CCI 2016 Proposals and Announcements - Stakeholder Comments

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Document Title and page #	Existing Text	Comment or Suggested Edit
Sustainable Enrollment page 4	How should the eligible populations be divided between September and October of 2016? o Start with the Medi-Cal health plan cross-walk, then Medi-Cal FFS; o Start with Medi-Cal FFS, then the Medi-Cal health plan cross-walk; o Divide by birth months, regardless of Medi-Cal enrollment status; or o Other.	Anthem and CareMore suggest dividing populations by birth months, regardless of Medi-Cal enrollment status. This will allow an equitable number of members to enroll each month and ease the HRA and outreach process.
Sustainable Enrollment page 5	In addition, DHCS would continue to utilize enrollment approaches that make a beneficiary's transition into Cal MediConnect as smooth as possible. Where possible, beneficiaries would be cross-walked into the Cal MediConnect health plan that corresponds with their existing Medi-Cal health plan or D-SNP to ensure continuity of providers. DHCS would use Medicare claims data to assign members in Medi-Cal FFS to Cal MediConnect health plans that include their providers, where possible.	DHCS should assign equal number of members to Cal MediConnect health plans that include their providers. This will help ensure sustainable membership for all plans. Santa Clara MMP provider networks are largely similar among Anthem and SCFHP.
Sustainable Enrollment pages 3-8	Annual Passive Enrollment into Cal MediConnect	Will the plan be able to receive the HCO or 834 file for the prospective passive enrollments before the members are received on the TRR? This way we will not need to manually enter in member information to hit the 72 hour timeframe for 4Rx transactions to CMS.
Sustainable Enrollment pages 3-4	Annual Passive Enrollment into Cal MediConnect: Beneficiaries who became eligible prior to January 2016—but have	Please confirm plans are responsible for following existing 2016 Marketing Guidance. MMPs must send enrollees who are passively enrolled the following materials for receipt no later than 20 calendar

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	never received a passive enrollment notice before— would be notified about Cal MediConnect beginning in June 2016, and passively enrolled in Cal MediConnect in September and October of 2016. Beneficiaries who became eligible for Cal MediConnect beginning in January 2016 would be passively enrolled in 2017 before July 1.	days prior to the effective date of enrollment: • A welcome letter, which must contain 4Rx information, consistent with a model developed jointly by CMS and the State • A comprehensive integrated formulary (List of Covered Drugs) • A combined Provider and Pharmacy Directory, or separate notice alerting enrollees how to access or receive the directory, consistent with section 60.4 of the MMG. • An SB In addition, MMPs must provide enrollees who are passively enrolled an EOC (Member Handbook) and a single Member ID Card for receipt by the end of the month preceding the month the enrollment will take effect (e.g., the Member ID card must be received by a beneficiary by March 31 for an April 1 effective enrollment date).
Sustainable Enrollment page 9	Exploring Extending the Deeming Period for Beneficiaries in Cal MediConnect - Despite this, extending the deeming period is complicated at the county level. As such, DHCS and its sister departments seek to explore whether a longer deeming period is feasible. If and where feasible, Cal MediConnect health plans will be asked to commit to extending their deeming period beyond the one-month period.	Please clarify if plans would be responsible for direct payments to IHSS providers through CMIPS if plans will be asked to commit to extending their deeming period beyond the one-month period.
Streamlining the Cal-Mediconnect Voluntary Enrollment Process page 3	Voluntary Enrollments processed by the plan if an existing MLTSS member	Would plans submit the voluntary enrollment request file to HCO, who would then review and submit to CMS? Plans would prefer to submit transactions directly to CMS. Would this also include disenrollment or cancellation requests or do those still need to be handled by DHCS? Plans should be given the option to process enrollment directly as they do today for Medicare Advantage.

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2016 Coordinated Care Initiative Program Improvements page 4	**Strengthening Continuity of Care** DHCS, in partnership with CMS, is exploring two modifications to existing policy: a. Aligning the Medicare continuity of care timeframe with what is required for Medi-Cal providers. This will extend the current continuity of care period for Medicare services from 6 months to 12 months. b. Aligning the Cal MediConnect continuity of care number of specialist visits with what is required on the Medi-Cal side. This will modify the current continuity of care requirement that requires two visits with a specialist within the past 12 months to require only one visit.	Anthem and CareMore agree with these modifications in an effort to retain members and prevent member churn or opting in and out of MMP multiple times.