Policy:	EE.1145
Title:	**Prospective Health Network**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	*/s/ Michael Hunn 03/06/2025*
Effective Date:	03/06/2025
Revised Date:	Not Applicable
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the criteria to add a prospective Health Network to CalOptima Health. To be considered, the applicant must fulfill all the requirements stated in this policy.

II. POLICY

A. The prospective Health Network must meet all the criteria included in this policy:

1. Contract with a minimum of twenty-five (25) new Primary Care Providers (PCPs) not contracted with CalOptima Community Network (CHCN) or an existing health network contracted with CalOptima Health;

2. Have a robust provider network in Orange County that meets provider network adequacy standards including access and availability for Medi-Cal and Medicare Dual Special Needs Plan (D-SNP) enrollees;

3. Demonstrated experience managing delegated risk;

4. Be registered with the Department of Managed Health Care (DMHC) as a Risk Bearing Organization (RBO);

5. Has no open deficiencies or corrective actions with DMHC;

6. Pass a network solvency review audit conducted by CalOptima Health;

7. Accepts claims, credentialing, and utilization management delegated functions, in accordance with CalOptima Health's policies and requirements;

8. Has subcontracted Providers with hospital admitting privileges at CalOptima Health's contracted hospitals;

9. Must not be excluded or precluded from participating in a federally funded healthcare program (e.g., Medicaid/Medi-Cal, Medicare);

10. Provide services for all age-ranges; and

11. Achieve and maintain enrollment of a minimum of 5,000 Members within thirty-six (36) months from the effective date of becoming a Health Network in accordance with CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment.

B. The prospective Health Network must execute a Medi-Cal and OneCare Contract for Health Care Services by selecting one of the contract models defined in section II.C. subject to CalOptima Health's discretion, network strategy, and the successful completion and approval of a Readiness Assessment including a pre-delegation review and implementation requirements.

C. The prospective Health Network has the option of two Contract Models:

1. Shared Risk (SRG)

2. Global Risk/Full Risk (HMO)

D. Entities that submit a contracting request are not guaranteed approval to contract with CalOptima Health.

1. CalOptima Health reserves the right to deny any contracting request from an entity seeking to contract as a new Health Network at its sole and absolute discretion. Nothing in this Policy is intended to indicate the entity requesting a contract with CalOptima Health as a Health Network is guaranteed to be approved.

E. Entities seeking to contract with CalOptima Health as a new Health Network must participate in all CalOptima Health programs offered and may apply to contract under a different contract model for each program, subject to CalOptima Health's discretion and approval.

F. Entities seeking to contract with CalOptima Health as a new Health Network must submit all required documents for review and approval and shall meet all CalOptima Health operational requirements and applicable state and federal requirements under the requested contract model.

G. Entities seeking to contract with CalOptima Health as a new Health Network must meet the designated timeframes, as outlined in CalOptima Health Policy GG.1619: Delegation Oversight, for readiness assessment and implementation unless an extension request is approved by CalOptima Health.

H. Entities seeking to contract with CalOptima Health as a new Health Network must fulfill all licensure, pre-evaluation, Readiness Assessment, policy review, contractual, and regulatory requirements to contract with CalOptima Health under the requested contract model for the respective line(s) of business.

I. If approved by CalOptima Health as a new Health Network, the new Health Network for the duration of the contract is required to notify CalOptima Health of any assignment changes including:

1. The change of more than fifty percent (50%) of the directors or trustees of;

2. The merger, reorganization, or consolidation of the Health Network with another entity when the Health Network is not the surviving entity; or

3. A change in the management of the Health Network from the management by persons appointed, elected or otherwise selected by the governing body of the Health Network (e.g., the Board of Directors) to a third-party management person or entity. In addition, the Health Network must obtain CalOptima Health's prior written consent for any change of control. For purposes of this policy, a change of control includes the change of more than fifty percent (50%) of the ownership or equity interest in the Health Network (whether in a single transaction or in a series of transactions).

J. New Health Network contracts are subject to approval by the CalOptima Health Board of Directors.

III. PROCEDURE

A. Submission and Review of Contracting Request and Required Applications and Documents

1. Prospective Health Networks seeking to contract with CalOptima Health must submit a written Letter of Intent (LOI) to the Executive Director of Network Operations via email or other written form signed and dated by Chief Executive Officer, or designee, that has been granted authority to make decisions on behalf of the prospective Health Network. The CalOptima Health Executive Director of Network Operations shall review the request within fifteen (15) business days of receipt of the prospective Health Network's LOI. The Executive Director will send a written response informing the prospective Health Network of the requirements to move forward with the application process.

B. Initial Review

1. Upon receipt of initial application, CalOptima Health shall verify the prospective Health Network is not excluded or precluded from participating in a federally funded healthcare program (e.g., Medicaid/Medi-Cal, Medicare), as outlined in CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring.

2. Upon verifying the prospective Health Network is not excluded or precluded from participating in a federally funded healthcare program, the prospective Health Network's LOI proposal and initial application will be reviewed.

3. If the documentation does not meet the requirements, the CalOptima Health Executive Director of Network Operations shall notify the applicant of the decision.

C. CalOptima Health Review Team

1. If the prospective Health Network meets the requirements and all required documentation is received, the Executive Director of Network Operations shall forward the prospective Health Network application packet to the CalOptima Health review team. The team will review and score the documents in accordance with the instructions on the scoring tool. The CalOptima Health review team will review and tally the scores and will make a recommendation. Based on their recommendation, the documents will be sent to CalOptima Health's Delegation Oversight Department to conduct the Readiness Assessment.

D. Readiness Assessment Activities

1. Following approval to move forward from the CalOptima Health review team, the Executive Director of Network Operations, and the CalOptima Health Contracting Department will pursue contract(s) with the prospective Health Network.

CalOptima Health's Delegation Oversight Department shall conduct a Readiness Assessment including a pre-delegation review of the prospective Health Network and present the findings of the Readiness Assessment to CalOptima Health's Compliance Committee, as outlined in CalOptima Health Policy GG.1619: Delegation Oversight.

2. CalOptima Health will assign project management resources to develop a project plan and workgroup comprised of CalOptima Health departments to implement the onboarding of a new Health Network.

    a. The CalOptima Health workgroup shall monitor deliverables and milestones for the onboarding of the new Health Network contract, in partnership with other functional areas within CalOptima Health. Regular meetings will be established with the new Health Network entity and the CalOptima Health workgroup.

    b. Within sixty (60) calendar days of the proposed effective date or change, CalOptima Health shall submit to the Department of Health Care Services (DHCS) the proposed delegation and a copy of the proposed delegates compliance plan utilizing the DHCS template which includes but is not limited to:

        i. All CalOptima Health's contractual relationships with Subcontractor and Downstream Subcontractors;

        ii. CalOptima Health's oversight responsibilities for all delegated obligations; and

        iii. How CalOptima Health intends to oversee all delegated activities, including, but not limited to, details regarding key personnel who will be overseeing each delegated function.

    c. CalOptima Health's Contracting Department will coordinate with CalOptima Health's Regulatory Affairs & Compliance Department to submit a copy of the new proposed Health Network contract to DHCS at least sixty (60) calendar days prior to the proposed contract effective date if there are significant changes to the contract template approved by DHCS.

3. Once the prospective Health Network has met all necessary readiness requirements, and both CalOptima Health and the Health Network have agreed to contract language, terms and rates, CalOptima Health's Executive Director of Network Operations shall present the findings to CalOptima Health's Executives.

4. Executive leaders will present a CalOptima Health Board Action Referral (COBAR) to the CalOptima Health Board of Directors for approval. The Board of Directors may approve subject to approval by DHCS.

5. Upon CalOptima Health Board approval, the contract will be submitted for full execution by CalOptima Health and the Health Network.

IV. REFERENCE(S)

A. CalOptima Contract for Health Care Services
B. CalOptima Health Contract with Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
D. CalOptima Health Policy EE.1106: Health Network and CalOptima Health Community Network Minimum and Maximum Member Enrollment

E. CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts
F. CalOptima Health Policy GG.1619: Delegation Oversight
G. CalOptima Health Policy HH.2005: Corrective Action Plan
H. CalOptima Health Policy HH.2021: Exclusion and Preclusion Monitoring
I. CalOptima Health DHCS D-SNP Contract/State Medicaid Agency Contract (Exclusively Aligned Enrollment (EAE) SMAC)
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-006: Delegation and Subcontractor Network Certification (Supersedes APL 17-004)
K. Prospective Health Network Packet
L. Title 28, California Code of Regulations (CCR), Section 1300.51
M. Title 42, Code of Federal Regulations (CFR), Section 438.3 – Standard Contract Requirements

V. REGULATORY AGENCY APPROVAL(S)

None to Date

VI. BOARD ACTION(S)

Date	Meeting
03/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/06/2025	EE.1145	Prospective Health Network	Medi-Cal OneCare

VIII. GLOSSARY

Term	Definition
Compliance Committee	The committee designated by the Chief Executive Officer (CEO) to implement and oversee the Compliance Program and to participate in carrying out provisions of this Compliance Plan. The composition of the Compliance Committee shall consist of Executive staff that may include, but is not limited to, the: Chief Executive Officer; Chief Medical Officer; Chief Operating Officer; Chief Financial Officer; Chief Compliance Officer; and Chief Human Resources Officer.
Downstream Subcontractor	An individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.
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) Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	A beneficiary enrolled in a CalOptima Health program.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and Primary Care to Members; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: 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.
Readiness Assessment	An assessment conducted by a Review Team prior to the effective date of a Health Network's, or other contracted entity's, Contract with CalOptima Health of the Health Networks, or contracted entity's, compliance with all or a specified number of operational functional areas as determined by CalOptima Health.
Subcontractor	An individual or entity that has a Subcontractor Agreement with CalOptima Health or CalOptima Health's Subcontractor that relates directly or indirectly to the performance of CalOptima Health's obligations under its contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.