Cal MediConnect Demonstration (CMC)

This contract was re-executed on January 1, 2018 to:

- Perform general clean-up and make technical changes to streamline provisions across all three-way contracts for the capitated model demonstrations under the Medicare-Medicaid Financial Alignment Initiative. These changes include:
    - Clarifying and updating requirements regarding primary care providers as well as in- and out-of-network Indian Health Care Providers that Indian Enrollees can see (1.58, 2.10.14)
    - Updating model of care requirements to specify the Medicare-Medicaid Plan (MMP) abide by the care delivery model described within the contract and eliminate previous model of care MMP submission requirements (2.5.1, 2.8.2)
    - Updating the MMP out of network reimbursement rules with regard to emergency or urgent care services (2.8.4.1.9)
    - Updating provider network requirements to include mandatory provider education (i.e., beneficiary's grievance, appeal, and fair hearing rights and the procedures and timeframes involved) by MMP upon provider entering into a contract (see 2.9.10.2).
    - Clarifying that the MMP must assist Enrollees with confirming oral Appeals in writing (2.15.3.1)
    - Clarifying that an Enrollee, or their authorized representative, can request a State Fair Hearing either orally or in writing (2.15.3.6.1)
    - Adding language clarifying the quality withhold calculation when a demonstration year crosses a calendar year (4.2.7.1.2)
    - Adding final Medicare reconciliation and settlement language regarding an MMP that terminates or non-renews, and how the CMS final settlement phase for terminating contracts applies to MMPs (4.6.3.1)
- Update the contract in relation to In-Home Supportive Services (IHSS) consistent with the 2017-2018 California Budget associated legislation. These updates include:
    - Clarifying that MMPs coordinate with IHSS for ongoing care coordination and Interdisciplinary Care Team (ICT) participation (2.5.2.6.3, 2.5.2.6.5, 2.5.2.8, 2.5.2.13.2.7)
    - Adding requirements that the MMPs develop and implement processes that support appropriate referral of enrollees to IHSS agencies (2.5.2.16, 2.6.2, 2.6.2.1.2)
    - Clarifying that the CA Department of Health Care Services (DHCS) and California Department of Social Services (CDSS) will continue to provide MMPs with IHSS assessment data (2.6.2.1.3)
    - Updating the IHSS Network section to remove certain MMP responsibilities with respect to the provision of IHSS services, per budget legislation (2.10.7)
    - Updating the payment terms section to indicate that MMPs will no longer receive payments for IHSS as it is not a covered service effective January 1, 2018 (4.3.5.1.2.1, 4.3.6.5, 4.6.2.1)
    - Removing IHSS as a covered service effective January 1, 2018 (A.2.1.3.1)
- Update Care Coordination requirements. These edits include:
    - Adding a definition of Care Coordination (see section 1.19)

    - Mandating that the MMPs provide adequate care coordinator to enrollee ratios in order to support the care coordination requirements of the three-way contract (2.5.2.7.1)
    - Adding a requirement that the care coordinator provide their contact information to an enrollee, and revisit ICT participation when the enrollee's primary care provider changes, even in the event the enrollee initially refuses an ICT (2.5.2.8.8.)
    - Adding a requirement that MMPs engage with enrollees yearly on care planning in the event the enrollee refused to participate in care planning initially (2.5.2.10)
    - Adding a requirement that MMPs share assessment, Interdisciplinary Care Plan (ICP) and other pertinent information with other MMPs for the purposes of care coordination, in the event a beneficiary moves from one MMP to another (2.5.2.12)
- Update ICP requirements. These edits include:
    - Adding a requirement MMPs include the name and the contact information for the MMP care coordinator, enrollee's PCP and any specialists in the ICP (2.5.2.11.1-2), and adding a new requirement that a current list of the enrollee's medication be included in the ICP (2.5.2.11.3)
    - Adding the requirement that the name and contact information for the IHSS county social worker and IHSS worker both be included in the ICP (2.5.2.11.8)
    - Noting that ICP completion deadlines will be noted in a Dual Plan Letter (DPL) (2.8.3.1)
- Clarify and streamline Grievance requirements. These edits include:
    - Adding language clarifying Exempt Grievances (see 1.46, 2.14.2.1.2.7)
    - Creating a consolidated definition of a Grievance, and remove separate definitions for Medicare and Medi-Cal grievances (see 1.51)
    - Adding language clarifying MMP responsibilities related to External Grievances for Medi-Cal services, including reporting Enrollee notification responsibilities (2.14.3.2)
- Clarify MMP obligations with regard to state Knox-Keene licensure (see 1.29, 2.13)
- Add a definition of MMP (1.79)
- Clarify the process that DHCS and CMS will follow prior to DPL issuance in the event an All Plan Letter is applicable to an MMP (see 2.1.6)
- Clarify current enrollment processes. These changes include:
    - Adding language regarding Streamlined Enrollment, consistent with current demonstration enrollment processes (1.99, 2.3.1.7, 2.17.1.1.2)
    - Clarifying the state's intelligent assignment process as it relates to beneficiaries in Dual Special Needs Plans (DSNPS) with corresponding MMP products (2.3.1.5.3.1.2)
- Add language to clarify that enrollees with a share of cost who do not meet their share of cost on the first of the month, will be deemed eligible for up to two months (see 2.3.2.3 and Appendix J)
- Update language around Care Plan Option (CPO) Services. These updates include:
    - Clarifying that an appeals process applies to CPO services (1.21, 2.4.3.1)
    - Removing potential CPO services that are also home- and community-based services (2.4.3.3.2)
- Require that the MMP include the name and telephone number of the health care professional responsible for the delay, denial or modification of an authorization request that in any written communication to a physician or other health care provider (2.11.5.5.4)
- Update language on the timing of MMP rate reports from twice annually to annually (4.1.2)

- Update timing of CMS and DHCS payment settlements to MMPs and more accurately reflect final reconciliation timing (4.3.1.1.3, 4.3.1.3.2, 4.3.3.1.2)
- Update language to provide more accurate and nuanced MMP payment terms (4.3.5)
- Update the MMP and county Behavioral Health shared accountability terms to reflect the demonstration extension (4.3.7.4.1)
- Update the Non-Medical Transportation and Non-Emergency Medical Transportation Benefits consistent with California state law (A.3.2.)
- Update requirements relative to IHSS recipients with a share of cost (Appendix J)
- Remove Appendix K as initial passive enrollment has concluded