Disability Rights California

California's Protection & Advocacy System

Coordinated Care Initiative: Basics for Consumers

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1. What is the CCI?

The Coordinated Care Initiative (CCI) is a program that changed the way certain people in California get their health care and their long-term services and supports (LTSS). The CCI combines and coordinates certain health and other services, including mental health and other long-term services and supports (LTSS). The CCI affects people who get Medi-Cal only and people who get both Medi-Cal and Medicare (dual eligibles) who reside in one of these seven counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Under the CCI:

Most people who get Medi-Cal must enroll in a Medi-Cal managed care health plan to receive Medi-Cal services. Your Medi-Cal health plan coordinates your Medi-Cal covered services and helps arrange the care you need. In most counties, there is a choice of two plans. If you did not choose one, the state chose one for you.

- You will receive most long-term services and supports from the Medi-Cal managed care plan. Those services are **Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and nursing home care.** In-Home Supportive Services (IHSS) are provided through the IHSS office in your county. Your Medi-Cal managed care plan should refer and connect you to needed IHSS services. For more information on your county's IHSS office, see: http://www.cdss.ca.gov/inforesources/County-IHSS-Offices

- Dual eligibles (people who get Medicare and Medi-Cal) who want to get Medicare services through managed care can voluntarily enroll in a health plan that combines Medicare and Medi-Cal, called "Cal MediConnect." While enrollment in a Medi-Cal managed care plan is required in most cases, individuals have a choice to enroll in a Cal MediConnect plan for both Medicare and Medi-Cal.
- Dual eligibles do not have to change their Medicare services but most will have to be in managed care for their Medi-Cal services.

For a chart of who is included and excluded from Cal MediConnect, see: http://www.calduals.org/wp-content/uploads/2015/03/CCI-Participating-Populations_March2015.pdf

2. Why did I get a notice from the State telling me I have to choose a health plan?

If you got a notice from the State, it means that you are in one of the groups of people affected by the CCI. The groups who receive notices are those individuals who are still in fee-for-service Medi-Cal, who are new dual eligibles, or who move from a non-CCI county to a CCI county. These individuals will need to choose a Medi-Cal plan or will be automatically enrolled in one. They also have the choice to enroll in a Cal MediConnect plan if they are dual eligibles. These individuals will have thirty days to make a Medi-Cal plan choice.

3. I get Medi-Cal only. How does the CCI affect me?

Most Medi-Cal only recipients are required to enroll in Medi-Cal managed care. This includes people who are in nursing facilities. People who may not have to enroll in Medi-Cal managed care:

- are children under 21; or
- live in certain rural zip codes; or
- have other health coverage in certain counties; or
- live in a veterans' home or ICF-DD in certain counties.

See each county's Medi-Cal managed care plans to learn more, available at: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx, or see www.calduals.org for more information.

Under the CCI, you will get most of your Long-Term Services and Supports (LTSS) through your managed care plan: nursing facilities, Community Based

Adult Services (CBAS), and the Multi-Purpose Senior Services Waiver (MSSP). This means that your providers must have a contract with your Medi-Cal plan in order for you to receive covered services and for the provider to be paid for these services.

If you live in a county with two managed care plans and you do not choose a plan, the State chooses one for you. The only way to avoid enrolling in a Medi-Cal managed care plan is to apply for a Medical Exemption Request (MER), which, if granted, allows you to put off enrolling for up to 12 months. If your MER is granted, you do not have to enroll in managed care for your long term services and supports. The State says MERs are only available for people who get Medi-Cal only, not dual eligible, and only in limited circumstances. See Question 11 for more information about MERs.

4. I get Medicare and Medi-Cal. How did the CCI affect me?

If you get both Medicare and Medi-Cal, you are called a "dual eligible." If you are a dual eligible and you live in one of the seven counties (see Question 1), the CCI affects you in two ways:

A. You are generally required to enroll in a Medi-Cal managed care plan to get your Medi-Cal benefits, including most LTSS;

AND

B. You can enroll in a managed care plan that combines Medicare and Medi-Cal benefits, also called Cal MediConnect.

There are some dual eligibles who are not eligible for Cal MediConnect. These are people who:

- Are Regional Center clients (for more information, see: http://www.calduals.org/wp-content/uploads/2013/05/FAQ-DD-5.8.13.pdf) ; or
- Are children under age 21; or
- Do not routinely meet their Medi-Cal share of cost.

Dual eligibles who are enrolled in other programs, like the Program of All-Inclusive Care for the Elderly (PACE) or a Medicare Advantage plan or who are enrolled in a Home & Community-Based Services (HCBS) waiver, will be disenrolled from that program if they enroll in Cal MediConnect.

5. I get Medicare but not Medi-Cal. How does the CCI affect me?

If you get only Medicare (and not Medi-Cal also), the CCI does not affect you.

6. I do not live in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, or Santa Clara counties. How does the CCI affect me?

If you do not live in one of the seven counties, the CCI does not affect you. If you move into a CCI county, you will likely have to enroll in a Medi-Cal plan.

7. I am enrolled in Cal MediConnect. Can I disenroll?

Before you disenroll, you should make sure that is the right choice for you. Cal MediConnect may offer you more services than you could get under fee for service Medicare, or Medicare Advantage, including vision and care coordination services. On the other hand, certain doctors and regular medical providers you want to see may not be part of Cal MediConnect. It is very important to make an informed decision and to get help in deciding whether to enroll or disenroll from Cal MediConnect.

If you enrolled in Cal MediConnect, you can disenroll at any time from the Medicare managed care portion only. You cannot disenroll from Medi-Cal managed care. To find out who to call for help in making these decisions, see separate county materials available at www.calduals.org.

8. What are my options if I am dually eligible (have both Medicare and Medi-Cal) and want to enroll in Cal MediConnect now?

You can enroll in Cal MediConnect at any time by calling Health Care Options (at 1-844-580-7272) or the Cal MediConnect plan you want to join. If there is a specific Cal MediConnect plan you want to join, you could also contact them to get more information. See question 7 and 10 about what to look for in choosing a plan under Cal MediConnect.

9. I got a notice about enrolling in Medi-Cal managed care. What happens if I don't enroll?

Since enrollment in Medi-Cal managed care is mandatory for almost all Medi-Cal recipients, you either will choose a plan or the State will choose one for you. See separate materials about your county to learn more about the plan(s) available to you at http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx, or at www.calduals.org.

10. Could I keep my doctor if I enrolled in managed care? What if my doctor does not belong to the managed care plan that I enrolled in?

One of the most important things to look for in a Cal MediConnect or Medi-Cal managed care plan is whether your doctor and your other regular medical providers are part of the plan. Call your doctor to ask if she or he is part of a managed care plan you enrolled in. If your doctor(s) are not part of the plan you enrolled in, then you can:

- Call the plans in your county to get a list of the doctors who are part of your county's plans and call them to find out if they are taking new patients and if they would be a good fit for your needs.
- If you have Medicare, you can opt out or consider disenrolling from Cal MediConnect. You will be able to keep seeing your doctor and your primary care providers. You will likely still need to enroll in a Medi-Cal managed care plan, but you will not need to consider whether your Medicare doctors are part of this plan's network since Medicare will be the primary insurer.
- If you get only Medi-Cal, you should have asked for a Medical Exemption Request to delay enrolling in Medi-Cal managed care. If you did not submit a MER prior to enrollment, this is no longer an option for you. If you are new to Medi-Cal and live in a CCI county, or have been on Medi-Cal and recently moved to a CCI county, you may still request a MER. See Question 11 for more information.
- If your doctor is not part of your plan, you should have been able to keep seeing your regular doctor for 12 months even if you enrolled in Cal MediConnect or Medi-Cal managed care. See Question 12 about Continuity of Care for more information.

If I am new to Medi-Cal, can I get a Medical Exemption from Medi-Cal managed care?

If you are new to Medi-Cal (and receive only Medi-Cal) and live in one of the seven CCI counties, or you recently moved to one of the seven CCI Counties and receive only Medi-Cal, you may be able to request an exemption from enrolling in Medi-Cal managed care. You and your doctor should fill out the Medical Exemption Request (MER) form. Call Health Care Options (HCO) at 1-800-430-4263 or 1-844-580-7272 to get a copy of the MER form. You can access the form here: https://www.healthcareoptions.dhcs.ca.gov/sites/default/files/Documents/MU_00003383_ENG_TempMedExemptionWEB.pdf

When you request a MER, your doctor should include information describing the ongoing medical supervision and/or complex medical treatment you receive, and why this prevents you from transferring into managed care. Call HCO if you have any questions. You or your doctor can receive help with your MER by calling the Medi-Cal managed care ombudsman at 1-888-452-8609, or sending an email to the following address: merhelp@dhcs.ca.gov. If your request is denied, you can file a request for Medi-Cal fair hearing and stay in fee-for-service Medi-Cal pending the hearing. You should ask to stay in fee-for-service Medi-Cal in your request for hearing.

You are NOT eligible for a MER if any of the following apply to you:

- You have been a member of a managed care plan for more than 90 calendar days;
- Your current Medi-Cal provider is contracting with the plan;
- You begin or are scheduled to begin treatment after the date of plan enrollment. 22 C.C.R. § 53887(a)(2)(B)(1)-(3);
- You are a dual eligible, meaning you receive Medicare and Medi-Cal. As a dual eligible, you currently are not eligible for a Medical Exemption for your Medi-Cal Managed Care enrollment; or
- If you are not new to Medi-Cal, and live in one of the seven CCI counties, your timeframe for requesting a MER has passed. This is because if you did not request a MER prior to enrollment, then you were a member of a managed care plan for more than 90 calendar days and barred from requesting one now.

Please note that people with HIV/AIDS or Native Americans may disenroll from Medi-Cal managed care at any time without a MER.

11. Can I keep seeing my doctor even if the doctor is not in my health plan?

You have certain rights to continue seeing your doctors and providers, for a period of time, even if they are not in your health plan. These are called Continuity of Care rules. Doctors and other providers who are not part of the plan are also called “out of network” providers.

If you have Medicare and enroll in Cal MediConnect, you may see your current Medicare medical providers and keep your current service authorizations, for up to 12 months, if:

- You have an existing relationship with the provider before enrolling in Cal MediConnect and you have seen that provider at least once in the last twelve months for a non-emergency visit.
- Your provider will accept either the plan payment rate or the Medi-Cal or Medicare rate, whichever is higher.
- Your provider would not be excluded from the plan’s network because of quality problems or not meeting state or federal requirements.

If you have Medi-Cal only, you may see your current medical providers for up to 12 months, if:

- You have an existing relationship with the provider;
- The provider meets applicable professional standards; has no disqualifying quality of care issues; and if
- The provider will accept the health plan’s rate, or for nursing facilities and Community-Based Adult Services, the applicable Medi-Cal fee-for-service rate, whichever is higher.

Contact your health plan to find out how you and/or your doctor can request Continuity of Care. If your request is denied, you should be able to file an appeal and/or a grievance. See Question 19 for more information.

12. What services do I get from Cal MediConnect?

- Cal MediConnect plans will provide all needed Medicare and Medi-Cal services. This includes:

- Medicare Part A (hospital coverage) and Part B (outpatient coverage)
- Medicare Part D prescription drug coverage
- All required Medi-Cal services, including:
- MLTSS (See Question 14 for more about MLTSS)
- Non-emergency, accessible medical transportation
- Preventative, restorative, and emergency vision benefits
- Non-emergency transportation to medical services
- Care coordination
    - Care Plan Option services, which are not required but may be offered by Cal MediConnect plans. See Question 17 for more information.
- Some Cal MediConnect plans offer additional dental benefits beyond those covered by Medi-Cal Dental.

13. What are Managed Long-Term Services and Supports (MLTSS)?

The LTSS that now is part of Medi-Cal managed care are: nursing facilities, Community Based Adult Services (CBAS) and Multi-Purpose Senior Services Waiver (MSSP).

Nursing facilities: Your managed care plan will refer you to a nursing facility if that is recommended by your doctor and is where you agree to go for treatment. Your Medi-Cal managed care plan will also pay for your nursing facility placement, if it is not paid for by Medicare. Since managed care plans will now have to pay for nursing facility placement, it is possible that they will now be willing and able to pay for services to help you stay in, or return to, the community. Community services are often less expensive and preferred by consumers and their families.

MSSP: MSSP will stay the same for the time being, as managed care plans will have to contract with all MSSP providers in the seven counties, though MSSP services will likely be offered outside of managed care and operate as a waiver benefit in the future.

CBAS: Community Based Adult Services (CBAS), which used to be called Adult Day Health Care (ADHC), has been a Medi-Cal managed care benefit since 2012. People who stopped going to CBAS programs because they did not enroll in Medi-Cal managed care will now be able to go back to CBAS if their managed care plan agrees. People who have not gone to CBAS in the past may ask their

managed care plans to refer them to a local program if they (or their doctor or family) think it would help them stay healthy and avoid going to a nursing facility.

IHSS: In-Home Supportive Services (IHSS) are not provided through your managed care plan, but through the IHSS office in your county. Your Medi-Cal managed care plan should refer and connect you to needed IHSS services. For more information on your county's IHSS office, see: http://www.cdss.ca.gov/inforesources/County-IHSS-Offices

14. Will I be able to keep IHSS under the CCI?

Yes! In-Home Supportive Services (IHSS) are provided through the IHSS office in your county. For more information on your county's IHSS office, see: http://www.cdss.ca.gov/inforesources/County-IHSS-Offices

Even after you enroll in Medi-Cal managed care or Cal MediConnect, you should not notice any changes in your IHSS services. You still are able to hire, fire and supervise your IHSS provider. You still are able to file for a hearing if you are unhappy with a decision about your eligibility or your hours. Your county will continue the IHSS assessment and authorization processes, including final determinations of IHSS hours, and the current IHSS fair hearing process will remain the same.

If you are in Cal MediConnect, you can ask for a care coordination team to help you make your services work better. If you want a team, you can include anyone you want, including your IHSS providers. A Cal MediConnect plan can – but does not have to – offer additional IHSS hours through Care Plan Options (see 17).

15. Can I keep my mental health services under the CCI?

Under the CCI, your plan must provide you with all mental health and substance abuse services that are now covered by Medicare and Medi-Cal. This does not include "carved out" mental health services, which will continue to be provided by county mental health. These "carved out" services include Specialty Mental Health services such as intensive day treatment, crisis intervention, day rehabilitation, residential treatment, targeted case management, and Medi-Cal drug services such as methadone treatment. Your managed care plan will be responsible for coordinating with county mental health if you get county mental health services, and you should continue to get these services and as a result of

the CCI, data sharing agreements are in place between county mental health and managed care plans.

For more on mental health services and the CCI, see:
http://www.calduals.org/implementation/policy-topics/bh-coordination/

16. What are Care Plan Option (CPO) services?

Care Plan Option services (CPO) are services that only Cal MediConnect plans may provide, but they are not required to. CPO services will not be available through Medi-Cal only managed care plans. CPO services may include additional behavioral health (mental health) services, home and community based services, and personal care beyond what is provided by IHSS. CPO benefits may be offered to help people avoid or leave institutional placements, or avoid emergency room visits and hospitalization. CPO benefits may also include:

- Home delivered meals
- Respite (in or out of home)
- Habilitation
- Environmental (home) adaptations
- Other services that the plan decides to provide

Each plan will have to have policies and procedures for providing CPO benefits. Since the State is not requiring Cal MediConnect plans to provide these services, each plan may provide them differently, or not at all. In addition, if you disagree with your plan about CPO benefits, you will not have the same notice and appeal rights that you do with other Medicare and Medi-Cal services. Call your Managed Care Provider or see your Managed Care Provider's website for more information on appealing a CPO service.

17. If I am on a HCBS Waiver, or on a waitlist for one, what will happen to my Waiver services?

If you are on a Home and Community-Based Waiver and you also have Medicare, you must enroll in a Medi-Cal managed care plan for your Medi-Cal benefits, or the State will choose a plan for you. This will not affect your Waiver services, although your managed care plan will have some role in coordinating your Medi-Cal benefits, including the Waiver services. You will keep your Medicare services the way they are now. If you want to participate in Cal MediConnect, you will need to disenroll from your Waiver.

If you are on a waitlist for a Home and Community-Based Waiver and you join Cal MediConnect, you will not lose your place on the Waiver waitlist. When your name comes up on the waitlist, if you want Waiver services, you will have to disenroll from Cal MediConnect and go back to regular Medicare. You will still need to be enrolled in a Medi-Cal managed care plan for your Medi-Cal benefits.

18. What if I disagree with a decision by my managed care plan?

Enrollment: If you are required to enroll in managed care for Medi-Cal services, you cannot appeal that requirement. See Question 11 for information on Medical Exemption Requests.

Services: If you disagree with a decision by your managed care plan about the services you have requested or think you need, there are appeal and grievance rights (except for Care Plan Option benefits, see Question 17).

Important: If you are getting a service and your managed care plan wants to reduce or end the service, make sure to file an appeal within 10 days of getting your notice and request "aid paid pending." This means that your services may continue while your hearing is decided.

Deeming: If it is determined that you are no longer eligible for full-scope Medi-Cal, "deeming" allows you to remain in a Cal MediConnect plan for a certain period of time before being disenrolled from the plan. This provides you a grace period for maintaining Cal MediConnect eligibility. If you are able to reestablish eligibility for full-scope Medi-Cal during this deeming period, you will remain enrolled in Cal MediConnect. If you are not able to reestablish eligibility, you will return to fee-for-service Medicare. For more information, see: http://www.dualsdemoadvocacy.org/wp-content/uploads/2017/04/Updated-Cal-MediConnect-Deeming-042017.pdf

Call Disability Rights California or for more information about your appeal rights in Medi-Cal managed care and Cal MediConnect.

Much of the information contained in this fact sheet comes from the *Advocate's Guide to California's Coordinated Care Initiative*, by Justice in Aging) and the Disability Rights Education and Defense Fund (DREDF). The Guide is available at https://www.justiceinaging.org/wp-content/uploads/2017/12/Advocates-Guide-to-Californias-Coordinated-Care-Initiative-Version-6.pdf

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