



Policy and Procedure No: PR 17.2		Revision No: 2
Division: Care Management		
Department: Provider Relations		
Title: PHC-CA Letter of Agreement		
Effective Date: 7/1/2014		
Supersedes Policy No: 92017, PR 17.0, PR 17.1		
Reviewed/Revised by: Sandra Holzner		Review/Revision Date: 12/1/2025
Approving Committee: Member Provider Committee		Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025		

Purpose:

To define a process by which a PHC California (Health Plan) enrollee may be allowed to access an out-of-network provider for medically necessary services.

Policy:

1. The Health Plan shall allow enrollees to be treated by an out-of-network provider if the provider signs a letter of agreement (LOA) and passes the credentialing verification requirements including but not limited to verification of current licensure and query of the Office of Inspector General (OIG) and Excluded Parties List. Health Plan LOA's require completed Medi-Cal Screening and Enrollment Provider Attestation. Health Plan LOAs (Letter of Agreement) specify that Members are not to be charged or balance-billed for services furnished out of network.
2. The Health Plan shall follow procedures to obtain LOAs from out-of-network providers in the following circumstances:
 - a. The enrollee requires subspecialty care that is not available in network.
 - b. The Health Plan does not meet network adequacy standards set forth in W&I Code section 14197; or, the Health Plan does not have an alternate access standards (AAS) approved by California's Department of Health Care Services (DHCS) and fails to meet the network adequacy standards.
 - c. The Health Plan fails to comply with the requirements for timely access to appointments.
 - d. The Health Plan does not have in-network long term care (LTC) capacity.
 - e. The provider type is unavailable within the Health Plan's provider network but is available within the adjoining counties.
3. The Health Plan shall provide protocols to the provider in the LOA and authorization documents that include referring provider, authorization number, ICD-10 diagnosis(es) and approved HCPCS (Healthcare Common Procedure Coding System). Should the out-of-network provider request additional clinical information, the Health Plan shall review requested clinical information and send it to the requesting provider in a timely manner.
4. The Health Plan shall reimburse providers for out-of-network services in a timely manner.

Procedure:

1. Enrollees may obtain medically necessary services from an out-of-network provider upon approval of the Health Plan’s utilization management leadership.
2. Out-of-network provider must contact the Health Plan’s Utilization Management Department to request and receive authorization to provide covered medical services to an enrollee.
3. The Health Plan’s Utilization Management Department notifies the Contracting and Provider Relations Department via a LOA Request Form that a LOA is required for an out-of-network provider to provide medically necessary covered services.
4. Upon notification, the Health Plan’s Contracting and Provider Relations Department contacts the out-of-network provider to negotiate an agreed reimbursement rate for covered medical services for a specific period.
5. The Contracting and Provider Relations Department submits a Quick Check to the Credentialing Department for verification of current licensure and queries the Office of Inspector General (OIG) and Excluded Parties List within one (1) working day.
 - a. Contracting and Provider Relations confirms active Medi-Cal Enrollment to ensure compliance with Department of Healthcare Service (“DHCS”) All Plan Letter (“APL”) 23-013.
 - b. See Credentialing Policy and Procedure PHC-CA Provider Screening and Enrollment.
6. In the event Health Plan’s Credentialing Department identifies a verification concerning included but not limited to CMS Exclusion, the Credentialing Department notifies Contracting and Provider Relations Department the non-participating provider failed initial verification, Contracting and Provider Relations Department notifies the Utilization Management Department within one (1) working day.
7. The Health Plan’s Utilization Management Department contacts the out-of-network provider and advises the authorization request has been declined.
8. In the event the out-of-network provider passes the verification of current licensure and queries of Office of Inspector General, (OIG) and Excluded Parties List review process, the Contracting and Provider Relations Department contacts the out-of-network provider within one working day to secure and execute a LOA.
9. LOA Cost of Care Review
 - a. Upon receipt of a signed LOA from the Out-of-Network Provider
 - i. Standard Rates (100% of Less Medicare)

The Director or Associate Director or Manager of Contracting and Provider Relations countersigns the LOA.
 - ii. Non-Standard Rates

The Director or Associate Director counter signs all LOA’s (101% to 105% of Medicare)
The Chief of Managed Care or Designee counter signs all LOAs with identified rates of greater than 105% of Medicare.



- b. The assigned Provider Relations Representative contacts the Utilization Management Department to obtain the authorization number for inclusion on the LOA as documentation.
 - c. The assigned Provider Relations Representative forwards the signed/counter signed LOA (electronic version) to the Provider Data Management Department which loads provider details into the Health Plan's database as an enrollee-specific LOA "Non-Participating Provider."
11. Enrollee may receive covered services from the out-of-network provider and the Health Plan processes out-of-network provider claim(s) for covered medical services rendered to the enrollee for a maximum of ninety (90) days unless the Utilization Management Department determines the authorization should be extended for medically necessary reasons. To ensure compliance with California regulatory standard AB (Assembly Bill) 1642, the Plans Provider Relations Department will ensure that all enrollee-specific LOAs include provider reimbursement no less than the then current Medi-Cal Fee for Service ("FFS") rates.
 12. The Health Plan has established alternative access (time and distance) standards for in network providers and out of network providers specialists identified during the letter of agreement review process. Based upon deficiencies in the Plan's network, the Plan will utilize approved alternative access standards for applicable letter of agreements to ensure access for members requiring services from out of network providers. The Plans alternative access standards are reviewed and approved annually by the Department of Health Care Services (DHCS) as part of the Plan's Annual Network Certification. See Provider Relations Policy and Procedure PHC-CA Network Development and Management.

Definitions:

1. Letter of Agreement (LOA): a document between a non-participating provider and Plan to provide authorized services to a specific Plan Member at an agreed reimbursement rate for specific period of time.
2. Non-Participating Provider: a Provider who has not entered into a contract with Plan to provide covered services to a Plan Member.
3. Participating Provider: a Provider who has entered into contract with Plan to provide covered services to a Plan Member

Monitoring:

This policy is updated as often as necessary and reviewed and approved at least annually by the Member Provider Committee.

Reference(s):

1. Medi-Cal Screening and Enrollment Provider Attestation
2. Letter of Agreement Standard Operating Procedure (SOP)
3. Provider Relations Policy and Procedure PHC-CA Network Development and Management



4. Credentialing Policy and Procedure PHC-CA Provider Screening and Enrollment
5. Department of Health Care Services (“DHCS”) All Plan Letter (“APL”) 22-013 [Provider Credentialing/Re-Credentialing and Screening/Enrollment \(Supersedes APL 19-004\)](#), Revised August 24, 2022.
6. W&I Code section 14197

