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ADVOCATE'S GUIDE

# CalAIM for Older Adults and People with Disabilities

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Tiffany Huyenh-Cho, Senior Attorney

## ABOUT THIS GUIDE

This guide is designed for advocates and individuals who provide assistance to older adults and persons with disabilities who are dually eligible for Medicare and Medi-Cal health coverage. California's Medicaid program (Medi-Cal in California) is embarking on a multi-year initiative, California Advancing and Innovating Medi-Cal (CalAIM), to transform the Medi-Cal delivery system, improve health outcomes, and address social determinants of health. CalAIM can improve health equity for populations that have experienced barriers to care, including poor quality of care or inadequate access to care, due to structural racism in health care, disruption in services, and poor care coordination. CalAIM is wide-reaching and includes policies that impact Medi-Cal populations of all ages.

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This guide specifically focuses on policy changes that affect older adults and people with disabilities. It is not an exhaustive guide to CalAIM and will focus on these topics:

- Medi-Cal program changes including compulsory managed care enrollment for previously excluded groups;
- Managed care carve-ins and carve-outs of services and continuity of care;
- Medicare-Medi-Cal coordination including Medicare-Medi-Cal plans (MMPs), Medi-Cal matching plan policy and Dual Eligible Special Needs Plan look-alikes;
- New Medi-Cal managed care services: Enhanced Care Management and Community Supports.

Please refer to the Department of Health Care Service's (DHCS) CalAIM webpage for comprehensive information and timelines.

Justice in Aging strives to make the information in this guide as accurate as possible as of the publication date. However, details about CalAIM are always evolving and ongoing. To receive the most up-to-date information, sign up for alerts, Justice in Aging webinars, and other trainings, please visit our website.

Justice in Aging advocates for the rights of low-income older adults and persons with disabilities to improve access to health care and economic security. 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 resources, see the section on Enrollment and Legal Resources for Beneficiaries and Appendix A.

# GLOSSARY

### Coordinated Care Initiative (CCI)
The CCI was a program intended to integrate and coordinate the delivery of health benefits and long-term services and supports (LTSS) to dually eligible individuals and persons with disabilities living in seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The CCI ended on December 31, 2022.

### County Organized Health Systems (COHS)
In COHS counties, there is only one Medi-Cal plan serving all Medi-Cal enrollees. The COHS plan is created and administered by a county's board of supervisors or other local health authority. Dually eligible individuals in the county, regardless of choice of Medicare coverage, are enrolled in the same Medi-Cal plan. The COHS counties are: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo counties.

### Department of Health Care Services (DHCS)
The California government department that is the single state agency responsible for overseeing the administration of the Medi-Cal program.

### Dually Eligible Individuals
Individuals enrolled in both Medicare and Medi-Cal.

### Dual-Eligible Special Needs Plan
A Medicare Advantage plan limited to serving dually eligible individuals.

### Fee for Service (FFS)
Fee for service is the payment model where a provider is paid directly from Medicare or Medi-Cal rather than contracting with a health plan. In FFS, a provider of health care services bills for each service provided. Under CalAIM, few individuals remain in Medi-Cal FFS.

### Health Insurance Counseling and Advocacy Program (HICAP)
A program that provides free and objective counseling about Medicare enrollment and Medicare plan choices.

### Home and Community-Based Services (HCBS)
Benefits that provide assistance with daily activities that generally help beneficiaries remain in their homes.

### In-Home Supportive Services (IHSS)
The IHSS program provides services that allow a beneficiary to remain safely in the home rather than in a nursing facility or other institution. IHSS services may include housecleaning, shopping, meal preparation, laundry, personal care services, accompaniment to medical appointments, and protective supervision for persons with cognitive impairments.

### Multi-Purpose Senior Services Program (MSSP)
A home and community-based services waiver program that provides social and health care management to 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.

### Seniors and Persons with Disabilities (SPDs)
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 full Medicare coverage. Individuals with Medicare Part A or B, but not both, and Medi-Cal coverage are included in the SPD group.

### Share of Cost (SOC)
Persons with incomes above the income limit for free Medi-Cal coverage can still receive Medi-Cal services by paying a share of the cost of the health care services they receive in a month. Once a person's health care expenses reach a specified amount each month (meeting the share of cost), Medi-Cal will pay for any additional accrued expenses in that month.

# WHAT IS CalAIM?

Starting January 1, 2022, California began a five-year initiative, CalAIM, to transform the Medi-Cal program, standardize the Medi-Cal delivery system, streamline managed care benefits, and promote integrated care options. CalAIM consists of a myriad of initiatives in payment reform, delivery reform, and risk stratification to improve health outcomes, address the social determinants of health and further health equity for low-income Californians. California sought and received approval for CalAIM under §1115 and §1915b waivers.[1] CalAIM incorporates elements of the Coordinated Care Initiative (CCI), such as mandatory managed care enrollment for dually eligible individuals and integrated Medicare and Medi-Cal plan options.

# POLICIES AFFECTING OLDER ADULTS AND PEOPLE WITH DISABILITIES

## Medi-Cal Managed Care Enrollment Is Mandatory Throughout the State

CalAIM requires groups previously excluded from Medi-Cal managed care to now enroll in Medi-Cal managed care plans. Older adults and people with disabilities were enrolled into managed care in primarily two phases: January 2022 and January 2023.

### IMPACTED POPULATIONS AND TIMELINES

January 1, 2022:[2]

- Trafficking and Crime Victims Assistance Program, except Share of Cost (SOC) (non-dually eligible and dually eligible)
- Beneficiaries living in certain rural zip codes[3] (non-dually eligible)
- Individuals in Accelerated Enrollment (dually eligible and non-dually eligible)

January 1, 2023:

- Dually Eligible Individuals[4]
- Individuals living in Skilled Nursing Facilities
- Home and Community-Based Waiver Enrollees

Before CalAIM, whether an individual had to enroll in Medi-Cal managed care plans could depend on a variety of factors, such as county of residence, population group, or if a person had other health care coverage. This led to confusion for both individuals and advocates. After January 2023, the majority of individuals with Medi-Cal are required to enroll into Medi-Cal managed care. Very few groups are exempt from this requirement.

CalAIM introduced two new benefits that are available only through Medi-Cal managed care plans: Enhanced Care Management, and Community Supports. Dually eligible individuals may now access these benefits through the Medi-Cal managed care plan. Please see the section on New Medi-Cal Managed Care Benefits for information on Enhanced Care Management and Community Supports.

Except for long-term care, Medi-Cal covered benefits that had been carved out of managed care are unchanged. For example, In-Home Supportive Services (IHSS) continues to be a FFS Medi-Cal benefit.

## Mandatory enrollment applies to almost all dually eligible individuals

Beginning January 2023, most dually eligible individuals are required to get their Medi-Cal benefits through enrollment in managed care plans.[5] Prior to January 2023, it was voluntary for dually eligible individuals to enroll in Medi-Cal managed care plans in 31 of California's 58 counties. Most dually eligible individuals residing in CCI and COHS counties were previously required to enroll into Medi-Cal managed care plans. However, some dually eligible individuals in CCI counties were impacted under the January 2023 policy. These include groups previously excluded from mandatory Medi-Cal managed care, such as dually eligible individuals with other health coverage (OHC) and those living in rural zip codes.

The following dually eligible aid code groups were required to enroll in Medi-Cal managed care:[6]

- Adult expansion
- Aged
- Breast and Cervical Cancer Treatment Program (BCCTP)
- Non-Disabled Adults (19+ years of age)
- Non-Disabled Children (<19 years of age)
- Individuals with other health coverage (OHC)
- Individuals living in rural zip codes[7]
- All Home and Community-Based Waiver Enrollees

This policy primarily impacted the counties of Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tuolumne, Tulare, and Yuba.

Enrollment is mandatory.[8] Written notices and materials were mailed to affected individuals at least 60 days in advance.[9] If an individual subject to mandatory enrollment did not choose a plan, DHCS chose a plan for them. Default enrollment into Medi-Cal managed care plans occurred on February 1, 2023.

### ENROLLMENT EXCEPTIONS[10]

- Program of All-Inclusive Care for the Elderly (PACE) enrollees and members of SCAN Fully Integrated Dual Eligible (FIDE) health plans[11]
- Residents of California Veteran Homes
- Individuals with HIV/AIDS who opt out of managed care
- American Indian/Alaska Native individuals who opt out of managed care

Dually eligible individuals retain freedom of choice in their Medicare delivery system. The requirement to join a Medi-Cal managed care plan does not impede a person's choice among Original FFS Medicare, Medicare Advantage, or the Program of All Inclusive Care for the Elderly (PACE).

## MEDICAL EXEMPTION REQUESTS (MERS) MAY BE AVAILABLE

To qualify for a temporary exemption from Medi-Cal managed care, an individual must meet the following criteria:[12]

- They have a complex condition, and
- Care for their complex medical condition is provided by a Medi-Cal FFS provider, and
- Their FFS Medi-Cal provider does not contract with any Medi-Cal plan in their county, and
- Their care and course of treatment cannot be changed without risk to their medical health, and
- They have not been a member of a Medi-Cal managed care plan for more than 90 days.

It is especially difficult for a dually eligible individual to meet the MER criteria because Medicare is their primary payor. The MER criteria requires that critical access to a *Medi-Cal FFS doctor* will be jeopardized. Dually eligible individuals in Medi-Cal managed care plans can still be treated by their Original Medicare providers even if the provider is not contracted with the new Medi-Cal plan. Because most dually eligible individuals are not being treated by Medi-Cal FFS medical providers, it may be difficult for a dually eligible individual to demonstrate that access to their primary or specialty care provider will be impacted by enrolling into a Medi-Cal managed care plan.

MERs are temporary and can be granted for up to one year. Please see DHCS's Medical Exemption Request form for more information.

## CONTINUITY OF CARE IS AVAILABLE FOR NEWLY ENROLLED

Medi-Cal managed care plans are now responsible for Medicare cost-sharing and for services not covered by Medicare, such as medical supplies, long-term services and supports, and transportation. Dually eligible individuals receiving services that are only covered by Medi-Cal, such as transportation or incontinence supplies, must use providers that are contracted with the Medi-Cal plan. There are specific continuity of care protections in place to prevent disruptions in access to Medi-Cal covered services, such as medical supplies.[13]

## CONTINUITY OF CARE AND IMPROPER BILLING PROTECTIONS

Dually eligible individuals newly enrolled in Medi-Cal managed care can continue to see Original Medicare providers.[14] Medi-Cal plan enrollment is not a barrier to treatment from Original Medicare providers and those providers can continue to bill the Medicare program. The Medi-Cal managed care plan is responsible for paying Medicare cost sharing, including deductibles, co-insurance, and co-payments. An individual does not need to see a Medicare provider who is in their 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 in FFS Medi-Cal. The Medicare provider does not have to have a contract with the Medi-Cal plan to receive payment.

Medicare providers often turn away patients who are enrolled in a Medi-Cal plan or bill their dually eligible patients for Medicare cost sharing. While Original Medicare providers can refuse to treat dually eligible patients, they are prohibited from billing dually eligible individuals under both federal and state law for Medicare and Medi-Cal covered services.[15]

### CONTINUITY OF CARE FOR MEDI-CAL COVERED DURABLE MEDICAL EQUIPMENT

Dually eligible individuals with existing Medi-Cal covered durable medical equipment (DME) rentals or medical supplies are provided continuity of care protections to ensure access to medically necessary DME and supplies. Individuals with existing prior authorizations can continue to rent their DME or supplies for a minimum of 90 days after the transition into the Medi-Cal plan.[16] This protection runs until the Medi-Cal plan has reassessed the individual for a new authorization, the new equipment or supplies are in possession of the individual, and the new equipment or supplies are ready for use.[17]

## Long-Term Care Carve-In and Mandatory Managed Care Enrollment for LTC Residents

Under CalAIM, Medi-Cal's institutional Long-Term Care (LTC) benefit will become a Medi-Cal managed care benefit in all counties by January 2024.[18] LTC facilities include skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities. The impact of this policy is two-fold: LTC residents will be required to enroll into Medi-Cal managed care plans and the long-term care benefit will be the responsibility of Medi-Cal managed care plans statewide.

Prior to CalAIM, Medi-Cal managed care plans in the CCI and COHS counties were responsible for the LTC benefit. In the remaining non-COHS or non-CCI counties, LTC will be carved in to Medi-Cal managed care plans in a two phased approach: January 1, 2023 and January 1, 2024.

Medi-Cal managed care plans (MCPs) will include the LTC benefit for the following facility types:

- Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital (January 2023)
- Intermediate Care Facility (ICF) (January 2024)
    - Intermediate Care Facility for Developmentally Disabled (ICF-DD)
    - ICF-DD/Habilitative
    - ICF-DD/Nursing
- Subacute (January 2024)
    - Subacute Facility
    - Pediatric Subacute Facility

Impacted Populations Residing in a LTC facility:

- Individuals dually eligible for Medicare and Medi-Cal, including those with a Medi-Cal SOC
- Medi-Cal-only individuals, including those with a Medi-Cal SOC

Impacted Counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tuolumne, Tulare, and Yuba.

Previously, Medi-Cal plan coverage of LTC was limited in the above 31 counties. Medi-Cal plan members who entered an LTC facility were disenrolled from their Medi-Cal managed care plan and enrolled in FFS Medi-Cal after the second continuous month of admission in the LTC facility.

### SKILLED NURSING FACILITY CARVE-IN

The SNF benefit became a Medi-Cal managed care benefit in the 31 counties listed above beginning January 1, 2023.[19] Current residents of SNF facilities will be required to join Medi-Cal managed care plans. Individuals admitted into SNF facilities will remain enrolled in their Medi-Cal plans and will not be disenrolled to FFS Medi-Cal. Medi-Cal plans are responsible for all SNF levels of care, including custodial care, skilled nursing facility care (NF-B), intermediate care (NF-A).[20]

### CONTINUITY OF CARE FOR SNF RESIDENTS

Current residents of SNFs as of January 1, 2023 and those entering a facility during the period from January 1, 2023 to June 30, 2023 can remain in their current SNF residence and do not have to move to a different SNF residence even if the current SNF is not contracted with their new Medi-Cal managed care plan.[21] This protection applies for 12 months. Individuals do not need to request this continuity of care protection from their Medi-Cal plan as it is automatically applied. After 12 months, individuals must request an additional 12 months of continuity of care using established procedures.[22]

To qualify for these continuity of care protections, the facility must be licensed with the California Department of Public Health, have no quality of care concerns under guidance established by DHCS, accept Medi-Cal rates, and be licensed as a Medi-Cal provider.[23] Medi-Cal managed care plans will pay contracted facilities in transitioning counties the same FFS rates as before the transition.[24]

Continuity of care protections apply to both approved treatment authorization requests for services that are included in the SNF rate and for services previously authorized that are exclusive of the SNF rate.[25] Medi-Cal plans are responsible for payment of these services for 12 months.

### INTERMEDIATE CARE FACILITIES AND SUBACUTE FACILITY CARVE-IN

Intermediate Care Facilities and Subacute facilities will be carved into Medi-Cal managed care effective January 1, 2024. DHCS is convening a workgroup to plan for the transition.[26]

## Some Populations Were Mandatorily Disenrolled from Managed Care and Transitioned to Fee-for-Service Medi-Cal

Beginning January 2022, some populations were mandatorily disenrolled from Medi-Cal managed care and into FFS. The primary group moving into FFS Medi-Cal were individuals with a Medi-Cal share of cost (SOC), except for those in long-term care facilities. Medi-Cal individuals with a SOC are excluded from Medi-Cal managed care enrollment in all 58 California counties. This policy applies to individuals dually enrolled in Medicare and Medi-Cal and individuals with Medi-Cal coverage only. This CalAIM policy primarily impacted individuals in CCI and COHS counties.

### SHARE OF COST (SOC) MEDI-CAL INDIVIDUALS LIVING IN THE COMMUNITY

Prior to January 2022, individuals with a SOC in the CCI and COHS counties were required to enroll in Medi-Cal managed care plans. In contrast, in the remaining non-COHS or non-CCI counties, it was voluntary for individuals with a SOC to join Medi-Cal managed care. These differing managed care enrollment rules caused confusion for enrollees and advocates, a person with a SOC in one county could be required to join a Medi-Cal managed care

plan but an individual with a SOC in a neighboring county was not. Under CalAIM's goal to standardize managed care enrollment, all individuals with a Medi-Cal SOC, except those in long-term care facilities, now receive services through Medi-Cal FFS.

Individuals with a Medi-Cal SOC and enrolled in managed care plans, including Medi-Cal plans and Cal MediConnect plans, were disenrolled and moved to FFS Medi-Cal effective January 2022.

**Exception:** Residents of skilled nursing facilities with a Medi-Cal SOC are exempt and remain in Medi-Cal managed care plans. See the section on Long-Term Care Carve-In and Mandatory Managed Care Enrollment for Long-Term Care Residents for more information.

### MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP) POPULATION

Effective January 2022, the Multipurpose Senior Services Program (MSSP) is a FFS Medi-Cal benefit in all counties statewide (except for San Mateo). Prior to January 2022, MSSP was a Medi-Cal managed care benefit in CCI counties.[27] Under CalAIM, MSSP delivery is now standardized in FFS Medi-Cal statewide.

MSSP is a §1915(c) waiver HCBS program, providing wrap around health care and social services to help people remain in their homes instead of living in an institution. There was little, if any, impact to MSSP enrollees in CCI counties. These MSSP beneficiaries continue to receive MSSP services at on-site locations. MSSP providers are now paid through Medi-Cal FFS instead of Medi-Cal managed care plans in the CCI counties.

## Medi-Cal Matching Plan Policy: Enrollment in Matching Medicare and Medi-Cal plans is Required

In 12 select counties, dually eligible individuals enrolled in Medicare Advantage plans that have "matching" Medi-Cal plans must enroll in the Medi-Cal plan that "matches" their Medicare Advantage plan choice.[28] A matching plan means the Medi-Cal plan is affiliated with the same company that operates their Medicare plan. Note that the Medi-Cal matching plan policy does not affect an individual's choice of Original Medicare or limit choices of Medicare Advantage plans. All dually eligible individuals retain the option to choose Original Medicare. If however they choose to enroll in a Medicare plan and if that Medicare plan sponsor also operates a Medi-Cal plan, then the plan sponsor for the Medicare plan enrollment and the plan sponsor for the individual's Medi-Cal managed care plan must align. Health Care Options maintains a list of Medicare and Medi-Cal matching plans by county.[29]

Example: Mr. Jones lives in Alameda county, which is a Medicare Medi-Cal matching plan policy county. He is enrolled in Plan Sponsor A's Medi-Cal plan and in Original Medicare. He decides to enroll in Plan Sponsor B's Medicare plan. Plan Sponsor B also operates a Medi-Cal plan. Because of his choice to join Sponsor B's Medicare plan, the state will disenroll Mr. Jones from Sponsor A's Medi-Cal plan and enroll him in Sponsor B's plan so that his Medicare and Medi-Cal plans align. The Medicare plan choice is primary and the Medi-Cal plan choice follows.

The Matching Plan policy is a separate policy layered onto the general requirement that all full-scope dually eligible individuals join a Medi-Cal managed care plan.

Impacted Counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus.

**Advocacy Tip:** Advocates should keep in mind whether their county is covered by the Medi-Cal matching plan policy. Individuals should be advised that, if their Medicare Advantage plan is affiliated with a Medi-Cal plan, they do not have a Medi-Cal plan choice. They will be automatically enrolled into the matching Medi-Cal plan.

### What if my client is in a Medicare Advantage plan but there is no matching Medi-Cal plan?

The matching plan policy applies if a matching Medi-Cal plan is available. If a matching Medi-Cal plan is not available, then the individual can be in mismatched or unaligned Medicare Advantage and Medi-Cal plans. A dually eligible individual still has to join a Medi-Cal plan, even if mismatched. For example, an individual 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.

## Phase Out of Dual Eligible Special Needs Plan Look-Alikes

Dual Eligible Special Needs Plans (D-SNP) "look-alikes" are Medicare Advantage plans with a high number of dually eligible individuals enrolled in the plan.[30] These plans are not D-SNPs, do not have a contract with DHCS, and are not required to coordinate both Medicare and Medi-Cal services or to provide enhanced protections for their dually eligible members, unlike true D-SNPs. Medicare Advantage plans are considered look-alikes if they have a projected enrollment of 80% or more dually eligible members. CMS will no longer enter into contracts with Medicare Advantage plans that project total enrollment of 80% or more dually eligible members and will not renew contracts with Medicare Advantage plans with actual enrollment of 80% or more dually eligible members.[31] Members of identified D-SNP look-alikes were transferred to a D-SNP operated by the same insurer (if available), another plan with a $0 premium operated by the same insurer (if available), or Original Medicare. This policy applies statewide. Impacted members were transitioned out of D-SNP look-alikes effective December 31, 2022. If additional look-alikes are identified in future plan years, the same process will take place.

Look-alike enrollment grew in large part due to misleading marketing by agents and brokers, including reports that certain populations were targeted, such as those in rural communities or those with limited English proficiency.[32] This led to confusion for dually eligible individuals who believed they were joining a D-SNP that would coordinate their Medicare and Medi-Cal benefits. The federally mandated phase-out of D-SNP look-alikes aligns with DHCS's long-term vision to enhance integrated care options for dually eligible individuals in California.

## Medi-Cal Rx: Medi-Cal Drug Coverage was Carved Out of Managed Care

On January 1, 2022, Medi-Cal's prescription drug benefit was carved out of managed care plans and into FFS Medi-Cal. This means Medi-Cal managed care plans are not responsible for providing or approving prescription drug coverage or related medical supplies[33] for Medi-Cal beneficiaries. While not enacted under the CalAIM framework, this change occurred statewide in all counties and all Medi-Cal managed care plans. For most dually eligible individuals, Medi-Cal Rx does not impact how they access prescriptions, as most access prescription drugs under Medicare Part D. Dually eligible individuals will continue to access prescription drugs through Medicare Advantage or Part D plans.

There are some Medi-Cal covered medications that Medicare does not cover, such as over-the-counter medications and medications for weight loss or gain. Dually eligible individuals can access these medications through the Medi-Cal Rx program.

### EXCEPTIONS

Medi-Cal Rx does not apply to Programs for All Inclusive Care for the Elderly (PACE), Senior Care Action Network (SCAN) Fully Integrated Dual Eligible (FIDE) plans, and Major Risk Medical Insurance Program (MRMIP).

# MEDICARE MEDI-CAL PLANS–THE STATE'S LONG-TERM VISION FOR DUALLY ELIGIBLE INDIVIDUALS

California is looking to integrated Medicare and Medi-Cal plan models, called Medicare Medi-Cal Plans or MMPs, as a way to better serve dually eligible individuals and promote coordinated care across the Medicare and Medi-Cal delivery systems. MMPs are currently only available in CCI counties and will eventually be available in every California county by 2026. MMPs are a plan choice amongst the various Medicare delivery options, including Original Medicare and other Medicare Advantage plans, including Dual Eligible Needs Plans (D-SNPs).

## What are MMPs?

A MMP is California's specific name for exclusively aligned D-SNPs and an affiliated Medi-Cal managed care plan operated by the same D-SNP parent sponsor.[34] Members of MMPs enroll into the D-SNP for their Medicare benefits and a matching Medi-Cal plan for their Medi-Cal benefits. This type of matching alignment is termed exclusively aligned enrollment (EAE).[35] MMPs are integrated plan models aimed at improving integration of Medicare and Medi-Cal benefits and improving care coordination between the two insurance programs. The MMPs build upon the Cal MediConnect plan model that combined Medicare and Medi-Cal benefits into a single plan. MMPs began January 1, 2023.

D-SNPs are Medicare Advantage plans that limit enrollment to dually eligible individuals. D-SNPs are specifically designed to improve health outcomes and increase coordination between Medicare and Medi-Cal benefits.[36] In the exclusively aligned enrollment model, the D-SNP insurer must have an affiliated Medi-Cal managed care plan and limit its membership to dually eligible enrollees who are also enrolled in that affiliated Medi-Cal managed care plan. The idea is that because the same insurer is responsible for both Medicare and Medi-Cal, communication between the Medicare and Medi-Cal plan will be improved. The insurer shares financial risk for both Medicare and Medi-Cal benefits and may be financially incentivized to improve care coordination across the two delivery systems.

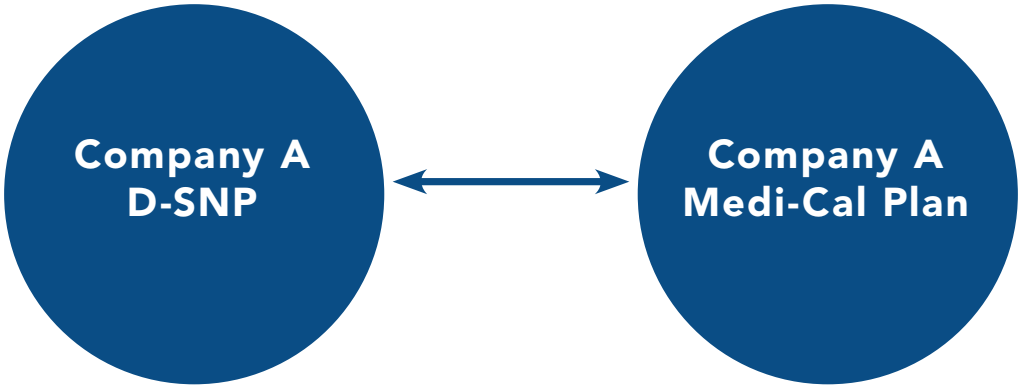
D-SNPs are required to coordinate Medi-Cal benefits across the delivery spectrum, whether Medi-Cal fee-for-service or managed care.[37] D-SNP sponsors sign contracts with the state Medicaid Agency, DHCS, outlining their obligations.[38] DHCS maintains a comprehensive D-SNP Policy Guide outlining the responsibilities of D-SNPs in California.[39]

Enrollment into MMPs is voluntary. Dually eligible individuals are not automatically enrolled into a MMP plan.

## Where are MMPs available?

MMPs currently operate in the 7 CCI counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara. All Medi-Cal plans statewide will be required to stand up MMP models by 2026.[40]

## Exclusively Aligned Enrollment




## Transition from Cal MediConnect to Medicare Medi-Cal Plans (MMPs)

Cal MediConnect was a demonstration program that combined Medicare and Medi-Cal benefits into a single, integrated managed care plan. Cal MediConnect enrollment was limited to dually eligible individuals and authorized by §1115 waiver authority as part of the Financial Alignment Initiative. Cal MediConnect was initially a three-year demonstration pilot under the CCI and extended multiple times. Cal MediConnect plans were available only in CCI counties. These plans ended December 31, 2022 and were replaced by Medicare Medi-Cal Plans (MMPs), which continue to be operated by the former Cal MediConnect plan insurers.

Cal MediConnect members received written and telephonic notice about the 2023 transition to a MMP in Fall 2022. Cal MediConnect members had the option to join the MMP, enroll into a separate Medicare Advantage plan, return to Original (fee-for-service) Medicare, or enroll into a Program of All-Inclusive Care for the Elderly (PACE), if eligible and available in their zip code.[41] Enrollees of Cal MediConnect plans were transitioned into MMPs operated by their former Cal MediConnect plan on January 1, 2023 if they did not make a choice otherwise.

## Eligibility for MMP Enrollment

MMP membership is limited to full benefit dually eligible individuals age 21 and older.

## MMP Covered Services

MMP plan coverage includes Medicare and Medi-Cal covered services, including hospital services, outpatient services, durable medical equipment, long-term care, transportation, vision, and prescription drug coverage. The D-SNP is responsible for Medicare Part A, B, and D benefits and the Medi-Cal plan is responsible for Medi-Cal services delivered through managed care. Existing Medi-Cal services provided through FFS Medi-Cal continue to be provided in the FFS Medi-Cal delivery system, such as In-Home Supportive Services (IHSS). Medi-Cal covered prescriptions are delivered through Medi-Cal Rx. *See the Medi-Cal Rx section of this guide for more information.*

## Medicare Continuity of Care Protections

On the Medicare side, D-SNPs, as part of the MMP, must offer continuity of care for providers, durable medical equipment, and prescription drugs for individuals newly enrolling into the D-SNP. These protections are in place to ensure continued access to Medicare providers and covered services for new MMP members. For Medi-Cal covered services and providers, Medi-Cal continuity of care protections apply.[42]

Continuity of care requests can be made by telephone and a paper form cannot be required. The individual member, their authorized representative, or provider, can make direct requests to the D-SNP for continuity of care requests. The D-SNP must act on continuity of care requests within at least 30 days from the date the request is received by the D-SNP, or within 15 days if there is an immediate or urgent need, such as upcoming appointments or urgent care needs, or within 3 days if there is a risk of harm to the individual.[43]

D-SNPs are also required to accept and approve retroactive continuity of care requests if all criteria is met. Retroactive continuity of care requests occur when an individual is seen and treated by an out-of-network provider without prior approval from the D-SNP. The provider can seek retroactive payment from the D-SNP as long as the continuity of care criteria are met, the dates of service are within 30 days of the first date of service requested, and the request for payment is made within 30 days of services rendered.[44] There are exceptions to the 30-day period if the provider submitted the claim to the wrong entity for payment.

## CONTINUITY OF CARE FOR MEDICAL PROVIDERS

If an individual's preferred Medicare primary or specialty provider is not in network with the MMP, they can make a continuity of care request to the MMP. The MMP must grant the request if three criteria are met:[45]

- A member has an existing relationship with a primary or specialty care provider. An existing relationship is established if the beneficiary has seen their provider at least once within the 12 months preceding plan enrollment for a non-emergency visit;
- The out-of-network provider is willing to accept, at a minimum, payment from the D-SNP based on the current Medicare fee schedule; and
- The out-of-network provider would not otherwise be excluded from the MMP's network due to quality of care issues

If continuity of care criteria are met, the plan should approve the out-of-network provider services for a time-limited period, at minimum twelve months.[46] D-SNPs must notify members at least 30 days in advance of the end of the continuity of care period. D-SNPs are not required, but may choose to extend the continuity of care period beyond the initial 12-month period.

## CONTINUITY OF CARE FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Continuity of care protections also extend to durable medical equipment (DME), supplies, and vendors covered by Medicare or Medi-Cal.

For Medicare-covered DME, individuals joining the D-SNP with an existing DME rental must be allowed to keep their existing rental equipment until the D-SNP can evaluate the member and replacement equipment is in the possession of the member and ready for use. For Medicare-covered supplies, the newly enrolled individual can continue to use their existing Medicare supplier for a minimum of 90 days and until the D-SNP has reassessed the member, and if medically necessary, supplies are authorized and an in-network provider has delivered the supplies.[47]

DME may be covered by either Medicare or Medi-Cal due to differences in the medical necessity criteria applied under Medicare or Medi-Cal. For Medi-Cal covered DME or supplies not covered by Medicare, such as incontinence supplies, there are continuity of care protections under Medi-Cal.[48]

### CONTINUITY OF CARE FOR PRESCRIPTION DRUGS

For prescription drugs, MMPs must also follow the Medicare Part D rules on transitions. This includes a one-time prescription 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 in the MMP formulary or is subject to utilization management controls.

## Integrated Materials

MMPs are required to use integrated materials addressing Medicare and Medi-Cal benefits. Integrated plan materials include the summary of benefits, the member handbook, provider and pharmacy directory, and a single member identification card. MMPs are required to make all integrated materials available in the Medi-Cal threshold languages for their service area.[49]

## Appeals and Grievances

A key feature of MMPs is provision of unified and integrated Medicare and Medi-Cal appeal and grievance processes at the plan level.[50] Enrollees have a single pathway to file a grievance or appeal, regardless of whether the disputed service is a Medicare or Medi-Cal covered benefit. This unified process applies to grievances, organization determinations, and reconsiderations,[51] and requires integrated materials, including plan level integrated denial notices and decisions.[52] The MMP is required to review prior authorization requests for a service or treatment under both Medicare or Medi-Cal standards.

The enrollee does not need to file separate appeals or grievances. Appeals at the internal plan level also must be reviewed under Medicare and Medi-Cal criteria. Plans are required to issue a single decision that addresses both Medicare and Medi-Cal coverage rules.

For appeals after the MMP plan level, enrollees can pursue separate appeals through the Medicare and Medi-Cal external appeal process. Enrollees can pursue appeals through Medicare or Medi-Cal, or through both routes simultaneously.

### ARE PART D PRESCRIPTION DRUGS PART OF THE UNIFIED APPEAL PROCESS?

No, Medicare Part D Appeals are not subject to the unified appeal process. Part D covered prescription drugs follow the Medicare Part D appeal process. To learn more about the Part D appeal process, please refer to Appendix A.

## Deeming

As part of their contract with DHCS, all MMPs must offer at least three months of deeming.[53] Deeming is a protection that preserves enrollment into the MMP. Only dually eligible individuals with full Medicare and Medi-Cal coverage are eligible for MMPs. If an individual's Medi-Cal benefits are discontinued or a Medi-Cal SOC is assessed, the member is not a full dual eligible and is ineligible for the MMP. This deeming period gives the MMP enrollee time to restore the Medi-Cal eligibility needed for enrollment in the MMP. If the individual reestablishes eligibility within the 90 day deeming period, enrollment will not be disrupted. If the individual does not reestablish eligibility, they will be disenrolled from the MMP. Enrollees will receive a notice when deeming is triggered and a disenrollment notice if eligibility is not reestablished.

Individual plans can choose to offer longer periods. Advocates are encouraged to contact their local MMP to determine the deeming period length that is offered.

### Enrollment and Disenrollment from Medicare Medi-Cal Plans

Individuals can enroll or disenroll from a MMP (or any other Medicare Advantage plan) once per quarter using a Special Enrollment Period (SEP). The three SEP periods are January to March, April to June, July to Sept 30 of every year. The enrollment or disenrollment choice will be effective the first day of the following month if a change is made in the first three quarters of the year. During the fourth quarter, dually eligible individuals must use the Annual Enrollment Period (Oct. 15 – Dec. 7), with their changes becoming effective January 1 of the following year.

Individuals will be automatically disenrolled from a MMP plan if they enroll in another Medicare product during a valid enrollment period. For example, if an individual enrolls in a different Medicare Advantage plan or in a different Part D plan, that enrollment choice effectuates disenrollment from the MMP.

Enrollment and disenrollment requests can be made by contacting the desired Medicare Advantage plan, contacting 1-800-Medicare, submitting a Medicare plan enrollment request via Medicare.gov, or contacting the current MMP to disenroll to Original Medicare. There are other SEPs and enrollment periods where an individual may disenroll from a MMP or other Medicare Advantage plan.[54]

### What about Part D?

MMP plans include prescription drug coverage. The D-SNP portion of the MMP is responsible for Medicare Part D prescription drug benefits. Accordingly, individuals moving from Original Medicare into a MMP are automatically disenrolled from their former Part D plan. They will receive a notice from their Part D plan informing them that they are being disenrolled.

A dually eligible individual who decides to disenroll from the MMP into Original Medicare will need to choose a new Part D plan. If they do not choose a Part D plan, they will be passively enrolled into a benchmark Part D plan. Passive enrollment into a Part D benchmark plan is random and the plan may not cover all the individual's prescribed medications. Advocates should encourage individuals to review plan formularies and affirmatively choose a plan that meets their needs. HICAP counselors can provide unbiased assistance. During the period of time after disenrollment from the MMP but prior to assignment to or choice of a new Part D plan, the individual will receive prescription drug coverage through the Limited Income Net Program (LINET).[55]

## NEW MEDI-CAL MANAGED CARE BENEFITS

Enhanced Care Management and Community Supports are two new CalAIM services intended to improve health equity and address the social determinants of health (SDOH), such as access to food, transportation, education, and housing. SDOH can lead to poor health outcomes and increase preventable health inequities that affect low-income populations.[56] Medi-Cal health plans are responsible for identifying and connecting qualifying individuals to these services.

## Enhanced Care Management

Enhanced Care Management (ECM) is a new Medi-Cal case management benefit intended to serve the most vulnerable and highest need individuals with comprehensive care management.[57] The vision for ECM is to coordinate care across the physical and behavioral health delivery systems for the highest-risk Medi-Cal managed care plan members.[58] ECM is only available through membership in a Medi-Cal managed care plan.[59] ECM was first introduced in January 2022 in select counties and expanded statewide in July 2022. ECM will be provided primarily through in-person interactions where individuals live, seek care, or prefer to access services.[60]

ECM is available to specific "populations of focus" who meet the ECM criteria.[61] There are several populations of focus but older adults and people with disabilities may fall into the following groups:

- Individuals and families experiencing homelessness
- Adults living in the community who are at risk of institutionalization
- Adult nursing facility residents who want to transition to the community
- Adults who are high utilizers of certain high-cost services, such as emergency departments and inpatient settings
- Adults transitioning from incarceration
- Adults with a serious mental illness or substance use disorder

**ECM POLICY AGAINST OVERLAP AND DUPLICATION OF SERVICES:**[62]

Some individuals might be receiving care management through other methods, including §1915(c) HCBS waiver enrollees (Assisted Living Waiver enrollees, MSSP enrollees etc), or through D-SNPs. To avoid duplicated services and confusion amongst individuals and care coordinators, some population groups are excluded from ECM services or cannot be enrolled in two programs. This is because these population groups receive case management in other programs that are duplicative of ECM services.

ECM Exclusions:

- Enrollees in SCAN FIDE-SNP plans, PACE, or Exclusively Aligned D-SNP and Medi-Cal plans (MMPs)
- Individuals in FFS Medi-Cal, including Medi-Cal SOC individuals living in the community
- Individuals receiving hospice services
- §1915(c) HCBS Waiver enrollees (may be enrolled in either but not both)

Individuals in FFS Medi-Cal, such as those with a share of cost and living in the community, are not eligible for ECM because they are prohibited from enrollment into Medi-Cal managed care. §1915(c) waiver enrollees cannot be enrolled in both ECM and the §1915(c) waiver at the same time. Because the population groups served by ECM and §1915(c) have overlap and receive similar level of care management, individuals must choose between continuing §1915(c) waiver services or ECM. This exclusion does not apply to individuals on §1915(c) waiver waitlists.

**Advocacy Tip:** Individuals on 1915(c) waiver waitlists may benefit from ECM while they wait for their waiver application to begin. Individuals, their caregivers or relatives, or their provider can make a request for ECM evaluation from their Medi-Cal plan.

## Community Supports

Community Supports are services Medi-Cal plans can offer in lieu of covered benefits to address social determinants of health, such as transportation, economic security and housing security.[63] Community Supports include housing transition services, housing deposits, respite services, and medically tailored meals and others and may be similar to services provided under HCBS waivers. Community Supports are optional and are not a Medi-Cal entitlement, meaning that Medi-Cal plans are not required to offer all 14 pre-approved Community Supports or to offer any at all. However, all Medi-Cal plans currently offer a number of Community Supports.[64] It is also optional for an individual to take up or decline an offer of Community Supports.

Community Supports can be paired with ECM services, such as ECM for adults experiencing homelessness paired with housing deposits under Community Supports. However, an individual does not have to be enrolled in ECM to qualify for Community Supports. For individuals in long-term care facilities that wish to return to the community, community supports relating to long-term care may support a transition to living in the community or community-like settings.[65] Community Supports can supplement services provided through Medi-Cal covered benefits but cannot supplant those services.[66]

The fourteen pre-approved Community Supports are:[67]

1. Housing deposits
2. Housing Transition Navigation Services
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)
6. Day Habilitation Programs
7. Caregiver Respite Services
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications)
12. Medically Supportive Food/Meals/Medically Tailored Meals
13. Sobering Centers
14. Asthma Remediation

**EXCLUSIONS**

Individuals in FFS Medi-Cal, such as those with a share of cost and living in the community, are not eligible for Community Supports because they are prohibited from enrollment into Medi-Cal managed care. Community Supports are only provided through Medi-Cal managed care.

# ENROLLMENT AND LEGAL RESOURCES FOR BENEFICIARIES

The Medicare Medi-Cal Ombudsman Program (MMOP) is available to provide assistance and advice on upcoming changes, how to access care, beneficiary care protections, and appeal and grievance rights. Advocates can contact the MMOP if a beneficiary is having difficulty disenrolling or changing their plan, if the beneficiary has been denied coverage or is experiencing a disruption in care, or with general questions about these changes.

The MMOP program is available by calling (855) 501-3077 (TTY: 855-847-7914), Monday through Friday, 9am-5pm. To find the local program acting as the MMOP in your county, visit the Health Consumer Alliance's website.

Individuals should contact their local Health Insurance Counseling & Advocacy Program (HICAP) to receive free individualized choice enrollment counseling for Medicare Advantage and Part D prescription drug plans. The HICAP counselors can help beneficiaries review their choices and make an informed decision. The HICAPs can be reached at (800) 434-0222.

# APPENDIX A: WRITTEN RESOURCES

- Justice in Aging and National Center on Law and Elder Rights (NCLER):
  - D-SNPs: What Advocates Need to Know (Justice in Aging)
  - Part C Medicare Advantage Basics (NCLER)
  - Part D Basics and Appeals (NCLER)
- National Health Law Program: Advocates Guide to Medi-Cal Services
- Western Center on Law and Poverty: Getting and Keeping Coverage for Low-Income Californians: A Guide for Advocates

# APPENDIX B: CalAIM TIMELINE

| Policy | Effective Date | Number of Counties | Counties | More Information |
|---|---|---|---|---|
| Medicare Advantage Matching Plan Policy | January 2022 & January 2023 | 12 | Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, and Stanislaus counties | Medi-Cal "Matching Plan Policy" for Dual Eligibles, *Dept. of Health Care Services* |
| Medicare Medi-Cal Plans* | January 2023 | 7 | CCI counties: Los Angeles, Orange County, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara | Medicare Advantage Information, *Dept. of Health Care Services*<br>*To be expanded statewide by January 2026 |
| Mandatory Medi-Cal Managed Care Enrollment for Dually Eligible Individuals | January 2023 | 58 | Statewide, primarily Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tuolumne, Tulare, and Yuba | Statewide Medi-Cal Managed Care Enrollment for Dual Eligible Beneficiaries in 2023, *Dept. of Health Care Services* |
| Long-Term Care Carve-In | January 2023 and January 2024 | 31 | Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Kern, Kings, Madera, Mariposa, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, Sierra, Stanislaus, Sutter, Tehama, Tuolumne, Tulare, and Yuba. | CalAIM Long-Term Care Carve-In Transition, *Dept. of Health Care Services* |
| Mandatory Medi-Cal Managed Care Enrollment for §1915(c) Home and Community Based Waiver Enrollees | January 2023 | 58 | Statewide | CalAIM 1915(b) Waiver Application, *Dept. of Health Care Services* |
| Mandatory Fee-For Service (FFS) for Share of Cost (not in LTC) | January 2022 | COHS and CCI counties | COHS and CCI counties | CalAIM 1915(b) Waiver Application, *Dept. of Health Care Services* |
| Multipurpose Senior Services Program (MSSP) Carve Out to Fee For Service | January 2022 | 6 Counties | CCI counties except for San Mateo: Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara | CalAIM 1915(b) Waiver Application, *Dept. of Health Care Services* |

| Policy | Effective Date | Number of Counties | Counties | More Information |
|---|---|---|---|---|
| Enhanced Care Management | January 2022 | 58 | Statewide | Enhanced Care Management and Community Supports, *Dept. of Health Care Services* |
| Community Supports | January 2022 | 58 | Statewide | Enhanced Care Management and Community Supports, *Dept. of Health Care Services* |

# ENDNOTES

1 Dept. of Health Care Services §1915(b) waiver application; §1115 Waiver Application.

2 Welf. & Inst. Code 14184.200; All Plan Letter (APL) 21-015.

3 These zip code are 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398. See APL 21-015 above.

4 This group includes individuals with other health coverage. In CCI counties, dually eligible individuals with other health coverage could voluntarily enroll in Medi-Cal managed care. After January 2023, managed care enrollment became compulsory.

5 Welf. & Inst. Code 14184.200(c)(1)

6 Id.; APL 21-015 and APL 21-015 Attachment 1.

7 Rural zip codes: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398.

8 Welf. & Inst. Code 14184.200(c)(1); California also received federal approval through their CalAIM §1115 renewal and §1915(b) waiver applications.

9 Dept. of Health Care Services, Medi-Cal Managed Care for Dual Eligible Beneficiaries: Outreach Materials and Notices.

10 Welf. & Inst. Code 14184.200(c)(2)

11 PACE and FIDE are delivery systems that integrate Medicare and Medi-Cal benefits through a comprehensive model. Medicare and Medi-Cal benefits are delivered through a single, integrated managed care model through PACE or FIDE health plans.

12 Cal. Code Regs. tit. 22 § 53887.

13 APL 22-032.

14 See DHCS, "Statewide Medi-Cal Managed Care Enrollment for Dual Eligible Beneficiaries."

15 Improper billing occurs when medical providers charge dually eligible individuals for co-pays, co-insurance, or deductibles. Dually eligible individuals are protected from improper billing under both federal and state law. See 42 U.S.C. Sec. 1396a(n)(3)(B); Welf. & Inst. Code § 14019.4. See Justice in Aging's Improper Billing webpage for resources and template letters.

16 APL 18-008.

17 APL 18-008 at pg. 11.

18 Welf. & Inst. Code 14184.201; The ICF and Subacute transition into managed care was originally slated for July 2023. DHCS proposed trailer bill language proposing to delay the transition until January 2024. Proposed language is available.

19 See APL 22-018.

20 DHCS, Skilled Nursing Facility Carve-In Frequently Asked Questions.

21 See APL 22-018 at pg. 6.

22 See APL 22-018 and APL 18-008.

23 Welf. & Inst. Code 14182.17 and APL 22-018 at pg. 6.

24 These rates must be honored between January 1, 2023 to January 1, 2025. Welf. & Inst. Code 14184.201(b)(2); see also APL 22-018.

25 APL 22-018 at pg. 6-7.

26 More information can be found on DHCS's webpage on the LTC Carve-In.

27 MSSP was carved into Medi-Cal managed care plans in the 7 CCI counties as part of the CCI in 2014. Prior to 2014, MSSP was a FFS benefit in the 7 CCI counties.

28 DHCS, "Medi-Cal "Matching Plan Policy" for Dual Eligibles."

29 For a full list of the Medicare and Matching Medi-Cal plans, visit Health Care Options website.

30 Georgia Burke, "Dual Eligible Special Needs Plan Look-Alikes: A Primer" (2019).

31 42 CFR 422.514(d) & (e); Center for Medicare and Medicaid Services, Dual Eligible Special Needs Plan "Look-Alike" Transitions for Contract Year 2023.

32 Burke, Dual Eligible Special Needs Plan Look-Alikes: A Primer at pg. 3.

33 Durable medical equipment (DME) is excluded from the Medi-Cal Rx transition.

34 DHCS, Medicare Advantage Information.

35 Integrated Care Resource Center, "Glossary of Terms Related to Integrated Care for Dually Eligible Individuals" (March 2021).

36 Georgia Burke, "D-SNPs: What Advocates Need to Know" (2022).

37 42 CFR 422.562(a)(5); see also DHCS 2023 Boilerplate 2023 State Medicaid Agency Contract (SMAC).

38 42 U.S.C. § 1395w-28(f)(3)(d).

39 DHCS, "D-SNP Policy Guide" (January 2023).

40 14184.208(c)(1).

41 PACE does not operate statewide and is available in select counties and zip codes. See DHCS' *Service Areas and Zip Codes* for a detailed list of PACE options and availability.

42 See APL 18-008.

43 D-SNP policy guide at pg. 17.

44 D-SNP Policy Guide at pg. 17.

45 D-SNP Policy Guide at pg. 15.

46 2023 EAE SMAC at pg. 12.

47 2023 EAE SMAC at pg. 19.

48 See APL 18-008.

49 D-SNP Policy Guide at pg. 31; see also APL 21-004.

50 MMPs meet the definition of applicable integrated plans under 42 CFR 422.561. Applicable integrated plans are a type of D-SNP and are required to have an integrated appeal process. See 42 CFR 422.107(c)(9).

51 42 CFR § 422.629-634; see also D-SNP Policy Guide.

52 42 CFR 422.631(d).

53 DHCS, 2023 EAE SMAC.

54 Medicare Rights Center, Special Enrollment Periods for Medicare Advantage Plans and Medicare Part D Drug Plans; see also Medicare.gov, "Special Enrollment Periods."

55 LINET ensures that low-income individuals do not lose access to prescription drug coverage. For more information, visit Humana's LINET Pharmacy resources page.

56 California Department of Public Health, An Update on The Portrait of Promise: Demographic Report on Health and Mental Health Equity in California, (February 2020).

57 Welf. & Inst. Code 14184.205.

58 ECM Policy Guide at pg. 56.

59 Welf. & Inst. Code 14184.205(b)(2).

60 CalAIM, Enhanced Care Management Fact Sheet.

61 Welf. & Inst. Code 14184.205(d); see also ECM Policy Guide.

62 See the chart on p. 56 of ECM Policy Guide for exclusions.

63 Welf. & Inst. Code 14184.206; see also DHCS, Community Supports Policy Guide, (January 2023).

64 DHCS, Community Supports Election Map (Updated February 2023).

65 These include Nursing Facility Transition/Diversion to Assisted Living Facilities, Community Transition Services/Nursing Facility Transition to a Home; Environmental Accessibility Adaptations (Home Modifications); Respite Services; and Personal Care and Homemaker Services.

66 Community Supports Policy Guide at pg. 12.

67 For definitions and eligiblity criteria, see Community Supports Guide pp. 7-54.