PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3139 (previously MCUP3139)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Criteria and Guidelines for Utilization Management</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/12/2020</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>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<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>☐ 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. MPQP1002 – Quality/ Utilization Advisory Committee
B. MPRP4001 – Pharmacy & Therapeutics (P&T) Committee

II. IMPACTED DEPTS:

A. Health Services
B. Compliance
C. Provider Relations

III. DEFINITIONS:

A. 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.
B. Standard of Care: The level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would provide under the same circumstance.

IV. ATTACHMENTS:

A. Table of Approved Criteria and Guidelines Referenced for Utilization Management

V. PURPOSE:

To establish an approved list of Utilization Management criteria and guidelines for reviewing Treatment Authorization Requests (TARs) and hospitalizations. (Note: The process for review and approval of criteria for pharmacy services can be found in policy MPRP4001 Pharmacy & Therapeutics [P&T] Committee.)

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California is responsible for reviewing requests for services submitted by network providers. A key element of these reviews is the use of specific criteria and guidelines to assist in determining the medical necessity and clinical appropriateness of services requiring approval. When

making decisions to approve, modify or deny service authorization requests, Partnership uses criteria and guidelines that are known, accessible and reflective of well-accepted standards of care. This policy will establish the process of Criteria and Guideline review and approval for use by the Partnership network of providers. All decisions are made in accordance with federal or state medical necessity requirements

B. Process of Review and Approval:
   1. On an annual basis, the Quality/ Utilization Advisory Committee (Q/UAC) will review a list of criteria and guidelines to be used by Partnership Utilization Management staff and Partnership medical directors in performing reviews of treatment authorization requests (TARs).
      a. This list will be evaluated during the Chief Medical Officer (CMO)/Medical Director (MD) meeting the month prior to presentation to Q/UAC.
      b. To be included in this list, a criteria set or guideline must be developed by a nationally recognized entity or a Partnership policy that has been approved through the standard committee process.
      c. These guidelines and criteria sets should be utilized by managed care organizations throughout the country or region. (This would mean that the criteria and guidelines reflect the generally accepted standard of care.)
      d. Guidelines and criteria sets should be supported by clinical literature and peer review.
      e. A specific guideline or criteria can be submitted for potential inclusion in the approved list by any provider within the Partnership network or by Partnership staff.
         1) This recommendation will be submitted to the Office of the CMO.
         2) The CMO will assign the suggested criteria or guideline to a specific medical director for evaluation. This medical director will present the review at the next CMO/MD meeting.
         3) After the medical directors have completed their evaluation of the guideline or criteria set, they will decide to either forward the document to Q/UAC with a recommendation for approval, or decide that the guideline or criteria should not be used by Partnership for performing reviews.
   2. Hierarchy of Guidelines and Criteria Sets:
      a. The guidelines and criteria can be grouped into the following groups:
         1) Required standards as set forth by the State of California (Department of Health Care Services [DHCS] or other agencies) where Partnership is contractually and legally obligated to follow the guidelines.
         2) Required Medicare standards as set forth by the Centers for Medicare & Medicaid Services (CMS) when applicable.
            a) For Partnership Advantage Members: TARs are reviewed according to Section 40 of the CMS Medicare guidance for Part C & D Organization/ Coverage Determinations. The hierarchy of guidelines and criteria sets is as follows:
               i. Medicare National Coverage Determination (NCD) policy
                  a. NCDs are applicable nationwide in the US to specify the Medicare coverage of certain services.
               ii. Medicare Local Coverage Determination (LCD) policy
                  a. In the absence of an NCD policy, an item or service may be covered based on an LCD. An LCD is a determination by a region-specific Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide basis. (*When both NCD and LCD guidance exist, an LCD should never contradict NCD guidance but may be used for supplemental information.*)
               iii. Partnership internal coverage criteria and evidence-based medical literature as described in this policy where no NCD or LCD is available.
         3) Industry accepted guidelines that are used by a variety of other managed care organizations

(e.g. InterQual® and National Comprehensive Cancer Network [NCCN]).

4) Guidelines developed through government agencies (e.g. Center for Disease Control [CDC] or Agency for Healthcare Research and Quality [AHRQ]).
5) Policies developed by Partnership.

b. There should be few circumstances where these groups of guidelines conflict. If they do, Partnership shall follow the guidelines required by the highest applicable legal or regulatory authority, and, when consistent with requirements, the use of the guidelines will prioritize the Member's health and safety.
c. The guidelines that are required by statute or contract shall be followed at all times, as long as the patient's safety is not compromised.
d. Partnership policies should be followed as long as there is no conflict with legally required or contractually required services.

C. See Attachment A for Table of Approved Criteria and Guidelines Referenced for Utilization Management.

VII. REFERENCES:

A. National Committee for Quality Assurance (NCQA) Guidelines UM 2 Clinical Criteria for UM Decisions Elements A
B. Contractual obligations with the Department of Health Care Services (DHCS)
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)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
08/13/2025; 08/12/26

Medi-Cal
08/11/21; 08/10/22; 08/09/23; 08/14/24; 08/13/25; 08/12/26

PREVIOUSLY APPLIED TO:
MCUP3139 (08/12/2020 – 08/12/2025)