PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3141</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ 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>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">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. MCUG3024 - Inpatient Utilization Management
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. MPUP3014 - Emergency Services
D. MPUP3039 - Direct Members
E. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
F. CGA024 - Medi-Cal Member Grievance System
G. CMP36 - Delegation Oversight and Monitoring
H. CMP02 - Risk Assessment, Audits and Monitoring
I. CMP38 - Escalation and Corrective Action
J. ADM47 - Administrative and Financial Sanctions

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Finance
D. Regulatory Affairs/Compliance

III. DEFINITIONS:

A. Adverse Benefit Determination (ABD) - The definition of an Adverse Benefit Determination encompasses all previously existing elements of an "Action" as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e. Partnership HealthPlan of California):
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
   6. The denial of the Member's request to obtain services outside the network.
   7. The denial of a Member's request to dispute financial liability.

B. Assigned Risk: In accordance with the Division of Financial Responsibility (DOFR), a determination made by Partnership HealthPlan of California (Partnership) concerning which entity, Partnership or the

Delegated Entity, will be financially responsible for the inpatient hospital services rendered to the Member under the capitation agreement and applied in accordance with the written understanding between Partnership and the Delegated Entity.

C. Capitated Hospital Admission: Admission of an assigned Member to a capitated hospital within a Delegated Entity's contracted network. Also known as capped to capped (CTC).
D. Capitation: Refers to a form of reimbursement between Partnership and the Delegated Entity of a fixed amount per member per month.
E. Delegated Entity(ies): The hospital that has assumed certain financial responsibilities including Utilization Management (UM), and who has entered into a capitated contractual arrangement with Partnership to perform inpatient services specifically related to fulfilling Partnership's obligations to the Department of Health Care Services (DHCS) under the terms of the DHCS/Medi-Cal contract or those duties Partnership would otherwise perform as defined by the National Committee for Quality Assurance (NCQA).
F. Delegation Oversight: The process whereby Partnership monitors a Delegated Entity's delegated activities to ensure their compliance with statutes, regulations, policies and contractual obligations, including the Delegation Agreement and/or NCQA standards and DHCS requirements.
G. Delegation Agreement: A written agreement between Partnership and the Delegated Entity that defines the obligations and responsibilities of the Delegated Entity.
H. Direct Member: 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.
I. Division of Financial Responsibility (DOFR): DOFR shall be defined as the written understanding between Partnership and the Delegated Entity regarding Assigned Risk.
J. Emergency Medical Condition: Per DHCS County Organized Health System (COHS) contract Exhibit A, Attachment 1 Definitions, a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in one or more of the following:
    1. Placing the health of the individual (or, the case of a pregnant member, the health of the Member or Member's unborn child) in serious jeopardy
    2. Serious impairment to bodily functions
    3. Serious dysfunction of any bodily organ or part, or
    4. Death
K. Out-of-Area Admission (OOA): An inpatient hospital admission that occurs at a facility that is not in the Delegated Entity's service area as defined by the contractual agreement between Partnership and the Delegated Entity.
L. Utilization Management (UM): The process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define processes, procedures and respective responsibilities that apply when Partnership HealthPlan of California (Partnership) delegates inpatient utilization management functions to hospitals.

Policy/Procedure Number: MCUP3141			**Lead Department: Health Services** **Business Unit: Utilization Management**
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Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Delegated Entity(ies):
   1. Adventist Health (*Clear Lake, Howard Memorial, Mendocino Coast, St. Helena and Ukiah Valley*)
   2. MarinHealth Medical Center
   3. NorthBay Medical Center/ VacaValley Hospital
   4. Providence (aka St. Joseph Health) Queen of the Valley Medical Center

B. Preauthorization Process for Elective Admissions to the Delegated Entity
   1. Partnership performs prior authorization review to determine if the proposed services meet medical necessity criteria. Partnership notifies the requesting provider of the determination in writing.

C. Preauthorization Process for Elective Admissions outside of the Delegated Entity's Contracted Service Area
   1. Partnership receives the Provider's request and forwards it to the Delegated Entity's UM Designee for their review within one (1) business day of receipt.
   2. Delegated Entities are responsible for reviewing authorization requests according to the terms of their DOFR agreement and in accordance with policy MCUP3041 Treatment Authorization Request (TAR) Review Process. This may include, but is not limited to, the following actions:
      a. Reviewing the medical necessity of the requested elective services
         1) The Delegated Entity's Medical Director, or physician designee, must review cases where medical necessity is in question, utilizing nationally recognized criteria approved by Partnership.
         2) For any denial or modification of medical necessity (adverse benefit determination), the Provider must be notified in writing or electronically within 24 hours of the decision, using an NCQA/DHCS-approved letter template. A copy of the notification must be sent to Partnership, which will mail the notification to the Member. The notice must include the medical rationale for the determination.
      b. Determining if the elective procedure(s) can be provided (and redirected) within the Delegated Entity's network or whether they will allow the Member to receive services out-of-network.
      c. Complying with the following DHCS review and timeliness standards:
         1) Rendering a decision within five (5) business days from receipt of a preauthorization request; or
         2) 72 hours from receipt of an urgent request

D. Concurrent Review at Delegated Hospitals
   1. Admission: The Delegated Entity notifies Partnership of any admission to their hospital within one (1) business day.
      a. Admission notification may be made using Partnership's secure Online Services (OLS) Portal https://provider.partnershiphp.org/UI/Login.aspx or by submission of a patient demographic "face sheet" via fax to (707) 863- 4118.
      b. Upon submission, a Treatment Authorization Request (TAR) number is generated in Partnership's electronic system.
   2. The Delegated Entity is responsible for concurrent review throughout the inpatient stay.
   3. Discharge
      a. The Delegated Entity must complete the final review and determination of the request.
         1) Delegated Entities utilizing Partnership's electronic system must populate the discharge information directly into the system to generate the determination correspondence for the UM review.
         2) Delegated Entities not utilizing Partnership's electronic system must generate the determination correspondence for the UM review and notify Partnership by phone or fax to update the status in Partnership's system. A copy of the correspondence must also be received by Partnership.

E. Emergency Admissions at Hospitals Outside of the Delegated Entity's Contracted Service Area
   1. When Partnership is notified that a capitated Member has been admitted emergently to an out-of-area hospital, Partnership notifies the Delegated Entity of the Member's admission within one (1) business day.
   2. The case is assigned to a Partnership Concurrent Review Nurse to perform an initial clinical review.
   3. Partnership performs concurrent review during the hospital stay or until the Delegated Entity is determined to be financially responsible for the hospital stay. This occurs when Partnership's Chief Medical Officer, or physician designee, determines that the Member is medically stable for transfer to the Delegated Entity's hospital. Upon determination, the Delegated Entity is notified and becomes financially responsible for the continued hospital stay on the next calendar day or in accordance with their contractual agreement with Partnership.
   4. The Delegated Entity may choose to allow continued hospitalization at the current hospital or make arrangements to repatriate the Member to their hospital; however, the financial risk remains with the Delegated Entity. The Delegated Entity must notify Partnership's Nurse Coordinator of the decision, with the outcome documented in Partnership's electronic system.
   5. In the event the out-of-area hospital fails to notify Partnership in a timely manner (that is after the Member becomes medically stable for transfer to the Delegated Entity's hospital), Partnership's Chief Medical Officer, or physician designee, reviews the clinical documentation and determines the date of medical stability. Partnership then notifies the Delegated Entity of the effective date of the determination.
      a. If Partnership and the Delegated Entity do not agree on the effective date of the Delegated Entity's financial responsibility, both parties agree to negotiate in good faith to resolve the issue or as defined by the contractual arrangement between Partnership and the Delegated Entity.

F. Other Services/Considerations
   1. Provider Education
      a. Although Partnership will assist the Delegated Entity with Partnership network resources, it is the Delegated Entity's responsibility to keep their network physicians and/or staff informed of the services that are available within the Delegated Entity's network.
      b. Collaborating with network providers increases the opportunity to keep referrals within the network.
   2. Referrals
      a. If a Partnership Member is referred by their Primary Care Provider (who is linked with the Delegated Entity) to an out-of-area specialist for ongoing specialty care and as a result, the Member is hospitalized on either an elective or an emergency basis in an out-of-area hospital by the out-of-area specialist, Partnership will assign the financial risk to the Delegated Entity at the time of the hospital admission.
   3. If a Member is transported by ambulance from the Delegated Entity's hospital to an out-of-area hospital because the service is not routinely provided by the Delegated Entity's hospital, the Delegated Entity maintains the financial responsibility.
   4. In the event that an emergency occurs in the Delegated Entity's service area, but the Member is transported to an out-of-area hospital, the financial responsibility remains with the Delegated Entity.
   5. If the Delegated Entity's hospital emergency department is on diversion status (unable to accept patients) and the Member is transported to another hospital, the financial responsibility remains with the Delegated Entity.

G. Member Removal from Capitation
   1. Certain Partnership Members may be removed from capitation status based on special service needs e.g. Member's medical condition, prime insurance, demographics or administrative eligibility status.
   2. In order for Partnership to consider a Member's removal from capitation, the Delegated Entity must securely submit a request with supporting clinical documentation and a detailed description of the

circumstances that necessitate removal. Reference should be made to Partnership's policy MPUP3039 Direct Members to determine under what Direct Member status category the request for removal from capitation status is being made and that specific status should be indicated in the letter of request. Requests may be addressed to the Senior Director of Care Management and the Associate Director, UM Regulations at Partnership.

3. The Member will remain under the Delegate's capitation agreement pending written outcome of the review determination.
4. The request and clinical documentation will be reviewed by a Partnership Medical Director and the requesting Delegate will be notified of the determination in writing.
5. If it is determined by Partnership's Medical Director that the Member should be placed in a Direct Member status, the effective date of the Direct Member status will be at the discretion of the Medical Director, based on each Member's individual circumstances and reviewed on a case-by-case basis.

H. Provider/Member Appeals and Member Complaints/Grievances
1. Partnership assumes responsibility for processing all Provider and Member appeals, complaints and grievances on behalf of the delegated entities.
2. Delegated Entities must comply with the Appeal/Complaint/Grievance processes by providing all written relevant clinical documentation, review determination rationale and any other available documents pertinent to the subject of the dispute in accordance with regulatory requirements.
3. If the Appeal/ Complaint/ Grievance review results in the overturning of the Delegated Entity's previous determination, the Delegated Entity must abide by Partnership's determination and remains financially responsible for the disputed services.

I. Regulatory Compliance and Oversight
1. Delegated Entities are required to meet UM standards as set forth NCQA and DHCS.
2. Delegated Entities must comply with all oversight activities, which may include, but not be limited to, the following:
   a. Monthly reporting of all inpatient acute admissions to the Delegated Entity's network hospitals. (If the Delegated Entity is using Partnership's electronic system, this report can be generated by Partnership.)
   b. Participation in a Compliance audit at least annually to include (at a minimum) Partnership review of the Delegated Entity's UM policies, procedures, and decisions.
3. Delegated Entity agrees to comply with all requirements set forth in the Delegation Agreement.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III Section 2.3 Utilization Management Program and Exhibit A, Attachment 1, Definitions
B. National Committee for Quality Assurance (NCQA) Guidelines UM Standards
C. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 06/08/22; 08/09/23; 08/14/24; 09/10/25; 08/12/26

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PREVIOUSLY APPLIED TO:
Medi-Cal (UP100333; MCUP3033: 01/10/1995 to 06/09/2021)
01/10/95; 10/10/97 (name change only); 12/15/99; 03/22/00 by Commission; 12/20/00; 09/19/01; 10/16/02; 06/16/04; 09/21/05; 10/19/05, 10/18/06; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 02/20/13; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 08/12/20; ARCHIVED 06/09/2021

*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.

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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.