



OneCare
CalOptima Health

OneCare Model of Care

2026

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members' social determinants of health.

Learning Objectives

- After completing the module, you will be able to:
 - Define OneCare and Model of Care (MOC).
 - Identify the four core elements of the OneCare MOC.
 - Describe eligibility for OneCare participation and identify specialized services for most vulnerable OneCare members.
 - Define Care Coordination, Health Risk Assessment (HRA), Individualized Care Plan (ICP) and Interdisciplinary Care Team (ICT).
 - Understand the essential role of the contracted network of providers, adherence to care standards and oversight.
 - Describe the Quality Measurement and Performance Improvement outcomes of the MOC.
 - Define how MOC effectiveness is measured.

Course Content

- OneCare Model of Care Overview
- OneCare Population
- Care Coordination
- Care Staff Roles and Responsibilities
- Key Components
 - Health Risk Assessment
 - Individualized Care Plan
 - Interdisciplinary Care Team
 - Care Transition Protocols
- Specialty Programs
- Evaluating the Model of Care

Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

Course Content (cont.)

- Communication Processes and Methods
- Updates to D-SNP - 2026

Content of this course was current at the time it was published. As Medicare policy changes frequently, check with your immediate supervisor regarding recent updates.

Overview

- The Centers for Medicare and Medicaid Services (CMS) require:
 - All Medicare Advantage Special Needs Plans (MA-SNP) to have a Model of Care (MOC).
 - All employed and contracted personnel and providers of the MA D-SNP are to be trained on the MOC.
 - The OneCare MOC is CalOptima Health's "road map" for care management policies, procedures, and operational systems.
- This course describes the OneCare MOC and how CalOptima Health and the network of contracted providers work together to ensure the success of the MOC and enhance the coordination of care for the members.

What is OneCare?

- OneCare is:
 - CalOptima Health's Medicare Advantage Special Needs Plan
 - Also known as:
 - HMO-SNP
 - SNP-plan
 - D-SNP (Duals Special Needs Plan)
 - Serves people:
 - Eligible and enrolled in CalOptima Health for both Medicare and Medi-Cal (Medicaid) benefits
 - Residing in Orange County
 - Age 21 and older

Model of Care (MOC)

- A document required by Centers for Medicare and Medicaid Services (CMS) for a D-SNP
 - Defines the care management policies, procedures and operational systems for OneCare
 - Is “member-centric” with the ongoing focus on the member and the member’s family/caregiver
- Four core elements are:
 - Population description of SNP
 - Care coordination
 - Provider network
 - Quality measurement and performance improvement

OneCare Population

- OneCare population description includes:
 - Eligibility to participate
 - Health status and health disparities such as health status, where OneCare members live, living conditions, social and environmental context, and COVID 19 vulnerability
 - Demographics such as age, gender, race/ethnicity, language, and health disparities
 - Unique characteristics of the OneCare population

OneCare Population (cont.)

- Department of Health Care Services (DHCS) has identified specific populations who are eligible for California Integrated Care Management (CICM).
- OneCare identifies members eligible for CICM as the most vulnerable members.
- OneCare members who may meet the criteria for CICM and these members must be provided OneCare CICM case management services.
- OneCare is responsible for providing CICM services to members who are eligible and agree to enroll.

OneCare Population (cont.)

- OneCare's CICM populations include the following:
 - Experiencing or at risk for Homelessness
 - At risk for avoidable hospital or ED admission
 - Serious mental illness and/or Substance Use Disorder (SUD)
 - Transitioning from incarceration
 - At risk for institutionalization or long-term care
 - Transition to the community from institutionalization or long-term care
 - Pregnant or postpartum and subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality
 - Documented Dementia needs

OneCare Population (cont.)

- OneCare's most vulnerable members also include members with serious illness eligible for palliative care (Medi-Cal disease-specific criteria)

Knowledge Check

1. What does the acronym OC MOC mean?
 - a. Orange Coast Care Model of Orange County
 - b. Open Care Coordinator Model of Orange County
 - c. OneCare Model of Care
 - d. OneCare Medicare Order for Care
2. Care coordination is one of the four core elements of the MOC
 - a. True
 - b. False

Knowledge Check (cont.)

3. OneCare vulnerable members include those who are:
 - a. Eligible for palliative care
 - b. Serious mental illness and/or Substance Use Disorder
 - c. Documented dementia needs
 - d. All of the above

Knowledge Check - Answers

1. c. OneCare Model of Care
2. a. True
3. d. All of the above

Care Coordination

- Care coordination includes:
 - Organization of member care activities
 - Sharing information among all the health care participants involved with a member's care
 - Achieving safer and more effective care
 - Closed-loop coordination of all benefits, including Medicare, Medi-Cal, LTSS
- Main goal of care coordination is:
 - To meet members' needs and preferences in the delivery of high-quality, high-value health care

Care Coordination (cont.)

- Care coordination components include:
 - Staff structure
 - Administrative, clinical, and oversight roles specific to OneCare including a Personal Care Coordinator (PCC)
 - Health Risk Assessment (HRA)
 - Assessment of the OneCare members' health and social needs
 - Face-to-Face Encounter
 - In-person or an interactive telehealth visit involving the OneCare member and a participant of their Interdisciplinary Care Team or CalOptima Health's case management team or designee

Care Coordination (cont.)

- Care coordination components include:
 - Individualized Care Plan (ICP)
 - A plan of care for the OneCare member based on information from the HRA
 - Interdisciplinary Care Team (ICT)
 - The ICT includes the member's PCP, Case Manager, and others, as appropriate. Each OneCare member has a care team to ensure care coordination occurs in a structured collaborative process. The team is involved in the creation and updates of the ICP. They may have formal meetings as needed to discuss the member's care, review the ICP and ensure care coordination occurs as appropriate.
 - Care transition protocols
 - Guidelines on how to manage the OneCare member across the care continuum

Staff Structure and Roles

- Organized to align with essential care management roles:
 - Administrative
 - Personal Care Coordinator (PCC)
 - At CalOptima Health
 - At contracted health networks
 - Clinical
 - Oversight

Administrative

- Manages:
 - Enrollment
 - Eligibility
 - Claims
 - Grievances and provider complaints
 - Information communication
 - Collection, analysis, and reporting of performance and health outcomes data

Personal Care Coordinator (PCC)

- At CalOptima Health
 - Administers the HRA for each member
 - Initial and annual
 - May be face-to-face, virtual, telephonic, or paper-based
 - Enters HRA responses into data platform for licensed health care professional to review
 - Note — HRA collection not delegated to the health networks
 - Conducts warm transfer calls of the member to the health network
 - Maintains knowledge of all benefits including Medicare, Medi-Cal, and LTSS

PCC (cont.)

- At a health network:
 - Member's point of contact and liaison between the member, provider, health network and CalOptima Health
 - Role:
 - Guides member in understanding and accessing their benefits with awareness of all Medicare, Medi-Cal and LTSS benefits
 - Schedules, facilitates, and participates in ICT meetings, as appropriate
 - Assists member with scheduling appointments, facilitate referrals
 - Assists with coordination of member's health care needs
 - Notifies member's care team of key events
 - Facilitates communication of ICP to Primary Care Provider (PCP) and other care team members, including member

Clinical Staff

Examples of clinical staff may include:

- PCP
- Registered Nurse (RN) Case Manager
- Licensed Clinical Social Worker (LCSW) or Masters in Social Work (or related degree)

Roles:

- Advocate for, inform and educate members
- Coordinate care
- Identify and facilitate access to community resources
- Educate members on health risks and management of illnesses
- Empower members to be advocates of their health care
- Maintain and share records and reports
- Assure HIPAA (Health Insurance Portability and Accountability Act) compliance

Oversight

- CalOptima Health and the health networks collaborate to support the MOC.
- Role:
 - Monitor MOC implementation
 - Evaluate effectiveness of the MOC
 - Assure licensure and competency
 - Assure statutory and regulatory compliance
 - Monitor contractual and delegated services
 - Monitor Interdisciplinary Care Teams
 - Assure timely and appropriate delivery of services
 - Assure providers use evidence-based clinical practice guidelines
 - Assure seamless transitions and timely follow-up

Health Risk Assessment (HRA)

○ Process:

- CalOptima Health PCC:
 - Administers initial HRA and annual HRA for each member
 - Uses a standardized HRA tool
 - Note — HRA completion is not delegated to health network
- May be completed face-to-face, virtual, telephonic, or paper-based
- Identified care needs are categorized into Care Domains:
 - Physical Health, Behavioral Health, LTSS, Access to Care, Care Coordination, and promotion of Self-Management/Health and Wellness Monitoring

HRA (cont.)

○ Process (cont.):

- Used by clinical staff to evaluate the medical, psychosocial, cognitive, functional needs, identify any engaged caregiver and caregiver support needs, and current services received with medical and behavioral health history
 - Caregivers should be actively engaged in the member's ICP and ICT.
- Used to develop a member's Individual Care Plan (ICP) and inform the members' ICT.

Face-to-Face Requirement

- The main purpose of the face-to-face encounter is to promote and ensure OneCare members are seen and clinically assessed at least annually by their PCP or specialist serving as the PCP.
- OneCare is required to provide a face-to-face encounter for the delivery of health care or care management or care coordination services between the member and a member of their care team or the case management team.
- CalOptima Health will track and monitor OneCare members to ensure they have or are offered a face-to-face encounter at least annually.

Face-to-Face Requirement (cont.)

- CICM populations engage through in-person contact in alignment with member preferences.
- CICM services must provide in-person care management and outreach for Members identified as experiencing homelessness.
- CICM is delivered by trained case managers and care coordinators working directly with members in community settings, shelters, or other accessible locations.

Face-to-Face Requirement (cont.)

- In-person engagement includes the following:
 - Conducting assessments and care planning in the member's environment
 - Facilitating connections to housing-related Community Supports
 - Respecting member autonomy and ensuring voluntary participation in CICM

Individualized Care Plan (ICP)

- CalOptima Health ensures that all OneCare members have an ICP.
- The ICP is the person-centered plan of care that incorporates the member's specific physical health, behavioral health, functional needs, cognitive functioning, social health, support system, resource needs and personal health care preferences.
- Includes prioritized, personalized and measurable goals to meet a member's specific needs
- Initial ICP for newly eligible OC members must have a completed ICP within 90 days of CalOptima Health enrollment.

ICP (cont.)

- Integrates information from the HRA, the member's risk care level, historical utilization and case management data, comprehensive assessments, LTSS/Community Supports, identified barriers to care and the member's main health concern to develop the plan of care.
 - Comprehensive assessments include any case management supplemental assessments such as additional case management assessments, the Benjamin Rose Institute Caregiver Strain Instrument, and the AD8 Dementia Screening Interview.

ICP (cont.)

- ICP goals will be reassessed at least annually, upon identification of changes in the member's health care status or to address barriers to meeting goals.
- Supports the development, implementation and ongoing monitoring and modification of a member's ICP through an ICT process, in conjunction with the member and/or their caregiver and providers.

ICP (cont.)

- ICP must include non-contracted and carved-out services that address member needs and must facilitate referrals to the following:
 - Community Based Organizations
 - County mental health and SUD services
 - Housing and homelessness providers
 - Community Supports providers
 - 1915(c) waiver programs, including MSSP
 - LTSS programs, including IHSS and Community-Based Adult Services (CBAS)
 - Medi-Cal transportation to access Medicare and Medi-Cal services
 - Medi-Cal Dental benefits

ICP (cont.)

- Maintained in the clinical documentation platform.
- Considered part of the member's case management record and stored in accordance with HIPAA and in compliance with state, federal and HIPAA requirements.
- Shared with the member, PCP and applicable participants of the ICT initially and as part of the members ongoing care and coordination.

Interdisciplinary Care Team (ICT)

- Facilitates the participation of the member, their caregiver or authorized representative in the development of their ICP.
- Supports member's right to self direct care.
- Ensure member's holistic needs are identified.
- Facilitates linkage to appropriate LTSS.
- Improves member/provider engagement, satisfaction and communication.
- Prevents duplication of services.
- Prevents transition to a higher level of care.
- Closes gaps in care through communication with the ICT participants.

ICT (cont.)

- Ensure invitation of Community Supports provider to formal ICT meeting with member's consent.
- The ICT composition is determined based upon the member's medical condition and their responses to the HRA.
- All coordination and communication are documented in the clinical documentation platform, and the ICP is updated accordingly.

ICT (cont.)

- Formal vs. Informal ICT
 - All OC members have an Interdisciplinary Care Team
 - All OC members should have evidence of Informal ICT collaboration
 - Examples include:
 - Collaboration with the PCP and other Specialists
 - Input from members of the ICT into the ICP
 - Formal ICT meetings will be held for:
 - High Risk members
 - Any members enrolled in Care Coordination or Complex Case Management
 - Member identified in a vulnerable population including CICM
 - Palliative Care Agency must-participate in a Palliative Care ICT for those members enrolled in Palliative Care
 - If member or PCP requests

Composition of the ICT Meeting

- ICT composition is determined by member's needs and preferences

Core Participants:

- Member and/or designated representative
- PCP assigned to member
- Medical Director
- Case Manager
- Care Coordinator
- Social Worker

Additional Participants:

- Behavioral health specialist
- Pharmacist
- Therapist (speech and/or physical)
- Nutritionist
- Appropriate specialist
- Health educator
- Disease management specialist
- LTSS Liaison
- Dementia Care Specialist
- Palliative Care Provider
- Community Supports Provider

Composition of the ICT Meeting (cont.)

- Vulnerable populations include the following:
 - At Risk for Avoidable Hospital or ED: the member's caregiver according to member preferences.
 - Experiencing Homelessness: Community Supports community-based case manager or housing provider if applicable.
 - Serious Mental Health and/or SUD Needs: the member's caregiver and behavioral health or substance use provider according to member preferences.
 - At risk for institutionalization/LTC: the member's caregiver according to member preferences.
 - Palliative Care: Members receiving Palliative Care will have a Palliative Care ICT.
 - Documented Dementia Needs: the member's caregiver and a trained Dementia Care Specialist.

Care Transition Protocols

- OneCare Transitions Program addresses comprehensive biopsychosocial care needs before, during and after a transition to prevent readmissions and ensure safe and coordinated care across the care continuum.
- OneCare Transition Program protocols are provided to all members to address transition needs and include assignment of a single point of contact to support a member through a transition event.

Care Transition Protocols (cont.)

- OneCare Transition Program includes but is not limited to the following objectives:
 - Early identification of risk
 - Utilization Management support, Case Management interventions and self-management coaching of members through transition events
 - Communication with the ICT, Practitioners and Providers, and member
 - Reduction of unnecessary emergency department use and unplanned transitions
 - Analyzing, tracking, and trending utilization and assessment data for process improvement opportunities

Care Transition Protocols (cont.)

- For transitions
 - Member receives outreach within two business days for screening or assessment and communication plan for ICP follow up.
 - Elements of the ICP are also shared between care setting providers within two business days of notification that a transition has occurred.
 - The Utilization Management Inpatient Review nurse, Care Coordinator or Case Manager are responsible for communicating with the member and or designee and health care setting teams regarding changes to the member's health status and ICP.

LTSS Liaison

- OneCare must have staff to serve as liaisons for the LTSS provider community to help facilitate member care transitions.
- These staff must be trained to identify and understand the full spectrum of Medicare and Medi-Cal LTSS, including home- and community-based services and long-term institutional care, including payment and coverage rules.
- Staff serving as liaisons for the LTSS provider community must participate in the ICT, as appropriate.

Dementia Care Specialists

- OneCare has *Dementia Care Specialists* who have received intensive training through Alzheimer's Orange County.
- The training includes understanding Alzheimer's Disease and Related Dementias (ADRD); symptoms and progression; understanding and managing behaviors and communication problems caused by ADRD; caregiver stress and its management; and, community resources for enrollees and caregivers.
- The Dementia Care Specialist must participate in formal ICT meetings for members with dementia.

Dementia Care Specialists (cont.)

- The care team for members with documented dementia care needs must include the member's caregiver and a trained Dementia Care Specialist to the extent possible and as consistent with the member's preferences.
- These ICT members must be included in the development of the member's ICP to the extent possible and as consistent with the member's preference.
- The ICP should also include any referrals to Community Based Organizations such as those serving members with dementia (e.g. Alzheimer's organizations).

Palliative Care

- Palliative Care is available to OneCare members.
 - Eligibility criteria is outlined in the D-SNP Policy Guide.
 - D-SNP Policy Guide can be found at DHCS.ca.gov
 - Providers must be educated on the program and process to make referrals.
 - OneCare members enrolled in a Palliative Care program:
 - The Palliative Care Coordinator serves as lead Care Manager.
 - Palliative Care Agency must participate in a Palliative Care ICT.
 - Palliative Care is part of the member's care team.
 - The ICP is developed and updated by, and/or shared with the Palliative Care team as appropriate.

Dementia Care Aware

- The Dementia Care Aware training and resources are available to support providers when detecting cognitive impairment.
 - <https://www.dementiacareaware.org/>
- Face-to-Face encounters and/or responses to the HRA may indicate potential cognitive impairment.
 - Members should be referred to their providers for further diagnostic evaluation when appropriate.
 - Providers should conduct a full diagnostic workup when memory concerns are identified.

Continuity of Care

- May be telephonic requests from Member, Authorized Representative, or treating Providers.
 - Includes DME and Medical Supply Providers.
- Requests will be completed within:
 - 30 calendar days from request;
 - 15 calendar days if Member's medical condition requires immediate attention; or
 - 3 calendar days if there is risk of harm to the Member.
- Member notification within 7 calendar days of completion.

Continuity of Care (cont.)

- Must notify Member 30 calendar days before the end of the continuity of care period.
- Must allow the Member to continue treatment for up to the 12-month continuity of care period.

Knowledge Check

1. Who administers the initial HRA?
 - a. Member's doctor
 - b. Member's caregiver
 - c. CalOptima Health PCC
 - d. Member's care coordinator
2. Who develops the member's ICP?
 - a. Member's care coordinator
 - b. ICT
 - c. Health network PCC
 - d. Member's caregiver

Knowledge Check (cont.)

3. The purpose of care coordination is to organize and coordinate the member's care activities.
 - a. True
 - b. False

Knowledge Check - Answers

1. c. CalOptima Health PCC
2. b. ICT
3. a. True

OneCare Provider Network

○ CalOptima Health:

- Contracts with board-certified providers
- Monitors network providers to assure they use nationally recognized clinical practice guidelines
- Assures that network providers are licensed and competent through a formal credentialing review
- Maintains a broad network of specialists that include palliative care, pain management, chiropractors and psychiatrists
- Monitors network adequacy to ensure access to care
- Provides training on OneCare MOC for the providers and those who routinely interact with OneCare members:
 - Assures provision and attestation of initial and annual MOC training

OneCare Provider Network (cont.)

- OneCare provider network includes:
 - Primary care providers
 - Specialized expertise:
 - Specialists
 - Hospitalists
 - Skilled nursing facility (SNF) providers
 - Allied health providers
 - Behavioral health providers
 - LTSS services of CBAS, MSSP, IHSS, LTC
 - Pharmacists
 - Community-based Palliative Care Providers
 - Ancillary providers
 - Community Supports

OneCare Provider Network (cont.)

- OneCare provider network includes:
 - Acute facilities
 - Dialysis centers
 - Specialty outpatient clinics
 - Residential Care facilities
 - Radiology and imaging facilities
 - Laboratory facilities
- Use of evidence-based clinical guidelines and care transition protocols
 - Formalize oversight of provider network adherence to nationally recognized care standards.

Evaluating the Model of Care

- CMS defines processes and tools to measure health care outcomes.
 - Purpose is to ascertain that health plans provide high-quality health care for their members.
- Processes include:
 - Quality measurement (QM)
 - Performance improvement (PI)

Evaluating the Model of Care (cont.)

- Methods include:
 - Quality Improvement Committee
 - Measurable goals and health outcomes measurements
 - Measuring patient experience of care
 - Ongoing performance improvement evaluation
 - Dissemination of SNP quality performance related to the MOC

Performance Measurement

- Uses standardized quality improvement measures to measure performance and health outcomes such as:
 - Healthcare Effectiveness Data and Information Set (HEDIS)
 - Disease management measures
 - Utilization management measures
 - Member satisfaction (surveys)
 - Provider satisfaction (surveys)
 - Ongoing monitoring of complaints and grievance summaries
 - Tracking and assessing completion of MOC training

Measurable Goals

- Evaluates measurable goals that:
 - Improve coordination of care
 - Appropriate utilization of services for preventative health and chronic conditions
 - Improve member experience
 - Enhanced care transitions across all healthcare settings and providers

Measurement of Effectiveness

- Evaluates measures of effectiveness by collecting and reporting data on:
 - Improvement in access to care
 - Improvement in member health status
 - Staff implementation of MOC
 - Comprehensive HRA
 - Implementation of ICP
 - Provider network of specialized expertise
 - Application of evidence-based practice
 - Improvement of member satisfaction and retention

OneCare Clinical Guidelines

- Supports the physician management of chronic conditions
 - Disseminates best practices, evidence-based guidelines
 - Shares provider tool kits to promote education and adherence

Communication Processes and Methods

- Utilizes an integrated system of communication for members and providers on both a scheduled and as needed basis
- Methods include:
 - Member newsletters
 - CalOptima Health website
 - Networking sessions
 - Conferences: face-to-face, telephonic, electronic
 - Committees:
 - Utilization Management Committee (UMC)
 - Quality Assurance Committee (QAC)
 - Member Advisory Committee (MAC)
 - Provider Advisory Committee (PAC)

Knowledge Check

1. CalOptima Health monitors network adequacy to ensure members have access to care.
 - a. True
 - b. False
2. Specialty programs or services for OneCare members include:
 - a. Behavioral health
 - b. Dialysis centers
 - c. Pharmacists
 - d. All of the above

Knowledge Check (cont.)

3. OneCare develops their own quality improvement measures to measure performance and health outcomes.
 - a. True
 - b. False

Knowledge Check - Answers

1. a. True
2. d. All of the above
3. b. False

Updates to OneCare - 2026

- Introduction of California Integrated Care Management (CICM) that replaced ECM-Like
 - Added population of Members with Documented Dementia Needs along with Medi-Cal ECM Populations of Focus
- Inclusion of vulnerable population of Members with serious illness eligible for palliative care

Model of Care Summary

- OneCare's Model of Care:
 - Defines and creates a comprehensive strategy and infrastructure for care of our members
 - Meets the unique needs of the dual-eligible population by:
 - Setting agency-wide strategic goals
 - Contracting with expert practitioners
 - Striving to meet each member's unique medical, psychosocial, functional and cognitive needs

Acronyms List

ADRD	Alzheimer's Disease and Related Dementias
CBAS	Community-Based Adult Services (formerly Adult Day Care)
CICM	California Integrated Care Management
CMS	Centers for Medicare and Medicaid Services
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
D-SNP	Dual Special Needs Plan
ECM	Enhanced Care Management
HEDIS	Health Care Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act
HRA	Health Risk Assessment

Acronyms List (cont.)

ICP	Individualized Care Plan
ICT	Interdisciplinary Care Team
IHSS	In-Home Supportive Services
LCSW	Licensed Clinical Social Worker
LTC	Long Term Care
LTSS	Long-Term Services and Supports
MAC	Member Advisory Committee
MA-SNP	Medicare Advantage Special Needs Plan
MOC	Model of Care
MSSP	Multi-Purpose Senior Services Program
PAC	Provider Advisory Committee

Acronyms List (cont.)

PCC	Personal Care Coordinator
PCP	Primary Care Physician
PI	Performance Improvement
QM	Quality Measurement
QAC	Quality Assurance Committee
RN	Registered Nurse
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SUD	Substance Use Disorder
UMC	Utilization Management Committee

Authorities

- H5433_2026 CalOptima Health D-SNP MOC_Off-Cycle

References

- CalOptima Health Policy GG.1204: Clinical Practice Guidelines
- CalOptima Health Policy EE.1103: Provider Network Training
- CalOptima Health Policy MA.6009: Care Management and Coordination Process
- CalOptima Health Policy MA.6021a: Continuity of Care for New Members
- CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment
- CalOptima Health Policy MA.6026: Coordination of Care, Medi-Cal Covered Services for OneCare

References (cont.)

- CalOptima Health Policy MA.6030: Transition of Care
- CalOptima Health Policy MA.6032: Model of Care
- CalOptima Health Policy MA.6040 First Tier, Downstream, or Related Entities (FDR) Model of Care – Roles and Responsibilities with Specific Personal Care Coordinator (PCC) Requirements
- CalAIM Dual Eligible Special Needs Plans: Policy Guide – Contract Year 2026



OneCare

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