SAN FRANCISCO HEALTH PLAN

PR-19: Continuity of Care for Newly Enrolled Members and Members Affected by Provider Terminations

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	8/27/2025	Policy Update
Signed by: Jenn Moore 1CDB68C0E64A4B9...	COO	8/28/2025	

San Francisco Health Plan℠

SFHP POLICY AND PROCEDURE

Continuity of Care for Newly Enrolled Members and Members Affected by Provider Terminations

Policy and Procedure Number:	PR-19
Department:	Provider Network Operations
Accountable Lead:	Director, Provider Network Operations
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☒Medicare Advantage D-SNP ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐All lines of business and coverage programs as listed above

POLICY STATEMENT

To ensure availability and Continuity of Care (COC), San Francisco Health Plan (SFHP) allows newly enrolled members to request continuation of care from a non-participating provider under specified circumstances. This policy applies when a newly-enrolled member is receiving a course of treatment from a provider who is not contracted with SFHP, or when an existing member is undergoing care for a qualifying condition by a provider who terminates with SFHP.

The ultimate goal is to transition the new member to a provider within the member's medical group as soon, and as safely, as possible. This policy ensures optimization and coordination of members' care including, but not limited to, all medically necessary services delivered both within and outside of SFHP's provider network. This policy applies to the provision of medical and behavioral health benefits, but does not extend to durable medical equipment, transportation, other ancillary services, and services not covered by the member's benefit plan.

For Care Plus D-SNP members, SFHP complies with both DHCS and DMHC continuity of care requirements.

PROCEDURE

Newly-enrolled and existing members are informed of their right to receive continuity of care in the Evidence of Coverage/Disclosure Form (EOC/DF). Members are instructed to submit their request for continuation of care to Customer Service either verbally or in

writing. The written request should include the member's name, ID number, provider name and a description of the services they currently receive.

SFHP's ultimate goal is to transition new members to in-network medical group providers as soon, and as safely, as possible, and ensures that reasonable consideration is given to the potential clinical effect of a change of provider on the member's treatment for the condition.

I. **COC Request Intake:** COC requests are received via telephone calls to Customer Service or Provider Relations, via prior authorization submissions by non-participating providers, or as denied Medical Exemption Requests (MER).

   Customer Service forwards COC requests received for members that are assigned to one of SFHP's Delegated Medical Groups that are delegated for utilization management to the assigned Delegated Medical Group for processing.

   MER requests for non-participating providers are processed as COC requests. Additional MER requirements are located in PR-22: Members with a Medical Exemption or Emergency Disenrollment Exemption Denial.

II. **Processing COC Requests:** SFHP begins to process COC requests within five (5) business days following the receipt of the request. COC requests that are received via a phone call to Customer Service are entered into SFHP's Care Management system to route the request appropriately. Each COC request is completed within the following timeline:
   A. 30 calendar days from the date SFHP received the request;
   B. 15 calendar days if the beneficiary's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or
   C. Three (3) calendar days if there is risk of harm to the beneficiary.

   When COC requests are received via telephone calls, Provider Network Operations (PNO) contacts the non-participating provider and determines the provider's willingness to continue the member's care. If the non-participating provider is willing to continue seeing the member, PNO assists the provider with submitting a prior authorization to Clinical Operations.

III. **Newly-enrolled Medi-Cal Members Transferring from Other Medi-Cal Programs (DHCS COC)**: Members who are assigned an aid code that mandates a transition into managed care have a right to continue treatment with an out-of-network provider for up to 12 months after they are enrolled into managed care if all of the following conditions are met:
   A. The member has an existing relationship with the with the out-of-network provider or has a scheduled appointment with the out-of-network provider. An "existing relationship" means that the member has seen the provider at least once for a non-emergency visit during the 12 months prior to managed care enrollment.

B. The provider is willing to accept the higher of SFHP's standard contract rates or Medi-Cal FFS rates
C. The provider has no disqualifying quality of care issues
D. The provider is Enrolled in the Medi-Cal program
E. The Provider agrees to supply SFHP with all relevant treatment information

For approved COC requests, Clinical Operations notifies the member 30 calendar days before the end of the COC period about the process that occurs to transition his or her care at the end of the COC period.

A COC request of this type is considered complete or closed when any of the following occurs:

A. The conditions above are satisfied and the member is informed of their right to continued access;
B. SFHP and the non-participating provider are unable to agree to a rate;
C. SFHP has documented and disqualifying quality of care issues; or
D. SFHP makes a good faith effort to contact the non-participating provider and the provider is non-responsive for 30 calendar days.

IV. Members with a Qualifying Condition (DMHC COC): A newly enrolled Medi-Cal or Healthy Workers HMO member, or any existing member of these programs who is receiving services from a terminating provider, may request to continue receiving covered services if, at the time of the member's enrollment with SFHP or at the time of the provider's contract termination, the member was receiving services from that provider for one of the following conditions:

A. An Acute Condition: services are provided for the duration of the acute condition..
B. A Serious Chronic Condition: covered services are provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider consistent with good professional practice, as determined by SFHP in consultation with the member and the non-participating provider. Completion of covered services is not provided beyond 12 months from the effective date of enrollment, or from the date of the provider's contract termination date.
C. Pregnancy: services are provided for the duration of the pregnancy and the immediate postpartum period of 12 months.
D. Maternal Mental Health Condition: services are provided for up to 12 months from the diagnosis or from the end of pregnancy, whichever is later.
E. A Terminal Illness: services are provided for the duration of the terminal illness, and may exceed 12 months.
F. Care of a newborn child in the first 36 months, if the newborn is the member: services are not provided beyond 12 months from the effective date of the member's (newborn child's) enrollment, or from the date of the provider's contract termination date.
G. An authorized covered service: previously authorized as part of a documented course of treatment and been recommended and documented by the provider to occur within 180 days of the effective date of the Member's enrollment with SFHP, or 180 days of the provider's contract termination date.

V. COC Period: If a member qualifies for both DHCS and DMHC COC, the COC period is the longer of the two timeframes.

VI. Review of Prior Authorization Requests for COC: Clinical Operations Department staff, reviews prior authorization requests for COC according to Clinical Operations policies and procedures and makes a determination based upon the medical indications and potential clinical effects of terminating the relationship between the member and the non-participating provider. For Medi-Cal members, services authorized by another Medi-Cal entity are regarded as approved by SFHP for the first 90 days of eligibility with SFHP, without requiring a new *request* to SFHP. The member or provider must furnish Clinical Operations with a copy of the authorization and SFHP may validate the authenticity of the authorization at its option. COC services to continue beyond the first 90 days of eligibility do require reassessment by SFHP via a new authorization *request*. Clinical Operations only approves requests for the continuation of services that would otherwise be Covered Services under the terms of the member's benefit program. Retroactive COC requests are reviewed for medical necessity by Clinical Operations and are paid accordingly by Claims. Members are notified of SFHP's decision in writing.

VII. LOA Process: Once a prior authorization request is received, Clinical Operations processes it pursuant to the process outlined in CO-22: Authorization Requests, with the additional COC requirements described below. If the non-participating provider does not have an existing arrangement with SFHP, Clinical Operations initiates the existing Letter of Agreement (LOA) process. The non-participating provider must:

A. accept SFHP or Medi-Cal rates, whichever is greater, for the duration of the COC period,
B. Not have quality of care issues per the SFHP or Medical Group standard credentialing process, and
C. Either:
    1. For DHCS COC Requests: have had an appointment with the member within the 12 months prior to the member's enrollment with SFHP, or
    2. For DMHC COC Requests: have been providing services for one of the conditions listed below (in section 4) at the time of the provider's termination or member's enrollment with SFHP.

If the above three (3) conditions are met, Contracts may execute a LOA with the non-participating provider. A LOA may not be needed if the non-participating provider will accept Medi-Cal rates.

If any of the conditions above is not met, Customer Service assists the member to transfer their care to in-network providers.
The non-participating provider is subject to the same contractual terms and conditions that are required of all SFHP non-capitated contracted providers providing similar services, including, but not limited to, credentialing, hospital privileges, quality improvement activities, peer review, and utilization management requirements.

Utilization management determinations are documented in writing or in a customized on-line tracking system and maintained in a secure location. Requests for services are monitored in compliance with Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) requirements, and SFHP Clinical Operations Process – CO-22. If the non-participating provider does not agree to comply or does not comply with these contractual terms and conditions, SFHP does not allow for the continuation of the provider's services.

Contracts and the non-participating provider agrees, in writing, in advance of the continuation of the services to a payment method for the continued services. Payment rates are similar to those used by SFHP for currently-contracting providers providing similar services who are not capitated. If SFHP and the provider cannot agree to payment terms, then SFHP does not allow for the continuation of the provider's services.

VIII. Member Cost sharing: The amount of, and the requirement for payment of, copayments, deductibles, or other cost sharing components during the period of the completion of covered services from the non-participating provider are the same as would be paid by the member if receiving care from a SFHP provider.

IX. Pharmacy Services COC: Refer to policy and procedure "Pharm-02: Pharmacy Prior Authorization" for COC related to pharmacy benefits.

MONITORING

Once per month, Clinical Operations runs a report ("COC Transition Report") of Medi-Cal members receiving COC that are approaching the end of their COC period. Clinical Operations sends a letter to those members to assist moving their care in-network.

Once per month, Contracts runs a report ("COC Provider Follow-Up Report") of all members that called Customer Service to request COC to ensure that the non-participating provider has submitted an authorization for the requested services. Contracts follows up with any non-participating providers that have not yet submitted a prior authorization for the services requested by the member.

The policies of medical groups that are delegated to perform utilization management are reviewed though annual audits performed by the Clinical Operations and Delegation Oversight Teams. In the event a medical group is non-compliant, the Delegation Oversight Team or designee notifies the medical group in writing that corrective action is required, pursuant to the process outlined in PR-20: Enact Corrective Action Plans.

DEFINITIONS

Acute Condition: a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Care of a Newborn Child: between birth and age 36 months.

Delegated Medical Group: a contracted medical group acting on SFHP's behalf. The medical group has the authority to carry out functions that SFHP would otherwise perform. This authority includes the right to decide what to do and how to do it, within the parameters agreed upon by SFHP and the medical group.

Letter of Agreement (LOA): a contractually binding document used to define the terms of a service agreement between two parties.

Maternal Mental Health Condition: a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

Non-Participating Provider: a Provider who does not have an active contract with San Francisco Health Plan SFHP to provide services under the member's plan contract.

Pregnancy: the three trimesters of pregnancy and the immediate postpartum period.

Provider: a medical group, clinic, or an individual practitioner whom members may select or be assigned to receive primary care services from. Provider also includes a hospital at which a member is required to receive hospital services as part of a network relationship with a member's assigned or selected medical group, clinic, or individual practitioner.

Serious Chronic Condition: a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Terminal Illness: an incurable or irreversible condition that has a high probability of causing death within one year or less.

AFFECTED DEPARTMENTS/PARTIES

Compliance & Regulatory Affairs
Delegation Oversight
Health Services – Clinical Operations
Health Services – Health Outcomes Improvement
Operations – Customer Service

Operations – Member Eligibility Management

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. CO-22: Authorization Requests
2. CT-01: Letters of Agreement
3. PR-18: Termination of Medical Group or Hospital Contracts (Block Transfers)
4. PR-22: Members with a Medical Exemption or Emergency Disenrollment Exemption Denial
5. SFHP Provider Manual

REVISION HISTORY

Effective Date:	2/12/2015
Revision Date(s):	2/13/2019; 04/22/2020, May 19, 2022, December 15, 2022; January 23, 2025; August 21 ,2025

REFERENCES

1. Health and Safety Code Section 1373.95, 1373.96
2. DHCS/SFHP Contract Exhibit A, Attachment III, Sections 4.3 (Population Health Management and Coordination of Care) and 5.2 (Network and Access to Care)
3. SPD Amendment, April 2011
4. DHCS APL 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023