

Advocates Guide To California's Coordinated Care Initiative

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About This Guide

This Guide is designed for advocates and individuals who provide assistance to dual eligibles and seniors and persons with disabilities. Justice in Aging strives to make the information in this Guide as accurate as possible as of the publication date (October 6, 2016). However, many of the details about the Coordinated Care Initiative (CCI) are still evolving. To get the most up-to-date information on the CCI and sign up for alerts, Justice in Aging webinars, and other trainings, please visit our website <http://dualsdemoadvocacy.org/california> or email Shelby Minister, sminister@justiceinaging.org. You can also subscribe to the California Department of Health Care Service's official listserv to receive program updates at www.calduals.org.

Justice in Aging advocates for the rights of low-income older adults and persons with disabilities to access healthcare. Justice in Aging cannot represent individuals in their claims for benefits, but can provide technical assistance and advice to advocates. For more information about other organizations that assist consumers, see Appendix A.

This is version 5 of the Guide. The CCI has undergone significant changes from the last publication of this Guide. Prior versions are outdated and should be discarded.

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Executive Summary

Implementation of the Coordinated Care Initiative (CCI) is now underway in Los Angeles, Orange, Riverside, San Diego, San Bernardino, San Mateo, and Santa Clara counties. There have been significant changes to the CCI since the release of the fourth version of the Advocate's Guide to California's Coordinated Care Initiative in June 2015. Version Five of the Guide includes these important changes and provides the most recent information on the CCI. If you have a saved or printed Version Four, please replace it with Version Five because the former contains outdated information.

Justice in Aging provides regular updates to advocates on the CCI through an Advocates Alert. To sign up for these updates, please contact sminister@justiceinaging.org.

Acknowledgments

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Glossary

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

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

CCI = Coordinated Care Initiative.

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

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

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

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

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

DME = durable medical equipment.

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

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

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

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

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

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

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

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

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

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

MSSP = Multi-Purpose Senior Services Program. A program that provides social and health care management to frail elderly individuals age 65 and older. It allows individuals, who without the program would be placed in a nursing facility or other institution, to remain living in their community.

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

SNF = skilled nursing facility.

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

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

Introduction

The Coordinated Care Initiative (CCI) is a new program that, in the seven counties in which it is being implemented, changes the way that California's dually eligible individuals – i.e., those who have both Medi-Cal and Medicare, “duals” or “Medi-Medis” – and seniors and persons with disabilities with Medi-Cal only (“SPDs”) get their health care. Anyone who represents or works with duals and SPDs in these seven counties should be familiar with the CCI. An understanding of the program and its rules is the best way to make sure that at-risk Californians do not lose access to vital health services. This Guide is intended to assist advocates in understanding the CCI. It includes a description of what the CCI is, whom the CCI impacts and how beneficiaries are affected, why it has been 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' living in seven² California counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.³ The CCI involves three distinct changes:

- 1 SPDs refer to a specifically defined population of individuals who qualify for Medi-Cal only (not Medicare) based on age or disability.
- 2 Originally, eight counties were slated to implement the CCI. On November 13, 2014, DHCS announced that Alameda County would not move forward with the CCI.
- 3 On June 27, 2012, the California Legislature passed, and the Governor signed, two pieces of legislation creating the CCI: [SB 1008](#) (Chapter 33, Statutes of 2012) and [SB 1036](#) (Chapter 45, Statutes of 2012). On June 17, 2013, the California Legislature passed [SB 94](#), on June 12, 2014, [SB 857](#) was passed, and on June 24, 2015, [SB 75](#) was passed, which all amend portions of the CCI legislation.

[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 seven CCI counties to enroll in a managed care plan to receive their Medi-Cal benefit. Enrollment is mandatory.⁶ If a beneficiary fails to choose a plan, the State will choose a plan for the beneficiary.⁷

[LTSS 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

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

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

Enrollment Terms

“Opt-out” versus “Voluntarily Disenroll” versus “Involuntarily Disenroll”

During passive enrollment (which has concluded), beneficiaries were automatically enrolled in a Cal MediConnect plan unless they affirmatively decided not to participate in the program or “opted out.” If the beneficiary did not “opt out” of the program *prior* to her effective coverage date in the program, she was enrolled.

After a beneficiary’s effective coverage begins in a Cal MediConnect plan, she has the right to “voluntarily disenroll” from the program. Voluntary disenrollment can also occur if a beneficiary decides to enroll in a different Medicare product, like a new Part D plan or a Medicare Advantage plan.

A beneficiary is “involuntarily disenrolled” when she loses eligibility for the program. For example, when a beneficiary loses full-scope Medi-Cal coverage, she is involuntarily disenrolled from the Cal MediConnect plan.

[adhc/adhc.aspx](#)); and the websites of the California Association for Adult Services (CAADS) ([www.caads.org/](#)), and Disability Rights California ([www.disabilityrightscalifornia.org/advocacy/Darling-v-Douglas/index.html](#)).

10 Individuals residing in COHS counties already receive nursing facility care and CBAS through their Medi-Cal managed care plan. The CCI now requires 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 is the inclusion of the other LTSS into their managed care plan.

Cal MediConnect¹¹

The CCI created a new type of managed care program, known as Cal MediConnect, which combines a dual eligible’s Medi-Cal and Medicare benefits into one integrated managed care plan.¹² Cal MediConnect is a three-year demonstration program. CMS has offered states the option to extend the demonstration to five years. California, while expressing an intent to extend the demonstration, has not to date—committed to the extension.¹³ Cal MediConnect impacts dual eligible beneficiaries, not SPDs or individuals with Medicare only. The Cal MediConnect plans in the seven CCI counties entered into three-way contracts with the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). The three-way contracts outline the plans’ responsibilities under the Cal MediConnect program.¹⁴ Cal MediConnect health plans are paid a monthly fee for each individual enrollee, called a “capitated” rate, and are responsible for providing a package of Medicare and Medi-Cal services in exchange for that rate.¹⁵

11 WIC § 14132.275. California received federal approval of Cal MediConnect through the Memorandum of Understanding entered into between DHCS and CMS on March 27, 2013 [hereinafter “MOU”]. The MOU is available online at [www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf](#).

12 Cal MediConnect is not the first example of integrated care for dual eligibles. The Program for All-Inclusive Care for the Elderly (PACE) has been using an integrated care model for many years; see p.13 for more information about the PACE option.

13 On July 16, 2015, CMS presented states with the option to extend their demonstrations from three to five years, available at [https://goo.gl/WnirVa](#). On August 26, 2015, California submitted its letter of intent to CMS to extend the demonstration, but has not committed to the extension to date. [https://goo.gl/bPeQWe](#)

14 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/CACContractwithoutSub.pdf](#).

15 The rate paid to the health plans is a combination of a Medicare rate and a Medi-Cal rate. The amount paid by each program starts with a ‘baseline’ that then is adjusted to the acuity of the enrolled population and reduced by a predetermined savings percentage. MOU pp. 45-52. A

Cal MediConnect plans 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.¹⁶ This is in contrast to a dual eligible with traditional, fee-for-service Medicare and Medi-Cal who can see any doctor or other provider who accepts Medicare or Medi-Cal.

Initial enrollment in Cal MediConnect happened on a rolling basis through passive enrollment. Passive enrollment means that when a dual eligible received a notice and did not “opt out” of Cal MediConnect or did not affirmatively choose a particular Cal MediConnect plan, the individual was automatically placed in a Cal MediConnect plan chosen by the State.¹⁷

Cal MediConnect is a voluntary program. While passive enrollment has ended, individuals can voluntarily enroll at any time and once enrolled, an individual can change plans or disenroll at any time. The dual eligible does not have to cite a reason to disenroll from Cal MediConnect. Enrollment and disenrollment transactions become effective the first day of the month following the transaction.¹⁸ If a dual eligible disenrolls from Cal MediConnect, she will receive her Medicare benefits through Medicare fee-for-service, or, if she chooses, a Medicare Advantage plan.¹⁹ Dual eligibles who decide not to enroll in a Cal

MediConnect plan must still be enrolled in a Medi-Cal managed care plan for their Medi-Cal benefits.

If a dual eligible opted out of Cal MediConnect during passive enrollment, she will not again be subject to passive enrollment into the program throughout the life of the demonstration.²⁰ Individuals who either voluntarily or involuntarily disenroll from Cal MediConnect, however, could be subject to passive enrollment again.²¹

As of the date of this Guide, DHCS has committed not to employ passive enrollment to enroll dual eligibles into Cal MediConnect. That is subject to change.²²

Remember, while Cal MediConnect is a voluntary program, enrollment into managed care for Medi-Cal is mandatory.

Frequently Asked Questions

What is passive enrollment?

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

summary of the Medicare rates for 2014 is available at www.calduals.org/wp-content/uploads/2014/04/4-22-14-CA-MediConnect-Rate-Report-clean.pdf and the Medi-Cal portion of the Cal MediConnect rates for 2014 is available at www.calduals.org/wp-content/uploads/2014/01/CCI-Medi-Cal-rates1-23.pdf.

- 16 Beneficiaries have continuity of care rights when transitioning into the CCI. See p. 30 for more information about continuity of care.
- 17 Passive enrollment has now ended in every county. See CCI Enrollment Timeline available at <http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf>.
- 18 MOU p. 11 & p. 63. See also three-way contract § 2.3.2, pp. 27-29, for disenrollment triggers.
- 19 Duals will also have the option to enroll in PACE if eligible.

See p. 13 for more information about the PACE option.

- 20 See “Medicare Medicaid Plan Enrollment and Disenrollment Guidance,” dated Sept. 2, 2016, p. 25, available at <https://goo.gl/8sOeR6>.
- 21 *Id.*
- 22 In response to stakeholder feedback, DHCS announced it would not move forward with its annual passive enrollment proposal and would commit to voluntary enrollment. DHCS, however, stated that “should voluntary enrollment not prove to be a viable option for sustainable enrollment in the program, passive enrollment remains an option in future years.” See, “Important CCI Updates,” dated May 5, 2016, available at <http://www.calduals.org/news-and-updates/page/2/>.

she was automatically enrolled in Cal MediConnect.

Cal MediConnect passive enrollment has ended. Dual eligibles can voluntarily enroll in Cal MediConnect through the health plan in all counties or through Health Care Options (HCO), the state's enrollment broker, in two-plan and GMC counties.

Individuals who become eligible for Medi-Cal or who move into a CCI county will be subject to passive enrollment into a Medi-Cal plan moving forward.

Can a beneficiary disenroll from Cal MediConnect after being enrolled?

Yes. A beneficiary can disenroll from Cal MediConnect at any time for any reason. Disenrollment becomes effective the first day of the month following the disenrollment request. Disenrollment can happen in several ways. The individual can call Health Care Options, the enrollment broker and disenroll. If she does nothing more, she will receive her Medicare Part A and B benefits through fee-for-service and she will be auto-enrolled in a Part D plan. A beneficiary will also be disenrolled if she chooses to enroll in a Medicare Advantage Plan or if she chooses to change her Part D coverage by enrolling in a Prescription Drug Plan (PDP).²³ However, disenrollment will only apply to her Medicare benefit. A beneficiary still has to be enrolled in a managed care plan for her Medi-Cal benefit.

²³ Three-way contract, § 2.3.2, pp. 27-29.

Authority for the CCI

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

Enacting Legislation

- [Senate Bill 1008](#), June, 27, 2012
- [Senate Bill 1036](#), June 27, 2012
- [Senate Bill 94](#), amending SB 1008, June 17, 2013
- [Senate Bill 857](#), amending SB 1008, June 12, 2014
- [Senate Bill 75](#), extending transition of MSSP, June 24, 2015

Statutory Authority

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

CMS Waiver Authority

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

Cal MediConnect Specific Sources

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

Whom Does the CCI Impact and How?

The CCI impacts dual eligibles and SPDs in the seven CCI counties. Individuals who only qualify for Medicare and have no Medi-Cal coverage are not impacted by the CCI. Dual eligibles and SPDs are impacted differently under the CCI. We have provided a pull-out table on page 18, which provides a summary of how dual eligibles and SPDs are affected, including:

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

Medi-Cal Managed Care

Most SPDs and duals must enroll 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 codes²⁴, 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.²⁵ The table on page 18 outlines these exceptions in detail.

²⁴ Only one health plan is available in these rural zip codes. Except in County Organized Health System (COHS) counties, federal law prohibits mandatory enrollment into Medi-Cal managed care if there is only one health plan available. 42 USC § 1396u-2(a)(1)(A)(i)(I); 42 USC § 1396u-2(a)(3)(A); see also CMS “2014 Capitated Financial Alignment Demonstration Timeline” (p. 5), available at <http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2014PlanGuidance01092013.pdf>.

²⁵ WIC § 14182.16(c)(1).

Cal MediConnect

In general, most dual eligibles are eligible for Cal MediConnect. However, certain dual eligible beneficiaries are not permitted to participate in Cal MediConnect, including, for example, beneficiaries under age 21, beneficiaries who do not routinely meet their Medi-Cal share of cost, beneficiaries with developmental disabilities receiving services through a Regional Center (except in San Mateo County), and beneficiaries with End Stage Renal Disease in certain circumstances.²⁶

Individuals enrolled in other Medicare health plans (e.g. a Medicare Advantage or D-SNP) can participate in the program, but will be disenrolled from their current plan. Likewise, individuals who are enrolled in PACE or in Home and Community-Based Services (HCBS) waivers can enroll in Cal MediConnect, but they will be disenrolled from PACE or their waiver.²⁷ The table on page 18 shows these different exceptions in detail.

DUALS AT A GLANCE²⁸

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%

²⁶ WIC § 14132.275(l)(3)(A); MOU pp. 8-9.

²⁷ MOU p. 9.

Remember that dual eligibles who were not enrolled into Cal MediConnect or who are not able to participate in Cal MediConnect still have to enroll in a Medi-Cal managed care plan for their Medi-Cal benefit.

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

Frequently Asked Questions

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

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

What about new Medi-Cal and new Medicare beneficiaries?

Since passive enrollment has ended, thousands of beneficiaries have become newly eligible for both Medi-Cal and Medicare.

Individuals with Medicare who are new to Medi-Cal or who moved to a CCI county post passive enrollment have not been mandatorily enrolled in a Medi-Cal plan and they have not received information about Cal MediConnect. These individuals are currently in fee-for-service for their Medi-Cal benefit.

DHCS intends to send these new dual eligibles notices that will require them to choose a Medi-Cal plan. If they do not choose a plan, they will automatically be enrolled in a Medi-Cal plan. The notices will also include the option to enroll in Cal MediConnect and PACE, if eligible.²⁹

28 See “Medi-Cal’s Coordinated Care Initiative Population Combined Medicare & Medi-Cal Cost, Utilization, and Disease Burden” (November 2012), available at <http://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.

29 See, “Ensuring Sustainable Coordinated Care Initiative Enrollment,” April 2016, available at <http://www.calduals.org/wp-content/uploads/2016/04/4.7.16-Sustainable-Enrollment.pdf> and “Important CCI Updates,” May 2016, available at <http://www.calduals.org/news-and-updates/page/2/>.

Medi-Cal enrollees who become newly eligible for Medicare do not currently receive any information from DHCS about Cal MediConnect. Plans, however, are permitted to contact members enrolled in their Medi-Cal plan to discuss their Cal MediConnect product (See Marketing Rules on p. 28).

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.³⁰

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.³¹ Beneficiaries who meet the PACE eligibility criteria may find that it is a well-tested alternative to Cal MediConnect. As a community-based program, PACE is only available in certain zip codes in six of the seven CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara).³²

PACE remains an enrollment option for dual eligibles who meet the eligibility criteria. In addition, if a dual eligible beneficiary was already enrolled in PACE, that individual was not subject to passive enrollment in Cal MediConnect. If a PACE member wishes to enroll in Cal MediConnect, she will be disenrolled from PACE.

A PACE participant is not mandatorily enrolled

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

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

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

in Medi-Cal managed care, since PACE is already a managed care plan that includes Medi-Cal benefits.

What is the 200,000 cap in Los Angeles county?

The cap on enrollment of 200,000 in Los Angeles only applies to Cal MediConnect enrollment. If the cap is reached, individuals who want to enroll in Cal MediConnect will be placed on a waiting list. When a slot becomes available, the individual will be able to enroll in Cal MediConnect.³³ Most likely the cap in Los Angeles will not be reached. As of the publication date of this Guide, approximately 37,000 dual eligibles were enrolled in Cal MediConnect plans in Los Angeles County.

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

Dual eligibles who meet their Medi-Cal share of cost on a continuous basis are eligible to enroll into Cal MediConnect.³⁴ Individuals residing in a nursing facility and those enrolled in MSSP are deemed to meet their share of cost continuously.

Under passive enrollment, those with IHSS living in the community were deemed to continuously meet their share of cost if they met it the first day of the fifth and fourth months prior to their passive enrollment date. Now that passive enrollment is over, it is not clear how individuals who have IHSS in the community are certified to continuously meet their share of cost. Advocates have asked for clarification of this policy.³⁵

What happens if a Cal MediConnect member's Medi-Cal eligibility changes?

Only dual eligibles with full scope Medicare and Medi-Cal are eligible for Cal MediConnect. If a beneficiary loses Medi-Cal eligibility or is assessed a new share of cost, she has two protections to remain

33 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.

34 MOU p. 7.

35 In addition, advocates have asked for clarification as to whether individuals with a share of cost are required to join a Medi-Cal plan.

enrolled in a Cal MediConnect plan:

- *Aid Paid Pending*: If she timely appeals and asks for Aid Paid Pending, her Cal MediConnect enrollment will not be impacted until a final Medi-Cal determination is made.
- *Deeming*³⁶: If a beneficiary does not timely appeal or request aid paid pending, deeming is triggered. Deeming allows a Cal MediConnect enrollee to remain enrolled in the Cal MediConnect plan for a certain period of time to resolve the Medi-Cal eligibility issue. If the beneficiary reestablishes eligibility within the deeming period, enrollment will not be disrupted. If a beneficiary does not reestablish eligibility, she will be disenrolled from the Cal MediConnect plan. Beneficiaries receive a notice when deeming is triggered and a disenrollment notice if eligibility is not reestablished.

All the Cal MediConnect plans offer a 30-day deeming period except for the Health Plan of San Mateo, which offers a 60-day deeming period.

CMS recently announced that it will allow states to utilize a “rapid reenrollment” process. This new process would act to automatically reenroll beneficiaries who were disenrolled from a Cal MediConnect plan if they reestablish eligibility within two months of being disenrolled. DHCS is likely to consider adopting this process.³⁷

Can a beneficiary with an ESRD diagnosis enroll in Cal MediConnect?

Beneficiaries with a diagnosis of ESRD are required to join a Medi-Cal plan. With regard to Cal MediConnect, individuals who have an ESRD diagnosis are able to voluntarily enroll if they are already enrolled in a health plan operated by a Cal MediConnect plan sponsor. For example, an individual

36 For more information on deeming, see “Two Cal MediConnect Enrollment Protections,” available at <http://www.justiceinaging.org/wp-content/uploads/2016/02/Cal-MediConnect-Deeming-final.pdf>.

37 For more information, see CMS’s “MMP Enrollment and Disenrollment Guidance,” available at <https://goo.gl/GrI98c>.

with an ESRD diagnosis in LA Care's Medi-Cal plan can voluntarily enroll in LA Care's Cal MediConnect plan. During passive enrollment, individuals with an ESRD diagnosis were excluded from passive enrollment into a Cal MediConnect plan unless they were in a COHS county or if they were enrolled in a plan operated by Cal MediConnect plan sponsor.³⁸

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

Beneficiaries who have a developmental disability and receive services through the Developmentally Disabled (DD) waiver, Regional Center, or state developmental center are not able to participate in Cal MediConnect (except in San Mateo County).³⁹ However, these individuals are still required to enroll in Medi-Cal managed care plans to receive their Medi-Cal benefit.

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

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

Remember, if she opted out of or disenrolls from Cal MediConnect, she still has to be enrolled in a Medi-Cal managed care plan to receive her Medi-Cal benefit.

Dual eligibles who decide not to participate in Cal MediConnect do not lose any benefits to which they are entitled under Medi-Cal and Medicare. They, however, will not receive the additional benefits available under Cal MediConnect, including the additional transportation benefit or vision benefit (see page 22).

38 MOU p. 8.

39 The Health Plan of San Mateo pursuant to, [AB 461](#), can enroll individuals receiving services through a regional center into San Mateo's Cal MediConnect plan. San Mateo is the only county that is permitted to enroll this population.

What about Part D?

Cal MediConnect plans include prescription drug coverage. In other words, the Cal MediConnect plan is also the Part D plan. Accordingly, individuals who enroll in Cal MediConnect are automatically disenrolled from their Part D plan. They will receive a notice from their Part D plan informing them that they are being disenrolled from their Part D plan.⁴⁰

If someone is enrolled in Cal MediConnect and decides to enroll in a new Part D plan (or any other Medicare product), the individual will automatically be disenrolled from Cal MediConnect.

A dual eligible who decides to disenroll from Cal MediConnect into fee-for-service Medicare will have to choose a new Part D plan. If she does not choose a Part D plan, she will be passively enrolled into a Part D plan by CMS. Passive enrollment into a Part D benchmark plan is random; it cannot be assumed that she will be re-enrolled in her old Part D plan. During the period of time after disenrollment from the Cal MediConnect plan but prior to assignment to a new Part D plan, the beneficiary will receive drug coverage through the Limited Income Net Program (LI NET).⁴¹

What if a beneficiary is enrolled in a Kaiser plan?

Individuals enrolled in a Kaiser plan⁴² were not subject to passive enrollment in Cal MediConnect. However, individuals enrolled in a Kaiser Medicare plan still have to enroll in a Medi-Cal managed care plan for their Medi-Cal benefit. If a beneficiary enrolled in Kaiser would like to enroll in Cal MediConnect, she will be disenrolled from her Kaiser plan when she enrolls in a Cal MediConnect plan.⁴³

40 Individuals who enroll in a Cal MediConnect plan receive a notice from their Part D plan available at <https://goo.gl/6NAVdn>.

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

42 This exception applied to both Medicare and Medi-Cal Kaiser plans.

43 Kaiser enrollees were not subject to passive enrollment in Cal MediConnect. MOU p. 9.

How does the CCI affect people currently in waivers?

Individuals who are currently in an HCBS waiver (e.g., Assisted Living, NF/AH, IHO waiver, DD waiver) are able to participate in Cal MediConnect, but they will be disenrolled from their waiver. Individuals who were on waiver waiting lists were subject to passive enrollment into Cal MediConnect. They did not lose their spot on the waiver waiting list by enrolling in Cal MediConnect. If a waiver slot opens, they can disenroll from Cal MediConnect and join the waiver.

NOTE: Individuals who are in waivers still must enroll in Medi-Cal managed care. They will remain in the waiver programs. The waiver provider, not the plans, will provide the waiver services. The Medi-Cal managed care plan is responsible for coordinating services with the waiver providers.⁴⁴

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

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

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

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

Yes. Institutional deeming eligibility rules and requirements will still apply, but only if the managed care plan decides that the beneficiary needs “Care Plan Option” (CPO) services. CPO services are like HCBS waiver services, but they are services that Cal MediConnect plans can, but are not required, to offer. See page 23 for more information about CPO services.

⁴⁴ 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.

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

People who have “other health coverage”—including a Medigap plan or other private health insurance—are excluded from both Cal MediConnect and Medi-Cal managed care.⁴⁵ In order to enroll in Cal MediConnect, the beneficiary would have to drop the other health coverage.

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

Many beneficiaries who have other health coverage do not have the proof of coverage documented in the Medi-Cal system and consequently erroneously receive notices about enrollment in Medi-Cal managed care plans. Other health coverage can be added to a beneficiary's record online at

http://www.dhcs.ca.gov/services/Pages/TPLRD_OCU_cont.aspx

Can duals still enroll in a D-SNP in CCI counties?

Individuals who were enrolled in a Duals Special Needs Plan (D-SNP) during passive enrollment could remain in that D-SNP (as long as the D-SNP did not operate a Cal MediConnect plan), but these D-SNPs cannot enroll new members who are eligible for Cal MediConnect. While this prohibition is in place for D-SNPs, duals can still enroll in standard Medicare Advantage plans. Advocates should advise duals to carefully consider whether joining a Medicare

⁴⁵ Exception: Beneficiaries living in COHS counties with other health insurance must enroll in a Medi-Cal managed care plan.

Advantage plan provides any benefit to the dual. It is best to direct the beneficiary to a HICAP counselor for benefits counseling.

Individuals who were enrolled in a D-SNP operated by the same plan sponsor as a Cal MediConnect plan were “crosswalked” into the Cal MediConnect plan.⁴⁶

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.⁴⁷ Instead, the beneficiary would remain in FFS Medi-Cal. This "matching" policy does not apply to the CCI.⁴⁸ For example, an individual who is enrolled in UnitedHealthcare for Medicare Advantage still has to enroll in a Medi-Cal managed care plan despite the fact that UnitedHealthcare does not offer a Medi-Cal managed care plan. This beneficiary would be enrolled in two managed care plans: one for her Medicare and one for her Medi-Cal.

46 See SB 857; § 14132.277. For more information on the D-SNP policy, refer to the All Plan Letters 14-007 and 14-014 and Justice in Aging’s county specific fact sheets available at <http://dualsdemoadvocacy.org/trainings-and-education-materials>.

47 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.

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

	Required to enroll in managed care for Medi-Cal		LTSS will be integrated into Medi-Cal managed care plan		Eligible to enroll in Cal MediConnect	Were passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
Under age 21	No	No	No	No	No	No
American Indian Medi-Cal beneficiaries	Yes ⁱ	Yes	Yes	Yes	Yes	Yes
Beneficiary Diagnosis						
Prior End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	No ⁱⁱ	No ⁱⁱ
Subsequent End-Stage Renal Disease Diagnosis	Yes	Yes	Yes	Yes	Yes	Already Enrolled ⁱⁱⁱ
Beneficiaries with HIV/AIDS	Yes ^{iv}	Yes ^{iv}	Yes	Yes	Yes	Yes

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

ii Except in COHS counties or where a beneficiary receives ESRD services from a parent plan also operating a Cal MediConnect plan.

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

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

	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	Were 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 ^v	No	No	No	No	No	No
Resident of certain zip codes in San Bernardino County ^{vi}	No ^{vii}	No ^{vii}	No ^{vii}	No ^{vii}	Yes	No
Resident of Veterans Home	No	No	No	No	No	No
Resident of ICF-DD	No ^{viii}	No ^{viii}	No ^{viii}	No ^{viii}	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	Yes	Yes	Yes	Yes	Yes ^{ix}	Yes ^x
Share of Cost not regularly met	Unknown	Unknown	Unknown	Unknown	No	No

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

vi 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.

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

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

ix Advocates have asked DHCS for clarification on how an IHSS consumer with a SOC can voluntarily enroll in Cal MediConnect .

x 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	Were passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
Beneficiary enrolled in Medicare Advantage or other health care plan						
Enrolled in Medicare Advantage (except a D-SNP)	N/A	Yes ^{xi}	N/A	Yes	Yes	No
Enrolled in D-SNP that is a sponsor of a CMC plan	N/A	Yes	N/A	Yes	Yes	Yes
Enrolled in a D-SNP NOT a sponsor operated by a CMC plan	N/A	Yes	N/A	Yes	Yes	No
Enrolled in PACE	No	No	No	No	Yes ^{xii}	No
Enrolled in AIDS Healthcare Foundation	No	No	No	No	Yes ^{xiii}	No
Beneficiaries enrolled in Kaiser	Yes	Yes	Yes	Yes	Yes ^{xiv}	No
MSSP Enrollees	Yes	Yes	Yes	Yes	Yes	Yes
Beneficiary with "Other Health Insurance"	No ^{xv}	No ^{xv}	No	No	No	No

xi 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. 17.

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

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

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

xv 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	Were passively enrolled in Cal MediConnect
	SPDs	Duals	SPDs	Duals	Duals	Duals
Beneficiary enrolled in waiver or on waiver waiting list						
DDS waiver or receiving services from a regional center or State developmental center	Yes	Yes	Yes	Yes	No ^{xvii}	No
Enrollees in NF/AH, HIV/AIDS, assisted living, or IHO waiver	Yes ^{xvi}	Yes	Yes	Yes	Yes ^{xviii}	No
Beneficiaries on waiver waiting lists	Yes	Yes	Yes	Yes	Yes ^{xix}	Yes
Miscellaneous						
Partial Dual Eligibles ^{xx}	Yes	Yes	Yes	Yes	No	No
Beneficiaries with a MER	No	No	No	No		
Duals Who Opt Out of Cal MediConnect		Yes		Yes		

xvi Exception: In San Mateo County, individuals in a DS waiver or receiving services through a regional center or developmental center can enroll in Cal MediConnect pursuant to AB 461.

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

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

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

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

Covered Benefits

Medi-Cal Managed Care Benefits

Beneficiaries who are not eligible for Cal MediConnect or who opted out or disenrolled from Cal MediConnect receive their Medi-Cal benefit, including nursing facility care, In-Home Support Services (IHSS), Multi-Purpose Senior Services (MSSP), and Community Based Adult Services (CBAS), through managed care. Medi-Cal managed care plans are also responsible for Medicare cost sharing for duals as Medi-Cal fee-for-service was before and for those services not covered by Medicare (e.g., incontinence supplies).⁴⁹

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

⁴⁹ See "Medicare and Medi-Cal Payments & Services," Feb. 2014, available at www.calduals.org/wp-content/uploads/2014/02/PaymentsunderCCI-14-02-13.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.⁵⁰ Plans must coordinate a beneficiary's care in a person-centered manner by following the beneficiary's direction and providing the beneficiary with services in the least restrictive setting. Plans are responsible for coordinating care among the many different types of service providers including medical and LTSS, with a focus on providing smooth transitions between care settings. Plans must evaluate beneficiaries for behavioral health needs and coordinate services with county service providers. In order to accomplish effective care coordination, the health plans are required to conduct a health risk assessment with every member, develop individualized care plans with beneficiaries, and provide each beneficiary with an interdisciplinary care team, as necessary.

This level of care coordination is new for most plans.

⁵⁰ MOU pp. 68-79. Care coordination standards were developed through the stakeholder process and are available here www.calduals.org/2013/02/20/cc_standards/ and here www.calduals.org/implementation/bh-coordination/.

⁵¹ See the Dual Plan Letter on Interdisciplinary Care Team and Individual Care Plan guidance (March 9, 2015), available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPsandPolicyLetters/DPL2015/DPL15-001.pdf.

Evaluation data to date shows that only one third of Cal MediConnect enrollees report having a care coordinator (See Appendix B for evaluation data).

Care Plan Option Services

Cal MediConnect plans may, but are not required to, provide additional services that go beyond the benefits listed above and which might help members avoid institutionalization or emergency room visits, including additional HCBS and behavioral health services.⁵² These services may include, for example, supplemental home care services, home delivered meals, respite care, environmental adaptations, and counseling.⁵³ These are called “Care Plan Option” services (CPO services). Historically, plans have not provided CPO services. Plans are required to have policies and procedures governing the provision of these services and cannot provide them in an arbitrary or discriminatory manner.⁵⁴

Carved Out Benefits

Cal MediConnect plans are required to provide their members with all mental health and substance abuse services currently covered by Medicare and

Medi-Cal.⁵⁵ However, some Medi-Cal funded services are “carved out” and are not included in the capitated rates paid to Cal MediConnect plans.⁵⁶ These include specialty mental health services and Medi-Cal mental health drug services.⁵⁷ County agencies continue to remain responsible for financing and administering these services, but Cal MediConnect plans and county agencies have written agreements regarding coordination of these services.⁵⁸ In other words, the plans are responsible for coordinating these carved out mental health benefits so that the beneficiary receives seamless services.

On June 18, 2013, the California Legislature approved a partial restoration of the adult dental benefit eliminated in 2009. All Medi-Cal beneficiaries, including those enrolled in Cal MediConnect plans, started receiving preventive and denture services beginning May 1, 2014.⁵⁹ The dental benefit is provided through Denti-Cal. The Cal MediConnect plans are not responsible for providing or coordinating the dental benefit. Some Cal MediConnect plans have opted to provide a supplemental dental benefit in addition to the dental benefit provided for under Medi-Cal. The supplemental dental benefit and its provision differs from plan to plan.⁶⁰

52 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.

53 MOU pp. 93-94.

54 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.

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

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

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

58 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.

59 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.

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

Frequently Asked Questions

How does the CCI affect IHSS?

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

Because IHSS is now a Medi-Cal managed care benefit, however, the plans have become involved in IHSS. Plans are required to have agreements with county IHSS offices and Public Authorities. The plans and counties share information about IHSS consumers' needs.⁶¹ A plan could, if it chooses, authorize additional personal care hours beyond the limits allowed by the current IHSS program through Care Plan Option services.⁶² 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.⁶³ A new universal assessment tool for all LTSS, including IHSS,

[materials](#).

- 61 Sharing mechanisms between the counties and plans will comply with state and federal privacy laws. MOU p. 76.
- 62 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.
- 63 After this transition, counties may determine whether local public authorities will continue the following duties: obtaining Department of Justice background checks, conducting new IHSS provider orientations, and maintaining a registry of eligible providers. See DHCS "In-Home Supportive Services and the Coordinated Care Initiative: Frequently Asked Questions," available at http://www.calduals.org/wp-content/uploads/2015/01/FAQ-IHSS_1.27.15.pdf. WIC §14186.35.

could result in changes to hours, authorizations, and increased plan involvement generally.⁶⁴ IHSS appeals could be altered as a result of the new assessment tool or integrated appeals process.⁶⁵

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

The future of MSSP is unknown. Pursuant to the CCI legislation, MSSP would remain in place for the first 19 months of the demonstration after which plans would no longer be required to contract with MSSP providers, but would still be required to offer the MSSP benefit. This period of time was extended to December 31, 2017.⁶⁶

What does the Cal MediConnect vision benefit 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.⁶⁷

What does the Cal MediConnect transportation benefit include?

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- 64 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 had been established to work on the new tool, but has not met regularly in over a year.
 - 65 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).
 - 66 WIC § 14186(b)(7)(A); MOU p. 85. The transition date was extended to December 31, 2017 through [SB 75](#). The bill requires DHCS to evaluate the readiness of managed care plans to commence the transition. See All Plan Letter, APL 15-002, dated January 22, 2015, available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-002.pdf.
 - 67 Three-way contract p. 188.

The Cal MediConnect plans provide an additional transportation benefit to beneficiaries to travel to medical services. Currently, Medi-Cal pays for transportation to medical appointments for those beneficiaries who cannot travel by car or public transportation. The Cal MediConnect transportation benefit provides 30 one-way trips to medical services over a twelve-month period to beneficiaries who can travel by car or public transportation.⁶⁸ This benefit is often referred to as a “taxi voucher” program.⁶⁹ Some plans offer more than the 30 required rides.

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

No. In general, dual eligibles enrolled in just a Medi-Cal plan should not be assigned a primary care physician (PCP) by the Medi-Cal plan.⁷⁰ A PCP is only assigned if the beneficiary requests one or if assignment is deemed necessary through the health risk assessment. Some beneficiaries have been erroneously assigned a PCP. If this occurs, the beneficiary should contact the Medi-Cal plan and have the assignment removed.

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

Medi-Cal plans are required to provide care coordination to beneficiaries enrolled in Medi-Cal plans. The extent of coordination depends on whether the enrollee is an SPD or a dual.⁷¹ Unfortunately, there is currently no data available to assess how well the

68 Three-way contract p. 188.

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

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

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

Medi-Cal plans are providing care coordination.

Purpose of the CCI

The stated goals of the CCI, according to DHCS, are to improve access to care by providing the right care at the right time at the right place, with an emphasis on person-centered care and providing services that promote independence in the community.⁷² The CCI is intended to result in cost savings for both California and the federal government.⁷³

Frequently Asked Questions

Will beneficiaries get better or worse care under Cal MediConnect?

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

How do beneficiaries know if Cal MediConnect

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

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

plans are doing a good job?

Prior to the start of Cal MediConnect, plans had to pass readiness reviews by DHCS and CMS.⁷⁴ The State also developed metrics for evaluating the quality of Cal MediConnect plans.⁷⁵ The plans' rates are reduced by quality withholds at the beginning of each year.⁷⁶ 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.⁷⁷ It is always a good thing to check a plan's local reputation and experience with particular populations and services. Plans also have to report complaints and the resolution of those complaints to DHCS and CMS so these agencies can further monitor the quality of plans.⁷⁸

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

75 See, "Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements," dated Aug. 10, 2016, available at <https://goo.gl/62w6jx>. See also the California-Specific Reporting Requirements dated Mar. 25, 2016, available at <https://goo.gl/nIvWjh>.

76 MOU pp. 52-54.

77 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.nslc.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.nslc.org/wp-content/uploads/2013/02/Guide-LTSS-Outcome-Measures-Final.pdf. See also, "Demonstrations to Improve the Coordination of Medicare and Medicaid for Dually Eligible Beneficiaries: What Prior Experience Did Health Plans and States Have with Capitated Arrangements?" (April 21, 2015), available at http://kff.org/medicare/report/demonstrations-to-improve-the-coordination-of-medicare-and-medicoid-for-dually-eligible-beneficiaries/?utm_campaign=KFF:%20General&utm_content=14249003&utm_medium=social&utm_source=twitter.

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

DHCS has released a number of performance dashboards that review how plans are performing. The most current dashboards (March 2016) are available at <http://www.calduals.org/wp-content/uploads/2016/03/CMC-Performance-Dashboard-March-2016-Release.pdf>.

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

- CMS has contracted with RTI International to conduct a multi-year evaluation of the Cal MediConnect program.⁷⁹
- The SCAN Foundation is funding an evaluation of Cal MediConnect that is being conducted jointly by the UCSF Community Living Policy Center and the UC Berkeley Health Research Action Center. This three-year evaluation documents the impact of Cal MediConnect on dual eligible beneficiaries' experiences with care through focus groups with beneficiaries, telephone surveys, and interviews with health care and social service providers.
- DHCS and The SCAN Foundation are working together to conduct rapid cycle polling through telephone surveys with beneficiaries. The telephone surveys target both beneficiaries who have opted out of Cal MediConnect and beneficiaries who are enrolled in Cal MediConnect plans to document their experiences. As of the publication of this Guide, three waves of the polling have been conducted.

For a full summary of both state and federal evaluations of Cal MediConnect available to date, see Appendix B.

CCI Timeline and Enrollment

The CCI commenced on April 1, 2014.⁸⁰ As noted

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

80 Under the MOU, the CCI was scheduled to begin on October 1, 2013. MOU p. 1. On May 6, 2013, DHCS

previously, Cal MediConnect is a three year pilot that the State has the option to extend to five years. If Cal MediConnect is deemed successful at the end of the pilot period, California could expand the program. Passive enrollment into the program concluded in July 2016.⁸¹

Individuals who opted out of the program or who become eligible for the program can voluntarily enroll through the health plan or enrollment broker, Health Care Options.

Since passive enrollment has ended, thousands of beneficiaries have become newly eligible for both Medi-Cal and Medicare.

Individuals with Medicare who are new to Medi-Cal or who moved to a CCI county post passive enrollment have not been mandatorily enrolled in a Medi-Cal plan and they have not received information about Cal MediConnect. These individuals are currently in fee-for-service for their Medi-Cal benefit.

DHCS intends to send these new dual eligibles notices that will require them to choose a Medi-Cal plan. If they do not choose a plan, they will automatically be enrolled in a Medi-Cal plan. The notices will also include the option to enroll in Cal MediConnect and PACE. These notices are scheduled to be sent in late 2016 or early 2017. Moving forward, newly eligible duals will receive notices when they become eligible.

Medi-Cal enrollees who become newly eligible for Medicare do not currently receive any information from DHCS about Cal MediConnect.

Notices

Since passive enrollment has ended, the only individuals who will receive notices are individuals who become newly eligible for Medi-Cal or move into a CCI county. As noted previously, these individuals will receive a 30-day notice requiring them to choose a Medi-Cal plan. The notices will also include information about Cal MediConnect and PACE with the option to enroll if eligible. If a beneficiary does not make a selection, she will be automatically enrolled in a Medi-Cal plan.

These notices are supposed to begin in late 2016 or early 2017 to those dual eligibles who are not currently enrolled in a Medi-Cal plan. Moving forward, dual eligibles will receive notices as they become eligible for Medi-Cal or move into a CCI county.

Cal MediConnect Plans

The following table includes the plans approved for Cal MediConnect.⁸² Beneficiaries who are enrolled in Cal MediConnect have the right to change plans at any time. The plan change becomes effective the first day of the next month.

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 November, 20, 2014, and is available at <http://www.calduals.org/wp-content/uploads/2014/11/CCI-enrollment-by-County-11.20.14.pdf>.

81 DHCS proposed a renewed round of passive enrollment for new dual eligibles, but decided not to pursue that strategy after stakeholder feedback. See stakeholder comments available at <http://www.justiceinaging.org/wp-content/uploads/2016/04/CCI-Proposals-Comments-FINAL.pdf>.

82 This table lists Cal MediConnect plans in the seven demonstration counties. The Medi-Cal managed care plans are essentially the same as the Cal MediConnect plans with a few variations. See DHCS “Medi-Cal Managed Care Counties,” available at www.dhcs.ca.gov/individuals/pages/mmedhealthplandir.aspx.

County	Duals Demo Health Plans
Los Angeles ^A	Care1st
	CareMore
	Health Net
	LA Care ^B
	Molina
Orange (COHS)	CalOptima ^C
San Diego (GMC)	Care 1 st
	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

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

^BL.A. Care received a Medicare low-performing icon (LPI) as a result of receiving low star rating for three consecutive years. As a result, L.A. Care could not accept passive enrollment into its Cal MediConnect plan until it removed the icon. However, starting in July 2014, L.A. Care was permitted to accept passive enrollment of beneficiaries into its Cal MediConnect plan who were already enrolled in the L.A. Care Medi-Cal plan. L.A. Care's LPI was removed in September 2014 and was able to start passive enrollment in December 2014.

^CCMS imposed sanctions on CalOptima's Medicare Advantage plan on January 24, 2013, and suspended enrollment of Medicare beneficiaries into CalOptima plans. These sanctions were lifted on February 5, 2015, and CalOptima began passive enrollment into its Cal MediConnect plan in August 2015, which concluded in July 2016.

Marketing Rules

CCI plans must adhere to Medicare marketing guidelines issued by CMS⁸³ and California-specific guidelines set forth by the State.⁸⁴ 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"). Cal MediConnect plans are permitted to contact any individual enrolled in another product line within the same parent company.⁸⁵ Advocates should report plans that engage in prohibited marketing activities to CMS, DHCS, and the Department of Managed Health Care (DMHC).

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

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

83 See CMS, "Medicare Marketing Guidelines," available at <https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2017MedicareMarketingGuidelines2.pdf>; CMS also released marketing guidance specific to Cal MediConnect available at <https://goo.gl/SC15aL>.

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

85 Accordingly, Cal MediConnect plans can contact any member of their Medi-Cal plan to discuss the Cal MediConnect program. Plans, however, cannot turn an outbound call into an enrollment call. Plans can only enroll individuals through inbound calls initiated by the beneficiary. See Medicare Marketing Guidelines, Rule 80.2 available at <https://goo.gl/xcb7GL>.

Factors a Beneficiary Should Consider in Deciding to Enroll Cal MediConnect

Dual eligible beneficiaries should seek independent enrollment counseling to help them decide whether to enroll in Cal MediConnect. If a beneficiary decides she wants to participate in Cal MediConnect, she then must choose which Cal MediConnect plan meets her needs.⁸⁶

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

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

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

a transportation and vision benefit, which are currently not covered by Medi-Cal or Medicare fee-for-service.⁸⁷ Some plans also offer additional dental benefits not covered by Denti-Cal.

Frequently Asked Questions

Who processes enrollments?

In two-plan counties and in San Diego County, Health Care Options (HCO) serves as the independent enrollment broker.⁸⁸ All the health plans are also now able to accept enrollments.⁸⁹ In COHS counties, the health plan processes the enrollments. In non-COHS counties, the health plans can accept an enrollment request and then forward that enrollment to HCO to process. HCO will contact the beneficiary (up to three attempts) to verify that the individual wants to enroll in Cal MediConnect. If the individual confirms enrollment or if HCO is not able to reach the individual, the enrollment will be effectuated. If an individual states that they do not want to enroll, HCO will send a notice canceling the enrollment. In COHS counties (San Mateo and Orange), the COHS plan processes enrollments. Health Care Options (HCO) has a dedicated call center for the CCI with its own phone number separate from the Medi-Cal Health Care Options center. The CCI-specific HCO call center number is 1-844-580-7272.

⁸⁷ Some Medicare Advantage plans also provide dental, vision, and transportation benefits. Beneficiaries should compare benefits available under their Medicare Advantage plan to the benefits offered in the Cal MediConnect plans when making a decision.

⁸⁸ See www.healthcareoptions.dhcs.ca.gov.

⁸⁹ In April 2016, DHCS announced a proposal to allow health plans to accept enrollments into their Cal MediConnect plans through a process known as streamlined enrollment. Plans moved forward with streamlined enrollment in August 2016 after undergoing readiness testing. Prior to this new process, only Health Care Options could accept enrollments in two-plan and GMC counties. See "Ensuring Sustainable CCI Enrollment," available at <http://www.calduals.org/wp-content/uploads/2016/04/4.7.16-Sustainable-Enrollment.pdf>.

⁸⁶ Dual eligibles living in a COHS county will only have one Cal MediConnect plan choice.

Who can make an enrollment decision?

In most circumstances, the beneficiary is only individual able to make an enrollment decision by either contacting Health Care Options (or the health plan in COHS counties) or by mailing in a completed choice form.

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

1. A conservator/guardian appointed by the court
2. A designated Power of Attorney
3. An Authorized Representative – a beneficiary files an Authorized Representative form with the county Medi-Cal office.
4. An Enrollment Assistant – a family member, friend, or advocate acting in the beneficiary's best interest. The Enrollment Assistant must attest to his or her authority to make an enrollment decision on the beneficiary's behalf and cannot have a conflict of interest in making such decision.⁹⁰

Can beneficiaries receive enrollment counseling?

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

90 See "Designating an "Enrollment Assistant" to Represent Medi-Cal Beneficiaries with their Enrollment Decisions" available at <http://www.calduals.org/wp-content/uploads/2015/09/Cal-MediConnect-Enrollment-Assistants-REVISED-VERSION.pdf>.

Continuity of Care⁹¹

Continuity of Care: Cal MediConnect

Beneficiaries who are enrolled in Cal MediConnect are able to keep seeing their current providers and maintain their service authorizations for up to twelve months for both Medicare and Medi-Cal services.⁹² In order to qualify for continuity of care, the following conditions must be met:

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

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, at minimum twelve months. Beneficiaries and their providers can request continuity of care, and the plan must process continuity of care

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

92 Continuity of care minimums are spelled out in WIC §§ 14132.275(k)(2)(A)(ii-iii); 14182.17; 14132.276(k)(14); 14132.276(b)(13); and the MOU pp. 95-96. DHCS has issued more expanded continuity of care protections through a Dual Plan Letters. The latest version, DPL 16-002, dated July 5, 2016, is available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2016/DPL16-002.pdf>.

requests within three days if there is a risk of harm to the beneficiary.

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.⁹³

In the event a beneficiary enrolled in a Cal MediConnect plan visits an out-of-network provider without having first requested continuity of care from the plan, the provider can seek retroactive payment for services rendered as long as the continuity of care criteria are met and the request for payment is made within 30 days of services rendered. There are exceptions to the 30-day period in circumstances where the provider submitted the claim to the wrong entity for payment.⁹⁴

For beneficiaries enrolled in a Cal MediConnect plan that contracts with Independent Physician Associations (IPAs) or Preferred Provider Groups (PPGs), beneficiaries must see providers within the IPA/PPG network. If a provider is within the plan's network but not within the IPA/PPG network, beneficiaries will have to switch to an IPA/PPG provider after the continuity of care period has expired.⁹⁵

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,⁹⁶ however, enrollment in Cal MediConnect should not disrupt an IHSS recipient's access to his chosen provider.

For prescription drugs, Cal MediConnect plans must also follow the Medicare Part D rules on transitions.⁹⁷ 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.⁹⁸

Of course, dual eligibles can choose to maintain relationships with Medicare providers by either staying in FFS Medicare or in their preferred Medicare Advantage plan. Individuals who enroll in Cal MediConnect also have the right to disenroll from the program at any time and return to FFS Medicare or a Medicare Advantage plan.⁹⁹

Continuity of Care: Medi-Cal Managed Care¹⁰⁰

On the Medi-Cal side, there are two different types of continuity of care rights. First, as described above, a beneficiary who is enrolled in Medi-Cal managed care can continue to see an out-of-network provider of Medi-Cal services for up to 12 months, if the applicable criteria are met (the beneficiary has an ongoing relationship with the provider; the provider will accept the plan rate or Medi-Cal FFS rate, if higher; and the provider is otherwise qualified). An SPD also can receive services, like a scheduled surgery as part of a documented course of treatment, that are set to occur within 180 days of enrollment.¹⁰¹ Like Cal MediConnect protections, nursing facility residents enrolled only in a Medi-Cal managed care plan have the right to continue residing in an out-of-network facility as long as they were residing in the facility at the time of enrollment into the Medi-Cal plan.¹⁰²

93 Duals Plan Letter 16-002, p. 7.

94 IDual Plan Letter 16-002, pp. 4-5.

95 Dual Plan Letter 16-002, p. 4. Advocates attempted to define continuity of care at the prime plan level rather than the IPA/PPG level so that beneficiaries have access to the full network of plan providers, but were unsuccessful.

96 WIC § 14186.35(a)(2).

97 WIC § 14132.275(j)(1)(A)(iv).

98 For more information about Medicare prescription drug transition rights, see generally Justice in Aging, "2015 Transition Rights to Medications Under Medicare Part D," available at <http://justiceinaging.org/wp-content/uploads/2015/05/Transition-2015.pdf>, and Chapters 6 and 14 of the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326.html.

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

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

101 HSC § 1373.96.

102 See All Plan Letter, 15-004, "Medi-Cal Managed Care

Second, an SPD in a two-plan or GMC county who would otherwise be subject to enrollment in Medi-Cal managed care under the CCI may file a Medical Exemption Request (MER) to avoid enrolling in Medi-Cal managed care altogether, instead staying in FFS Medi-Cal. 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.¹⁰³ To file a MER, a beneficiary and her doctor must fill out a form and submit it to Health Care Options.¹⁰⁴ We recommend that beneficiaries enlist the assistance of an advocate in the MER process.¹⁰⁵ An approved MER is still temporary, exempting beneficiaries from managed care for up to 12 months, though at the end of that time beneficiaries can file for a renewal of a MER. Once the beneficiary's condition is stabilized, as determined by the beneficiary's treating FFS physician, she will be required to enroll in Medi-Cal managed care. If a MER is denied, a beneficiary can request a state fair hearing (see Appeal Rights below). People with HIV/AIDS and Native Americans may disenroll from Medi-Cal managed care at any time.¹⁰⁶ To do so, they should file a MER, which ought to be approved automatically.

Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect” dated February 12, 2015, available at <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-004.pdf>.

103 22 CCR § 53887.

104 The form is available online at http://www.healthcareoptions.dhcs.ca.gov/hcocsp/enrollment/content/en/forms/MU_0003383.pdf.

105 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).

106 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).

Remember that the plans determine whether a beneficiary can continue to see out-of-network providers, whereas DHCS decides whether a beneficiary should be granted a Medical Exemption Request. Continuity of care protections are in place for beneficiaries who transition to Medi-Cal managed care after a MER period expires.¹⁰⁷

Frequently Asked Questions

When is a MER available?

A MER is only available to individuals who have Medi-Cal only (an SPD) or where Medi-Cal is the primary payer of medical services. The MER is not available to dual eligible beneficiaries. The MER process does not apply to Cal MediConnect because a beneficiary has the right to opt out of or disenroll from Cal MediConnect at any time for her Medicare benefits.¹⁰⁸

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 Against Non-Discrimination

CMS, DHCS, and the participating health plans are all considered covered entities under Section 1557 of the Affordable Care Act and therefore subject to its non-discrimination mandate.¹⁰⁹ Since CCI implementation began, the Department of Health and Human Services

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

108 There is an exception to Medi-Cal enrollment for dual eligibles for “medically necessary” reasons set forth in WIC § 14182.16(c)(1)(D). Advocates have asked DHCS for guidance on how this exception is defined and implemented.

109 42 U.S.C. § 18116; 45 C.F.R. §§ 92.2, 92.4.

(DHHS) released final regulatory guidance for the statute.¹¹⁰ Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age and disability and does so by incorporating the existing protections from the Age Act, Titles VI and IX, and the Rehabilitation Act, applying them specifically to the healthcare context.¹¹¹ These prohibitions apply regardless of whether the services or actions in question have been delegated to contractors, as covered entities are responsible for ensuring their contractors are compliant with Section 1557's mandate.¹¹² Individuals who have been discriminated against can file an administrative complaint with DHHS's Office of Civil Rights (OCR) or file a lawsuit against the covered entity in federal district court.¹¹³ The regulations clarify that Section 1557 permits both lawsuits challenging intentional discrimination as well as those alleging disparate impact.¹¹⁴

Furthermore, in accordance with federal law,¹¹⁵ all plans participating in Cal MediConnect must ensure that communication and services are accessible to those with limited English proficiency.¹¹⁶ The MOU

110 45 C.F.R. § 92.

111 45 C.F.R. § 92.101(a).

112 81 Fed. Reg. 31383.

113 45 C.F.R. 92.8(a)(7); see also: <http://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

114 45 C.F.R. § 92.301; 81 Fed. Reg. 31439-31440.

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

116 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

requires plans to provide translated written materials in languages spoken by at least 3,000 beneficiaries in a county.¹¹⁷ 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 or have been discriminated against for purposes of Section 1557, contact Justice in Aging.

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

The MOU requires every participating plan to certify “that it intends to fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the ADA and the Rehabilitation Act of 1973.”¹¹⁸ In addition to the MOU, the Affordable Care Act (ACA) explicitly incorporates the requirements of the ADA and Rehabilitation Act.¹¹⁹

The three federal laws address disability discrimination and together require health care providers to provide physical and programmatic access

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).

117 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.

118 MOU p. 62.

119 As detailed above, the ACA's non-discrimination provision in § 1557 broadly states that “an individual shall not [on grounds prohibited in a series of listed civil rights laws, including the ADA and Section 504] be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance.” 42 U.S.C. § 18116.

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

Health care entities must also provide auxiliary aids and services such as sign language interpreters, assistive listening devices, and written medical information in such alternative formats as Braille and large-font print, unless the provider can establish that doing so would fundamentally alter the nature of the health care service or constitute an undue burden.¹²⁰

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 provide staff training on disability discrimination and disability cultural competency, and should be prepared to deal with a network provider or plan representative's failure to provide effective reasonable accommodations or policy modifications. The three-way contracts have

120 42 U.S.C. § 12182(b)(2)(A)(iii); C.F.R. § 36.302. “Undue burden” is defined as “causing significant difficulty or expense.”

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.”¹²¹ 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.”¹²² 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.¹²³ 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.¹²⁴

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.¹²⁵ Notices about these decisions, and appeal procedures and hearings, should be understandable

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

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

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

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

125 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 Justice in Aging.

and accessible, including to people with disabilities and those who are limited English proficient. Notices should include specific information, including the decision made, the facts and law relied upon, the right to appeal and how to appeal.¹²⁶ Plans also have an internal grievance and complaint process that beneficiaries should follow when they are unhappy with the quality of their services or with someone from the health plan. The internal grievance and complaint process should also be accessible to people with disabilities and those who are limited English proficient.

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

Medi-Cal Managed Care

If a Medi-Cal managed care plan denies, reduces or terminates services, a beneficiary has appeal rights. A beneficiary can file both an internal appeal with the health plan and request a state fair hearing (the same process as in FFS Medi-Cal).¹²⁷ Generally, advocates recommend filing both an internal appeal and a request for a fair hearing at the same time, and then withdrawing or postponing the fair hearing if the plan favorably resolves the internal appeal. The appeal may result in more information from the plan about the issue as well as quicker resolution of the dispute, while the request for a state fair hearing maximizes

126 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).

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

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.¹²⁸ This protection is also known as an "aid paid pending" appeal. In any case, a request for a fair hearing must be made within 90 days of the notice of action unless there is a good reason that the deadline was missed (e.g., the notice was not received).

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

To file an internal plan appeal, the beneficiary should follow the managed care plan's internal appeal process. If the plan's initial response does not favorably resolve the issue, the beneficiary then may file the appeal with the Department of Managed Health Care (DMHC) for an external review of the decision.¹²⁹

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.¹³⁰ 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

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

129 COHS plans are not subject to Knox Keene and therefore do not provide the IMR process through DMHC. For more information on the distinctions between the COHS, two-plan, and GMC models, see p. 39.

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

requested is experimental or investigational.¹³¹ 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

Currently, Cal MediConnect enrollees wishing to appeal a decision by a plan to deny, reduce, or terminate services 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 a grievance and appeal processes that complies with state and federal law,¹³² and they are required to provide their members notice of appeal rights when services are denied, reduced, or otherwise amended.¹³³

For Medi-Cal covered services, the appeals process is the same as that described on page 35 above for Medi-Cal managed care. "Beneficiaries are allowed to seek a state fair hearing at any time,"¹³⁴ although they are "encouraged" to appeal first through the plan's member services or navigation office. Initial requests for a state fair hearing must be filed within 90 days of receiving a notice of action. Plans cannot put any requirements on appeals and grievances that are stricter for Medi-Cal services than the current requirements in the FFS Medi-Cal system.¹³⁵

131 HSC §§ 1374.30-1374.35.

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

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

134 MOU p. 99.

135 MOU p. 82.

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.¹³⁶ For Medicare-covered benefits, there is no state fair hearing option, but aid paid pending is available through the internal plan appeal process as long as the appeal is made within ten days.¹³⁷

Appeals for Part D-covered prescription drugs follow existing Medicare rules. This means that if coverage for a particular drug is denied at the pharmacy, the individual must either meet a prior authorization requirement or file a request for an "exception" with the Cal MediConnect plan. If the plan denies the request for an exception, then the appeals process can begin.¹³⁸ Appeals regarding drugs that are NOT covered by Medicare Part D (for instance, over-the-counter drugs, or drugs for weight loss or gain) follow the usual Medi-Cal rules.

With regard to overlapping services covered by both Medicare and Medi-Cal (e.g., home health services, durable medical equipment, and other skilled service), an appeals process was supposed to be spelled out in the three-way contracts with CMS, the plan, and DHCS.¹³⁹ Unfortunately, the three-way contracts are silent on appeals for overlapping services and the process has yet

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

137 Three-way contract p. 98.

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

139 MOU pp. 99-100.

to be formalized. At a minimum, the appeals process includes the right to a state fair hearing.¹⁴⁰

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.¹⁴¹ 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. 23-24, 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.¹⁴²

[Care Plan Option Services](#)

As described on p. 23, plans are not required to provide Care Plan Option services. If plans do decide to provide such services, according to DHCS, they are not subject to the Medi-Cal or Medicare formal grievance and appeals processes. Instead, plans are required to

140 MOU p. 100.

141 MOU p. 98.

142 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.

create an internal grievance procedure to record and address complaints.¹⁴³ The internal grievance procedure differs from plan to plan.

Frequently Asked Questions

Who can help beneficiaries with appeals?

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

While the independent ombudsman is funded only to provide assistance to dual eligibles impacted by Cal MediConnect, the selected Ombudsman program made it clear that it serves both Cal MediConnect dual eligibles and individuals impacted by the CCI generally.¹⁴⁴ See Appendix A for the ombudsman contact information and additional resources available to consumers.

143 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.

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

Medi-Cal¹⁴⁵ 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).¹⁴⁶ 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.¹⁴⁷ 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. 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%.¹⁴⁸ They can, however, decide not to accept a dual eligible patient.

Medicare offers private health plans, called Medicare Advantage, as an alternative to original Medicare. Once a beneficiary enrolls in a Medicare Advantage plan, she receives all Part A and Part B benefits through the plan, and usually Part D prescription drug coverage as well. Medicare Advantage plans include HMOs, 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.¹⁴⁹ Some SNPs serve individuals with particular chronic conditions (C-SNPs) or those requiring an institutional level of care (I-SNPs). The majority of SNPs, however, are designed to serve dual eligibles (D-SNPs). Some D-SNP sponsors also have Medi-Cal contracts in the same county where they operate, while others do not. In all cases, D-SNPs are required to provide some coordination of Medicare and Medi-Cal benefits.

Medi-Cal

Medi-Cal is California’s state Medicaid program, funded in part by the state and in part by the federal government.¹⁵⁰ 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

145 The Health Consumer Alliance has an entire manual dedicated to Medi-Cal available at <http://healthconsumer.org/publications.htm#manuals>. Also see, the Western Center on Law and Poverty 2016 health Care Eligibility Guide available at <https://wclp.org/advocate-resources/manuals-2/2016-health-care-guide/>.

146 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.

147 42 U.S.C. § 1395 (prohibiting federal interference in the manner in which medical services are provided).

148 See www.cms.gov/MLN MattersArticles/downloads/SE1128.pdf.

149 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.

150 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/.

services and supports and other medical services. If an individual is eligible for both Medicare and Medi-Cal, Medicare acts as the primary payor for services, and Medi-Cal pays for the portion Medicare does not cover (see above Medicare summary). California, like many states, has two delivery systems for its Medi-Cal program, fee-for-service and managed care.

Fee-For-Service

Under FFS, healthcare providers are paid for each service they provide to a beneficiary. For example, a provider will receive reimbursement from DHCS for an office visit, test, or procedure. Beneficiaries with FFS Medi-Cal can see any provider who accepts Medi-Cal.

Medi-Cal Managed Care

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

Over the last decade, California has been moving most populations eligible for Medi-Cal benefits from fee-for-service into managed care. Today, approximately 10.6 million Medi-Cal beneficiaries 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.¹⁵¹ DHCS expanded Medi-Cal managed care for SPDs into rural counties in 2014.¹⁵²

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

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

California has adopted six models of managed care:¹⁵³

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. Four of the counties affected by the CCI—Los Angeles, Riverside, San Bernardino and Santa Clara—are two-plan counties.
2. **County Organized Health Systems (COHS).** Under this model, there is one health plan in the county created by the County Board of Supervisors with input from the community. These plans are managed by the individual counties. All Medi-Cal beneficiaries (including duals) residing in a COHS county have the same managed care plan for their Medi-Cal. Two of the counties affected by the CCI—San Mateo and Orange—are COHS counties.
3. **Geographic Managed Care (GMC).** Under this model, the State contracts with several commercial plans to provide Medi-Cal services. Beneficiaries can choose among these plans. Only one CCI county, San Diego, uses the GMC model.
4. **Regional.** Under this model there are two commercial plans that contract with DHCS.
5. **Imperial.** Under this model, DHCS contracts with two commercial plans (different commercial plans than in the Regional model)
6. **San Benito.** In this model, there is only one commercial plan available. Beneficiaries have the option of enrolling in managed care or remaining in Medi-Cal fee-for-service.

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

Except now in CCI counties, certain groups are excluded from Medi-Cal managed care enrollment, including dual eligible beneficiaries, share of cost beneficiaries, and individuals receiving nursing facility care.¹⁵⁴ These groups continue to receive services through Medi-Cal fee-for-service.

154 In COHS counties, beneficiaries residing in a nursing facility are enrolled in Medi-Cal managed care. Also, in order to receive CBAS benefits, beneficiaries, including dual eligibles, have to enroll in Medi-Cal managed care.

Appendix A - Resources

Contact Information for Plans

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

PACE Contact Information

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

Consumer Assistance

Resource	Assistance Provided	County	Contact Information
CCI Ombudsman	Assistance with CCI, including Cal MediConnect, enrollment, appeals, and grievances	All CCI counties	855-501-3077 www.calduals.org/terms-and-conditions/ombudsman-resources
HICAP	Free information and counseling about Medicare for individual beneficiaries.	Los Angeles	Center for Health Care Rights 213-383-4519
		Orange	Council on Aging - Orange County 714-560-0424 www.coaoc.org
		Riverside/San Bernardino	909-256-8369
		San Diego	Elder Law and Advocacy 858-565-8772 www.seniorlaw-sd.org
		San Mateo	Self Help for the Elderly 650-627-9350 www.selfhelpelderly.org
		Santa Clara	Sourcewise 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

State and Federal Contacts

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

Cal MediConnect Resources

Resource	Link
Cal MediConnect Physician Toolkit	http://www.calduals.org/2016/08/24/updated-physician-toolkit/
Cal MediConnect Beneficiary Toolkit	http://www.calduals.org/2016/08/24/new-cal-mediconnect-beneficiary-toolkit/
Care Coordination Fact Sheet	http://www.calduals.org/wp-content/uploads/2016/07/CMC_PartnersinCare_Flyer_EN_07.25.16.pdf
CalMediConnect Video	https://online.care1st.com/aboutcmc.html

Opportunities for Systemic Advocacy

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

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

Appendix B

Evaluations

Name	Date	Link
Evaluation of Cal MediConnect: Key Findings from a Survey with Beneficiaries	August 17, 2016	http://www.thescanfoundation.org/sites/default/files/uc_duals_phonesurvey_2016.pdf
Cal MediConnect: How Have Health Systems Responded	July 2016	http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf
Findings from Waves 1-3 of Rapid Cycle Polling Project	June 2016	http://www.thescanfoundation.org/sites/default/files/wave_3_powerpoint_summary_report_june_2016.pdf
Issues affecting dual-eligible beneficiaries: CMS's financial alignment demonstration and the Medicare Savings Programs	June 2016	http://www.medpac.gov/docs/default-source/reports/chapter-9-issues-affecting-dual-eligible-beneficiaries-cms-s-financial-alignment-demonstration-and-t.pdf?sfvrsn=0
Evaluation of Cal MediConnect: Key Findings from Focus Groups with Beneficiaries	March 2016	http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_key_findings_brief_march_2016.pdf?utm_source=3-23-16+%28TSF%3A+Cal+MediConnect+report+%26+brief%3B+Hispanic+poll+results+%29&utm_campaign=3-23-16&utm_medium=email
Additional Oversight Needed of CMS's Demonstration to Coordinate the Care of Dual-Eligible Beneficiaries	December 2015	http://www.gao.gov/assets/680/674340.pdf
Report on Early Implementation of Demonstrations under the Financial Alignment Initiative	October 2015	https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf
Dual Eligible Demonstrations: The Beneficiary Perspective	August 2015	http://files.kff.org/attachment/issue-brief-dual-eligible-demonstrations-the-beneficiary-perspective
Experiences with Financial Alignment Initiative Demonstration Projects in Three States	May 2015	https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf

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