Cal MediConnect Demonstration (CMC)
Summary of Changes to the Three-Way Contract

The three-way contract was re-executed on September 1, 2019 with the following updates:

1. Effectuated a three-year extension of the Cal MediConnect demonstration through December 2022 (Section 4.1.2.1 and 5.8). The following provisions were also added as part of the extension agreement:
   
a. Incorporated language throughout the contract to extend the demonstration for an additional 3 years, through December 31, 2022. (Sections 4.1.2 and 5.8.1, Figure 4.2, and Appendix H)
   
b. Added a limited one-sided risk corridor for Demonstration Years 6-8, including one-sided risk corridor parameters, the calculation of gains and losses, clarification on allowable expenditures, and risk sharing settlement. (Sections 4.2.3.3.3 and 4.4 and Figure 4-4)
   
c. Applied additional 1% quality withhold to the Medicare A/B rate component only beginning in Demonstration Year 6. (Sections 4.8.1.3 and 4.9.1.1)
   
d. Beginning in Demonstration Year 5, CMS applied a retrospective financial penalty to the Medicare A/B component of the capitated rate for Medicare-Medicaid Plans (MMPs) with high disenrollment rates, calculated using the existing Medicare Part C measure “Members Choosing to Leave Plan.” The penalty will be calculated annually and applied on a sliding scale starting at one percent and up to two percent. This penalty is intended to address selection bias that may be impacting Medicare costs for the Cal MediConnect Demonstration and to align incentives for MMPs to improve quality for all enrollees. (Section 4.10)

2. Made revisions throughout Section 4 to clarify demonstration financial provisions. These edits include:
   
a. Clarified the risk adjustment stratification for the Medicaid component of the rate for Demonstration Years 4-8. (Section 4.2.1.1.2)
   
b. Clarified that savings percentages will not be applied to the Part D component of the capitated rate. (Section 4.2.3.2)
   
c. Clarified specifications for plan reporting of expenditures for risk corridor specific to Demonstration years 1-3. (Sections 4.3.1.1.2 and 4.3.1.3.1)

3. Clarified that California is allowing for a continuous enrollment period for the demonstration (Section 2.3.2.4, Appendix L)

4. Removed requirement that for current enrollees, a summary of benefits be sent with the annual notice of change. (Section 2.17.5.2)
5. Made revisions throughout to align with Medicaid regulations related to managed care, program integrity requirements, and service requirements (42 CFR Parts 438 and 455):
   a. Added a requirement that MMPs must report all employees, providers, and enrollees suspected of fraud, waste, and/or abuse that warrants investigation. (Section 2.1.4.1)
   b. Added a requirement that MMPs must adopt and implement policies consistent with the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act. (Section 2.1.8)
   c. Added requirement that MMPs permit an out of network Indian Health Care Provider to refer an Indian enrollee to a network provider. (Section 2.10.14.7)
   d. Added requirements related to grievances and appeals, such as adding specificity regarding what must be included in grievance and appeal records, updating timeframes for resolving grievances and appeals, clarifying notification requirements for grievance and appeal decisions, etc. (Sections 2.15.1, 2.15.2, 2.15.3 and 2.15.4)
   e. Added clarification that MMPs may provide notice to enrollees on how to access a member handbook online and how to request a hard copy. (Section 2.17.5.1.1)
   f. Added requirements for MMPs to report to CMS and the state any identified overpayments and to recover overpayments to providers. (Section 4.14.2)
   g. Updated requirement that MMPs report information to the state Medicaid Drug Rebate no later than 45 days after the end of each quarterly rebate period. (Section 5.1.14.2)
   h. Added requirement that contractors make standard contracts available in a timely manner to pharmacies that meet the contractor’s reasonable and relevant standard terms and conditions. (Appendix E)

6. Updated certain care coordination requirements. These edits include:
   a. Incorporated existing DHCS Duals Plan Letter 15-001 provisions regarding Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT) into the three-way contract, including:
      i. Added requirements related to the composition of the ICT, its communication to enrollees, and its purpose. (Section 2.5.2.8)
ii. Added requirement that enrollees must have the opportunity to review and sign the ICP, the MMP must provide a copy of the ICP to the enrollee, and that the ICP must be made available in alternative formats and in an enrollee’s preferred written or spoken language. (Section 2.5.2.9.1)

iii. Added requirement that the ICP must incorporate measurable objectives and timetables as determined through input from member, the HRA, MSSP, CBAS, and other data sources. (Section 2.5.2.11.5)

iv. Added requirement that when appropriate the, MMP coordinate carved-out services, and members are referred to community-based services. (Section 2.5.2.11.6)

b. Clarified that the ICP must be completed within 90 calendar days of enrollment. (Section 2.8.3.1)

c. Updated contract to align with current state policy that member must have seen an out of network provider at least once, not twice, within the previous twelve months in order to continue to receive services from the out of network provider. (Section 2.8.4.1.2.1)

d. Added requirement to reflect the expectation that the MMP coordinates dental care for enrollees. (Sections 2.5.2.6.6, 2.5.2.19.4, and 5.2.13.2.7)

7. Updated grievance and appeal requirements:

a. Removed complaints about quality of care from definition of Exempt Grievance, as complaints about quality of care are not eligible for exemption. (Section 1.44)

b. Clarified that retrospective review of claims applies only to Medi-Cal services, and that the MMP may, at its discretion, apply retrospective review to Medicare services. (Section 2.11.7.3)

c. Updated requirement that the MMP acknowledge receipt of enrollee’s Medi-Cal appeal in writing within five calendar days of receipt. (Section 2.15.3.3.1)

d. Clarified that in the event of conflicting appeals decisions, the MMP must act in accordance with the decisions favorable to the enrollee. (Section 2.15.6)

8. Updates based on Part C and D 2019 rule:

a. Modified eligibility and enrollment language to clarify requirements, including the exclusion of individuals at risk or potentially at risk for overuse of specified prescription drugs from passive enrollment per 42 C.F.R. §§ 423.100 and 423.153(f). (Sections 2.3.1.5.3 and 3.2.1.3)
b. Added requirement that MMPs must ensure that all network providers that deliver Medicare covered services do not appear on the CMS preclusion list. (Sections 2.4.4.4 and 2.9.5)

c. Updated requirement that the MMP provide enrollees with at least 30 calendar days advanced notice regarding certain formulary changes. (Section 2.17.5.8)

9. Made technical corrections, updated cross-references, and performed general clean-up to clarify terms and language:

a. Replaced “medical cost per member per month” with “median cost per member per month” for consistency throughout. (Section 1.5)

b. Removed definition of, and references to, Adverse Action and Public Authority, as the terms are no longer used in the contract. (Sections 1.8.6 and 1.9)

c. Updated name of Medi-Cal-provided dental benefit from “Denti-Cal” to “Medi-Cal Dental” throughout. (Section 1.65)

d. Updated recurrence of DHCS’s CCI Quarterly Network Adequacy Reports to be due quarterly. (Section 2.3.1.5.1)

e. Clarified that intelligent assignment is specific to passive enrollment. (Section 2.3.1.5.4)

f. Clarified the requirements around the deeming period for enrollees with a share of cost. (Section 2.3.2.3)

g. Removed duplicative information related to the MMP requesting for-cause disenrollment of an enrollee. (Section 2.3.2.4.3)

h. Removed Model of Care requirements to align with updated demonstration policy. (Section 2.5.2.11.8.3)

i. Revised requirements for coordination with In-Home Supportive Services (IHSS), as IHSS is carved out of the demonstration. (Section 2.5.2.11.9)

j. In Figures 4.5 and 4.6, updated quality withhold measure names and sources to align with the applicable quality withhold technical notes. Removed the measure descriptions from both figures. Full details and measure descriptions can be found in the quality withhold technical notes.