SAN FRANCISCO HEALTH PLAN

CO-68: Out-of-Network Coverage

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	12/23/2025	New Policy
Signed by: Steve O'Brien 60DFB20814944C4...	CMO	12/23/2025	

San Francisco Health Plan℠

SFHP POLICY AND PROCEDURE

Out-of-Network Coverage

Policy and Procedure Number:	CO-68
Department:	Clinical Operations
Accountable Lead:	Clinical Operations Policy Analyst
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☒SFHP Care Plus (HMO D-SNP) ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) members have access to medically necessary out-of-network (OON) services when SFHP's network fails to meet timely and geographic access adequacy standards. SFHP is responsible for arranging, covering, and providing services to secure OON care in a timely manner.

This policy describes the requirements and process for authorization of OON services.

Prior Authorization is not required for OON emergency, urgent care clinic, and special arrangement (family planning, sexually transmitted infection services, HIV testing) services.

All sections within this policy apply to SFHP's three (3) managed care lines of business unless otherwise specified.

PROCEDURE

I. Circumstances Warranting OON Access

SFHP authorizes services with OON providers when the service is not available within network. Services are determined to be unavailable in network if any of the following are true:

1. Network adequacy requirements are not met (set forth in W&I Code section 14197).
2. SFHP does not have an Alternative Access Standard (AAS) approved by DHCS and fails to meet the network adequacy requirements.

3. Timely access to appointment standards is not met.
4. Provider type is unavailable within the network (including SNF/LTC, second opinions, and seldom used or unusual specialty services).

II. Arranging for OON Services

1. Clinical Operations staff arrange for services from OON providers when the provider type is unavailable within the network but available in an adjoining county(ies). If there is no network provider in the adjoining county(ies), SFHP authorizes OON services to the most appropriate provider as close to time or distance requirements as possible.
2. SFHP's Clinical Operations department provides the following services to secure medically necessary OON options that are available to the enrollee within geographic and timely access standards:
    a) At a member or referring provider's request, SFHP will contact noncontracted providers with the appropriate expertise within geographic access standards on behalf of the member to confirm they have appointments available within the timely access standards and advise the member of available appointment times of at least one non-contracted provider option within geographic access standards, if available.
    b) At a member or referring provider's request, SFHP will schedule an appointment with the non-contracted provider with the appropriate expertise and within geographic access standards on behalf of the member. SFHP will notify the member and/or referring provider if we are unable to schedule an appointment on the member's behalf per that non-contracted provider's policy.
    c) Schedules Non-Medical Transportation (NMT) or Non-Emergency Medical Transportation (NEMT) to the OON provider.

III. Authorizing OON Services

1. If Clinical Operations staff receives an authorization request for an OON provider and identifies a network limitation, then the authorization for medically necessary services will be approved. A letter of agreement (LOA) may be initiated if requested by the non-contracted provider/facility, which agrees to accept the member. SFHP's LOA policy and procedure is contained in CT-01.

2. If Clinical Operations staff receives an authorization request for an OON provider and finds there is no network limitation, the authorization will be denied. The provider and member denial NOA letters will state at least one network provider option, when appointments are available, instructions for finding alternative network providers and how the member can ask their primary care provider or specialist for referral to a network provider when referral is needed.

IV. Reimbursement

1. SFHP must adequately and timely cover and reimburse providers for OON services rendered to its members for as long as SFHP is unable to provide these services in its network. SFHP must ensure that the member is not charged for

services furnished OON. SFHP must also ensure that members are not balance-billed for any service provided OON.

MONITORING

A. Monthly, the utilization management (UM) workgroup monitors authorization and appeal metrics, clinical member grievance (including Independent Medical Reviews, State Fair Hearings, and Consumer Complaints) trends, as well as service utilization trends. The UM workgroup submits reports to the Utilization Management Committee (UMC) and Quality Improvement and Health Equity Committee (QIHEC) for oversight, input, and strategic direction. Collaboratively, the committees make recommendations for corrective action and/or identify where UM processes can be revised, if necessary, to improve member experience, address barriers, and ensure the UM criteria are consistent with current industry and evidence-based practices and state/federal regulations.

B. Quarterly, the Clinical Operations Nurse Trainer Auditor conducts an internal audit of authorization files including adverse and favorable determinations. The purpose of the internal audit is to ensure authorization files meet the statutory/regulatory requirements of CMS/DHCS/DMHC as well as accreditation guidelines of NCQA. The audit follows NCQA's 8/30 audit sample methodology.

C. Annually, inter-rater reliability audits are conducted for both physician and nurse reviewers to ensure decision making accuracy and consistency.

D. Annually, the Clinical Operations Director leads a cross-functional evaluation of the UM Program's effectiveness. The evaluation process includes reassessment of program structure, scope, processes and sources used to determine benefit coverage and medical necessity. It considers member and practitioner experience, regulatory compliance, data trends, and a status assessment of annual goals and activities. The UM Evaluation informs the UM Workplan. The UM Evaluation, UM Workplan, and UM Program Description are reviewed and approved by the UMC and QIHEC.

E. The SFHP Chief Medical Officer (CMO), Medical Director, or physician designee identifies potential quality issues (PQI), including provider preventable conditions (PPCs), and follows the PQI process defined in QI-18 and the PPC process defined in QI-19.

F. Annually, medical groups delegated to perform utilization management are audited as outlined in DO-02: Oversight of Delegate. In addition, to provide real-time oversight, SFHP's Delegation Oversight Nurse conducts quarterly authorization files review audits.

DEFINITIONS

Letter of Agreement (LOA): A one-time member-specific written agreement between SFHP and a Provider that details terms and reimbursement for specific authorized service(s) or episode(s) of care

Out-of-Network (OON) Provider: A provider that does not have a contract with SFHP.

AFFECTED DEPARTMENTS/PARTIES

Compliance and Regulatory Affairs – Delegation Oversight
Delegated Groups
Operations – Claims
Operations – Provider Network Management

RELATED POLICIES & PROCEDURES, DESKTOP PROCESS and PROCESS MAPS

1. CO-19: Specialty Care and Standing Referrals
2. CO-22: Medical Authorization Requests & Decision Timeframes
3. CT-01: Letter of Agreement
4. CT-02: Claims OON Providers
5. PR-07: Provider Network Composition
6. PR-19: Continuity of Care
7. QI-05: Monitoring Accessibility of Provider Services

REVISION HISTORY

Original Date of Issue: December 18, 2025
Revision Approval Date(s):

REFERENCES

1. DHCS 2024 Contract, §5.2.7 Out-of-Network Access
2. California Code, Welfare and Institutions Code - WIC §14197