PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3039 (previously UP100339)</td><td colspan="2">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Direct Members</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="3">Next Review Date: 04/10/2025
Last Review Date: 04/10/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☒ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 04/10/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MPCP2002 – California Children's Services
D. MCUP3104 – Transplant Authorization Process
E. MCUP3020 – Hospice Service Guidelines
F. MCUP3103 – Coordination of Care for Members in Foster Care
G. MCUP3051 – Long Term Care SSI Regulation
H. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Other Health Coverage (OHC): Where PHC does not act as primary insurance.
C. Whole Child Model (WCM): In participating counties, this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (PHC) pediatric members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. Direct Member Designation Grid

V. PURPOSE:

To define criteria for assigning members to Direct Member status.

VI. POLICY / PROCEDURE:

A. Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see PHC network providers and/or certified Medi-Cal providers willing to bill PHC for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to

maintain good communication with the PCP.

B. As of January 1, 2019, PHC assumed responsibility for authorizing and coordinating care for California Children's Services (CCS) eligible conditions under the Whole Child Model (WCM) in participating counties.[1] To maximize the patient-provider relationship and to best coordinate care, these members are assigned to a medical home and a "HealthWCM" Direct Member status (as per Attachment A). The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating specialty services.

C. Services for Direct Members will be paid on a fee-for-service basis based upon prevailing PHC rates. The Treatment Authorization Request (TAR) system will be in place for all PHC services that require the use of a TAR.

D. Generally, members become eligible for Direct Member status either due to a specific clinical condition or due to a specific administrative service category (refer to Attachment A, Direct Member Designation Grid).

E. Members, their authorized representative, or the primary care office they are assigned to, may request consideration for Direct Member status.
   1. Member requests will be processed through Member Services and reviewed by Health Services staff who will contact the member's providers as necessary to obtain medical documentation.
      a. Health Services staff will notify the member and their assigned primary care office of the decision.
      b. If the request is approved, an alternate provider (other than the previously assigned PCP) will be identified and informed of PHC's TAR procedures. The member will be encouraged to obtain all care from the alternate provider.
      c. If the request is denied, the reason(s) will be outlined in a letter to the member.
         1) Members may appeal a Direct Member status decision according to the process outlined in policy CGA024 Medi-Cal Member Grievance System.
         2) For Continuity of Care requests (HP5 Direct Member status), appeals of decisions will go through the physician review process.

F. Other Considerations
   1. Member assignment to Direct Member status is based on a time-limited or condition-limited (e.g., pregnancy) interval. After the interval has elapsed, the case will be reconsidered, and the member removed from Direct Member status if circumstances warranting this status no longer exist.
   2. The Chief Medical Officer or physician designee may review cases where the circumstances of a clinical condition warrant consideration of the status change by the HealthPlan and may consult with other specialty physicians as needed to complete the review.
   3. The Health Services Department will encourage all Direct Members to utilize the PHC network.
   4. Members assigned to Direct Member status will receive a letter with a new ID card from the Member Services Department. The Member ID Card will reflect "Direct Member" in lieu of a PCP name.
   5. Agencies/facilities will continue to administer their case management activities as mandated by state, federal and regulatory agencies.

[1] For Members under age 21 with a CCS-eligible condition, services and supplies for the CCS-eligible condition will either be authorized by PHC under the Whole Child Model program (see policy MCCP2024 Whole Child Model for California Children's Services (CCS), or by the State CCS program (see policy MPCP2002 California Children's Services). In PHC's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in PHC's service area are participants in the State's CCS program and are not participants in PHC's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.

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Applies to:	☒ **Medi-Cal**	☐ **Employees**

VII. REFERENCES:

A. Medi-Cal Aid Codes Master Chart
B. Department of Health Services (DHCS) All Plan Letter (APL) 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (CalAIM) (*10/18/2021 with Attachments Revised* 10/14/2022)
   1. Attachment 1: Mandatory Managed Care Enrollment (MMCE) Requirements
   2. Attachment 2: Major Organ Transplant Requirements

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES:

Medi-Cal 03/01/95; 10/10/97 (name change only); 6/14/00; 8/15/00; 11/20/00; 03/07/01; 10/17/01; 11/11/03; 03/10/04; 02/08/05; 10/10/06; 11/19/08; 08/18/10, 06/19/13; 03/18/15; 03/16/16; 01/18/17; *02/14/18; 03/13/19; 03/11/20; 09/09/20; 01/13/21; 03/09/22; 10/12/22; 11/08/23; 04/10/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.

PHC's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.