PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3039 (previously MCUP3039, UP100339)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Direct Members</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 08/12/2027
Last Review Date: 08/12/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="3">☐ P & T</td><td>☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☒ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/12/2026</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. MCUP3104 – Transplant Authorization Process
D. MCUP3020 – Hospice Service Guidelines
E. MCBP8015 – Coordination of Care for Child Welfare-Involved Members
F. 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 Partnership does not act as primary insurance.
C. Partnership Advantage: Effective January 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.
D. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS-eligible condition(s) insured by Partnership.

IV. ATTACHMENTS:

A. Direct Member/ Health Conditions Category Designation Grid

Policy/Procedure Number: MPUP3039 (previously MCUP3039, UP100339)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Direct Members			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994		**Next Review Date: 08/12/2027** **Last Review Date: 08/12/2026**	
Applies to:	☒ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

V. PURPOSE:

To define criteria for assigning Members to Direct Member status to ensure access to covered services.

VI. POLICY / PROCEDURE:

A. Direct Members are those whose service needs are such that assigning a Primary Care Provider (PCP) would not meet their care needs. 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 Partnership network providers and/or certified Medi-Cal providers (or Medicare providers as applicable for Partnership Advantage enrollees) willing to bill Partnership 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. When a PCP is not assigned, Partnership supports coordination of care among providers.

B. Under the Whole Child Model (WCM), Partnership is responsible for authorizing and coordinating care for Members under age 21 with California Children's Services (CCS)-eligible conditions. To maximize the patient-provider relationship and to best coordinate care, these Members are assigned to a medical home and a "Whole Child Model" 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 Partnership rates. The Treatment Authorization Request (TAR) system will be in place for all Partnership services that require the use of a TAR. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process)

D. Generally, Members become eligible for Direct Member status either due to a specific clinical condition or by meeting a defined administrative service category (refer to Attachment A, Direct Member/ Health Conditions Category 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 the Member Services department 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 Partnership's TAR procedures. The Member will be encouraged to obtain all care from the alternate provider.
    c. If the request is denied, the Member will receive written notice that includes the reason for the decision and appeal rights.
        1) Partnership Medi-Cal Members may appeal a Direct Member status decision according to the process outlined in policy CGA024 Medi-Cal Member Grievance System.
        2) Partnership Advantage enrollees may appeal a Direct Member status decision according to the process outlined in Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (ODAG).
        3) For Members with a Continuity of Care health condition, 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 Partnership 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.

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
C. Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)
D. Code of Federal Regulation, Title 42 § 438.206

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
08/13/25; 08/12/26

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; (MPUP3039) 08/13/25; 08/12/26

*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 Partnership 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 Partnership.

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