MCP: Special Projects

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The Department of Health Care Services (DHCS) may develop new managed care county programs or pilot projects in California to extend coordinated, competent care to identified populations. These special projects are designed to improve recipients' health status and to avoid unnecessary costs. This section describes managed care plans (MCPs) not mentioned in other MCP sections.

Note: MCP is used interchangeably with HCP (Health Care Plan). For example, recipient eligibility messages use HCP, while manual pages use MCP. Special project plan names, addresses, telephone numbers and HCP code numbers are included in the MCP: Code Directory section in this manual.

AIDS Health Care Foundation dba Positive Health Care

For information about AIDS Health Care Foundation, dba Positive Health Care, refer to the *MCP: Primary Care Case Management (PCCM)* section in this manual.

PACE

Program of All-Inclusive Care for the Elderly (PACE) plans receive a monthly capitated payment from both Medicare and Medi-Cal to offer and manage the health, medical and social services needed to restore or preserve the independence of frail elderly individuals. PACE plans include the following

- AltaMed PACE – Orange County
- AltaMed Senior BuenaCare – East Los Angeles
- Bakersfield PACE – Kern and Tulare Counties
- Brandman Centers for Senior Care – Los Angeles County/San Fernando Valley
- Center for Elders Independence – Alameda and Contra Costa counties
- Central Valley PACE – San Joaquin and Stanislaus counties
- Central Valley Medical Services – Fresno County
- Community Eldercare of San Diego dba St. Paul's PACE
- Family Health Centers of San Diego – San Diego County
- ‹‹Fresno PACE – Fresno County››
- Gary and Mary West PACE of Northern San Diego – San Diego County
- Humboldt Senior Resource Center – Humboldt County
- InnovAge PACE – El Dorado, Placer, Riverside, Sacramento, San Bernardino, San Joaquin, Sutter and Yuba Counties
- L.A. Coast PACE – Los Angeles County

- North East Medical Services – San Francisco County
- ‹‹Neighborhood Healthcare PACE – Riverside and San Bernardino counties››
- OC PACE – Orange County
- On Lok Lifeways – Alameda County
- On Lok Lifeways – San Francisco County
- On Lok Lifeways – Santa Clara County
- Orange County Health Authority dba CalOptima PACE
- Pacific PACE – Los Angeles County
- San Ysidro Health Center dba San Diego PACE
- Sequoia PACE – Fresno, Kings, Madera and Tulare counties
- Stockton PACE – San Joaquin and Stanislaus Counties
- Sutter Senior Care – Sacramento County

Eligible Recipients

Enrollment is voluntary and individuals qualify for plan services if they meet the following criteria:

- Are 55 years of age or older
- Live in a specific geographic area
- Are certified by DHCS as nursing-home eligible
- Able to live safely in the community without jeopardizing their health or safety

Noncapitated Services

The services listed below are not capitated and are not reimbursed by PACE plans. Providers should follow the billing instructions for noncapitated services (regular Medi-Cal) as specified in policy sections of the Medi-Cal provider manual.

- Alpha-Fetoprotein testing program laboratory services administered by the DHCS Genetic Disease Branch
- California Children’s Services (CCS)
- California Community Transition (CCT) services
- Child Health and Disability Prevention (CHDP) program services
- County hospitals for the treatment of tuberculosis, or chronic medically uncomplicated narcotism or alcoholism services

- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) - Marriage, family and child counseling
- EPSDT onsite investigation to detect the source of lead contamination
- Federal or State governmental hospital (for example, Veteran Hospital or Prison Hospital) services
- Local Educational Agency (LEA) assessment services rendered to a member who qualifies for LEA services
- LEA services pursuant to an Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP)
- Newborn Hearing Screening Program services
- Newborn screening, mental retardation

Authorization

Authorization for services are approved by each plan's interdisciplinary disciplinary team, which consists of primary care physicians, nurses, physical and occupational therapists, social workers, recreation therapists, home health aides, dieticians and drivers. Each PACE plan must be reachable after hours to provide authorization for after hours services, except in the case of an emergency.

Border and Out-of-State Providers

Providers in designated border communities and out-of-state providers must obtain plan authorization when rendering services to plan members, except in case of an emergency.

Where to Submit Claims

All claims for capitated services must be submitted to PACE. Claims for noncapitated services must be sent to the California MMIS Fiscal Intermediary.

See the *MCP: Code Directory* section in this manual for plan address and telephone number information

Family Mosaic Project

The Family Mosaic Project is a program offered by the San Francisco City and County Department of Public Health. It serves severely emotionally disturbed children who are candidates for out-of-home placement.

This pilot project is capitated for Short-Doyle/Medi-Cal and fee-for-service mental health benefits.

Eligible Recipients

Recipients between the ages of ‹‹0 and 18›› who reside in San Francisco City and County (ZIP codes 94101 through 94188) and meet the project's criteria are eligible to enroll.

Noncapitated Services

The services listed below are not capitated and not reimbursed by the Family Mosaic Project. Providers should follow billing instructions for noncapitated services (regular fee-for-service Medi-Cal) as specified in policy sections of the Medi-Cal provider manuals.

- Acupuncture services
- Alpha-Fetoprotein testing program laboratory services administered by the DHCS Genetic Disease Branch
- Chiropractic services
- Community-Based Adult Services (CBAS)
- Directly Observed Therapy (DOT) for tuberculosis
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) individual outpatient drug-free counseling for alcohol and other drugs
- EPSDT onsite investigation to detect the source of lead contamination
- Federal or State governmental hospital (for example, Veteran Hospital or Prison Hospital) services
- Heroin detoxification services
- ‹‹Home and Community-Based Care Waiver Programs:
  - Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Waiver
  - Assisted Living Waiver (ALW)
  - Home and Community-Based Alternatives (HCBA) Waiver
  - Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
  - Multipurpose Senior Services Program (MSSP) Waiver
  - Self-Determination Program (SDP) Waiver››
- Local Educational Agency (LEA) assessment services rendered to a member who qualifies for LEA services
- Multipurpose Senior Services Program (MSSP)

- Newborn Hearing Screening Program services
- ‹‹Non-Pharmacy-Dispensed Drugs – see “Capitated/Noncapitated Drugs” elsewhere in this section››
- Optical lenses and services rendered under the Prison Industries Authority (PIA) State contract
- ‹‹Pharmacy-dispensed drugs, select medical supplies and enteral nutrition products are noncapitated. Providers should follow Medi-Cal Rx billing instructions as specified in the Medi-Cal Rx Provider Manual for more information.››

Capitated/Noncapitated Drugs

All drugs are noncapitated for the Family Mosaic Project Health Plan. Providers should follow billing instructions for noncapitated drugs (fee-for-service) as specified in the appropriate Part 2 manual. ‹‹See the Medi-Cal Rx website (*https://medi-calrx.dhcs.ca.gov/*) for pharmacy-billed drug policy.››

Erectile Dysfunction Drugs

‹‹Erectile dysfunction (ED) drugs that are listed in the Contract Drugs List on the Medi-Cal Rx website (*https://medi-calrx.dhcs.ca.gov/*) are noncapitated when used for the treatment of ED, which is not a Medi-Cal or Medi-Cal Rx benefit, and therefore not a covered service.›› For all other indications, ED drugs are capitated to the plans.

Authorization

Authorization requests for Short-Doyle and mental health services must be submitted to the Family Mosaic Project, not to the TAR Processing Center.

Where to Submit Claims

Providers submit claims for capitated services to the plan. See the *MCP: Code Directory* section in this manual for plan address and telephone number information.

Providers submit claims for noncapitated services (fee-for-service) to the California Medicaid Management Information System (MMIS) Fiscal Intermediary (FI) specified in the appropriate Part 2 manual.

SCAN Health Plan

The Senior Care Action Network (SCAN) Health Plan is a Medicare Advantage Special Needs Plan with a comprehensive risk managed care contract to serve the Medicare/ Medi-Cal dual eligible population. SCAN covers Medi-Cal state plan services plus offers home and community-based services to members who are determined to require nursing facility level of care. SCAN's goal is to provide comprehensive managed care to the senior population. SCAN also provides services to members who need long-term care in a nursing facility. Each of the following counties house two SCAN plans:

- Los Angeles
- Riverside
- San Bernardino

Eligible Recipients

Individuals qualify for SCAN services if they meet the following criteria:

- Are 65 years of age or older
- Live in specific geographic areas of Los Angeles, Riverside and San Bernardino
- Have both Medicare Part A and B benefits
- Do not have End Stage Renal Disease (ESRD) prior to enrollment

Noncapitated Services

The services listed below are noncapitated and are not reimbursed by SCAN Health Plans. Providers should follow billing instructions for noncapitated services (fee-for-service) as specified in policy sections of the appropriate Part 2 manual.

- California Community Transition (CCT) services
- County hospitals for the treatment of tuberculosis, or chronic medically uncomplicated narcotism or alcoholism services
- Federal or State governmental hospital (for example, Veteran Hospital or Prison Hospital) services
- Short-Doyle/Medi-Cal services

Authorization

Authorization of plan-capitated services must be directly obtained from SCAN or the participating Independent Physicians Association (IPA) in certain cases. The Medi-Cal field offices do not authorize capitated services. Authorization of noncapitated services is provided by the Medi-Cal field offices, and *Treatment Authorization Requests* (TARs) for those services must be submitted to the TAR Processing Center.

Border and Out-of-State Providers

Providers in designated border communities and out-of-state providers must obtain plan authorization when rendering services to plan members, except in case of an emergency.

Where to Submit Claims

Providers submit claims for capitated services to the plan. See the *MCP: Code Directory* section in this manual for plan address and telephone number information.

Providers submit claims for noncapitated services (fee-for-service Medi-Cal) to the CA-MMIS FI as specified in the appropriate Part 2 provider manual.

End Stage Renal Disease Pilot Project: VillageHealth

SCAN is involved in a pilot project (begun January 1, 2006) that was developed to provide care for recipients with End Stage Renal Disease (ESRD) who otherwise would be excluded from Medicare health plan enrollment. For this pilot project, SCAN operates VillageHealth, a specialty health plan that performs the functions of a Medicare Health Maintenance Organization (HMO). This project has been extended through December 31, 2022.

Information about Medicare HMOs is included in the *Medicare/Medi-Cal Crossover Claims Overview* and *Other Health Coverage (OHC) Guidelines for Billing* sections in this manual and the *Other Health Coverage (OHC)* section in the appropriate Medi-Cal Part 2 manual.

VillageHealth

VillageHealth is a Medicare primary payer for this pilot project, acting like a Medicare fee-for-service contractor. SCAN and its affiliate VillageHealth is partnered with DaVita, the company that provides the dialysis services to pilot-project patients.

Recipient Eligibility

VillageHealth serves recipients in select ZIP codes in San Bernardino and Riverside counties. The eligibility verification message returned for recipients who qualify for this plan will include the following wording:

> "…other health insurance cov under Medicare risk HMO, [VillageHealth]…"

Billing

Providers bill for services rendered to VillageHealth members as follows:

- Plan-covered services to VillageHealth
- Copayments, coinsurance and deductibles for plan-covered services to Medi-Cal, similar to crossover claims
- Services denied or not covered by VillageHealth to Medi-Cal as standard fee-for-service claims

Claim Completion for Copayments Coinsurance and Deductibles

Claims for copayments, coinsurance or deductibles must be submitted as paper claims. Instructions for submitting paper claims closely parallel the instructions for billing Medicare/Medi-Cal hard copy crossover claims. Therefore, billers should refer to the Hard Copy Submission Requirements of Medicare-Approved Services in the appropriate Part 2 manual.

In their interpretation of the manual, billers should consider VillageHealth the same as Medicare. For example, Medicare approved service would also be interpreted as VillageHealth approved service.

In addition, claims for copayments, insurance or deductibles treated like crossovers must be billed to Medi-Cal with the same national codes and modifiers billed to VillageHealth and include the following:

- A copy of the *Remittance Advice* received from VillageHealth. The RA must state "SCAN ESRD PILOT" for VillageHealth claims in the *Remarks* section at the bottom left and include the address and telephone number for the plan in the upper right corner.

  Outpatient Clinic/Hospital Providers: The RA provided by VillageHealth must be in the Medicare National Standard Intermediary (Medicare RA) format equivalent to the latest PC Print single claim detail version with billed amounts, paid amounts, group codes, reason codes, amounts showing line level coinsurance, and deductible amounts and other adjustments, as appropriate.

- VillageHealth Automated Eligibility Verification System carrier code S323, as appropriate, in the *Insurance Plan Name or Program Name* field (Box 11C) on the *CMS-1500* claim or *Health Plan ID* field (Box 51) on the *UB-04* claim

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.