Cal MediConnect Capitated Financial Alignment Model Demonstration (CMC)

Summary of Changes to the Three-Way Contract

The three-way contract was re-executed on June 1, 2022 with the following updates:

1. The following provisions were added or adjusted for the demonstration close-out and transition to D-SNPs:
    a. Removed the requirement that enrollment into Medicare-Medicaid Plans (MMPs) terminate six months prior to the end of the demonstration given that 2022 eligibility rules in California provide limited integrated care options for dually eligible beneficiaries in demonstration counties absent the demonstration. Eligible beneficiaries can elect an MMP through the end of 2022, and will be automatically transitioned to a D-SNP operated by the same parent organization as their MMP effective January 1, 2023. (Section 2.3.1.2)
    b. Added language recognizing California's current ongoing stakeholder process meets demonstration phase-out plan requirements articulated in Section III.L.4 of the MOU, (Section 3.3)
    c. Added Medicare waivers to allow for the following demonstration close-out activities:
        i. Allow MMPs to discuss the MMP transition with their current enrollees earlier than 90 days until the end of the demonstration (L4)
        ii. Allow plans to utilize a special integrated Annual Notice of Change/Evidence of Coverage for 2023

2. The contract was updated to reflect changes in benefits for Demonstration Year (DY) 8:
    a. Added new requirements with respect to the Community Supports benefit (Sections 1.25, 2.43, 2.44, 2.5.2.19)
    b. Updated to reflect the carve-out of Multi-Purpose Senior Services Program (MSSP) benefit effective January 1, 2022. New language added requiring MMPs coordinate with MSSP programs and sites for Demonstration Year (DY) 8 (Section 1.83, 2.5.2.12.10, 2.5.2.8.8.7, 2.6.1, 2.6.2.4, 2.9.1, A.2.1.3.2, Appendix J)

3. The below provisions adjusted requirements with respect to marketing or enrollee communications:
    a. Added or updated language with respect to reasonable accommodations, standard formats and enrollee communications to members with limited English proficiency (2.11.1.2, 2.11.1.5, 2.17.2.4)
    b. Added or clarified marketing and enrollee communication provisions:
        i. Updated requirements with respect to Enrollee Service telephone Responsiveness (2.11.2.1)
        ii. Added pharmacy technical health call center requirements (2.13.3)
        iii. Updated citations with respect to Marketing, Outreach and enrollee communications (Section 2.17, Appendix G, Appendix H)

4. The below provisions were adjusted with respect to appeals and authorization requirements:
    a. Updated authorization decision and notification requirements with respect to Medicare Part D drug and non-Medicare Part D drugs (Section 2.11.5, 2.11.5.6, 2.11.5.7, 2.15.1.2, 2.15.1.3)
    b. Added language regarding the dismissal of appeals (2.15.3.6)

5. Updates and clarifications were made to the finance provisions in Section 4:
    a. Updated the underlying rate structure for the Medi-Cal rate component (Section 4.2.1), and updated the underlying demonstration authority to a 1915(b) for DY8 (Section 4 throughout)
    b. Clarified the timing of the release of the Medicare Advantage Final Rate Announcement (4.2.2.2.2)
    c. Clarified MMP requirements for enrollees electing hospice (Section 4.2.2.2.5)
    d. Corrected one-sided risk corridor language (Section 4.4.2)
    e. Reorganized the Quality Withhold Policy section, clarified that Quality Withhold guidance is located is located in separate technical notes and made updates consistent with the current Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes (Section 4.8)
    f. Adjusted the disenrollment penalty benchmark methodology for DY8 (Section 4.10.2) to give CMS flexibility should MMP disenrollment patterns significantly change in DY8

6. Additional contract edits are articulated below:
    a. Updated or added definitions for Alternative Format (Section 1.9), Cultural Competence (Section 1.33), Data Exchange System (Section 1.34), Incentive Arrangement (Section 1.59), Marketing, Outreach and Enrollee Communications (Section 1.67), Network Provider (Section 1.87) Post-Stabilization Care Services (Section 1.87), State Plan (Section 1.99), Telehealth (Section 1.101), and Threshold Language (Section 1.102)
    b. Added a requirement that MMPs provide CMS and DHCS with information related to the plans' latest NCQA accreditation review, as applicable (Section 2.1.9)
    c. Clarified the requirement that an MMP must develop an Integrated Care Plan (ICP) based on claims data or other information for enrollees unable to be reached or unable to participate (2.5.2.11)
    d. Updated language with respect to MMP reporting (Section 2.16.4.1.3-5, 2.19.2)
    e. Updated contract administration requirements to reflect CMS reorganization (3.1.1.1)
    f. Added language for Special Contract Provisions related to Payment, which includes language regarding plan incentive arrangements for COVID-19 vaccinations (Section 5.1.7.5)
    g. Added language regarding processes for when a contract term is no longer authorized by law (Section 5.3.13.6)
    h. Updated language to reflect changes to 42 CFR Part 423 regulations.
    i. Corrected contract formatting, numbering and cross-references throughout