



A Public Agency

OneCare Connect
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OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

Grievances and Appeals

Learning Objectives

After completing this module, you will be able to:

- Define the terms **grievance** and **appeal**.
- Identify who has responsibility for handling grievances and appeals.
- Differentiate between a grievance or appeal.
- Assist members with filing a grievance or appeal.
- Understand the basic steps in the processes for handling grievances and appeals.
- Identify resources to assist a OneCare Connect member in resolving grievance or appeal.

Course Content

- Program and Eligibility Requirements
- Member Rights
- Definitions – Grievance, Appeal
- California Ombudsman
- Health Insurance Counseling and Advocacy Program (HICAP)
- Medicare Grievance Procedure
- Medicare Appeal Procedure
- Medicare Expedited Appeals Procedure
- Medi-Cal Appeals Procedure
- Oversight and Quality Improvement

Note: 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.

OneCare Connect Plan

- California's Cal MediConnect plan:
 - Combines Medicare and Medi-Cal benefits.
 - Coordinates all care, supports and services via one plan — CalOptima OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan).
 - Integrates behavioral health benefits with physical health benefits.
 - Offers improved access to Long-Term Services and Supports, including nursing facilities, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP).
- Coordination of care through OneCare Connect enables the member to receive quality services to achieve optimal outcomes, independence, health and quality of life.

Eligible Members

- OneCare Connect members must meet all criteria to be eligible for benefits.
- Must be:
 - Age 21 and older
 - Residing in Orange County
 - Enrolled in Medicare Parts A, B, D
 - Receiving full Medi-Cal benefits (\$0 Share of Cost)
 - Share of Cost exception: Members who reside in a nursing home, are enrolled in the Multipurpose Senior Services Program (MSSP) or have In-Home Supportive Services (IHSS).

**Excluded are people under 21, with other health insurance, with other share of cost, in certain waiver programs, receiving services through state or regional developmental centers or intermediate care facilities, confined to correctional facilities, or living in a veteran's home.*

Member Rights

- All CalOptima members have the same basic rights.
- OneCare Connect members can find a list of their rights on the CalOptima website — www.caloptima.org.
- Rights are also described in detail in the Member Handbook.
- Rights pertinent to this module include the right to:
 - Participate in all aspects of care.
 - Exercise all rights of appeal.
 - Receive their Medicare and Medi-Cal appeal rights in a format and language understandable and accessible to them.
- No negative consequence to exercising a right, even if it's a complaint or a grievance or an appeal.

Grievances and Appeals

- CalOptima members in all programs have grievance and appeal rights.
 - Grievance: any complaint expressing dissatisfaction with the manner in which a CalOptima or a delegated entity provides health care services.
 - Appeal: a decision made by CalOptima or a delegated entity that the member wants reconsidered.
- Grievances and appeals are important:
 - Learn about member perceptions of CalOptima.
 - Find opportunities for improving our services.
- Grievance and Appeals Resolution Services (GARS) staff are responsible for all complaints and appeals that are the adjudication responsibility of CalOptima.

OneCare Connect Members

- Adults who are eligible for both Medicare and Medi-Cal benefits.
- Note:
 - Medicare benefits follow the Medicare grievance and appeal process.
 - Medi-Cal benefits follow the Medi-Cal grievance and appeal process.
 - For “overlapping benefits,” the member has Medicare and Medi-Cal appeal rights for second level of appeal.
 - For example, home health, DME or skilled therapies.

Definition of Grievance

- Grievance:
 - Any **complaint or dispute**, other than one involving an organization determination (coverage decision), **expressing dissatisfaction** with the manner in which CalOptima or a delegated entity provides health care services, regardless of whether any remedial action can be taken.
 - May include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item, or about the quality of the care.
 - Disputes involving “coverage decisions” are not considered grievances.
 - A coverage decision is any decision made by a Medicare health plan regarding:
 - Receipt of, or payment for, a managed care item or service;
 - The amount a health plan requires an enrollee to pay for an item or service; or
 - A limit on the quantity of items or services

Definition of Grievance (cont.)

- Grievance:

- An **expedited grievance** is a “fast complaint” and may be requested for the following circumstances:
 - OneCare Connect refused to expedite a coverage decision or appeal, or invoked an extension to a coverage decision or appeal time frame.
 - If a person has an urgent problem that involves an immediate and serious risk to their health.
- A member or their authorized representative may make the complaint or dispute, either verbally or in writing, to CalOptima.
- If a member's request for an item or service is denied in whole or in part and a Notice of Denial is issued, the member may appeal the decision to the plan by requesting an appeal.
 - The process of reviewing the decision is called appeal.

Medicare and Medi-Cal Definitions

Grievance:

- Any complaint or dispute, other than an organization determination, expressing dissatisfaction with any aspect of the Plan's or Provider's operations, activities, or behavior, is requested.
 - **Medicare Grievance:** A complaint from a member related to Medicare benefits and services pursuant to 42 C.F.R. 422.564.
 - **Medi-Cal Grievance:** A complaint from a member related to Medi-Cal benefits and services pursuant to Welfare and Institutions Code Section 14450 and California Health and Safety Code Sections 1368 and 1368.1.

Medicare and Medi-Cal Definitions (cont.)

Appeal:

- A member's actions, both internal and external, to the Plan requesting review of the Plan's denial, reduction or termination of benefits or services, from the Plan.
 - **Medicare Appeal:** A member's request for a formal review of an adverse action of the Contractor in regard to a Medicare service in accordance with Section 2.15 of the Three-Way Contract.
 - **Medi-Cal Appeal:** A request for a fair hearing in accordance with California Code of Regulations (CCR) Title 22, Section 51041.1 and Welfare and Institutions Code section 10950.

Definition of Appeal: Pharmacy

- Pharmacy Appeal:
 - A **Medicare Part D** term for any of the procedures that deal with the review of **adverse coverage decision** made by CalOptima on the benefits under a Part D plan that the member believes he/she entitled to receive, including a delay in providing or approving the drug coverage (when a delay would adversely affect the health of the member), or on any amounts the member must pay for the drug coverage.
 - These procedures include **Redeterminations** by CalOptima, Reconsiderations by the Independent Review Entity (IRE), a hearing before an Administrative Law Judge (ALJ), reviews by the Medicare Appeals Council (MAC), and judicial reviews.

Informing Members of Rights

- CalOptima informs members of their appeal rights at specific times, including:
 - At initial enrollment, and annually thereafter
 - In the OneCare Connect Member Handbook and periodic member newsletters
 - Upon notification of an adverse coverage decision (such as a denial letter)
 - Upon notification of a service or coverage termination (a notice required for certain services provided by providers such as a hospital, a comprehensive outpatient rehabilitation facility, a home health agency, or a skilled nursing facility)
 - Upon member request

Identifying a Grievance or Appeal

- A member may state they want to make a grievance or appeal.
- A member may not use the words grievance or appeal but convey that they want to make a complaint or ask for a reconsideration of a decision made by CalOptima.
 - Members do not need to use the specific words.
 - ***Listen or read carefully to make sure grievance and appeal rights are identified and granted.***
- There is no wrong door for members wanting to make a grievance or appeal.
 - May submit in writing by letter, fax or email
 - Or orally in person or by phone

Assisting Members

- If unclear about a member's intentions or the member needs help deciding whether to initiate a grievance or an appeal, transfer the member to the Customer Service department.
- The CalOptima Customer Service department assists members in determining whether to file a grievance, request for a coverage decision, or request an appeal.

Expedited Appeals

- Members have the right to request an expedited appeal.
- An **expedited appeal** is done if the standard time for making a determination could seriously jeopardize the member's life, health or ability to regain maximum function.
- A Medical Director determines if an appeal meets the requirements for an expedited appeal.

Grievances Handled Externally

- CalOptima staff provides members with a toll-free contact number, or other contact information, to outside entities for complaints regarding services for which CalOptima is not responsible. These include:
 - Multipurpose Senior Services Program (MSSP) services provided out of county
 - Behavioral Health Services provided by the County
 - In-Home-Support-Services provided by the County
- The toll-free numbers for these services are found in the Provider Manual on CalOptima's website.

Cal MediConnect Ombudsman

- The Ombudsman is a state-supported member resource for OneCare Connect (Cal MediConnect). Members may contact the Ombudsman service for:
 - Help with a provider, health plan, coverage denial, or payment for a medical decision
 - Continuity of care issues
 - Filing an appeal
- Contact Information:
 - Monday through Friday from 9 a.m. to 5 p.m.
 - For Cal MediConnect: 855-501-3077 or TTY: 855-847-7914
 - For Medi-Cal: 888-452-8609

Health Insurance Counseling & Advocacy Program (HICAP)

- Members may also contact the Health Insurance Counseling & Advocacy Program (HICAP).
- Members may contact HICAP to:
 - Make a change to their health plan
 - Choose a different Cal MediConnect or Medi-Cal plan
 - Opt out of Cal MediConnect
- Contact Information:
 - Monday through Friday from 8 a.m. to 4 p.m.
 - 800-434-0222

Provider Complaint Process

- CalOptima maintains a provider complaint process to review and resolve provider disputes for claims, utilization management (UM) decisions or other non-claim issues related to the CalOptima program.
- Key elements of CalOptima's provider complaint process:
 - A complaint may be an appeal or a grievance.
 - All written complaints are acknowledged within 15 working days or within two working days if submitted electronically.
 - The resolution to the complaint will be sent to the provider in writing within 45 working days from the receipt of the complaint or amended complaint.
- For more information about filing a provider complaint, contact CalOptima's Grievance and Appeals Resolution Services at **714-246-8554** or grievancemailbox@caloptima.org.

Knowledge Check

1. OneCare Connect members have:
 - a) Medicare appeal rights for Medicare benefits
 - b) Medi-Cal appeal rights for Medi-Cal benefits
 - c) Medicare and Medi-Cal appeal rights for “overlapping benefits”
 - d) a and b
 - e) a, b and c

2. Members may make a grievance in writing by letter, fax or email, or orally in person or by phone
 - a) True
 - b) False

Knowledge Check (cont.)

3. A member calls to complain that payment for a service they received was denied (because the member did not receive prior authorization for the medical service). This is a grievance.
- a) True
 - b) False
4. A member calls CalOptima to report that a contracted PCP's office is dirty and the staff was rude. This is a:
- a) Grievance
 - b) Appeal
 - c) Both a and b
 - d) Neither a nor b

Knowledge Check Answers

1. e) a, b and c
2. a) True
3. b) False – this is an appeal
4. a) Grievance

GARS Department Processes

The Grievances and Appeals Resolution Services team has specific procedures for handling:

- Grievances
- Appeals
- Expedited appeals
- Expedited grievances

Grievances

Grievance Procedure

- The CalOptima GARS team handles:
 - Medical and pharmacy grievances
 - Member complaints about a network provider, including complaints about the quality of care or service
- CalOptima resolves grievances as expeditiously as the member's case requires, based on the member's health status, but no later than **30 calendar days** after the date CalOptima receives a verbal or written grievance.

Grievance Procedure: Intake Process

- Grievances are directed to the GARS program assistant who:
 - Verifies or works with Customer Service to request an Appointment of Representative (AOR) form if anyone other than the member files a grievance.
 - Date stamps receipt of the grievance and logs required information into the database.
 - CalOptima accepts any information or evidence concerning a grievance verbally or in writing at any time.
 - Creates a case file and includes any relevant documents.
 - Reviews the grievance for appealable component(s).
 - Sends member acknowledgement letter **within five (5) calendar** days of receipt.

Grievance Procedure: Standard Process

- The GARS specialist triages, investigates and/or forwards appropriate cases to the respective department.
 - GARS tracks all activity and time frames in the database and ensures affected departments make timely response.
- The affected department designee:
 - Reviews the grievance
 - Conducts an investigation
 - Provides a resolution or recommendation
- The grievance resolution or recommendation is returned to the GARS specialist within the specified time frame. Includes:
 - Action taken
 - Recommendation/resolution

Grievance Procedure: Resolution

- GARS mails a closure letter to the member/representative within **30 calendar days** from receipt of the grievance.
 - Grievances filed verbally may be responded to verbally, unless the member requests a written response, or the grievance involves a quality of care issue.
 - Grievances filed in writing must be responded to in writing and will include an explanation of the proposed resolution in plain language that is easily understood by a member.
 - Specific corrective actions concerning a practitioner's medical care will not be revealed in that letter.
- The GARS specialist completes all fields required in the database and includes all relevant documents.

Grievance Procedure: Expedited

- The expedited grievance is promptly processed when a member disagrees with an extension to a coverage decision or appeal; or an expedited coverage decision or appeal is not granted; or the member has an urgent problem that involves an immediate and serious risk to their health.
- The GARS specialist forwards any additional clinical information provided by the member and/or authorized representative to the Medical Directors for additional review.
- The decision to expedite the review or not is returned to the GARS specialist within **24 hours**.
- The GARS specialist contacts the member within **24 hours** of receipt of the grievance to notify the member the extension stands, or the case will be reviewed as expedited or routine and follows up with a written notification.

Grievance Procedure: Misclassification

- If CalOptima incorrectly classifies a grievance as an appeal:
 - CalOptima immediately, upon discovery, mails the misclassification notice to the member informing them that the complaint was misclassified.
 - The time frame for processing this as a grievance begins on the **date and time** that the complaint was originally received by CalOptima as opposed to the date the error was discovered.

Grievance Procedure: Maintaining Records

The GARS database contains the following grievance elements:

- Date complaint received
- Date acknowledgement letter sent to the member
- Issue being investigated
- Date complaint finalized or resolved
- Date member notified of the grievance disposition

Appeals

Medicare Appeals Process

- The majority of benefits provided to OneCare Connect members are covered by Medicare as the primary coverage.
- Appeals may be made before a service has occurred (pre-service) or after a service has occurred (post-service).
- The following slides describe the Medicare appeals process.

Who May Request an Appeal?

- A member, a treating physician acting on the member's behalf, a member's representative, a non-contracted physician or CalOptima provider.
 - An authorized representative will have all of the rights and responsibilities of the member.
 - An authorized representative must be authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal.
 - An authorized representative may complete a Centers for Medicare & Medicaid Services (CMS) approved Appointment of Representative (AOR) form.
 - A physician who is providing treatment to a member may, upon providing notice to the enrollee, request a standard pre-service appeal without submitting a representative form.

Appeal Procedure: Intake Process

- A member or representative may request a standard appeal with a signed written request or by calling the Customer Service department.
- A member or representative must submit the appeal within **60 calendar days** from the date of the notice of denial, except in the case of an extension of the filing time frame.
- If a verbal appeal request is received, the time frame for processing the appeal begins with acceptance of the verbal request.
 - The verbal request is recorded in the member's own words, repeated back to the member to confirm the accuracy, and placed into the database by Customer Service staff.
 - An acknowledgment letter is mailed to the member within **five (5) calendar days**.

Appeal Procedure: Reconsideration of Initial Decision

- A person at CalOptima who was not involved in making the initial decision is designated to do the review.
 - If the initial decision was based on a lack of medical necessity, then the appeal is reviewed by a physician with expertise in the field of medicine that is appropriate for the services requested.
 - The physician need not, in all cases, be of the same specialty or subspecialty as the treating physician.
- In cases involving an emergency medical condition, CalOptima applies the “prudent layperson” standard definition, when handling the appeal.

Appeal Procedure: Standard Process

- The GARS specialist submits the case to the physician for review and decision.
- A written response to the member or member representative is made **within 30 calendar days** for pre-service appeals, and **within 60 calendar days** for post-service appeals, from the date CalOptima receives the request for appeal.
- The time frame may be extended by up to **14 calendar days**, for pre-service appeals, at the member's request or by CalOptima, if the delay is in the best interest of the member.

Appeal Procedure: Standard Process (cont.)

- The GARS specialist mails the member an appeal extension notice which includes the reasons for the delay and informs the member of the right to file an expedited grievance if the member disagrees with the decision to grant an extension.
- The Medical Director issues a determination as expeditiously as the member's health condition requires, but no later than the **last day** of the extension.

Appeal Procedure: Internal Resolution

CalOptima may resolve the appeal by:

- Reversing the initial decision (overturn)
- Affirming the initial decision (uphold)
- Reversing part of the initial decision (also called a partial decision and considered adverse because part of the initial decision is upheld)

Appeal Procedure: External Process

- For all upholds, the GARS nurse specialist prepares a written explanation and forwards to the GARS specialist to send the complete case file to the Independent Review Entity (IRE).
 - CalOptima's current IRE is MAXIMUS Federal Services.
- The GARS specialist concurrently notifies the member by mail that the case has been forwarded to the IRE.

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Appeal Procedure: External Process (cont.)

- If CalOptima fails to provide the member with a reconsidered determination within the time frame allowed by CMS, this failure constitutes an uphold and auto-forwards to the IRE.
- The GARS specialist follows the appropriate Reconsideration Process guide for detailed instructions on sending appeals to MAXIMUS Federal Services.

Appeal Procedure: Dismissal

- When a member requests a standard pre-service appeal but CalOptima learns that the member has obtained the service, the review process stops, and the entire case is dismissed.
 - A pre-service appeal is a request for reconsideration before the service is rendered.
- If the appeal is filed by a non authorized representative and the Appointment of Representative (AOR) form or legal document to act on behalf of a member is not received by the **44th day** (pre-service appeals) **or by the 60th day** (post service appeals) from the appeal receipt date, the case is dismissed.

Appeal Procedure: Dismissal (cont.)

- If the appeal is filed past **60 days** from the denial date and a good cause provided is not accepted, the case is dismissed.
- If the good cause is not provided by the **44th day** (pre-service appeals) **or by the 60th day** (post service appeals) from the appeal receipt date, the case is dismissed.

Appeal Procedure: Expedited Process

- A member, a member's representative or physician (including a non-contracted physician) are the only parties who may request an expedited appeal.
- A CalOptima Medical Director decides promptly whether to expedite or follow the time frame for standard appeals.
 - When the request is made or supported by a physician, GARS grants the expedited appeal if the physician indicates that the life or health of the member, or the member's ability to regain maximum function, could be seriously jeopardized by applying the standard appeal time frame.
 - For a member request not supported by a physician, CalOptima's Medical Director determines whether the life or health of the member, or the member's ability to regain maximum function, could be seriously jeopardized by applying the standard time frame.

Appeal Procedure: Expedited Process (cont.)

- An expedited decision and notification must be **within 72 hours of arrival time** (to the minute).
- **If expedited request is accepted/criteria met:** member will be **called within 24 hours**. The member is informed that the request is being processed as expedited and a decision will be issued **within 72 hours** from the receipt date (good cause not required if accepted as expedited).
- **If expedited request denied/criteria not met:** member will be **called within 24 hours**. The member is informed that the request does not meet criteria and will be processed as a standard appeal. Explain grievance rights and send Right to Expedited Grievance letter.

When Expedite Request Is Denied

If the request for an expedited appeal is denied, the GARS specialist or GARS nurse specialist gives the member prompt verbal notice of the denial for an expedited appeal, and then mails the written notification **within three calendar days** of the verbal notice.

- Explains that CalOptima will automatically process the request using the **30-day** time frame for standard appeals.
- Informs the member of the right to file an expedited grievance.
- Informs the member of the right to resubmit a request for an expedited appeal with physician support.
- Provides instructions about the grievance process and its time frames.

When Expedite Request Is Approved

If the request for an expedited appeal is approved, a GARS-Medical Director makes a determination **within 72 hours** from the time the request is received.

A GARS specialist:

- Provides verbal notice of decision to the member or authorized representative and mails written confirmation of its decision **within three calendar days** of the oral notice.
- The 72-hour time frame may be extended by up to **14 calendar days** if in the best interest of the member.

When Expedite Request Is Approved (cont.)

- When the time frame is extended, the member is notified in writing of the reasons and informed of his/her right to file an expedited grievance.
- If CalOptima does not notify the member within the required time frame of **72 hours** for an expedited appeal, this constitutes an adverse decision (uphold), and GARS submits the complete file to the IRE.

Medi-Cal Appeals

- For overlapping Medicare and Medi-Cal services (which include, but are not limited to, home health, durable medical equipment and skilled therapies), members have the right to file for a State Hearing.
 - The State Hearing is a judicial proceeding for resolving disagreements between the individual and the health plan.
 - A member's State Hearing request may be dismissed if a Medicare hearing has also been requested.

Medi-Cal Appeals: Time Frames

- Time frames for filing an appeal are the same for Medicare and Medi-Cal under current law (**60 days**).
- Time frames for resolution of an appeal for Medi-Cal are:
 - **30 days for standard appeal**
 - **72 hours** for an expedited appeal
 - Extensions up to **14 days** may apply
- Time frames for resolution of an appeal for Medicare are:
 - **60 days** for post service
 - **30 days** for pre-service (standard appeal)
 - **72 hours** for an expedited appeal
 - Extensions up to **14 days** may apply

Medi-Cal Appeals: Processes

- Members may file for a State Hearing within **120 days** from the date of the notice of appeal determination for appeals for Medi-Cal services.

Third-Fifth Level Appeals

- Appeals of Medicare benefits are filed with the Office of Medicare Hearings and Appeals (OHMA).
 - Medicare Appeals have up to five levels
- Medi-Cal does not have additional levels of appeal beyond the 2nd Level.
 - Appeals of Medi-Cal benefits are processed as State Hearings within **120 days** of the notice of appeal decision.

Oversight and Quality Improvement

- Grievances and appeals are tracked in a single database.
- The Quality Assurance Committee (QAC) regularly reviews reports of grievance and appeal activities, including trends in grievance and appeal topics, as well as overturn and upheld rates.
- Opportunities for department and organizational improvement are identified and acted upon.
- Grievance and appeals data are an important source for identifying issues and developing quality improvement projects.

Knowledge Check

1. An expedited appeal is granted when the life or health of the member, or the member's ability to regain maximum function could be seriously jeopardized by applying the standard appeal time frame:
 - a) True
 - b) False

2. Who determines if an appeal meets the standard to be expedited?
 - a) GARS, if a physician has requested or supported the need for an expedited appeal.
 - b) A CalOptima Medical Director if a physician has not requested or supported the need for an expedited appeal.
 - c) Both a and b

Knowledge Check (cont.)

3. An expedited appeal must be completed:
 - a) With 72 hours in all cases
 - b) Up to 14 additional calendar days, if an extension beyond 72 hours has been requested
 - c) Both a and b

4. An appeal will be handled by the same CalOptima medical director who made the initial decision to deny services.
 - a) True
 - b) False

Knowledge Check (cont.)

5. The Independent Review Entity (IRE) for CalOptima is MAXIMUS Federal Services.
- a) True
 - b) False
6. A State Hearing is:
- a) An appeal process for Medi-Cal benefits
 - b) Available to members after the appeal process at CalOptima has been exhausted
 - c) Available to OneCare Connect members for “overlapping benefits”
 - d) All of the above

Knowledge Check Answers

1. a) True
2. c) Both a and b
3. c) Both a and b
4. b) False, CalOptima assigns staff who were not involved in the initial decision.”
5. a) True
6. d) All of the above

Authorities

- DHCS/CMS/CalOptima Cal Medi-Connect 3-way Contract
- H8016-2018 Model of Care, Orange County Health Authority
- CMS/DHCS — California Duals Demonstration Memorandum of Understanding
- Current National Committee for Quality Assurance (NCQA) Health Plan Standards & Guidelines, UM 8 & 9
- CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, January 2020
- Dual Plan Letter (DPL) 14-001: Complaints Tracking Module

References

- CalOptima Policy CMC.9001: Member Complaint Process
- CalOptima Policy CMC.9002: Member Grievance Process
- CalOptima Policy CMC.9003: Standard Appeal
- CalOptima Policy CMC.9004: Expedited Appeal
- CalOptima Policy CMC.9005: Payment Appeal
- CalOptima Policy MA.9006: Provider Complaint Process
- CalOptima Policy MA.9007: Appeal Process for Member Discharge from Inpatient Facility
- CalOptima Policy MA.9008: Appeal Process for Coverage Termination of SNF, Home Health, or CORF Services
- CalOptima Policy MA.9009: Non-Contracted Provider Payment Disputes
- CalOptima Policy CMC.1003: CalOptima OneCare Connect Staff Education and Training
- CalOptima Policy EE.1103: Provider Education and Training

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



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CalOptima

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A Public Agency

Medi-Cal

CalOptima

Better. Together.



A Public Agency

OneCare (HMO SNP)

CalOptima

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OneCare Connect

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PACE

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