Clover Health

Utilization Management Program Description

2021

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1. PURPOSE

The Clover Health Utilization Management (UM) program provides a systematic method to manage the utilization of services provided to enrollees by providers in the Clover Health Network, while supporting its mission of helping its members live their healthiest lives. The UM Program adheres to Clover Health's core values of honesty, integrity, and excellence in business operations and delivery of health care services. Clover Health will strive to serve the needs of its members, participating providers, employees, and the communities within its service area. Management of services is achieved through evaluation of appropriateness of services provided based on medical necessity and ongoing performance monitoring and improvement activities, as set forth in this UM Program Description. The program is implemented and administered by the Clover Health Clinical Operations Department in accordance with the regulatory requirements of the Centers for Medicare and Medicaid Services (CMS). This program description details the scope, goals, structure, authority, and operations of the Clover Health UM program.

2. SCOPE

The Clover Health UM program consists of a set of activities that promote the appropriate allocation of health resources for members enrolled in a Clover Health PPO or HMO plan. The UM program is designed to ensure members receive services:

a. In the amount, duration, and scope deemed medically necessary to prevent, diagnose, improve, or cure conditions which may cause acute suffering, endanger life, result in illness or infirmity, interfere with the member's capacity for normal activity, or threaten some significant handicap.
b. In a cost effective and efficient manner.
c. In the most appropriate setting for the intensity of services required.
d. In accordance with the applicable requirements outlined by the American Disabilities Act, The Center for Medicare and Medicaid Services Member Rights, and the applicable State Department of Health.

The UM Program Description is intended to serve as a guide for conducting utilization management activities. Clover Health covers all items and services required as specified by the state and federal programs in which it participates. Utilization Management at Clover Health is conducted in a collaborative method which includes the Utilization Review Department, the Wellness Nurse Care Manager Department, the member's provider(s), and the member. Processes used within the context of UM include: benefit

verification, prospective and concurrent review, clinical policy development, discharge planning, and other Wellness Nurse Care Manager activities.

3. PROGRAM GOALS AND OBJECTIVES

The goal of the Clover Health UM Program is to ensure our members are receiving medically necessary care through delivery of cost effective, high quality services in the most appropriate setting required. In order to achieve this goal, The UM Program shall execute the following objectives:

1. Collaborate with the Wellness Nurse Care Manager Department, Providers, Members, and others involved in the delivery of health care services to promote a culture that is relevant [to] and respectful of the Member's needs.
2. Ensure authorized services, procedures, and treatments are consistent with the Member's plan structure and benefit allotment.
3. Employ nationally recognized utilization management standards. Adopt objective and evidenced-based guidelines, protocols, and criteria that support appropriate clinical decision-making;
4. Ensure health care services are coordinated based on medical necessity criteria (MNC) and administered in a timely and effective manner.
5. Ensure services are provided in the amount, duration, scope, and exigency deemed appropriate based on the Member's individual needs.
6. Facilitate and promote service provision by Participating Providers, unless otherwise indicated or authorized.
7. Collaborate with internal and external partners to support coordination of services and continuity of care.
8. Monitor activities to:
    a. Identify inappropriate or duplicative services, procedures, or treatments.
    b. Identify and correct under-utilization of services, procedures, or treatments, which may benefit the member.
9. Report any known or suspected fraud and abuse.
10. Collaborate with and/or provide notification to the Wellness Nurse Care Managers if any [known] event or authorization request could potentially impact the member's risk level, service needs, or plan of care.
11. Adhere and comply with all rules, regulations, guidelines, and standards established by the Centers for Medicare and Medicaid Services.
12. Promote transparency and continuous quality improvement through the integration of the Annual UM Work Plan and UM Program Description..

4. ORGANIZATIONAL STRUCTURE

The UM Program is administered by the Utilization Management Department, which is a subsidiary of the Clover Health Clinical Operations Department. Staff involved in utilization management activities or functions, whether directly or indirectly, carry out their responsibilities as defined by the scope of practice for their individual professional discipline(s) and assigned job description.

5. STAFFING AND ACCOUNTABILITY

It is the position of Clover Health that, regardless of role or position, all employees have an impact on the delivery of health care services; and therefore have a responsibility to: conduct themselves in a manner consistent with Clover Health's mission and corporate values; adhere to company policies; reduce tyranny in the healthcare system through monitoring and reporting of [known or suspected] quality of care issues, fraud and abuse; and to serve Clover Health members in an ethical, dignified, and respectful manner.

5.1 Utilization Management Staff

Senior Medical Director

The Senior Medical Director is a physician with an active medical license who is responsible for the purpose, goals, objectives, and strategic planning of the UM Program, and serves as the chairperson for the Medical Management Committee (MMC). Responsibilities include:

- Final administrative review and approval of the Annual UM Program Evaluation and Annual UM Work Plan.
- Final administrative review and approval of all UM Program standards, including clinical policies.
- Providing medical leadership, expertise, consultation, and education to Utilization Management Staff.
- Serving as a liaison between Clover Health and provider partners when formal communication(s) or education is indicated.
- Issuance of final determinations related to payment of services based upon eligibility or medical necessity for services.
- Communication with providers as needed throughout the utilization management and Wellness Nurse Care Manager processes, to facilitate or support access to care and services for Clover Health members.
- Review, intervention, and reconciliation [negotiation] with provider partners in instances of questionable practices including, but not limited to; inappropriate allocation of services and medical necessity discrepancies.

- Preparation and/or Implementation of the UM Annual Work Plan the Annual UM Program Evaluation, as well as maintenance of the UM Program Description.

Director of Utilization Management

The Manager of Utilization Management reports to The Chief Operations Officer, and is responsible for direction and oversight of the Utilization Management staff, day-to-day activities, and program objectives. Responsibilities include:

- Monitoring Utilization Management Federal and State laws, regulatory requirements, and applicable accreditation standards, to ensure department compliance.
- Planning, organizing, and directing staff of the Utilization Management Department, including oversight [or delegation] of departmental orientations and education.
- Development, implementation, and oversight of departmental utilization management standards, criteria, policies and procedures; and monitoring [staff] adherence.
- Periodic review of Utilization Management Department Policies and Procedures, as well as [other] departmental Policies and Procedures which may be relevant or impactful to program functions or objectives.
- Collaboration with [other] departments such as Member and Provider Services, Grievance and Appeals, and Compliance to identify opportunities for: improved member or provider satisfaction, quality, compliance, or general business operations.
- Analysis of data related to utilization management activities, services, members, and provider partners, for the purpose(s) of: predicated Federal and State reporting requirements, identification of over or under utilization of services, and quality improvement or cost savings opportunities.
- Develop and Implement Corrective Action Plans (CAPs) when indicated.
- Support Utilization Management staff in the application of appropriate medical policy or clinical decision making criteria throughout the utilization review process.

Clinical Staff

Utilization Management Department staff who function in a “clinical” role are qualified, licensed, health professionals.

Clinical Functions and Responsibilities include:

- Performing utilization management reviews based on medical necessity, and application of appropriate medical policy or clinical decision making criteria.
- Consultation or referral with/to the Senior Medical Directorfor physician review.

- Adherence to timeliness standards for completion [and notification] of UM organization determinations, with consideration for medical exigency, as specified in UM Program Policies and Federal or State regulatory guidelines.
- Performing routine clinical Quality Assurance (QA) case audits to support delegation oversight and monitoring of UM vendors.

Non-Clinical Support Staff

The term UM Service Coordinator or Specialist is used to describe administrative staff who support utilization management activities. UM Service Coordinators are limited to collection and transfer of non-clinical or structured delegated clinical activities that do not require clinical evaluation, interpretation, or intervention.

Administrative Functions and Responsibilities include:

- Intake screening and data collection related to authorization requests.
- Support development and/or maintenance of UM Department Policies and Procedures and associated Standard Operating Procedures (SOPs).
- Perform administrative delegation oversight and monitoring reviews to identify trends and errors in timeliness and regulatory processes.
- Address or escalate issues identified by other departments that are related to Utilization Management and/or the clinical care of members to ensure accurate and timely case processing, member satisfaction, and quality care delivery.
- Work cross-functionally with Clover's Experience, Network, Claims, and Enrollment teams for resolutions of payment, coding, and eligibility issues.
- Correspond with internal staff, provider partners, and delegated vendors to answer questions regarding UM processes.
- Develop, maintain, and monitor UM department analytics to identify utilization trends, compliance measures, and opportunities for process improvement.

5.2 Medical Management Committee (MMC)

The Medical Management Committee is responsible for oversight, implementation, and maintenance of the UM Program. In collaboration with the Quality Assurance Committee, the MMC monitors quality, continuity, coordination, and utilization of services; to promote compliance, ongoing process improvement, and effective delivery of health care services. The MMC is entrusted to review any discrete or aggregate utilization management issues or concerns, identify areas for improvement, and implementation of solution(s) or corrective action(s) as applicable.

The Medical Management Committee will be comprised of, but not limited to, the following participants: the Chief Medical Officer, Senior Medical Director, the Manager of Quality Improvement (QI), Chief Operations Officer, the Director of Appeals , the VP Ops Excellence ,the VP of Pharmacy Operations, the VP of Insurance Operations, the Behavioral Health (B) Medical Director, and the Compliance Officer. The MMC meets [routinely] on a quarterly basis, and as needed to fulfill the committee responsibilities.

In order to fulfill the aforementioned responsibilities, the Medical Management Committee members (or their delegates) shall execute the following actions:

1. Adopt, implement, and maintain UM Program standards, criteria, policies and procedures; and any associated documentation.
2. When indicated, monitor medical necessity determinations, relevant clinical information, and same [or similar] physician consultation(s).
3. Monitor overall effectiveness and process/quality improvement activities, including but not limited to, the Annual UM Program Evaluation and the Annual UM Work Plan.
4. Maintain knowledge related to trending utilization management performance measures.
5. Conduct inter-rater reliability (IRR) analysis to ensure consistency and accuracy in the application of utilization management standards and criteria.
6. Identify, evaluate, and resolve UM Program issues, including over and under-utilization of services.
7. Develop provider education and communication programs that encourage effective and efficient delivery of services to members.
8. Document MMC meeting minutes, including any actions or decisions rendered by the committee.
9. Create ad hoc sub-committees to support or assist with MMC functions or initiatives.

5.3 Delegation Oversight and Vendor Management

Clover Health Utilization Management Department is responsible for the oversight of all Utilization Management Activities for covered services, even if there is a delegation of these functions. For any delegated function, including vendor management, Clover Health and the delegated entity will have a mutually agreed upon document that is signed and dated. This document will describe the following: the responsibilities of Clover Health and the delegated entity, the delegated activities, the frequency of reporting to Clover Health, the delegated entity's performance evaluation process by Clover Health, as well as remediation options which may include the revocation of the delegation, if the delegated entity does not fulfill its obligations.

6. UM PROGRAM FUNCTIONS

The primary function of the UM Program is to complete medical necessity reviews for services requested, based on the member's individual health care needs; with consideration for: benefit allowance per medical policy and the member's evidence of coverage (plan contract), clinical criteria for appropriate allocation of services or level of care, medical exigency, and cost effective delivery.

6.1 Clinical Decision Making Criteria

Clinical coverage decisions are based on the eligibility of the member, state and federal mandates, the members certificate of coverage, evidence of coverage or summary plan description, and Clover Medical Policy, and for Medicare products CMS National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) and other evidence based clinical literature.

The Clinical Team utilizes evidence based MCG Criteria to guide hospital admission and level of care reviews. Application of clinical review criteria is integral to the UM process of clinical coverage review and inpatient admission review. Clinical review criteria are internally accessible via a fully licensed internet based site that is available to all clinical staff. Clover may also develop clinical review criteria with review and input from appropriate providers and based on current clinical principles and processes and evidence based practices.

The Clover Medical Management Committee reviews, evaluates and approves the clinical review criteria annually or more frequently as appropriate. The Medical Management Committee submits approved clinical review criteria to Clover Quality Improvement Committee for final review and approval.

The Clover Medical Management Committee is responsible for developing and approving all new and revised medical policies. Medical policies are developed to assist the UM team in accurately reviewing service requests within the context of the contract language in a plan document. New policies are developed in response to emerging technology or new treatments and are based on scientific evidence, where such evidence exists. Medical Policy Updates are communicated to all UM staff through Clover internal electronic communication.

Clover Health Pharmacy services are delegated to CVS/Caremark Part D Services. The UM program criteria are based on standards of medical practice, current clinical principles and processes of pharmacotherapy, evidence-based drug information, expert opinion from published guidelines and consensus statements, as well as information from other published literature such as those published in drug labeling approved by the U.S. Food and Drug Administration (FDA) and recognized compendia. Other appropriate

resources include randomized clinical trials, pharmacoeconomic studies and outcomes research data. Programs are approved by the CVS Caremark National Pharmacy and Therapeutics (P&T) Committee. Programs are reviewed at least annually, or more frequently when new indications or information become available that may impact the basis for coverage. In these situations, the information is reviewed through the P&T process if changes are necessary. After P&T Committee approval (in accordance to Chapter 6 of the Prescription Drug Benefit Manual for Medicare Part D Services). Medicare Part D Services UM edits (i.e., coverage determinations utilizing PA, ST, or QL) are submitted annually to CMS for approval before implementation.

Clover Health has formally delegated responsibility for the Pharmacy and Therapeutics Committee functions to the CVS/Caremark P&T committee. The CVS Caremark National P&T Committee helps ensure the integrity of CVS Caremark Part D Services formularies and medical drugs under Novologix by impartially evaluating the clinical information regarding drugs presented for consideration for inclusion on the drug list. CVS Caremark Part D Services utilizes the services of an independent P&T Committee to approve safe and effective drug therapies. The P&T Committee consists of external clinical experts (physicians and pharmacists) from a variety of medical specialties. Only P&T Committee members have voting rights for decisions regarding drug coverage on Medicare Part D Drug Lists and medical drugs under Novologix. CVS Caremark Part D Services ensures that its P&T Committee meets or exceeds all federal and state regulatory requirements for conflict of interest, including CMS and all industry accreditation standards, including URAC and NCQA. Members of the CVS Caremark P&T committee may not be “excluded providers” for any government program. The P&T Committee meets quarterly.

6.2 Medical Necessity Reviews

Requests for utilization reviews may be submitted electronically, telephonically, via facsimile, or in writing to the Utilization Management Department. Authorization requests may be submitted by a provider, on behalf of the member; or by the member [or authorized member representative] as a self-referral. All utilization review requests, related clinical information, and any review activities associated with the request are documented in the system of record. Members and providers are notified [verbally and/or in writing] in conformance with applicable timeliness standards, regulatory, and statutory requirements; of the determination. The types of utilization review(s) included in the scope of the UM Program are:

<u>Prospective Review</u> – Often termed Prior Authorization or Pre Authorization is conducted prior to a member’s service administration or course of treatment being

initiated. The term Pre Certification may also be used when describing a prospective review for an acute, intermediate, or long term admission to a hospital or care facility.

At Clover Health, UM Department staff conduct prior authorization reviews of all requested services that require pre-authorization. All pre authorization requests must be submitted in compliance with Clover Health's utilization management policy, following the procedure(s) detailed in The Member Handbook, Provider Manual, or verbal instruction from qualified staff. Information and education is provided to members and providers to inform them on prior authorization requirements and criteria; how to request and obtain prior authorization for services; and what rights are afforded to members and providers if a request for a service or course of treatment is denied.

Concurrent Review – Conducted during a member's admission, course of treatment, or when services are actively being provided. The terms Continued Stay Review or Extension of Services may also be used for Concurrent review of inpatient admissions or request for additional services, respectively.

At Clover Health**,** UM Department Staff conduct concurrent review(s) on requests for extension of previously approved treatments or services administered in an inpatient or outpatient setting, including, but not limited to: Acute Inpatient Hospitalization, Home-Based Care Services, Rehabilitation Therapies, Community Based Programs, and Durable Medical Equipment (DME) or Supplies.

Retrospective Review – Request for an organization determination from the Utilization Management department after care of services have been provided may result in a dismissal for untimely notification. Prior authorization review can not be completed for a service that has already been provided to a member. Providers who receive a dismissal of a retrospective authorization request may submit a claim to Clover health for the services provided. If an initial organization determination has not been issued by the Utilization Management department through prior authorization and a claim is received for care or services that requires authorization then the initial organization determination will be made through claims processing.

Providers contracted with Clover Health that provide a service without submitting a prior authorization will not have appeal rights and should refer to their contract regarding payment denial. All non-contracted providers may be allowed applicable appeal rights for adverse determination in accordance with CMS guidance.

UM PROGRAM REQUIREMENTS

7.1 Member Access to Services

Utilization Management Department staff are accessible to members and providers by toll-free telephone:

a. Directly - no less than forty (40) hours per week during normal business hours for purpose(s) of receiving calls related to member care including: request for services, notification of admission or transition, and quality of care concerns. Normal business hours are defined as 8:00 am to 8:00 pm EST, Monday through Friday, excluding federally recognized [public] holidays.
b. Indirectly – Calls received outside of normal business hours, including evenings and weekends, will be routed to a voice messaging system. Calls are returned within 1 business day.

Inbound phone calls are answered by appropriate staff with an introductory greeting which identifies the name of the call recipient, the name of the organization (Clover Health), and the name of the department (Utilization Management Department, Member Services, etc.). Based on the source and/or purpose of the incoming contact; the caller is transferred to the relevant or requested department, or individual staff person, via "warm transfer" whenever possible (and appropriate). Clinical staff receiving calls will identify themselves by name, title, and department. All staff who are requested [to] or involved in the exchange of *any* member information will verify the callers' purpose and relationship to member; and when applicable, validate consent for divulgence of information, prior to disclosing any personal health information. Staff are required to return calls within 1 business day or as expeditiously as the situation requires, based on medical exigency. If a staff person is unavailable for any extended period of time, it will be indicated on his or her personal voicemail, along with the contact information for an alternative staff person or resource.

7.2 Separation of Medical and Fiscal Decisions

No person(s) involved in the utilization management review process may receive compensation or incentives, financial or non-financial, directly or indirectly, to deny or delay approval for [covered] services deemed medically necessary. Clover Health does not reward internal or external providers for limiting or withholding services, promoting under-utilization, or issuing adverse determinations.

7.3 Appropriate Professionalism and Confidentiality

Clover Health adheres to the Centers for Medicare and Medicaid services (CMS) requirements related to the use of appropriate professionals in conducting reviews for medical necessity. Pursuant to statutory and regulatory guidelines, utilization review activities are conducted in a collaborative method by:

- Administrative personnel trained in the principles and procedures of intake screening and data collection; under the supervision of a licensed healthcare professional.
- Licensed [clinical] health care professionals who are appropriately trained in the principles, procedures, and standards of the UM Program.
- A Medical Director or physician designee (peer reviewer) when the review involves a partial or fully adverse determination.

At Clover Health, enrollee and practitioner information is confidential; therefore all internal staff, external [contractual or consulting] staff, external provider partners, and any other persons who act for, or on behalf of Clover Health are required to comply with designated confidentiality policies and procedures.

7.5 UM Timeframes for Organization Determinations

It is the right of all Clover Health members to receive medically necessary services in a timely manner. In order to facilitate the delivery of quality, efficient care to members; the Clover Health UM Program adheres to the general timeliness standards listed below for review, additional information requests, extensions, and notification of authorization request determinations, unless otherwise specified or indicated.

Any request received is considered "**Standard**" or non-urgent, unless it is deemed urgent by the clinical reviewer or the requesting provider, in which case, the review is "**Expedited**". Per Federal law and definition: An enrollee, or any physician (regardless of whether the physician is affiliated with the Medicare health plan), may request that a Medicare health plan expedite an organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

At Clover Health, each request received is assessed for medical exigency, and *all* **UM reviews are conducted as expeditiously as the member's health condition requires.**

Prior Authorization and Concurrent Review

- Standard request for coverage of items or services– Determination shall be made within 14 days from the receipt of the request.
- Standard request for coverage of part b drugs - Determination shall be made within 72 hours form the receipt of the request.
- Expedited request for coverage of items or services- Determination shall be made within 72 hours of the receipt of the request.
- Expedited request for coverage of part b drugs - Determination shall be made within 24 hours from the receipt of the request.
- Extension – Clover Health may invoke an extension for up to 14 days following the receipt of a standard or expedited pre-service organization determination if:
    - The enrollee requests the extension *or*
    - if the plan justifies a need for additional information and documents how the delay is in the best interest of the enrollee *and*
    - The authorization request is not for coverage of a part b drug (extensions are not allowed per CMS guidance for part b drug auths)

Additional details related to [making] organization determinations including timeliness, regulatory references and verbal/written notification specifications, can be found in the related policies and procedures.

8.0 UM PROGRAM ACTIVITIES

8.1 Analysis of Utilization Patterns

Under the guidance of the Chief Medical Officer (CMO), Senior Medical Director, and the Director of Utilization Management; the UM Department monitors, reviews, tracks , and analyzes, utilization data to identify atypical patterns, including: over and under-utilization, inappropriate utilization, hospital readmissions, length of stay by diagnosis or episode, emergency room visits, and out-of-area/out-of-network services and hospitalizations. Internally, the UM Department monitors patterns in: service denials, UM grievance and appeals, and Inter-Rater Reliability (IRR) performance; to ensure consistent and compliant application of UM Program standards, criteria, policies and procedures. The information gathered is used to identify potential [or known] opportunities for improvement, as they relate to UM Program activities; as well as to support the development of Corrective Action Plans (CAPs) which, when indicated, are implemented and monitored by the UM Department.

8.2 Annual UM Work Plan and UM Program Evaluation

The Annual UM Work Plan is drafted through the collaborative efforts of the Chief Medical Officer, Senior Medical Director and the Director of Utilization Management; and sets forth the goals and objectives of the UM Program including:

- Processes for monitoring and improving the UM Program.
- Annual improvement initiatives that support the goals of the UM Program.
- An implementation timeline for each initiative, along with details specific to the work group(s) or individual(s) responsible for deliverables.

The Annual UM Program Evaluation will be prepared by the Senior Medical Director and presented to the Medical Management Committee for review and approval. It will report upon the UM Program activities and outcomes from the previous year, including, but not limited to:

a. An evaluation of UM Program effectiveness and efficiency.
b. The impact of process improvement initiatives.
c. Areas for improvement in the UM Program.
d. Short and long term initiatives that will be evaluated for inclusion in [future] UM Program activities.

Each of the Annual UM Work Plan and UM Program Evaluation will be presented to the QIP Committee for review and approval as well as with the Medical Management Committee to assist in collaborative efforts towards improved quality measures, member/provider satisfaction, and overall program effectiveness.

The participating Medical Management Committee members, consisting of: The CMO, Senior Medical Director, Director of Utilization Management, and any other delegates; will annually reassess, amend, and approve the Utilization Management Program Description and UM Work Plan. Criteria used in decision-making will be reviewed on an annual basis. Utilization Management and [other] related departmental Policies and Procedures will be reviewed annually by the MMC.

9.0 UM PROGRAM INTEGRATION AND INTERDEPARTMENTAL COORDINATION

9.1 Wellness Nurse Care Manager Department

At Clover Health, Wellness Nurse Care Managers are crucial to ensuring Members receive the appropriate type and level of care [services] in a timely and relevant manner. The

UM Department works closely with the Wellness Nurse Care Manager Department to promote member autonomy through the provision of treatments and services that allow the member to live safely in his or her home for as long as possible. Collaboration and transparency between the UM and CM Programs supports Clover Health's Member-centric, holistic, and culturally sensitive approach to health management; while also serving to improve overall outcomes and reduce health care spending through minimizing the rate of unnecessary hospitalizations, re-admissions, emergency room visits, and [further] physical or functional deterioration.