Policy:	MA.6032
Title:	**Model of Care**
Department:	Medical Management
Section:	Case Management
CEO Approval:	*/s/ Michael Hunn 11/22/2024*
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Applicable to:	☐ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima Health shall develop, implement, manage, and evaluate the effectiveness of the Model of Care (MOC) for the OneCare Program.

II. POLICY

A. CalOptima Health shall have a MOC that is Member-centric and designed to ensure the coordinated provision of seamless access to individualized quality health care.

B. CalOptima Health OneCare's MOC is the framework for the provision of care management and coordination processes for Members enrolled in the Special Needs Plan (SNP).

C. The OneCare MOC shall be designed in accordance with Centers for Medicare & Medicaid Services (CMS) requirements and shall consist of the four (4) clinical and non-clinical elements as outlined in Section III of this Policy.

D. To ensure the successful implementation of the MOC, CalOptima Health strategic activities throughout the organization shall be linked to OneCare quality initiatives and align with departmental objectives and assignment of organization owners.

III. PROCEDURE

A. CalOptima Health shall implement the following components of the MOC:

1. Description of SNP Population

a. The OneCare MOC shall describe the specific Medicare and Medi-Cal characteristics of the target population.

b. OneCare is a Medicare Advantage Prescription Drug plan.

c. CalOptima Health enrolls Members who meet the following as of the effective date of coverage under OneCare:

i. Are entitled to receive services under Medicare Part A and Part B.

ii. Are entitled to receive services under Medi-Cal through CalOptima Health's Contract with the Department of Health Care Services (DHCS).

iii. Permanently reside in Orange County.

d. OneCare's MOC shall provide a description of the overall SNP population that includes the following:

i. Description of the process by which CalOptima Health staff will determine, verify, and track eligibility of SNP Members.

ii. Description of medical, social, cognitive, and environmental factors, living conditions and co-morbidities associated with CalOptima Health's SNP population.

iii. Identification and description of the health conditions impacting CalOptima Health's SNP beneficiaries.

iv. Description of the unique characteristics of CalOptima Health's SNP population.

e. OneCare's MOC shall provide a description of the most vulnerable beneficiary subpopulation that includes the following:

i. Identification and definition of the most vulnerable beneficiaries within CalOptima Health's SNP population.

ii. Explanation of how the average age, gender, ethnicity, language barriers, deficits in health literacy, poor socioeconomic status, as well as other factors, affect the health outcomes of OneCare's most vulnerable beneficiaries.

iii. Correlation between the demographic characteristics of the most vulnerable beneficiaries and their unique clinical requirements.

iv. Description of established relationships with partners in the community to provide needed resources.

2. Care Coordination

a. CalOptima Health shall ensure a comprehensive care coordination program that maximizes the use of effective, efficient, safe, high-quality OneCare Member services that ultimately lead to improved health care outcomes.

b. OneCare's MOC shall provide a description of the SNP staff structure that identifies employed and contracted staff performing the following roles:

i. Administrative functions;

ii. Clinical functions; and

iii. Administrative and clinical oversight functions.

c. OneCare's MOC shall describe how staff responsibilities coordinate with the job title.

d. OneCare's MOC shall describe contingency plans used to address ongoing continuity of critical staff functions.

    i. CalOptima Health and Health Networks shall ensure a contingency plan to prevent disruption in Member care and services when existing staff are unable to perform roles and responsibilities.

e. The OneCare MOC shall describe how the organization conducts initial and annual MOC training for its employed and contracted staff.

    i. CalOptima Health shall ensure initial and annual OneCare MOC training for all OneCare employees and contracted Providers which includes:

        a) OneCare employees, delegates, and contracted staff who routinely interact with CalOptima OneCare Members are provided the MOC training as part of their comprehensive orientation. This includes permanent, temporary and contracted staff/delegated entities of CalOptima Health.

    ii. The OneCare MOC training shall be part of a comprehensive orientation process for new employees and new Providers joining the network.

    iii. The OneCare MOC training shall include the roles and responsibilities of the Provider network, and the components and goals of the OneCare MOC indicated in Section III.A.3. of this policy.

    iv. OneCare MOC training methods shall include, but not be limited to, face-to-face, interactive, web-based platforms, and paper format.

    v. CalOptima Health shall monitor and track compliance with completion of MOC training.

    vi. The OneCare MOC shall describe the actions taken if staff does not complete the required MOC training.

f. The OneCare MOC shall describe how the organization uses the HRA to develop and update the ICP for each beneficiary.

    i. CalOptima Health shall ensure completion of initial and annual HRAs, in accordance with CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment.

    ii. CalOptima Health shall use a plan-developed HRA tool to conduct an initial health risk assessment, change in health status assessments, and annual reassessments of OneCare Members.

    iii. CalOptima Health shall complete the HRA by:

        a) Telephonic outreach;

        b) In person;

c) Face-to-face virtually;

d) Via the OneCare Member through other electronic methods;

e) Mail; or

f) Per Member's preference.

iv. The HRA questions shall be designed to assess each Member's medical, functional, cognitive, psychosocial, and mental health needs.

v. CalOptima Health shall conduct an initial assessment of a Member's health care needs within ninety (90) calendar days of enrollment.

vi. CalOptima Health shall conduct reassessment of Member's health care needs, at a minimum of annually for all active Members, prior to the anniversary of the completion date of the previous years' HRA.

vii. The PCP, CalOptima Health, and/or a Health Network shall conduct a reassessment as needed when there are changes to Member's health status.

viii. Upon receipt of a Member's completed HRA, CalOptima Health shall enter all HRA information into CalOptima Health's medical management system.

ix. HRA questions are scored and used to stratify the Members into care levels as follows:

a) High Risk: Complex Case Management, Enhanced Care Management (ECM) ECM-like coordination and care management;

b) Moderate Risk: Care Coordination;

c) Low Risk: Basic Case Management, or

d) Monitoring.

x. Responses to HRA questions shall be organized into six (6) core which includes the following:

a) Physical Health;

b) Behavioral Health;

c) Long Term Services and Support (LTSS);

d) Access to Care;

e) Care Coordination; and

f) Self-Management/Health and Wellness Monitoring.

xi. CalOptima Health shall utilize care management level and system of domains to facilitate development of the care plan and identification of the ICT participants.

xii. Pertinent information from the HRA and all other assessments is used in the development of the Individualized Care Plan (ICP).

xiii. CalOptima Health shall ensure review of HRA and ICP by a licensed professional such as a registered nurse (RN), licensed clinical social worker (LCSW), or Medical Director.

g. The OneCare MOC shall describe how the organization disseminates the HRA information to the ICT and how the ICT uses that information.

i. CalOptima Health shall make a Member's HRA available daily to the Member's Health Network on the secure File Transfer Protocol (FTP) site.

ii. CalOptima Health and the Health Network shall ensure the HRA is disseminated to the Member's PCP and ICT participants, as identified.

iii. The ICT shall ensure the HRA information is discussed with the Member and incorporated into the ICP.

h. The OneCare MOC shall describe the process of the face-to-face encounter. The description shall include policies, procedures, purpose, and intended outcomes.

i. OneCare Members shall have a face-to-face encounter at minimum of annually within the first twelve (12) months of effective enrollment, as feasible and with the Members' verbal consent. OneCare Members may refuse an annual face-to-face encounter.

a) The face-to-face encounter may be conducted in person or through an interactive telehealth visit based on the Member's preference and individualized needs.

ii. CalOptima Health and the Health Network shall identify staff who may conduct the face-to-face encounter including, but not limited to the following:

a) The Primary Care Provider (PCP) or specialist serving as the PCP.

1) Other ICT Participants or OneCare designees such as the Case Manager, Care Coordinator, Behavioral Health Specialist, Dementia Care Specialist, LTSS Liaison, Social Worker, Health Coaches and Health Educators, CalOptima Health Physical Therapist or designee, and Palliative Care team based on the Member's specific needs.

b) CalOptima Health shall verify through data collection that the Member has participated in a qualifying face-to-face encounter.

c) CalOptima Health and the Health Network shall provide care coordination services during or following the face-to-face encounter as appropriate.

i. The OneCare MOC shall describe essential components of the ICP.

i. An ICP is a personalized plan of care that incorporates a Member's specific physical, behavioral health, functional need, cognitive, social, support systems, resource needs and personal health care preferences.

ii. The Member's ICP must include, but is not limited to:

a) Personal health care preferences and Member strengths.

b) Synthesized assessment outcomes that include a description of services individualized to address the Member's specific needs

c) Prioritized, personalized goals that take into account Member's, or caregiver's:

a) Goals, objectives or preferences with targeted completion dates for each goal; and

b) Desired level of involvement in the case management plan.

d) Identification of barriers to meeting goals and complying with plan;

e) Self-management plan with individualized interventions, goals and objectives;

f) Scheduled time frame for re-evaluation;

g) Monitoring and identification of progress and goal status; including active, met or not met, with modifications, as needed;

j. Identification and coordination of services to keep the member in the least restrictive setting including the following:

i. Assessment and referral for supplemental health benefits such as no cost transportation, podiatry care, no cost gym benefit and vision benefit.

ii. Assessment and referral to community resources including referrals and connections to:

a) Community-Based Organizations serving members with disabilities (for example, Regional Center and Independent Living Centers) and those serving members with dementia (for example Caregiver Resource Centers and Alzheimer's Associations;

iii. Coordination of services carved out of the OneCare plan for example, CalAIM Community Support services;

iv. Coordination of treatment plan utilizing an interdisciplinary approach;

v. Communication of the treatment plan to all entities as necessary to ensure Continuity of Care (PCP, specialists, health care delivery organization, member, family, etc.);

vi. Integration of LTSS programs and 1915c Waivers (MSSP, IHSS, CBAS, etc.);

vii. Assessment of advanced care planning, goals of care, coordination of referral and services related to palliative care, as appropriate.

viii. Regular communication with members and their designated formal and informal support systems;

ix. Promotion of efficient, individualized and coordinated care;

x. Facilitation of Member referral and linkage to resources, as appropriate;

xi. Housing navigation programs to assist Member experiencing homelessness and address housing needs;

xii. Follow up process to determine whether Member acts on referrals and documentation of outcomes;

xiii. Coordination of dental health services;

xiv. Identification and coordination of care for Members before, during and after a transition in care settings; and

xv. Integration of Behavioral Health including County mental health and Substance Use Disorder services.

k. The OneCare MOC shall describe the process to develop the ICP, including how often the ICP is modified as beneficiaries' health care needs change.

i. CalOptima Health and its delegated Health Networks shall ensure the development, implementation, and modification of a Member's ICP through an Interdisciplinary Care Team (ICT) process, in conjunction with the PCP, Member and/or their caregiver, and other disciplines, as appropriate.

ii. The Member, Provider, caregiver, and/or Authorized Representative shall actively participate in development of the ICP by the most convenient means such as in writing, face-to-face in person or through interactive telehealth visit, or telephonically.

iii. Members shall have a comprehensive initial HRA completed by the Case Management or PCC Staff, which includes but is not limited to:

a) Member's Self-Perception of their health status;

b) Hospital and Emergency Department (ED) utilization or other Transitions of Care needs;

c) Access to Care/Primary Care Physician and Continuity of Care;

d) Medication adherence and drug-drug interactions;

e) Physical health, health literacy, disease management domains, disease progression assessment and self-management (progressive screening) including but not limited to:

1) Renal;

2) HIV/AIDS;

3) Cancer and Treatment Needs;

4) Transplant;

5) Cardiac Health (HTN, CHF);

6) Pulmonary Health (Asthma, COPD)

f) Intellectual and Developmental Disabilities;

g) Behavioral health (including SUDs):

1) Depression screening; and

2) Alcohol and Drug screenings.

h) Screening for cognitive impairment (assess unmet need of members with Alzheimer's disease and Dementia Diagnoses;

i) LTSS questions which includes but is not limited to functional needs such as Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL);

j) Use of Durable Medical Equipment (DME) and/or need for home modification and safety evaluation;

k) Fall Assessment and mobility limitations;

l) Informal supports, caregiver involvement/stress and support needs, and current resources;

m) Need for continuation of Medi-Cal services or LTSS services such as MSSP, IHSS or other waiver services through 1915C programs;

n) Uncontrolled Pain;

o) Advanced Care Planning/Assessment of Palliative care needs;

p) Housing instability;

q) Food insecurity; and

r) Access to transportation.

iv. HRA data, Member's risk and care level, historical case management and utilization information, results of condition specific and comprehensive assessment tools, and the Member's self-reported main health concern are key domains used to develop the Member's ICP.

v. The Member's PCP, CalOptima Health or Health Network care coordinator or Case Manager in collaboration with the Member, and other participants of the ICT, as applicable shall update or modify a Member's ICP based on the Member's level of complexity and clinical need:

a) At least annually;

b) With changes to health status, including but not limited to:

1) ED, Hospital or SNF admission;

2) New physical diagnosis;

3) New behavioral health diagnosis or referral;

4) LTSS needs or change in LTSS level;

5) Alteration in mental or functional status;

6) Identified changes in care setting/caregiver;

7) Significant change in medication regimen resulting in new Provider;

8) Multiple falls/functional needs/home safety; and

9) Authorization request for out-of-area Provider.

c) When barriers are identified, and modifications are required; and

d) When goals are met.

vi. Modifications to the ICP include but are not limited to:

a) Increased frequency of monitoring,

b) Implementation of a transition care plan;

c) Home Safety assessment;

d) Assessment for additional services, resources and benefits including physical health, behavioral health, dental health, social drivers of health and cognitive function;

e) LTSS referrals;

f) Community resource referrals; and

g) Assessment and coordination of palliative/hospice services.

vii. The Member's PCP, CalOptima Health or Health Network shall ensure the ongoing evaluation of Member's needs, services, and benefits and facilitate appropriate and timely access to care.

l. The OneCare MOC shall describe the personnel responsible for development of the ICP, including how Members and/or caregivers are involved.

i. The Member and the Care Coordinator or Case Manager engage directly to develop the ICP.

ii. The ICT is a structure for facilitating the collaborative process of developing, implementing and refining an ICP that facilitate integrated, informed and synchronized communication address the evolving needs and goals of each Member.

iii. The core participants of the ICT include the Member, PCP, CalOptima Health or the Health Network Case Manager, Social Worker, Care Coordinator and Medical Director. The Member may decline to participate.

a) With Member's consent, family, caregivers, and Authorized Representatives are invited to participate on the ICT.

iv. Additional participants such as the Behavioral Health Specialist, Clinical Pharmacist, Dietician, Long Term Support Services (LTSS) Coordinator, Utilization management Nurses, facility Discharge Planners, Palliative Care team, Dementia Care Specialists, therapists and community based organizations may be included in the ICT based on the Member's specific needs.

m. The OneCare MOC shall describe how the ICP is documented, updated, and where it is maintained.

i. The ICP is developed at CalOptima Health or the Health Network level ICT. The assigned Case Manager or Care Coordinator ensures the ICT recommended interventions are implemented into the ICP.

ii. The ICP is documented and maintained in the Health Network or CalOptima Health's clinical documentation platform.

iii. CalOptima Health and the Health Networks shall update the ICP at least annually and disseminate the ICP to the member in the modality of their choice including preferred language, PCP, caregiver or Authorized Representative, and other participants of the ICT.

iv. A Member or PCP can access an ICP at any time electronically through the telephonically from their Care Coordinator or Case manager, or request one in writing from OneCare Customer Service team via mail/secure email.

n. The OneCare MOC shall describe how updates and modifications to the ICP are communicated to the Member and other stakeholders.

i. The ICP and revisions to the ICP are developed and communicated with the member and coordinated formally and informally with their ICT.

ii. The care plan is communicated in a variety of ways, including but not limited to verbally, secure facsimile transmission, mail, or Electronic Medical Record (EMR) transfer to the other participants of the ICT.

iii. Each Member who experiences a transition is assigned a consistent single point of contact such as a Care Coordinator or Case Manager at CalOptima or the Health Network to support and educate the Member pre-transition through the completion of the transition.

iv. CalOptima Health or Health Network case manager or Care Coordinator ensures that the ICP is updated before, during and after a transition based on the Member's needs and preferences.

v. CalOptima Health or Health Network case manager or Care Coordinator facilitates communication of the Member's ICP across settings as appropriate within two (2) business days of notification that a planned or unplanned transition has occurred.

o. The OneCare MOC shall describe how the organization determines the composition of the ICT membership.

i. The OneCare ICT facilitates the process of communication and assists in developing the Member's care plan among the Member's medical, behavioral, social services, pharmacy and ancillary Providers.

ii. The composition of the ICT is determined based upon the Member's medical condition and their responses to the HRA.

iii. Formal ICTs shall be held for all Members stratified as high risk, those identified in a vulnerable population, and those requesting an ICT. All appropriate ICT participants shall be included in the ICT.

a) Member participation in the ICT is encouraged but is voluntary; continued ICT coordination will be conducted and facilitated if the member declines to participate in the ICT.

p. The OneCare MOC shall describe how the roles and responsibilities of the ICT Members (including Members and/or caregivers) contribute to the development of an effective interdisciplinary care process.

i. The core participants invited to the formal ICT include the member, PCP, Case Manager, Social Worker, Care Coordinator and Medical Director.

ii. Additional ICT participants will vary based on the individual needs of the Member and can include disciplines such as but not limited to:

a) Behavioral Health Specialist;

b) Clinical Pharmacist;

c) Dietician;

d) Long Term Support Services Coordinator;

e) Utilization Management Nurses;

f) Facility Discharge Planners;

g) Palliative Care team;

h) Dementia Care Specialist;

i) Therapists, and

j) Community Based Organizations.

iii. Additional ICT participants for Members identified as being in the four sub-populations of focus from the Medi-Cal Enhanced Care Management program as follows:

a) Individuals At Risk for Avoidable Hospital or ED usage, Individuals At Risk for Institutionalization/ LTC, or Member's identified as homebound will include the member's formal/informal caregiver according to Member's preference;

b) Individuals Experiencing Homelessness will include a member's community-based case manager or housing Provider;

c) Individuals with Serious Mental Health and/or SUD Needs will include the member's caregiver and behavioral health, or substance use provider according to the Member's preferences;

d) Members receiving Palliative care will include a palliative care team Member;

e) Members with a formal Alzheimer's or dementia diagnosis and/or documented dementia care needs will include the Member's caregiver and a trained Dementia Care Specialist to the extent possible and as consistent with the Member's preferences.

iv. Significant changes in the Member's health status may result in a change with the ICT composition.

v. The roles and responsibilities of the ICT include the following:

a) Ensures Member needs are identified and managed by an appropriately composed team;

b) Encourage participation of the Members, their caregiver or Authorized Representative in the ICT process in accordance with their individual physical and psychosocial capabilities, and their desired level of involvement.

c) Changes to a Member's health status may require a change in the ICT composition and immediate follow-up with ICT participants. Key events or conditions which may result in a change of the ICT composition include:

1) ED visit;

2) New behavioral health referral;

3) Alteration in mental or functional status;

4) Change in care setting;

5) Change in medication resulting in a new Provider;

6) Change in LTSS level;

7) Multiple falls, and

8) Authorization request for out-of-area Provider.

q. The OneCare MOC shall describe how ICT Members use the outcomes to evaluate, contribute, and continually manage and improve the health status of SNP beneficiaries.

i. ICT participants contribute to improving the health status of OneCare Members through sharing their expertise and perspective.

ii. The Member is the center of the ICT, and the entire ICT collaborates to support the member in improving their health.

iii. The Member and the ICT participants share responsibility for problem solving and care planning to maximize the member's potential for improved health outcomes through information sharing, integrated interventions, and active discussions.

iv. The Case Manager or Care Coordinator helps the member navigate the health care delivery system and facilitate access to care and services for all issues.

v. The Case Manager or Care Coordinator coordinate communication with the member to ensure referrals are made to community resources and linkages to needed LTSS services.

r. The OneCare MOC shall describe how CalOptima Health's communication plan to exchange Member information occurs regularly within the ICT, including evidence of ongoing information exchange.

i. The CalOptima Health or Health Network Case Manager or Care Coordinator shall ensure communication of the HRA and ICP to all members of the ICT.

ii. All Members receive ICTs with all ICT participants contributing to the development and coordinating to the implementation of the ICP.

iii. Communication to the ICT participants is through various modalities including use of automation or Electronic Medical Record (EMR) systems; written correspondence such as fax or mailing; and verbal updates telephonically, during formal ICT or face-to-face during Member ongoing outreach.

iv. Formal ICTs are held on a virtual platform which can be accessed both telephonically and through a computer, allowing ICT participants to live-view the documentation of the formal ICT discussion and recommendations in the clinical management system.

a) The ICP is updated and amended to include the discussion and follow-up action items as noted from the formal ICT then shared with the ICT participants.

b) The frequency of meetings is individualized to suit the Member's need.

s. The OneCare MOC shall describe how the organization uses care transition protocols to maintain continuity of care for SNP beneficiaries.

i. The goals of the OneCare Transition Program protocols are to address individualized Member needs, successfully navigate to the appropriate setting with support, coordination, and provide self-management education and other tools to help Members achieve optimal health outcomes before, during and after a transition of care event.

ii. The OneCare Transitions Program interventions are individualized based on the Member's risk level/care level and their needs and preferences.

iii. CalOptima Health delegates management of the transition of care process to CalOptima Health CCN or the Health Networks in conjunction with the Member's assigned PCP.

iv. CalOptima Health CCN or the Health Network shall assign a single point of contact to support the Member through a transition event. The coordinator shall be assigned based on the Member's needs and preferences and shall follow the Transition Program interventions

a) Members actively participating in case management of shall be followed by the assigned Case Manager or Care Coordinator who is expected to communicate pertinent information to the PCP and ICT.

b) Members not participating in case management receive outreach from a dedicated Transition Coordinator who shall facilitate communication among the Member's health care team before during and after a transition.

v. CalOptima Health or the Health Networks shall ensure all transition interventions are incorporated into the member care plan. Members who decline transition screening or follow up are still supported through provider-centric communication and outreach.

vi. The HRA may be updated based on change in health status to reflect the Member's need for ongoing case management and updates to the ICT and ICP.

vii. CalOptima Health's transition program promotes Continuity of Care by facilitating communication among the Member's healthcare team in a timely manner.

t. The OneCare MOC shall describe the personnel responsible for coordinating the care transition process.

i. CalOptima Health or the Health Network will define a method, process, and staff to identify and manage a planned, or unplanned, transition of a Member from the Member's usual care setting, or from one care setting to the next setting.

ii. The staff assigned the responsibility for coordinating the care transition process will have background and experience with CalOptima Health transition program training and case management core competency training.

u. The OneCare MOC shall describe how the organization transfers elements of the Member's ICP between health care settings when the Member experiences an applicable transition in care.

i. For planned and unplanned transitions from any setting to any other setting CalOptima Health or the Health Network, or designated staff, will do the following:

a) Notify the Member's PCP within two (2) business days of identification of a Member experiencing a transition.

1) The PCP shall be responsible for communicating and sharing the ICP with specialty care providers upon notification of a planned or unplanned transition

b) Outreach to the member and/or designee within two (2) business days for screening/assessment and communication plan for ICP follow up.

c) Facilitate effective transfer of the Member's care plan between the sending setting and the receiving setting within two (2) business days of notification that a transition has occurred.

v. The OneCare MOC shall describe how Members have access to personal health information to facilitate communication with Providers in other healthcare settings.

i. OneCare Members are assigned a single point of contact during the first ninety (90) calendar days of effective enrollment. The contact is either a Care Coordinator or Case Manager based on their assigned risk stratification and care level. CalOptima Health or the Health Network shall mail introductory letters to Members providing the name and contact information for the Member's contact.

ii. CalOptima Health and the Health Network shall coach the Member on completing a Personal Health Record to collect key health information such as medications, condition and signs and symptoms that may be shared with providers at each follow up visit.

iii. The member's ICP shall be made available to the member and their care Providers electronically or verbally to ensure adequate sharing of information across Providers and settings to support Coordination of Care.

iv. CalOptima Health CCN and the Health Network shall obtain and forward the Member's information to providers identified for post discharge follow up.

w. The OneCare MOC shall describe how beneficiaries and/or caregivers will be educated about the Member's health status to foster appropriate self-management activities and the expectation for demonstrating understanding of appropriate self-management.

i. CalOptima Health and the Health Network shall provide coaching to OneCare Members and/or the Member's designee before, during and after a transition on self-management of their condition and needs. Techniques used include but are not limited to motivational interviewing, teach-back methods and self-paced tools as share such as the Personal Health Record and symptom trackers.

x. The OneCare MOC shall describe how the Members and/or caregivers are informed about the point of contact throughout the transition process.

i. CalOptima Health or the Health Network shall assign each OneCare Member a single point of contact within ninety (90) calendar days of effective enrollment that follows and coordinates the member's needs throughout the transition process.

ii. CalOptima Health or the Health Network assigns each Member who experiences a transition to a Case Manager to support and educate the Member through the transition process within two (2) business days.

y. The OneCare MOC shall describe where within the MOC ECM-like services (those aligned with the seven ECM core services as outlined in the CalAIM Enhanced Care Management Policy Guide, August 2024) are reflected:

i. OneCare members requiring case management services may meet the criteria for an ECM Population of Focus.

ii. CalOptima Health or the Health Network shall offer ECM-like care management services coordinated through a single point of contact.

iii. CalOptima Health or the Health Network shall ensure a OneCare member receiving Medi-Cal ECM prior to their effective enrollment receives ongoing continuity of care with their existing ECM Provider, including ICT participation, integration of ICP to continue, when possible, until the Member graduates from ECM.

iv. Examples of ECM-like services include, but are not limited to the following:

a) Outreach and engagement;

b) Comprehensive assessment and care management plan;

c) Enhanced Coordination of Care;

d) Health promotion;

e) Comprehensive transitional care;

f) Member and family supports; and/or

g) Coordination of and referral to community and social support services.

3. Provider Network

a. CalOptima Health shall be responsible for ensuring the MOC identifies, fully describes, and implements the required elements for its Provider networks.

b. CalOptima Health shall have an adequate and specialized Provider network that maintains the appropriate licensure and competency to address the needs of the target population.

c. The OneCare MOC shall describe how Providers with specialized expertise correspond to the target population identified in Section III.A. of this policy, including community-based palliative care providers.

   i. CalOptima Health's Provider network shall be comprised of Providers with extensive experience in caring for Medicare and Medicaid populations, the dual-eligibles, and the needs of the frail elderly.

   ii. CalOptima Health's Providers shall also have expertise in managing complex medical conditions, behavioral and substance use, and seniors and persons with disabilities and cognitive impairment.

   iii. CalOptima Health's Provider network shall include different types of Providers including but not limited to: PCPs, Medical Specialty Care Providers, Hospitalist, SNFist, Case Management and Utilization Management Nursing Staff, Allied Health Providers, Behavioral Health Providers, Community-Based Adult Services (CBAS), Multipurpose Senior Service Program (MSSP) In-Home Supportive Services (IHSS), Long Term Care institutional services, Pharmacy Network, Ancillary Providers, Community-Based Palliative Care Providers, and Facilities.

   iv. CalOptima Health shall contract with facilities that are pertinent to the special needs of its population. These facilities shall include, but not be limited to, acute facilities, dialysis centers, specialty outpatient clinics, residential care facilities, radiology/imaging facilities, and laboratory facilities.

d. The OneCare MOC shall describe how CalOptima Health oversees its Provider network facilities and oversees that its Providers are competent and have active licenses.

   i. CalOptima Health shall have a comprehensive credentialing process that assures the providers and facilities are actively licensed and competent, in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Re-Assessment of Organizational Practitioners.

   ii. The Credentialing and Peer Review Committee (CPRC) provides guidance and peer input into the practitioner and Provider selection process; and determines corrective actions as necessary to ensure that all practitioners and Providers that serve OneCare Members meet generally accepted standards for their profession or industry.

e. The OneCare MOC shall describe how CalOptima Health documents, updates, and maintains accurate Provider information.

   i. CalOptima Health shall maintain a current list of all its contracted Providers, practitioners, and hospitals in the CalOptima Health Provider Directory and Web-based Directory in accordance with CalOptima Health Policy EE.1101: Additions, Changes,

and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory.

f. The OneCare MOC shall describe how Providers collaborate with the ICT and contribute to a Member's ICP to provide necessary specialized services.

   i. The Member's PCP shall act as the gatekeeper responsible for the coordination of services and benefits, in accordance with CalOptima Health Policy GG.1110: PCP Definition, Role, and Responsibilities.

   ii. CalOptima Health or the Health Network shall assign each OneCare Member a single point of contact for case management services. The assigned Case Manager or Care Coordinator shall ensure the following:

      a) ICT recommended interventions are implemented into the ICP; and

      b) Communication and coordination with ICT participants.

   iii. CalOptima Health shall utilize an integrated system to facilitate communication services and updates to the ICP to the Members, network physicians and other healthcare services Providers.

   iv. CalOptima Health shall ensure that Members have effective and appropriate access to covered services in a timely manner, in accordance with CalOptima Health Policy MA.7007: Access and Availability.

g. The OneCare MOC shall explain the processes for monitoring how network Providers utilize appropriate clinical practice guidelines and nationally recognized protocols appropriate to the target population.

   i. CalOptima Health's Quality Improvement Health Equity Committee (QIHEC) shall be responsible for reviewing and approving evidenced based clinical guidelines.

   ii. The CIHECIC shall be responsible for monitoring the use of the approved guidelines within the network.

   iii. CalOptima Health shall analyze data from multiple sources including the Utilization Management, Pharmacy, Quality Improvement/Analytics, Equity Community Health, and Case Management Departments on a regular basis to identify area of clinical performance that can be improved by the use of clinical practice guidelines.

h. The OneCare MOC identifies use of clinical practice guidelines or nationally recognized protocols is challenging for the OneCare population as many of their needs are socioeconomic in nature. These guidelines or protocols may not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals.

i. The OneCare MOC shall provide details regarding how decisions to modify clinical practice guidelines or nationally recognized protocols are made, incorporated into the ICP, communicated to the ICT, and acted upon by the ICT.

i. CalOptima Health and the delegated Providers shall use approved clinical practice guidelines and nationally recognized protocols to guide treatment and care provided to the OneCare Members.

ii. When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual Member the following steps may be taken:

a) ICT is convened with the Member, PCP, and specialists, as indicated.

b) Participants of the ICT review the case and mutually develop an ICP, prioritized per Member's preferences.

c) PCP or case manager facilitates referrals and linkages to supplemental benefits, community referrals and resources.

d) Timeframes shall be established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. The updated ICP shall be shared with the care team members including but not limited to the Member, caregivers, and PCP.

j. The OneCare MOC shall describe how SNP Providers maintain continuity of care using the care transition protocols outlined in CalOptima Health Policy MA.6030: Transition of Care.

i. CalOptima Health maintains a transition of care program that is focused on managing the process of transitions for care, facilitating the safe transitions and coordinating the care of Members between care setting, and where possible preventing unplanned transitions.

ii. CalOptima Health delegates management of the transition of care process to the Health Networks or CalOptima Health in conjunction with the Member's assigned PCP.

iii. CalOptima Health's transition program promotes continuity of care by facilitating communication among the Member's healthcare team including but not limited to out of network providers or transition care settings, before during and after a transition to support continuity of care needs.

iv. The goal of the CalOptima Health transition program is to ensure that the Member is in the least restrictive setting that meets the Member's healthcare needs.

v. A key objective of the program in monitoring transitions is to ensure that communication with practitioners and Members about the transition is accomplished in a timely manner.

k. The OneCare MOC shall describe the organization's requirements for initial and annual training for network Providers and out-of-network Providers seen by Members on a routine basis.

i. CalOptima Health shall ensure the initial and annual OneCare MOC training for all OneCare employees and contracted Providers, and out-of-network Providers who routinely interact with CalOptima Health OneCare Members.

ii. The OneCare MOC training shall be part of a comprehensive orientation process for new employees and new Providers joining the network.

iii. The OneCare MOC training shall include the roles and responsibilities of the Provider network and the components and goals of the OneCare MOC indicated in Section II.C of this policy.

iv. Training is also provided to the service and administrative staff of the delivery system when there are procedural, benefits, or regulatory changes that affect the activities of the MOC.

v. The methods used for training include, but are not limited to, face-to-face, interactive, web-based platforms and paper format.

l. The OneCare MOC shall describe how CalOptima Health documents evidence of training on the MOC.

i. CalOptima Health shall monitor and track compliance with completion of MOC training by network providers and staff in accordance with CalOptima Health Policy EE.1103: Provider Network Training.

ii. Commercially developed software is used to track and document participation and understanding for web-based participation.

iii. CalOptima Health's Office of Compliance oversees the completion and collection of the attestations of completion.

m. The OneCare MOC shall describe challenges associated with the completion of MOC training for network Providers and out-of-network Providers seen by Members on a routine basis; and how the organization takes action when the required MOC training is deficient or has not been completed.

i. CalOptima Health shall identify areas of deficiency and report them to the Compliance Department for action and follow up.

ii. The Compliance Department shall notify the contracted network staff or Provider of the deficiency and request immediate resolution.

iii. Continued non-compliance will be referred to the Compliance Committee for decision regarding potential sanction or de-delegation activities.

4. OneCare MOC quality measurement and performance improvements as follows:

a. The OneCare MOC shall describe the overall Quality Improvement Health Equity Transformation Program (QIHETP) plan and how the organization delivers or provides for appropriate services to Members, based on their unique needs, for appropriate quality measurement and performance improvement.

i. CalOptima Health must have a comprehensive QIHETP in place that establishes methods for objectively and systematically evaluating and improving the health equity, quality and

safety of clinical care, and quality of services provided to Members for both physical and Behavioral Health Services.

ii. The CalOptima Health Quality Improvement Health Equity Committee (QIHEC) shall oversee the development of the QIHETP.

iii. The QIHEC analyzes, evaluates and reacts as needed to the result of the QI and Health Equity activities, include annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of the OneCare MOC and Member outcome measures to develop a comprehensive QIEHTP Work Plan.

iv. The QIHETP description integrates activities from the QIHETP and Utilization Management Work Plans.

v. The QIHETP Work Plan focuses on activities that refine the structure and process of care delivery with emphasis on health equity, quality healthcare, Member-centric activity, and consistency with regulatory and accreditation standards.

b. The OneCare MOC shall describe specific data sources and performance and outcome measures used to continuously analyze, evaluate, and report MOC quality performance.

i. The performance measures for the OneCare MOC and Member outcome measures shall be collected and tracked using OneCare's clinical data warehouse and additional data sources as required.

ii. Some MOC measures are collected as part of the annual Healthcare Effectiveness Data and Information Set® (HEDIS®) data collection and reporting process.

c. The OneCare MOC shall describe how leadership, management groups, other personnel, and stakeholders are involved with the internal quality performance process.

i. The CalOptima Health QI workgroups shall be responsible for gathering, analyzing, and reporting on MOC performance.

ii. The CalOptima Health Utilization Management and Quality Improvement Health Equity Committees shall present results of the data analysis on a quarterly basis to the CalOptima Health Board Quality Assurance Committee (QAC).

iii. CalOptima Health shall utilize standardized measures such as HEDIS® indicators to evaluate performance of the MOC. CalOptima Health shall report the full Medicare reporting set and Special Needs Plan subset of HEDIS® measures.

iv. OneCare also participates in the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the Medicare Health Outcomes Survey (HOS) to evaluate Member satisfaction and health outcomes.

v. Results of performance improvement activities in the MOC shall be communicated to the appropriate departments, committees, or administrative team as determined by the nature of the activity.

vi. The performance improvement information shall be reported to the CalOptima Health Board of Directors through a committee structure as defined in the CalOptima Health (QIHETP) Program.

vii. CalOptima Health shall communicate the improvement activities to Providers and Members periodically by various media formats.

d. The OneCare MOC shall describe how measurable goals and health outcomes objectives are integrated in the overall performance improvement plan, as described in Section II.E.4. of this policy.

i. Each measurable goal and health outcome objective shall be evaluated and documented separately in the form of a QI or Utilization Management project.

ii. The QIHEC shall identify target areas for improvement and assist staff in determining interventions and actions.

iii. CalOptima Health shall prioritize areas for improvement by relevance to strategic priorities and important business processes.

iv. The QIHEC shall formulate a Quality Improvement Project Plan, indicating the interventions for implementation, the responsible person or department, and set a timeframe for completion.

e. The OneCare MOC shall identify and define the measurable goals and health care needs to improve access and affordability of the OneCare Members.

f. The OneCare MOC shall identify specific Member health outcome measures used to measure overall population health outcomes at the plan level.

i. Goals, benchmarks and timeframes for accomplishment specific to Member health outcome measures shall be defined annually by the CalOptima Health Utilization Management and Quality Improvement Health Equity Committees.

g. The OneCare MOC shall describe how CalOptima Health establishes methods to assess and track the MOC's impact on Members' health outcomes.

i. The CalOptima Health QIHEC shall be responsible for gathering, analyzing, and reporting on MOC performance.

ii. The CalOptima Health Utilization Management and Quality Improvement Health Equity Committees shall present results of the data analysis quarterly to the CalOptima Health Board Quality Assurance Committee.

h. The OneCare MOC shall describe the processes and procedures used to determine if health outcome goals are met and the steps taken if goals are not met in the expected time frame.

i. The QIHEC shall integrate the data and recommendations from the various pertinent workgroups and report recommendations back to the workgroups for recalibration of the process or measure to meet the stated goal.

ii. The QIHEC shall summarize progress to the measurable outcomes quarterly and report to the Quality Assurance Committee and to the CalOptima Health Board of Directors for further direction.

i. The OneCare MOC shall describe the process used to measure patient experience of care (Member satisfaction).

i. Member satisfaction is assessed annually by identifying the appropriate population and collecting valid data from that population about various areas of their health care experience.

ii. Opportunities for improvement are identified from this information and specific evidence-based interventions are implemented.

j. The OneCare MOC shall describe the specific survey used.

i. The tools used by CalOptima Health to evaluate patient experience include:

a) Medicare CAHPS® Member survey;

b) Network Adequacy Analysis;

c) Language Study; and

d) Timely Access Survey.

k. The OneCare MOC shall explain the rationale for the selection of a specific tool.

l. The OneCare MOC shall describe how results of patient experience surveys are integrated into the overall MOC performance improvement plan.

i. CalOptima Health uses the Medicare CAHPS® Member survey to identify areas to improve and tracks progress over time.

ii. Complaints and appeals are annually evaluated and categorized into five (5) areas:

a) Quality of Care;

b) Access;

c) Attitude and Service;

d) Billing and Financial Issues; and

e) Quality of Practitioner Office Site.

m. The OneCare MOC shall describe steps taken to address issues identified in enrollee survey responses.

i. The Quality Analytics Department analyzes survey results and discusses results, barriers, and opportunities for improvement.

ii. Analysis is presented to the QIHEC to identify target areas for improvement and determine interventions and actions.

n. The OneCare MOC shall describe how CalOptima Health will use the results of the quality performance indicators and measures to support ongoing improvement of the MOC.

i. The QIHEC annually conducts a formal performance evaluation and reports to QAC annually to develop strategies for continuous improvement for the coming year.

o. The OneCare MOC shall describe how CalOptima Health will use the results of the quality performance indicators and measures to continually assess and evaluate quality.

p. The OneCare MOC shall describe CalOptima Health's ability for timely improvement of mechanisms for interpreting and responding to lessons learned through the MOC performance evaluation.

q. The OneCare MOC shall describe how the performance improvement evaluation of the MOC will be documented and shared with key stakeholders.

i. Results of performance improvement activities and evaluation shall be communicated to the appropriate department, multidisciplinary committee, or administrative team as determined by the nature of the issue.

ii. The frequency of communication will be determined by the receiving groups and be reflected on the work plan or calendar.

iii. Given CalOptima Health is a public agency the complete process is transparent and available to stakeholders at the different reporting levels.

r. The OneCare MOC shall describe how performance results and other pertinent information are shared with multiple stakeholders.

i. Communication to Providers is coordinated through the Provider Network Department.

s. The OneCare MOC shall state the scheduled frequency of communications with stakeholders.

t. The OneCare MOC shall describe the methods for ad hoc communication with stakeholders.

u. The OneCare MOC shall identify the individuals responsible for communicating performance updates in a timely manner.

IV. ATTACHMENT(S)

A. 2024 Model of Care: Orange County Health Authority

V. REFERENCE(S)

A. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Policy EE.1101: Additions, Changes, and Terminations to CalOptima Health Provider Information, CalOptima Health Provider Directory, and Web-based Directory
C. CalOptima Health Policy EE.1103: Provider Network Training
D. CalOptima Health Policy GG.1110: Primary Care Practitioner Definition, Role, and Responsibilities
E. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
F. CalOptima Health Policy GG.1651: Credentialing and Recredentialing of Healthcare Delivery Organizations
G. CalOptima Health Policy MA.6022: Initial and Annual Health Risk Assessment
H. CalOptima Health Policy MA.6030: Transition of Care
I. CalOptima Health Policy MA.7007: Access and Availability
J. Department of Health Care Services CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract Year 2024, August 2024
K. Department of Health Care Services CalAIM Dual Eligible Special Needs Plans Policy Guide, Contract Year 2025, September 2024
L. Department of Health Care Services CalAIM Enhanced Care Management Policy Guide, August 2024
M. Medical Improvements for Patients and Providers Act (MIPPA) of 2008
N. NCQA Structure and Process Measures for Special Needs Plan
O. OneCare Quality Improvement Program
P. Title 42, Code of Federal Regulations (C.F.R.), Section 422.101(f) - 4138-IFC

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2013	MA.6032	Model of Care Policy	OneCare
Revised	01/01/2016	MA.6032	Model of Care	OneCare
Revised	04/01/2017	MA.6032	Model of Care	OneCare
Revised	10/01/2017	MA.6032	Model of Care	OneCare
Revised	08/01/2018	MA.6032	Model of Care	OneCare
Revised	04/01/2020	MA.6032	Model of Care	OneCare
Revised	12/31/2022	MA.6032	Model of Care	OneCare
Revised	11/01/2024	MA.6032	Model of Care	OneCare

IX. GLOSSARY

Term	Definition
Activities of Daily Living (ADL)	Personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, and bathing.
Authorized Representative	An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions
Basic Case Management (Care Management Level)	A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Member's health and functional needs. Services are provided by the Primary Care Physician (PC) or by a PCP-supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home. Coordination of services outside the health plan, such as community social services or specialty mental health or Drug Medi-Cal services, are considered basic case management services.
Behavioral Health Services	Services which encompass both Mental Health and Substance Use Disorder services.
Care Coordination (Care Management Level)	Case management provided to Members who are at moderate risk, but still have an acute or chronic medical condition that requires assessment and coordination of resources in order to maintain the Members in the least restrictive setting; it is provided by the Member's Health Network, in collaboration with their PCP.
Care Coordinator	A clinician or other trained individual who is employed or contracted by the Member's primary care provider or D-SNP, serves on one (1) or more Interdisciplinary Care Teams (ICT), and coordinates and facilitates meetings and other activities of those ICTs, as well as participates in the Health Risk Assessment of each Member on whose ICT they serve.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs
Complex Case Management (Care Management Level)	Case Management provided to Members who are at high-risk; defined as having medically complex conditions that include the following but is not limited to: 1. Spinal injuries; 2. Transplants; 3. Cancer; 4. Serious Trauma; 5. AIDS; 6. Multiple chronic illness; or 7. Chronic illnesses that result in high utilization.

Term	Definition
Continuity of Care	Continuity of care refers to the continuous flow of care in a timely and appropriate manner. Continuity includes: 1. Linkages between primary and specialty care; 2. Coordination among specialists; 3. Appropriate combinations of prescribed medications; 4. Coordinated use of ancillary services; 5. Appropriate discharge planning; and 6. Timely placement at different levels of care including hospital, skilled nursing and home health care.
Dementia Care Specialist	D-SNP care coordinators/managers trained in understanding Alzheimer's disease and related dementias, symptoms, and progression; understanding and managing behaviors and communication problems; understanding caregiver stress and its management; and connecting enrollees and caregivers to community resources.
Department of Health Care Services (DHCS)	Director: The Director of the California Department of Health Care Services.
Durable Medical Equipment (DME)	Equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Health Risk Assessment (HRA)	A tool designed to identify potential critical health factors and that is completed by a Member during the initial enrollment period and annually. The weighted score of the answers stratifies care management level based on the overall score.
Individual Care Plan (ICP)	A written plan of care developed after an assessment of a Member’s social and health care needs that reflects what services the Member will receive to reach and keep his or her best physical, mental, and social well-being.

Term	Definition
Interdisciplinary Care Team (ICT)	A team comprised of the Primary Care Provider and Care Coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the Individual Care Plan (ICP).
LTSS	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. LTSS includes all of the following: 1. Community-Based Adult Services (CBAS); 2. Multipurpose Senior Services Program (MSSP) services; 3. Skilled Nursing Facility services and subacute care services; and 4. In-Home Supportive Services (IHSS).
Quality Improvement (QI)	A process which addresses the quality of clinical care as well as the quality of health service delivery.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Medical Record	A Medical Record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical Records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Member	A beneficiary enrolled in the CalOptima Health OneCare program.
Model of Care (MOC)	A care management process which supports the unique health care needs of a population. MOCs provide the needed infrastructure to promote quality care management and care coordination processes.
Personal Care Coordinator (PCC)	A para-professional whose function is to promote coordination of care by bridging the gap between OneCare and the physician group . The role of the PCC is to facilitate communication between the Member, OneCare, the physician group, the Primary Care Provider (PCP) and the Interdisciplinary Care Team (ICT). The PCC assists the Member to navigate the healthcare delivery system and facilitates access to care and services.
Primary Care Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a Non-physician Medical Practitioner (NMP) (e.g., Nurse Practitioner [NP], Nurse Midwife, Physician Assistant [PA]) authorized to provide primary care services under supervision of a physician. For SPD or Whole Child Model beneficiaries, a PCP may also be a specialty care provider or clinic.

Term	Definition
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Special Needs Plan	Medicare Advantage coordinated care plans that serve the special needs of certain groups of individuals including; institutionalized individuals (as defined by CMS), those entitled to Medical Assistance under a State Plan under Title XIX and individuals with severe or disabling chronic conditions, as defined by CMS.
Transition of Care	The movement of a Member from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.