final letter telling you about these changes. Please read this notice carefully.

Unless you choose a different option, your coverage in
[Health Plan Name]
will become effective on MM/DD/YYYY. We chose this plan for you based on your past services and health care needs, but you still have the right to choose to stay in regular Medicare or to select a different Medi-Cal health plan.

How will this change affect me?

Enrolling in a Cal MediConnect plan will:

- Keep your Medicare or Medi-Cal benefits without any extra costs.
- Combine your Medicare and Medi-Cal benefits into a single plan.
- Help ensure that all of your doctors, specialists, and other providers work together to get you the care you need.
- Give you additional transportation and vision benefits.

How does a Cal MediConnect plan help me?

The change is happening so your Medicare and Medi-Cal benefits can work better together, and work better for you.

Your doctors, pharmacists, Long Term Services and Supports caregivers, and other providers will work together to care for you. The Cal MediConnect plan will help them coordinate the services that you need. This is called "care coordination."

MU_3003904_ENG1_0214

What are my plan choices?

You have several choices. You can contact Health Care Options at 1-844-580-7272 to make a choice to:

- **Stay in the Cal MediConnect plan we have selected for you.** If you decide that this plan is right for you, you do not need to do anything.
- **Select a different Cal MediConnect plan in your county.** You may review the plans available in your county to see if one of those is better for you.
- **Choose the Program of All-Inclusive Care for the Elderly (PACE).** You may be eligible to join a PACE plan.
- **Keep your Medicare the way it is now.** Even if you choose to stay in regular Medicare, you will still be required to select a Medi-Cal managed care plan to receive your Medi-Cal services.

Contact Health Care Options by MM/DD/YYYY to make a choice.

For help or more information

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

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

If you want to select a different Cal MediConnect plan, stay in regular Medicare, or get this letter in another language or alternate format – like large print, audio, or Braille, please call Health Care Options Monday-Friday 8am-5pm at 1-844-580-7272 or TTY: 1-800-430-7077.

If you need further help, please call the **Cal MediConnect Ombudsman** at 1-855-501-3077. This number will be operational starting 4/1/2014.

MLTSS 90-Day Notice

State of California — Health and Human Services

Department of Health Care Services

P.O. Box 989009, West Sacramento, CA 95798-9850

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information

The way you get Medi-Cal services is changing. You **must** enroll in a Medi-Cal managed care health plan to receive Medi-Cal services. The reason for this change is to help bring your Medi-Cal services together in one place.

Please read this notice carefully. You do not need to do anything yet. We will send you more information and health plan enrollment materials in about one month. If you are in Medicare, this change does not affect your Medicare coverage or your ability to see your Medicare doctor.

What services will you get from your Medi-Cal health plan?

Your Medi-Cal health plan will coordinate all of your Medi-Cal covered services.

- If you are in Medicare, your Medi-Cal health plan will pay for certain Medicare cost-sharing, certain additional benefits (such as prescription drugs not covered by Medicare), some transportation, and certain Long Term Services and Supports.
- If you just have Medi-Cal, your Medi-Cal health plan will be responsible for all of your medical care, some transportation, and certain Long Term Services and Supports.

What are Medi-Cal Long Term Services and Supports?

- **In-Home Supportive Services (IHSS)** are personal care services for people who need help to live safely in their homes. If you currently get IHSS, you do not have to change your IHSS providers and you can still hire, fire, and manage your providers.
- **Community-Based Adult Services (CBAS)** is daytime health care at centers that provide nursing, therapy, activities and meals for people with certain chronic health conditions.

- **Multipurpose Senior Services Program (MSSP)** provides social and health care coordination services for people age 65 and older. If you get MSSP, your health plan will work with your MSSP providers to better coordinate your care. If you currently get MSSP, you do not have to change your MSSP provider.
- **Nursing home care:** If you get care in a nursing home, your health plan will work with your doctor and nursing home to better coordinate your care. If you are currently in a nursing home, you do not have to change your nursing home.
- If you do not get these services now, your health plan can help you get them in the future, if you need them.

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

Yes, if you have Medicare, your Medicare providers will not change.

Can I see my Medi-Cal doctors after I enroll in a Medi-Cal health plan?

If you have Medi-Cal only, you will need to check with your health plan to determine if your providers work with the health plan. Generally, you are able to see your current doctors for 12 months.

Enrolling in a Medi-Cal health plan:

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

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

You will be receiving more information about your choices for a Medi-Cal health plan. If you do not make a choice, you will be enrolled in a Medi-Cal health plan starting MM/DD/YYYY.

What should I do now?

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

For help or more information

If you need this letter in another language or alternate format, like large print, audio, or Braille; or if you need help enrolling in a health plan please call:

Health Care Options

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

MLTSS 60-Day Notice

State of California — Health and Human Services

Department of Health Care Services

P.O. Box 989009, West Sacramento, CA 95798-9850

JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Information

The Way You Get Your Medi-Cal Benefits is Changing on [MM/DD/YYYY]

You must enroll in a Medi-Cal managed care plan to receive your Medi-Cal services. The reason for this change is to help bring your Medi-Cal services together in one place.

This is the second letter telling you about your options for choosing a Medi-Cal plan.

Based upon your past services and health care needs, you have been assigned to the Medi-Cal plan named below. **Unless you make a different Medi-Cal plan choice, you will be enrolled in the health plan below on**

MM/DD/YYYY: NAME OF PLAN

If you have Medicare, this change does not affect your Medicare coverage or your ability to see your Medicare doctor.

How will this change affect me?

- Your Medi-Cal plan will coordinate all of your Medi-Cal covered services.
- Your Medicare services and providers will NOT change.
- Your Medi-Cal services and benefits will NOT change.
- Your Medi-Cal eligibility does NOT change and it will not cost you extra.

Check with your health plan to determine if your providers work with your selected Medi-Cal plan.

What services will you get from your Medi-Cal health plan?

Your Medi-Cal plan will coordinate all of your Medi-Cal covered services, including Long Term Services and Supports.

- If you are in Medicare, your Medi-Cal health plan will pay for certain Medicare cost-sharing and other benefits that are not covered by Medicare, such as some transportation, certain medical supplies, and certain prescription drugs.

What are Medi-Cal Long Term Services and Supports?

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

If you do not get these services now, your Medi-Cal plan can help you get them in the future, if you need them.

When will I be enrolled in a Medi-Cal health plan?

You will be enrolled in a Medi-Cal health plan starting MM/DD/YYYY.

Can I choose a different Medi-Cal health plan?

Yes. You will soon get a packet of health plan information in the mail. Read the materials in this packet. This packet includes:

- A Choice Book that has instructions on how to choose and enroll in a Medi-Cal managed care health plan in your county.
- Provider directories that list the doctors who work with each plan.

What should I do now?

- Share this letter and information with your family or someone who knows about your health care needs.
- Talk to your doctors and other health providers to see which health plans they work with.
- If you have Medicare, please call the **California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 (TTY: 711).**
- To choose a different health plan, call Health Care Options Monday-Friday 8am-5pm at 1-844-580-7272 or TTY: 1-800-430-7077 by MM/DD/YYYY.

For help or more information

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

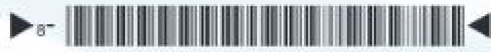
If you want to select a different Medi-Cal plan, and/or get this letter in another language or alternate format – like large print, audio, or Braille, please call Health Care Options Monday-Friday 8am-5pm at 1-844-580-7272 or TTY: 1-800-430-7077.

MLTSS 30-Day Notice

State of California — Health and Human Services

Department of Health Care Services

P.O. Box 989009, West Sacramento, CA 95798-9850



JOHN SAMPLE
1234 SAMPLE STREET
ADDRESS 2
ANYTOWN CA 90000

XX/XX/XXXX

Important Final Reminder

The Way You Get Your Medi-Cal Benefits is Changing on [MM/DD/YYYY]

You **must** enroll in a Medi-Cal managed care health plan to receive Medi-Cal services. The reason for this change is to help bring your Medi-Cal services together in one place.

This is the FINAL reminder letter telling you about your options for choosing a Medi-Cal plan.

Unless you choose a different Medi-Cal plan, your coverage in
[Health Plan Name]
will become effective on MM/DD/YYYY. We chose this plan for you based on your past services and health care needs, but you still have the right to choose a different Medi-Cal plan.

If you have Medicare, this change does not affect your Medicare coverage or your ability to see your Medicare doctor.

How will this change affect me?

- Your Medi-Cal plan will coordinate all of your Medi-Cal covered services, including Long Term Services and Supports.
- Your Medicare services and providers will NOT change.
- Your Medi-Cal services and benefits will NOT change.
- Your Medi-Cal eligibility does NOT change and it will not cost you extra.

If you have Medi-Cal only, you should check with your Medi-Cal plan to determine if your providers work with the plan.

What are Medi-Cal Long Term Services and Supports?

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

If you do not get these services now, your Medi-Cal plan can help you get them in the future, if you need them.

What are my choices?

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

For help or more information

If you have Medicare, please call the **California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 (TTY: 711).**

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

If you want to select a different Medi-Cal plan and/or get this letter in another language or alternate format – like large print, audio, or Braille, please call Health Care Options Monday-Friday 8am-5pm at 1-844-580-7272 or TTY: 1-800-430-7077.

WWW.DREDF.ORG

WWW.NSCLC.ORG

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

© 2014 National Senior Citizens Law Center