



**NOTICE OF PUBLIC MEETING – County of Santa Cruz  
IDEAL CRISIS SYSTEM (ICS) COMMITTEE of the  
MENTAL HEALTH ADVISORY BOARD**

**FRIDAY, JUNE 10, 2022 ♦ 3:30 PM-5:00 PM**

**HEALTH SERVICES AGENCY**

**1400 EMELINE AVENUE, BLDG K, ROOM 207, SANTA CRUZ, CA 95060**

**THE PUBLIC MAY JOIN THE MEETING BY CALLING (831) 454-2222, CONFERENCE ID 478 411 124#**

**ICS COMMITTEE MEMBERS:**

Jeffrey Arlt, Chair, 5<sup>th</sup> District | Jennifer Wells-Kaupp, 5<sup>th</sup> District  
Laura Chatham, 1<sup>st</sup> District | Michael Neidig, 3<sup>rd</sup> District | Serg Kagno, 4<sup>th</sup> District

**IMPORTANT INFORMATION REGARDING PARTICIPATION IN THE  
MENTAL HEALTH ADVISORY BOARD MEETING**

The public may attend the meeting at the Health Services Agency, 1400 Emeline Avenue, Room 207, Santa Cruz. All individuals attending the meeting at the Health Services Agency will be required to use face coverings regardless of vaccination status. Individuals interested in joining virtually may click on this link: [Click here to join the meeting](#) or may participate by telephone by calling (831) 454-2222, Conference ID 478 411 124#. All participants are muted upon entry to prevent echoing and minimize any unintended disruption of background sounds. This meeting will be recorded and posted on the Mental Health Advisory Board website.

If you are a person with a special need, or if interpreting services (English/Spanish or sign language) are needed, please call 454-4611 (Hearing Impaired TDD/TTY: 711) at least 72 hours in advance of the meeting in order to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format.

Si usted es una persona con una discapacidad o necesita servicios de interpretación (inglés/español o Lenguaje de señas), por favor llame al (831) 454-4611 (Personas con Discapacidad Auditiva TDD/TTY: 711) con 72 horas de anticipación a la junta para hacer arreglos. Personas con discapacidades pueden pedir una copia de la agenda en una forma alternativa.

**AGENDA**

- |           |   |
|-----------|---|
| 3:30      | Roll Call   |
| 3:30-3:45 | Public Comment<br>(No action or discussion will be undertaken <i>today</i> on any item raised during this Public Comment period except that Mental Health Board Members may briefly respond to statements made or questions posed. Limited to 3 minutes each)           |
| 3:45-3:50 | Adoption of AB361 – Resolution Authorizing Teleconference Meetings  |
| 3:50-4:05 | Create ICS Vision Statement   |
| 4:05-4:15 | Town Hall suggestions   |
| 4:15-4:30 | Discussion: What is a County Organized Health System (COHS) and how does it affect Santa Cruz County's behavioral health services?  |
| 4:30-4:35 | Confirm two goals for the committee from ICS Goals Sheet <ol style="list-style-type: none"><li>1. Create a vision and mission statement (Roadmap Executive Summary page 18)</li><li>2. Develop an implementation plan with behavioral health and stakeholders</li></ol> |
| 4:35-4:50 | Discuss Goal Two Process  |
| 4:50-5:00 | New Business  |
| 5:00      | Adjournment   |

**NEXT ICS COMMITTEE MEETING IS ON:**

**JULY 8, 2022 ♦ 3:30 PM – 5:00 PM**

**HEALTH SERVICES AGENCY**

**1400 EMELINE AVENUE, BLDG K, ROOM 207, SANTA CRUZ, CA 95060**

**TELEPHONE CALL-IN NUMBER (831) 454-2222; CONFERENCE ID # - TO BE ANNOUNCED**

**MINUTES – Draft**

**IDEAL CRISIS SYSTEMS COMMITTEE  
MENTAL HEALTH ADVISORY BOARD**

MAY 13, 2022 ♦ 3:30 PM - 4:30 PM  
1400 EMELINE AVE, ROOMS 206-207, SANTA CRUZ  
Microsoft Teams Meeting (831) 454-2222, Conference 298 041 202#

**Present:** Jeffrey Arlt, Jennifer Wells Kaupp, Laura Chatham, Michael Neidig, Serg Kagno  
**Staff:** Jane Batoon-Kurovski

- I. Roll Call. Meeting called to order at 3:36 p.m. by Jeffrey Arlt.
- II. Adoption of AB361 – Resolution Authorizing Teleconference Meetings  
Motion/Second: Serg Kagno / Michael Neidig  
Passed unanimously.
- III. Public Comments
  - None
- IV. Election of Committee Chair – Jeffrey Arlt  
Motion/Second: Serg Kagno / Laura Chatham  
Passed unanimously.
- V. Discuss Roadmap Updated Executive Summary  
Discussion included the following points:
  1. The Executive Summary is a great document however unclear on next steps for this committee without hearing from Behavioral Health Staff and their plans in the next few months.
  2. Proposed getting together with community partners who are already doing this and are interested in having a stake in the Behavioral Health community.
  3. The ideal crisis system should also include individuals with private insurance.
  4. Discussion of 10 Steps for systems leaders and advocates versus the 10 steps for communities.
  5. Goal is to develop a vision and come up with a plan. The key is to understand what Behavioral Health is planning, and for the committee to understand needs of entire community.

Motion by Laura Chatham to create vision statement for this committee.  
Second: Michael Neidig.  
Passed unanimously.

Draft Vision: Every individual and family with behavioral health needs including mental health, substance use, and developmental disorders receives the services they need, where they are, when they need them, every time they need them, for the duration and intensity needed to achieve the best possible outcome for a stable and meaningful life.

- VI. Discussion on goals for the committee
  - 1. Create a vision and mission statement
  - 2. Develop an implementation plan
  - 3. Disseminate this report as a guiding document

Discussion included combining the second and third point to state, “While partnering with behavioral health county staff and including stakeholders, develop an implementation plan using the roadmap as a possible guiding document.”

Third goal to be eliminated at this time until the Board hears from County Behavioral Health regarding their plan.

- VII. ICS Service Providers Sheet
  - A. Goal of this sheet is to inform the committee of the services that are physically in each district. Discussion included defining the services that will be on this list. Action item for each board member – research if a similar document already exists. Discussion to be continued at the next meeting.

- VIII. Adjournment
  - Meeting adjourned at 4:53 p.m.

**Vision:**

Every individual and family with behavioral health needs including mental health, substance use, and developmental disorders receives the services they need, where they are, when they need them, every time they need them, for the duration and intensity needed to achieve the best possible outcome for a stable and meaningful life.

**Mission:**

Everyone receives the behavioral health services they need, where they are, when they need them, every time they need them.

**Slogan:**

Everyone, Everywhere, Every time



# COUNTY ORGANIZED HEALTH SYSTEMS:

## A Tested Model Promoting Quality and Cost Effectiveness Locally

### WHO WE ARE

**A Tested Model:** First established 30 years ago, the County Organized Health System (COHS) plans were pioneers in managed care that specialize in serving Medicaid (Medi-Cal) populations. The COHS model has proven a high quality, innovative, culturally competent, locally responsive and cost-effective model for providing care to California’s most vulnerable residents. A COHS is a Medi-Cal managed care health plan model that exists in 22 California counties. COHS allow for enrollment in a single, local public health plan, making entry into the health care system and managing care for members more effective and efficient. COHS plans operate efficiently ensuring taxpayer savings in the Medi-Cal program.

**Locally Responsive:** Each of the COHS plans emerged from local movements to establish more cost-effective, coordinated and culturally responsive services for low-income residents. Commitment to low-income residents in specific communities has allowed the COHS plans to develop unique expertise in member outreach and follow-up, cultural competency, health promotion and disease management to serve low-income members effectively. COHS plans re-invest resources back into their communities and regularly outperform health plans in other counties. COHS plans are governed by local Boards of Directors established by state statute and County ordinances.

**Member Plans:** Collectively known as the California Association of Health Insuring Organizations (CAHIO), COHS plans include CalOptima, CenCal Health, Central California Alliance for Health, Gold Coast Health Plan, Health Plan of San Mateo and Partnership HealthPlan of California.

### COST EFFECTIVENESS

Plan	Counties Served	Started Operations
CalOptima	Orange	1995
CenCal Health	Santa Barbara, San Luis Obispo	1983
Central California Alliance for Health	Santa Cruz, Monterey, Merced	1996
Gold Coast Health Plan	Ventura	2011
Health Plan of San Mateo	San Mateo	1987
Partnership Health Plan of California	Marin, Mendocino, Sonoma, Solano, Napa, Yolo, Lake, Humboldt, Del Norte, Lassen, Modoc, Shasta, Siskiyou, Trinity	1994

1

An important measure of value and efficiency is the degree to which funding goes to patient care as opposed to non-care expenses, such as administrative overhead, profits or other expenditures. As demonstrated by standard industry measures, COHS plans invest nearly all of their resources directly into patient care.

**Medical Loss Ratio**

Compared to standards defined by the Affordable Care Act and overall industry standards, COHS plans invest an extremely high percentage of health care premiums directly into patient care. The *Medical Loss Ratio* (MLR) is a common measure used to evaluate the degree to which health insurance companies are investing resources in patient care. Simply stated, the MLR is

defined as the percent of health insurance premium dollars spent on medical services.

In 2012, the average MLR for the six COHS plans was 91.1% compared to an ACA standard of 85% for large group plans and an average of 88.6% across all full service plans as reported by the California Department of Managed Health Care. *This means that ninety-one cents out of every dollar in premiums is spent directly on patient care.*

### **Administrative Expenses**

Another important measure of efficiency and value is administrative expenses. COHS plans have been successful in maintaining extremely low administrative expenses while still delivering high quality care and improved access for members. According to California Department of Managed Health Care financial reports, COHS plans averaged administrative costs of 5.0% in 2012, compared to 9.5% for the two main commercial Medi-Cal plans and 7.0% for all full service plans (including Kaiser Permanente who administrative costs are partially passed onto their medical groups and hospitals) in California.

## **WHO WE SERVE**

**Our Communities:** Six COHS plans serve over 1.25 million patients across 22 counties throughout California's very urban and very rural areas (from Orange County to Modoc County). The COHS plans have enrolled more Medicaid eligibles than 31 states including New Jersey and Illinois. Within the next 5 years, it is anticipated that COHS will extend services to more than a quarter million additional members through Medi-Cal expansion under the Affordable Care Act.

**Our Members:** COHS members are the most vulnerable in our community suffering from poverty, disproportionate rates of chronic health conditions, and severe social, cultural and linguistic barriers. Despite these challenges, COHS plans seek to provide members with the highest quality care and improved access, superior customer service and meaningful improvement in health status. Each COHS plan is committed and experienced in providing culturally and linguistically appropriate services to members both by supporting cultural competence within provider networks and by ensuring that our staff reflect the communities and members served.

**Coverage Programs:** While the core business of COHS plans is Medi-Cal, historically, we have brought our experience and efficient management to operate other coverage programs for

low-income residents. COHS plans have adopted new programs in response to community requests based on our mission to serve the most vulnerable residents and proven track record in providing cost effective, high quality and culturally competent care locally. Our efforts seek to keep members living independently as possible at home, encouraging community stakeholders to participate in development of new programs, and enhancing benefits like rides to doctor's appointments to improve access. In addition to Medi-Cal, other programs supported by COHS plans have included:

- Five COHS plans participated in the Healthy Families Program;
- Three COHS plans have Special Needs (SNP) Plans for community residents who are dually eligible for Medi-Cal and Medicare;
- Five COHS plans provide managed care services for Healthy Kids, a program for low-income children who do not qualify for Medi-Cal or Healthy Families;
- Two COHS plans served as the third party administrator for the Low Income Health Program (LIHP), an initiative to identify and link to care patients who will become eligible for Medi-Cal under ACA expansion come low income health programs serving the uninsured.

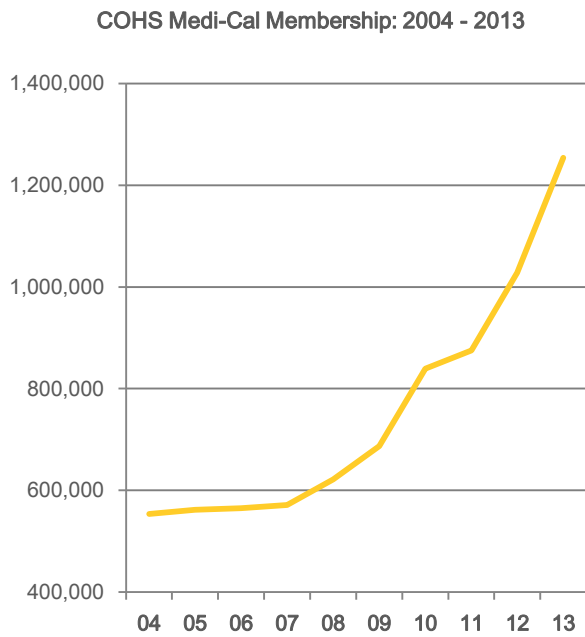


### **MEMBERSHIP TRENDS AND PROJECTED GROWTH**

COHS plans have played an integral role in managing care and costs for Medi-Cal and other vulnerable patient populations for many years. With major expansions in Medi-Cal planned under the Affordable Care Act, the number of Californians served by COHS plans is expected to grow significantly over the next 5 years.

**Historic Membership Trends**

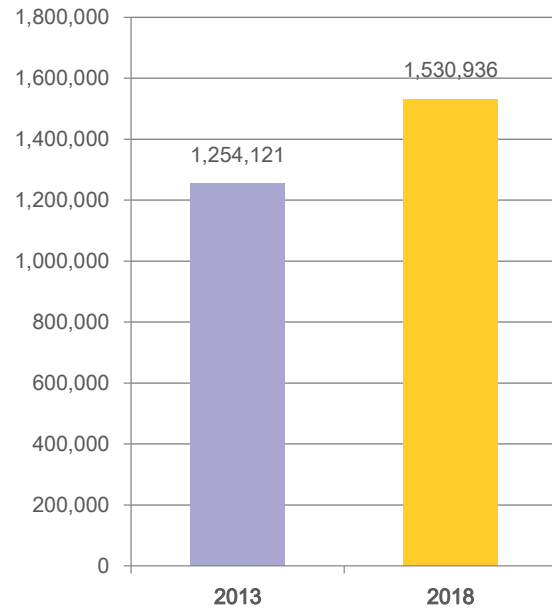
COHS plans currently care for over 1.25 million Medi-Cal members in California and another 64,000 individuals in other coverage programs. Between 2004 and September 2013, COHS Medi-Cal membership grew by more than 700,000 patients – a 127% growth rate. During this period, COHS plans expanded into six new counties and added seven new counties in the last three months alone, welcomed a new plan into service (Gold Coast Health Plan) and supported the transition of Healthy Families members into the Medi-Cal program.



**Future Growth Projections**

Due to the Affordable Care Act, a major increase in the number of Medi-Cal enrollees is anticipated to begin in January 2014. COHS plans stand to play a significant role in serving the new and current Medi-Cal enrollees during health care reform. Between September 2013 and 2018 Medi-Cal membership within COHS plans is projected to increase by another 275,000 to over 1.53 million members.

**Projected Growth in COHS Medi-Cal Membership: 2013 - 2018**



**CLINICAL QUALITY AND INNOVATION**

COHS plans achieve population health improvements, positive member response and lower costs both by investing in coordinated, locally responsive and culturally appropriate patient care and limiting administrative costs. COHS plans have a history of and ongoing commitment to investing in innovative care models and partnerships to identify new opportunities to improve care and reduce costs.

As an example of one plan’s approach to lower costs and improving access, Central California Alliance for Health - with its implementation in Merced County in 2009 - has seen an overall decrease in Emergency Department visits and an increase in Physician office visits as follows:

**Emergency Room Visits**

- 2008 (pre Alliance implementation) - 1,075 emergency room visits per 1000 members per year
- 2012 (post Alliance implementation) - 700 emergency room visits per 1000 members per year

**Physician Office Visits**

- 2008 (pre Alliance implementation) - 4,281 physician office visits per 1000 members per year
- 2012 (post Alliance implementation) - 5,900 physician office visits per 1000 members per year.

### *Health Effectiveness Data and Information Set (HEDIS)*

COHS plans have a demonstrated record of service and quality outcomes as highlighted by standard measures of health plan quality. COHS plans have consistently achieved the highest scores of all the Medi-Cal managed care models in California.

The Healthcare Effectiveness Data and Information Set (HEDIS) is a standard industry tool used by nearly all health plans and state payors to measure clinical quality and service. HEDIS enables comparison of quality performance between health plans. COHS plans as a group have consistently had the highest HEDIS scores among all of the Medi-Cal plans, especially when compared to the commercial plans. HEDIS performance levels and statewide recognition/awards highlight COHS plan clinical quality:

- In 2012, all 5\* participating plans scored above the 75<sup>th</sup> percentile among health plans in HEDIS for controlling blood sugar levels among diabetics (HbA1c <8.0) and 50<sup>th</sup> percentile for managing blood pressure control among diabetics (<140/90)
- All 5 participating plans scored above the 50<sup>th</sup> percentile, including three above the 75<sup>th</sup> percentile, in a standard measure of childhood immunizations (Combination 3)
- All 5 participating plans scored above the 75<sup>th</sup> percentile two important weight assessment and counseling requirements for children (Body Mass Index, Counseling for Nutrition)
- Since 2010, all 5 participating health plans received statewide quality awards, including the Best Plan Award for Medi-Cal Managed Care and several Health Plan Quality Awards for HEDIS performance

*\*Gold Coast Health Plan was a new plan during this period.*

### COHS Plan Quality Awards

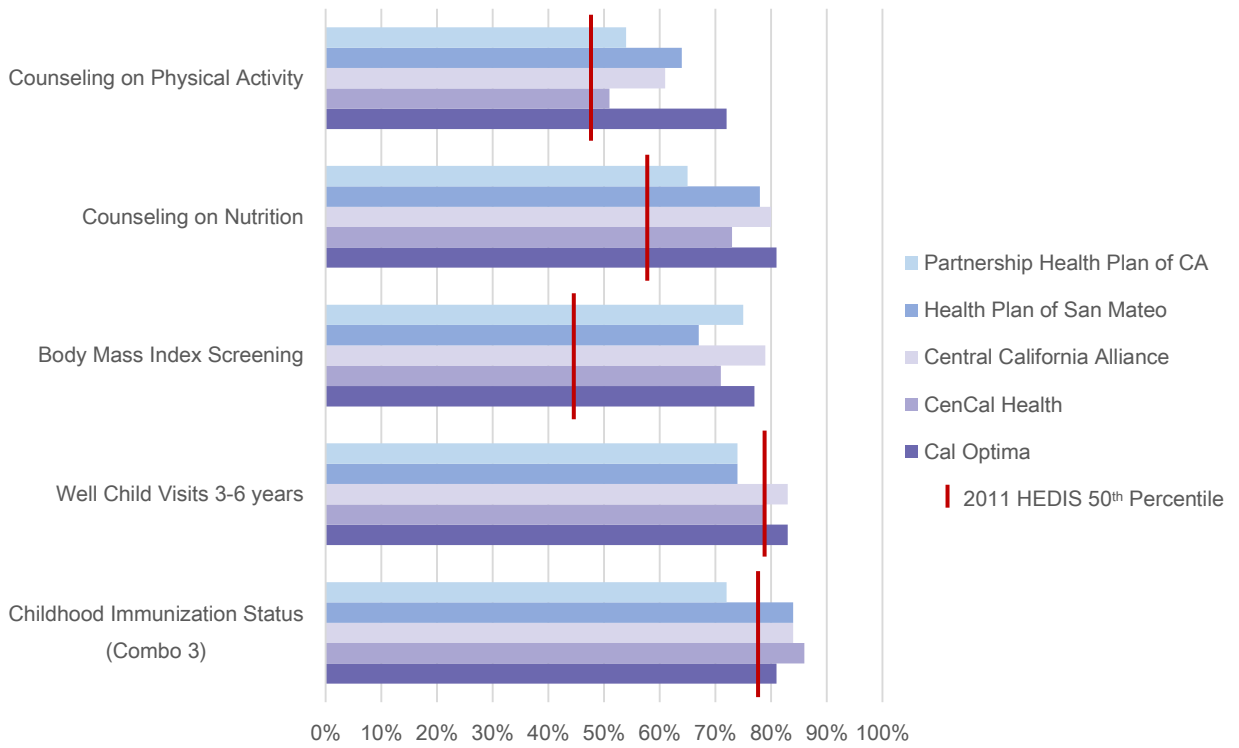
(awarded in competition with 36 other plans)

- **2012 Best Plan Award** for outstanding service and support to Medi-Cal Managed Care Plan Members in partnership with the Medi-Cal Managed Care Office of the Ombudsman (Partnership Health Plan of California)
- **2012 Honorable Mention Quality Award** for Outstanding Performance in the California Department of Health Care Services HEDIS Measures for Medi-Cal Managed Care (CalOptima)
- **2012 DHCS Bronze Quality Award** for outstanding performance in the State's HEDIS measures for Medi-Cal managed care (Central California Alliance for Health)
- **2012 MRMIB Health Plan Quality Award** for superior performance as a result of the quality of care provided to members of its Healthy Families program (Health Plan of San Mateo and CalOptima who has won this award four years in a row 2009-2012)
- **2011 Silver Quality Award** for outstanding performance in the State's HEDIS measures for Medi-Cal managed care (Central California Alliance for Health)
- **2010 Bronze Quality Award** from Department of Health Care Services (CenCal Health)



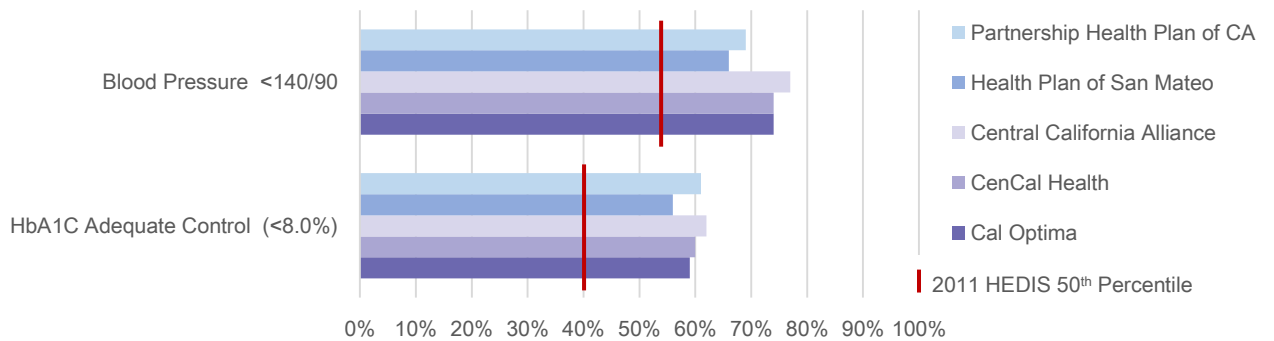


**2012 HEDIS Child Preventive Care**



*Note: Central California Alliance for Health includes data from Santa Cruz and Monterey County only. CenCal Health includes data from Santa Barbara County only as San Luis Obispo County joined CenCal during a later reporting period.*

**2012 HEDIS Comprehensive Diabetes Care**



*Note: Central California Alliance for Health includes data from Santa Cruz and Monterey County only. CenCal Health includes data from Santa Barbara County only as San Luis Obispo County joined CenCal during a later reporting period.*

## *Innovative Projects*

With a firm belief in innovation as a catalyst for improvement, COHS plans frequently invest in innovative partnerships to improve access to patient care, strengthen quality and lower costs. COHS innovations are bolstered by a firm foundation in local communities, strong relationships with the provider community and a commitment to evidence-based practice.

During the previous five years, COHS plans have participated in a number of local, regional and national of innovations addressing topics such as payment models, care coordination, inappropriate utilization reduction and improved quality, among others. Examples of COHS plan projects include:

- **Hospital Readmission Initiative:** To reduce the 30-day hospital readmission rate and related costs through post-discharge case management and active coordination with the primary care provider (CenCal Health and Partnership HealthPlan of California)
- **Covered Orange County:** To develop a coordinated approach among a coalition of nearly 40 community organizations to assist low-income Orange County residents gain access to the new coverage options that will be available under the Affordable Care Act (CalOptima)
- **Care Based Incentives:** Primary care provider incentive program to link payment to outcomes and generate improved health outcomes and increased patient access to services (Central California Alliance for Health and Partnership HealthPlan of California)
- **Geriatric Resources for Assessment and Care of Elders (GRACE):** Model of primary care for low-income seniors and their primary care physicians to improve the quality of geriatric care and increase functional status, decrease excess healthcare use, and prevent long-term nursing home placement (Health Plan of San Mateo)
- **Patient Centered Medical Home (PCMH):** Initiative in coordination with regional community health centers to generate discussion of payment reform options, pilot intensive case management models and support achievement of PCMH status by primary care providers (Partnership HealthPlan of California).

## **The Hospital Readmission Initiative (CenCal Health)**

Both nationally and at the state level, 30-day readmissions have drawn significant attention as a measure for quality of care. In 2010, there were approximately, 3,700 CenCal Health hospital admissions and nearly 500 readmissions for non-OB, non-Medicare Part A patients. At a cost of about \$10,000 per readmission, the financial impact is significant and represents an important opportunity to improve patient care.

CenCal Health's primary intervention is facilitating a timely visit to the member's PCP post-discharge with an emphasis on reviewing and validating the member's medication list - a process called medication reconciliation--followed by intensive individual case management for those members deemed to be at high risk for readmission, coordinated between the member's PCP and CenCal Health.

Results for the first 12-month pilot show enhanced quality, and reduced readmission rates and costs. In addition to enhancing the quality of care, the readmission rate dropped by 10.3% in the first year and resulted in fiscal savings of more than \$600,000.

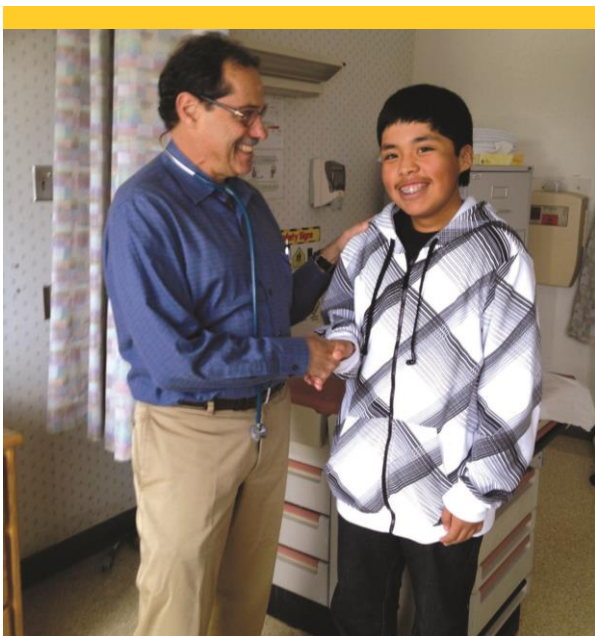


## CONCLUSION

The COHS model represents a unique and successful approach that ensures Medi-Cal beneficiaries access to comprehensive and cost-effective care that improves the health of the low-income residents in 22 California counties.

While a number of key features differentiate COHS plans from other managed care models, the underlying force behind the success of California's six COHS plans is their emphasis on arranging access to appropriate, quality health care services that, collectively, improve the health and well-being of the communities served.

Serving the needs of low-income, disabled beneficiaries, each COHS plan strives toward 100% quality care by providing easy access to health services, strong partnerships with the local medical community, local control of funds and policy, as well as ongoing advocacy and commitment to community needs and values. COHS plans are saving hundreds of millions of dollars for the State and Federal governments and have returned hundreds of millions of dollars over the years to their communities in shared savings and low administrative costs.



### Member Story: Maria Gotianun

Maria Gotianun, 60, has a simple measure of the quality of the CalOptima OneCare Medication Therapy Management program: Has she gone to the hospital this past year or not. Not, she says. And that's a big improvement from before when she would end up hospitalized two or three times each year.

Gotianun uses an electronic pill box to keep her 20+ medications meticulously arranged and scheduled. "The MedMinder is fantastic," she says. "Before, I used to forget to take my medicines." Now, four times a day, she gets a blinking light reminder to take care of herself. Because she lives with her two sons, they get involved as well. "It has become a family affair, putting medications in the pill box for the week. It's almost fun.

Managing multiple chronic conditions, including diabetes, diabetic neuropathy, kidney problems, high blood pressure, high cholesterol and gout, isn't easy, Gotianun says. But she now feels more in control. "I have prevented myself from going to the hospital. The program has really helped me a lot."

Gotianun is not alone, says Nicki Ghazanfarpour, Pharm.D., clinical pharmacist at CalOptima. Since its inception in 2006, the Medication Therapy Management program has helped hundreds of members, who come to CalOptima for medicine reviews once a year or more often. To participate, members must have complex conditions that require eight or more prescriptions. "When patients have a high pill burden, they are less likely to be adherent to the medications, so we try to help them in whatever capacity we can," she says. "We often make recommendations to members' physicians about ways to simplify and optimize medication regimens. We work with the member to improve adherence and understanding of how to take medication properly."

Gotianun has gained confidence about what she can do now that her health conditions are well managed. "I have a son who works in Northern California," she says. "When he visits me in Irvine, sometimes he will drive me back to his home so I can get out of the house. I can go out of town and bring my MedMinder. It's such a good feeling."

The good feelings are all around, Ghazanfarpour says. "The program really gives us a personal connection with our members. Often they don't expect to get this type of one-on-one service from their health plan."

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## **MCP: County Organized Health System (COHS)**

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Page updated: August 2020

A County Organized Health System (COHS) is a local agency created by a county board of supervisors to contract with the Medi-Cal program. Enrolled recipients choose their health care provider from among all COHS providers.

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

### **COHS Plans**

The following are County Organized Health System (COHS) plans:

- Cal OPTIMA (Orange County – HCP 506)
- Central California Alliance for Health (Merced County HCP 514, Monterey County – HCP 508 and Santa Cruz County – HCP 505)
- Health Plan of San Mateo (San Mateo County – HCP 503)
- Partnership HealthPlan of California (PHC) (Del Norte County – HCP 523, Humboldt County – HCP 517, Lake County – HCP 511, Lassen County – HCP 518, Marin County – HCP 510, Mendocino County – HCP 512, Modoc County – 519, Napa County – HCP 507, Shasta County – HCP 520, Siskiyou County – 521, Solano County – HCP 504, Sonoma County – HCP 513, Trinity County – HCP 522 and Yolo County – HCP 509)
- CenCal Health (San Luis Obispo County – HCP 501 and Santa Barbara County – HCP 502)
- Gold Coast Health Plan (Ventura County – HCP 515)

### **Authorization**

All services rendered to COHS recipients (except for emergency, sensitive, minor consent, and services not capitated under the COHS contract) must have prior approval from the recipient's primary care provider or the COHS medical director. Emergency services must be reported to the COHS within 24 hours of the initial emergency encounter.

## **Capitated/Noncapitated Services**

Providers should follow billing instructions for noncapitated services (fee-for-service Medi-Cal or special programs) as specified in the policy sections of the Medi-Cal provider manuals. «Policy for pharmacy dispensed drugs, select medical supplies and enteral nutrition can be found in the Med-Cal Rx provider manual.»

**Note:** For a list of noncapitated drugs, refer to “Capitated/Noncapitated Drugs” on a following page in this section. See also “Capitated/Noncapitated Clinic or Center Services” on a following page in this section for Community-Based Adult Services (CBAS), Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC) and Indian Health Services (IHS).

Any service not listed below is capitated by all COHS HCPs unless otherwise noted.

- Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related conditions (AIDS Waiver Program)
- Alcohol and drug treatment services available under the Short-Doyle/Medi-Cal program
- Alpha-Fetoprotein testing – See Expanded Alpha-Fetoprotein prenatal laboratory services testing on a following page
- Assisted Living Waiver
- Blood collection/handling – Handling and/or conveyance of specimen for transfer from the physician’s office to a laboratory
- Blood collection/handling related to other specified antenatal screening – See Expanded Alpha-Fetoprotein prenatal testing on a following page
- «California Children’s Services (CCS) are capitated for COHS plans (exception: all CCS services are non-capitated for HCP 515).»
- CCS physical therapy/occupational therapy services by designated, CCS-certified outpatient rehabilitation centers noncapitated for HCPs 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 513, 514, 517 and 520
- Dental services (Capitated for HCP 503 only)
- Directly Observed Therapy for tuberculosis
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) individual outpatient drug-free counseling for alcohol and other drugs

- EPSDT Marriage, Family and Child Counselor and EPSDT Social Worker services noncapitated for all HCPs except HCP 503
- EPSDT onsite investigation to detect the source of lead contamination
- EPSDT supplemental service Pediatric Day Health Care
- End of Life Option Act counseling and discussion regarding advance directives or end of life care planning and decisions
- Expanded Alpha-Fetoprotein prenatal laboratory testing; and, blood collection/handling with other specified antenatal screening diagnosis administered by the Genetic Disease Branch of the Department of Health Care Services (DHCS)

**Note:** See the *Genetic Counseling and Screening* section in the appropriate Part 2 manual for billing instructions.

- Fabricating optical laboratory services
- Heroin detoxification services
- Home and Community-Based Waiver Program
  - 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
- Hospital-inpatient state and federal services; for example, state mental institutions, prison and federal military hospitals and Veteran’s Affairs hospitals; currently none bill Medi-Cal

- «Injections – Mental health injections noncapitated for all HCPs»

**Note:** See the *Injections: An Overview* section in the appropriate Part 2 manual for billing instructions.

- Inpatient psychiatric and outpatient mental health services rendered by a psychiatrist; psychologist; Marriage and Family Therapist (MFT); or Licensed Clinical Social Worker (LCSW) noncapitated for all HCPs except HCP 503

**Note:** See “Capitated/Noncapitated Drugs” on a following page for psychiatric drugs.

- Local Educational Agency (LEA) assessment services rendered to a member who qualifies for LEA services

- Local Educational Agency (LEA) services pursuant to an Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP)
- Long Term Care (LTC) mental health services noncapitated for all HCPs
- LTC – Other than mental health services capitated for all HCPs
- «Medication Therapy Management (MTM) services»
- Mental health – See inpatient psychiatric and outpatient mental health, Long Term Care above or injections entry in this list
- Minor consent-related services
- Multipurpose Senior Services Program (MSSP) noncapitated for all HCPs
- Non-Pharmacy-Dispensed Drugs – see “Capitated/Noncapitated Drugs” on a following page in this section
- Newborn Hearing Screening Program services
- 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.
- Outpatient psychiatric – See inpatient psychiatric and outpatient mental health above
- Psychiatric – See inpatient psychiatric and outpatient mental health or Long Term Care in this list
- Specialty Mental Health Services

### Capitated/Noncapitated Clinic or Center Services

The following are capitated and noncapitated services for CBAS, RHCs, FQHCs and IHS:

**Table of Capitated and Noncapitated Clinic or Center Services**

Program or Service	Type of Coverage	HCP
Acupuncture	Capitated	All
CBAS	Capitated	All
Chiropractic	Capitated	All
Dental	Noncapitated	All
Differential rate	Noncapitated	All
End of life option	Noncapitated	All
Heroin detoxification	Noncapitated	All
Medi-Cal (per visit)	Capitated	All
Medicare	Capitated	All
Mental health	Noncapitated	All except 503
Norplant	Capitated	All
Optometry	Capitated	All

For more information and billing examples, refer to the *Rural Health Clinics (RHCs)* and *Federally Qualified Health Centers (FQHCs) Billing Examples* and the *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes* sections in the appropriate Part 2 manual.

**Note:** Differential rate applies to HCP services covered by managed care and rendered to recipients enrolled in Medi-Cal MCPs. The rate for this code approximates the difference between payments received from the managed care plan(s), rendered on a per-visit basis, and the Prospective Payment System rate.

## **Capitated/Noncapitated Drugs**

«All pharmacy-dispensed drugs are noncapitated. See the Medi-Cal Rx website (<https://medi-calrx.dhcs.ca.gov/home/>) for policy. The drugs below are noncapitated. For Physician Administered Drugs (PADs), providers should follow billing instructions for noncapitated drugs (fee-for-service) as specified in the appropriate Part 2 manual.»

## **Antiviral Drugs**

«The following HIV/AIDS/Hepatitis B treatment drugs that meet DHCS Medi-Cal Managed Care Division definitions are noncapitated for all COHS plans:»

Abacavir/Lamivudine	Cobicistat (Tybost)
Abacavir Sulfate	Darunavir/Cobicistat (Prezcobix)
Abacavir Sulfate/Dolutegravir/Lamivudine (Triumeq)	Darunavir/Cobicistat/Emtricitabine/Tenofovir Alafenamide (Symtuza)
Atazanavir/Cobicistat (Evotaz)	Darunavir Ethanolate
Atazanavir Sulfate	Delavirdine Mesylate
Bictegravir/Emtricitabine/Tenofovir Alafenamide	Dolutegravir/Lamivudine (Dovato)
	Dolutegravir (Tivicay)



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**«Antiviral Drugs (continued)»**

Dolutegravir/Rilpivirine	Fostemsavir Tromethamine
Doravirine	Ibalizumab-uiyk
Doravirine/Lamivudine/Tenofovir Disoproxil Fumarate (Delstrigo)	Indinavir Sulfate
Efavirenz	Lamivudine
Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate	Lamivudine and Tenofovir Disoproxil Fumarate (Cimduo)
Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate (Symfi)	Lopinavir/Ritonavir
Efavirenz/Lamivudine/Tenofovir Disoproxil Fumarate (Symfi Lo)	Maraviroc
Elvitegravir (Vitekta)	Nelfinavir Mesylate
Elvitegravir/Cobicistat/Emtricitabine/Tenofovir Alafenamide (Genvoya)	Nevirapine
Elvitegravir/Cobicistat/Emtricitabine Tenofovir Disoproxil Fumarate (Stribild)	Raltegravir Potassium
Emtricitabine	Rilpivirine Hydrochloride
Emtricitabine/Rilpivirine/Tenofovir Alafenamide (Odefsey)	Ritonavir
Emtricitabine/Rilpivirine/Tenofovir Disoproxil Fumarate	Saquinavir
Emtricitabine/Tenofovir Alafenamide	Saquinavir Mesylate
Enfuvirtide	Stavudine
Etravirine	Tenofovir Alafenamide Fumarate
Fosamprenavir Calcium	Tenofovir Disoproxil-Emtricitabine
	Tenofovir Disoproxil Fumarate
	Tipranavir
	Zidovudine/Lamivudine
	Zidovudine/Lamivudine/Abacavir Sulfate

## **Alcohol and Heroin Detoxification and Dependency Treatment Drugs**

Selected alcohol and heroin detoxification and dependency treatment drugs that meet DHCS Medi-Cal Managed Care Division definitions are noncapitated for all COHS plans.

- Acamprosate Calcium
- Buprenorphine extended release injection
- Buprenorphine HCl
- Buprenorphine/Naloxone HCl
- Buprenorphine implant (Probuphine)
- Buprenorphine transdermal patch \*
- Disulfiram
- Lofexidine HCl
- Naloxone HCl (oral and injectable)
- Naltrexone (oral and injectable)
- Naltrexone Microsphere injectable suspension

## **Blood Factors: Clotting Factor Disorder Treatments**

Selected clotting factor disorder treatments that meet DHCS Medi-Cal Managed Care Division definitions are noncapitated for all COHS plans.

- Antihemophilic factor VIII/von Willebrand factor complex (human)
- Anti-inhibitor
- Coagulation factor X (human)
- Emicizumab-kxwh (Hemlibra)
- Factor VIIa (antihemophilic factor, recombinant)
- Factor VIII (antihemophilic factor, human)
- Factor VIII (antihemophilic factor, recombinant)
- Factor VIII (antihemophilic factor, recombinant) (Afstyla), per IU
- Factor VIII (antihemophilic factor, recombinant) (Novoeight)
- Factor VIII (antihemophilic factor, recombinant) (Nuwiq), per IU
- Factor VIII (antihemophilic factor, recombinant) PEGylated, per IU

- Factor IX (antihemophilic factor, purified, nonrecombinant)
- Factor IX (antihemophilic factor, recombinant)
- Factor IX (antihemophilic factor, recombinant) (Rixubis)
- Factor IX albumin fusion protein, (recombinant), (Idelvion), per IU
- Factor IX complex
- Factor X (human), per IU
- Factor XIII (antihemophilic factor, human)
- Factor XIII A-Subunit (recombinant)
- Hemophilia clotting factor, not otherwise classified
- Injection, factor VIII (antihemophilic factor, recombinant) (Obizur)
- Injection, factor VIII (antihemophilic factor, recombinant) pegylated-aucI (Jivi), 1 IU
- Injection, factor VIII, fc fusion protein (recombinant)
- Injection Factor IX, (antihemophilic factor, recombinant), glycopegylated, (Rebinyn), 1 IU
- Injection, factor IX fusion protein (recombinant)
- Von Willebrand factor (recombinant) (Vonendi), per IU
- Von Willebrand factor complex (human), Wilate
- Von Willebrand factor complex (Humate-P)

## **Erectile Dysfunction Drugs**

Erectile dysfunction (ED) drugs listed in the *Part 2 – Pharmacy* provider manual are noncapitated when used for the treatment of ED, which is not a Medi-Cal benefit, and therefore not a covered service. For all other indications, ED drugs are capitated to the plans.

## Psychiatric Drugs

«Selected psychiatric drugs that meet DHCS, Medi-Cal Managed Care Division definitions are noncapitated for all COHS plans:»

Amantadine HCl	Molindone HCl
Aripiprazole	Olanzapine
Aripiprazole Lauroxil	Olanzapine/Samidorphan
Asenapine (Saphris)	Olanzapine Fluoxetine HCl
Asenapine Transdermal System	Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
Benztropine Mesylate	Paliperidone (oral and injectable)
Brexpiprazole (Rexulti)	Perphenazine
Cariprazine	Phenelzine Sulfate
Chlorpromazine HCl	Pimavanserin
Clozapine	Pimozide
Fluphenazine Decanoate	Quetiapine
Fluphenazine HCl	Risperidone
Haloperidol	Risperidone Microspheres
Haloperidol Decanoate	Selegiline (transdermal only)
Haloperidol Lactate	Thioridazine HCl
Iloperidone (Fanapt)	Thiothixene
Isocarboxazid	Thiothixene HCl
Lithium Carbonate	Tranlycypromine Sulfate
Lithium Citrate	Trifluoperazine HCl
Loxapine Inhalation Powder	Trihexyphenidyl
Loxapine Succinate	Ziprasidone
Lumateperone	Ziprasidone Mesylate
Lurasidone Hydrochloride	

**<<Legend>>**

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

<b>Symbol</b>	<b>Description</b>
<<	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.
*	Not all forms are FDA approved for the treatment of alcohol and heroin detoxification and dependency. The drug remains noncapitated regardless of the diagnosis for which it was used.

# Medi-Cal Managed Care

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems.

Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care.

Today, approximately 10.8 million Medi-Cal beneficiaries in all 58 California counties receive their health care through [six main models of managed care](#): Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial, and San Benito. Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network.

## Hot Topics

- [Housing and Homelessness Incentive Program](#)
- [Managed Care Plan County Model Change Information](#)
- [Managed Care Plan \(MCP\) Procurement – County Letter of Support](#)
- [County Managed Care Transition to Local Plan: Letter of Intent Instructions](#)
- [COVID-19 Updates](#)
- [Developmental Center Closures: Transitioning Medi-Cal Eligible Beneficiaries to Managed Care \(PDF\)](#)
- [Managed Care Organization \(MCO\) Tax Approval](#)
- [Directed Payments](#)
- [Dual Eligibles Coordinated Care Demonstration](#)
- [Health Homes Program](#)
- [DHCS Comments to CMS Proposed Managed Care Rule \(2019\)](#)
- [DHCS Comments to CMS Proposed Managed Care Rule \(2015\)](#)
- [Palliative Care and SB 1004](#)
- [Student Behavioral Health Incentive Program \(SBHIP\)](#)

## For Individuals

- [Provider Information Network \(PIN\)](#)

- [Continuity of Care](#)
- [Health Plan Directory](#)
- [Office of the Ombudsman](#)
- [Medical Exemption Request Documentation](#)

## For Health Plans

- [All Plan, Policy & Duals Plan Letters](#)
- [Auto Assignment Incentive Program](#)
- [Claims & Encounter Data Reporting](#)
- [Managed Care Enrollment Reports](#)
- [SB 97 Medi-Cal Ombudsman Reports](#)
- [Financial Reports](#)

## Contact Information

- [Medi-Cal Managed Care](#)

## Resources & Information

- [Medi-Cal Managed Care Quality Awards](#)
- [Aid Code Chart \(PDF\)](#)
- [Managed Care Boilerplate Contracts](#)
- [Managed Care County Map \(PDF\)](#)
- [Managed Care Models Fact Sheet \(PDF\)](#)
- [Managed Care Monitoring](#)
- [Managed Care Advisory Group \(MCAG\)](#)
- [Medi-Cal Managed Care Performance Dashboard](#)
- [Medi-Cal Managed Care Request for Proposal #20-10029](#)
- [Staying Healthy Assessment \(SHA\)](#)
- [CalAIM Section 1115 Demonstration & 1915\(b\) Waiver](#)
- [MIPPA - Medicare Improvements for Patients and Providers Act of 2008](#)
- [Health Plan Accreditation Status – January 2021](#)
- [Health Plan Accreditation Status-July 2020](#)

## Publications & Reports

- [Quality Improvement & Performance Measurement Reports](#)

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