Clover Health

2020 Quality Improvement Program Description

Clover Health Medicare Advantage HMO and PPO Plans
H5141 and H8010

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1. Introduction and Background

Clover Health is a federally qualified and state licensed preferred provider organization (PPO) and health maintenance organization (HMO). Since its inception, there has been a strong pledge to provide quality services to its customers (i.e., members and providers). This is reflected in the philosophy and mission statement and clearly communicated through its vision. Clover Health offers a Medicare Advantage and Prescription Drug (MAPD) benefit product to eligible individuals residing in multiple states. Products offered by Clover Health are indicated below.

H Contract	Product Type	Service Delivery Area
H 8010	HMO	New Jersey
		Texas
H 5141	PPO	Pennsylvania
		New Jersey
		Texas
		Arizona
		Georgia
		South Carolina
		Tennessee

2. Clover Health Mission, Quality Vision, and Values

a. Mission

Clover Health is dedicated to the provision of high-quality, cost-effective care and service that continually satisfies the unique and diverse needs of Medicare beneficiaries and providers where they live and work.

b. Quality Vision

Clover Health embraces the definition of quality from the Institute of Medicine, “Quality is the degree to which health services for the individuals and population increase the likelihood of desired health outcomes and are consistent with the current professional knowledge.” Clover Health’s quality vision is aligned with the Centers for Medicare and Medicaid Services (CMS) Quality Strategy for MAPD plans and the Quadruple Aim, a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. The premise of the Quadruple Aim is to simultaneously pursue four dimensions:

- Improving the patient experience of care (including quality and satisfaction);

- Improving the health of populations;
- Reducing the per capita cost of health care; and
- Improving the work life of health care providers, including clinicians and staff.

c. Values

i. **Clover First**
We value Clover Health's success over personal advancement. We're drawn to the difficulty and complexity of our mission to Improve Every Life.

ii. **Context & Transparency**
We communicate openly with each other about what we're doing, what brought us here, and why we're doing it. We share context and purpose.

iii. **Growth & Iteration**
We operate without ego, valuing diverse points of view. We look for opportunities to check our blind spots; we thrive on self-improvement and feedback.

iv. **Integrity**
We strive to be a trusted partner to our colleagues, stakeholders, and most importantly to the human beings under our care. We remember that trust is earned, not demanded, and work to earn and renew that trust every day.

v. **Action**
We take action and go beyond the conventions of our jobs to do what needs to be done. Each of us is here to make an impact with our work: to roll up our sleeves, get started right away, test assumptions, and deliver measurable results.

vi. **Sustainability**
Clover Health is here to change health care. We have a long road ahead, and we must be thoughtful about our approach. We bias toward efficiency, scalability, and rigorous planning so we can deliver high quality work products.

3. Program Goal and Objectives

The Clover Health quality improvement function assists in achieving the mission of the organization: Clover Health is dedicated to the high-quality, cost-effective care and service that continually satisfies the unique and diverse needs of Medicare beneficiaries and providers where they live and work. The purpose of the quality improvement function is to provide expertise and support to the organization in monitoring and improving health services and operations to encourage high quality, effective, efficient, and safe health care, care coordination, care management, disease prevention, and preventive health services for Medicare beneficiaries.

Quality Improvement improves organization functioning by supporting the organization in improving clinical and service outcomes for our customers. The Quality Improvement function:

- Measures and analyzes organization performance
- Contributes essential data and information to management decision-making; and
- Guides design and implementation of quality improvement projects and evaluation of interventions.

Clover Health strives to continuously improve the quality, appropriateness, availability, accessibility, coordination of care, and experience of care for our MAPD beneficiaries. The Program objectives that support this goal are:

- Maintain a Quality Improvement Program which continuously monitors the quality of care and service provided to beneficiaries
- Comply with the Centers for Medicare and Medicaid Services' (CMS) requirements regarding Quality Improvement Program activities
- Measure and report Quality Improvement and other program performance using standard measures and tools required by CMS
- Utilize a data-driven approach to improving care, safety, health outcomes and service of beneficiaries through the continuous monitoring and evaluation of industry recognized and internally developed key clinical care and service quality indicators
- Evaluate and improve upon the beneficiary experience with care and service through development of improvement actions based on results from the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, the Health Outcomes Survey (HOS®), beneficiary inquiry, grievance, and appeal data
- Identify, prioritize, and pursue opportunities to improve the quality of care and service beneficiary's receive through industry recognized measures such as HEDIS®
- Provide beneficiary access to, and the availability of, an adequate network of experienced practitioners, providers, delegates, vendors, and other needed resources
- Develop and implement pharmaceutical quality assurance measures and systems to identify and reduce medication errors, adverse drug interactions and improve medication use through retrospective and concurrent drug utilization review systems, as well as pharmaceutical policies and procedures
- Promote the effectiveness, efficiency, and compliance of all First Tier, Downstream and Related Entities (FDRs) with Clover Health contractual and

CMS requirements

- Ensure that pharmacy network providers comply with minimum standards for pharmacy practice as established by the applicable states where Clover Health conducts business
- Enhance the improvement of beneficiary health outcomes through the use of nationally recognized evidence-based clinical practice guidelines that incorporate individual beneficiary health care needs and preferences, including cultural, ethnic, linguistic and other social determinants of health
- Implement ongoing monitoring efforts to identify instances of questionable quality, to include beneficiary quality of care grievances, medication errors, and adverse events and ensure that corrective actions are implemented timely and monitored to evaluate the effectiveness of corrective actions
- Encourage provider participation in the planning, design, implementation, and evaluation of Quality Improvement program activities
- Coordinate Quality Improvement Program activities across Clover Health functional areas and with our network providers to improve beneficiary care, safety, and service
- Utilize a reliable and state of the art clinical information system to support beneficiary-centered care that is timely, effective, facilitates effective care coordination, and promotes shared decision making between beneficiaries and their care team
- Improve the health status of beneficiaries through collaborative care coordination, preventive/wellness activities, care management, and a chronic care improvement program (CCIP)

4. Program Scope

The scope and content of the Quality Improvement Program are designed to continuously monitor, evaluate and improve the quality and safety of clinical care and service provided to beneficiaries. In an effort to promote organization-wide performance improvement, specific process and outcome of care indicators are developed, measured and assessed by all appropriate departments in a timely manner through an ongoing process of data collection, analysis, improvement actions, and evaluation of the effectiveness of improvement actions. The scope of Quality Improvement Program activities includes, but is not limited to:

- Clinical services: Including acute, chronic, and preventive medical and behavioral care and services provided in the inpatient and outpatient settings by contracted provider groups, primary care and specialty practitioners, and organizational providers. Clinical services also include services provided by Clover Health staff and delegates, including but not limited to utilization

management, case management, chronic care improvement program (CCIP), prevention and wellness, beneficiary safety activities, clinical practice guidelines, and pharmaceutical management.

- Non-clinical services: Including functional and operational aspects of the Clover Health organization such as cultural and linguistic needs, customer service, claims, regulatory compliance, credentialing and recredentialing, complaints and appeals. Non-clinical services also includes identification of services and supports that may be identified through review of the demographic and epidemiologic needs of the MAPD population.

5. Authority and Accountability

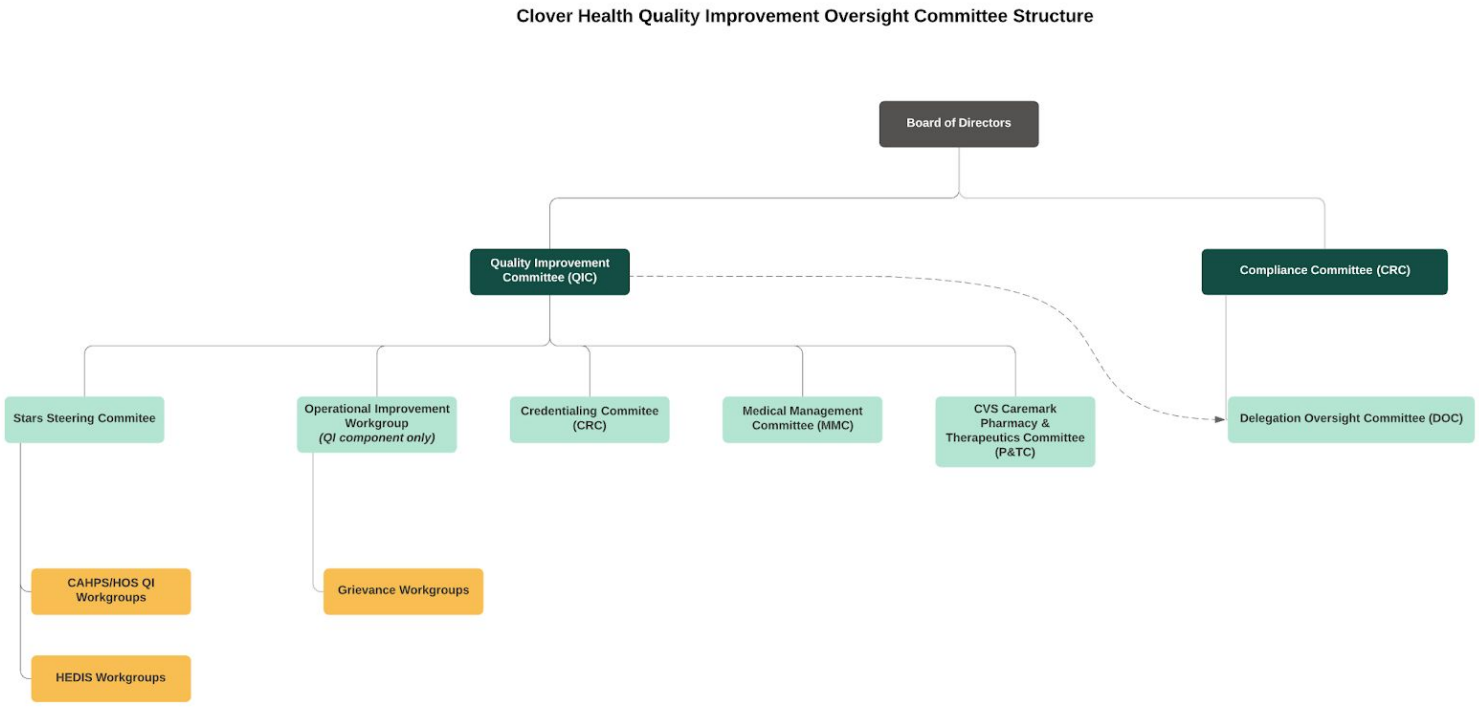
The Clover Health Insurance Company Board of Directors holds the final authority and accountability for the quality of care and service provided to Clover Health beneficiaries. The Board of Directors delegates quality improvement responsibility and authority to the Quality Improvement Committee (QIC). The Clover Health Insurance Company Board of Directors meets on a quarterly basis and provides oversight to the Quality Improvement Program. In turn, the Clover Health Insurance Company Board of Directors will review and approve, annually the Quality Improvement Program Description, Work Plan and Evaluation and will ensure that appropriate resources are available to carry out the Quality Improvement Program. The Clover Health Insurance Company Board of Directors may recommend a particular plan of action or changes to the Quality Improvement Program. The Quality Improvement Committee provides oversight and evaluates the Quality Improvement Program.

The Clover Health Quality Improvement (QI) Program is a systematic program that involves the entire organization working together at all levels. The Chief Medical Officer, Director of Clinical Quality Improvement, Medical Directors, providers, managers, and external representatives actively plan, develop, monitor, and adjust quality improvement activities targeting clinical care, service and organizational efficiency. These individuals manage quality improvement activities as a daily part of Clover Health's operational activities and as leaders within Clover Health's committee structures, which is described later in this document. In serving Clover Health's committees, they establish priorities for Clover Health's Quality Improvement program, review results of Quality Improvement monitoring and initiatives, and recommend changes to the program. Frontline employees participate in the quality improvement activities and serving on Quality Improvement workgroups. As a part of ongoing quality improvement, when improvement opportunities are identified, Clover Health initiates cross-functional workgroups to

analyze problems and develop solutions. Workgroup members may include managers, providers, and front line employees with content knowledge and expertise in the area being addressed. This structure encourages a collaborative multidisciplinary approach to improving quality, which fosters innovation, utilizes available employee knowledge and skills, encourages high employee morale, and results in more effective improvement work. Clover Health communicates and continuously reinforces the quality improvement program, initiatives, and results through training/seminars, program manuals, correspondence and other sharing of data.

6. Organization Structure

The organizational structure of the Quality Improvement Program is depicted below. All committees' minutes are recorded, reviewed, and approved by each committee, signed by the committee chair, and stored. They are made available to CMS and state and federal organizations as requested.



a. Key Individuals with Quality Improvement Oversight

i. Board of Directors

The Clover Health Insurance Company Board of Directors has full responsibility and authority for the quality of care and services provided to Clover Health beneficiaries. The Board of Directors meets on a quarterly basis or more frequently as needed to:

- Provide oversight of Clover Health's progress with achieving Quality Improvement objectives through the regular evaluation of Quality Improvement Committee and other management reports
- Make recommendations to executive leadership, CMO, and the Quality Improvement Committee regarding opportunities to improve care and service, or resolve problems, when indicated
- Provide oversight of the implementation and effectiveness of the Clover Health Compliance Program
- Review regular reports related to compliance activities, including fraud, waste, and abuse and take appropriate action to ensure compliance issues are resolved
- Review and approve the Quality Improvement Program Description, Annual Quality Improvement Work Plan and Annual Quality Improvement Evaluation
- Approve the annual budget and ensure adequate allocation of resources for the Quality Improvement program

The Board of Directors is the final review and approval authority for all Quality Improvement and Compliance program related activities. The Board of Directors has delegated full responsibility for the day-to-day implementation and management of the Clover Health's Quality Improvement Program to the Chief Medical Officer and the Quality Improvement Committee.

ii. Chief Medical Officer

The CMO is a board certified physician licensed in the state of practice with experience in Medicare managed care requirements, healthcare management, as well as, quality and care management. He/she reports to the CEO and has overall responsibility for leading medical and quality management activities for the organization and provides operational oversight for all clinical aspects of the Quality Improvement Program. All medical, clinical, and practitioner related activities are coordinated under this position. The CMO is responsible for ensuring the clinical accuracy of all coverage decisions made by Clover Health that involve medical necessity

and for providing senior clinical leadership for all escalated issues of clinical concern. He/she provides senior clinical leadership over the following functions: quality management, coordination of care, pharmacy services, behavioral health services, implementation and evaluation of clinical practice guidelines, medical and utilization management, benefits and claims management, credentialing, quality of care issues, processing coverage decisions in accordance with adjudication timeframes and notice requirements, provider/prescriber outreach, staff training, oversight of delegated entities, and provider performance reporting and education. The CMO also has oversight of the development, dissemination, implementation and evaluation of clinical practice guidelines, preventive health guidelines, and clinical studies and activities; communication of information and decisions to network practitioners and follow up on corrective action plans implemented for issues regarding quality of care, member safety or service. He/she ensures that quality activities are prioritized based on beneficiary needs and integrates the Utilization Management and Coordination of Care programs with the Quality Improvement Program. He/she chairs the Quality Improvement and Credentialing committees, and is a member of the Medical Management committee.

iii. Director, Clinical Quality Improvement

The Director of Clinical Quality Improvement (DCQI) is a Bachelor/Master/Doctoral level educated clinical professional with a current active and unrestricted Registered Nurse license who reports to the Senior Vice President of Health Plan Operations. The DCQI has professional experience in healthcare related to Public/Population Health, Health Administration or other related fields along with experience in quality improvement activities, measurement and analysis methods and quality requirements of regulatory authorities. Additionally, the DCQI has professional experience in CMS Star performance measures and partners with key internal and external stakeholders to develop strategy, key performance indicators, domain drivers, operational work plan, reporting efforts calendar of initiatives and root cause analysis around Stars. In addition, the DCQI has day-to-day authority and responsibility for directing the activities of the Quality Improvement program; including completion and maintenance of the quality program core documents; Part C and D data collection and reporting; coordination with external auditors on HOS and CAHPS survey completion; Healthcare Effectiveness Data and Information Set (HEDIS) data collection and reporting; preparation for regulatory audits;

ongoing data measurement for quality control and improvement; and chronic care improvement projects. in conjunction with the Delegation Oversight Committee, oversees the delegates' compliance with quality improvement program requirements. The DCQI collaborates with the Medical Management team for all provider related quality initiatives. The DCQI serves as the Co-Chairperson of the Corporate Quality Improvement Committee and is an active member of the Credentialing, Medical Management, Compliance, Delegation Oversight, and Stars Steering Committee within the committee structure.

iv. SVP, Health Plan Operations

The SVP of Health Plan Operations is an individual with a Bachelor's degree in healthcare or business administration, or preferable with an MBA, with 10+ years experience in a senior leadership role in a Federal government contractor environment. He/she reports to the CEO. He/she is responsible for developing and executing the Operations Plan, setting annual goals and building an organizational structure to support the quality program vision, identifying key performance indicators and demonstrating successful execution of business strategies. He/she is a member of the Quality Improvement and Delegation Oversight committees.

v. Behavioral Health Lead

The Behavioral Health (BH) Lead is a licensed clinical social worker in the state of practice with experience in behavioral health and reports to the CMO or his designee. He/she is a member of the Quality Improvement and Medical Management committees and provides clinical support and guidance regarding Behavioral Health to Quality Improvement staff and committees; review and approval of clinical guidelines and medical coverage guidelines related to Behavioral Health; and review and approval of Behavioral Health related Quality Improvement to ensure coordination of care for members with behavioral conditions. The Behavioral Health Lead also provides a Behavioral Health perspective on identified issues, as well as assessment of potential quality of care concerns and member safety issues, with provision of recommendations for further action as it relates to Behavioral Health.

vi. Utilization Management Medical Director

The Utilization Management Medical Director is a physician licensed in the state of practice with experience in quality of care and utilization

management. He/she reports to the CMO or their designee and oversees the functions related to medical management. He/she is a member of the Quality Improvement and Medical Management committees.

vii. **Medical director(s)/Clinical leadership of clinical programs**
The Medical Directors/Clinical leadership are board certified physicians with an active, unrestricted license in the state of practice who have experience in the field of work they are assigned to. He/she reports to the CMO or their designee and oversees the programs (e.g., Coordination of Care, Complex Care, etc.), strategy and evaluation of their assigned area. He/she is a member of the Quality Improvement and Medical Management committees.

viii. **Chief Compliance Officer (CCO)**
The Chief Compliance Officer (CCO) is a Bachelor/Master level educated professional who is well versed in state and federal regulations for health care. He/she reports to the CEO or their designee. His/her responsibilities are to ensure that all businesses at Clover Health are run in full compliance with state and federal regulations and accreditation standards. He/she or their designee chairs the Compliance Committee and is a member of the Quality Improvement and Delegation Oversight committees. He/she will ensure that all organization staff and contracted services are compliant with yearly education on areas such as fraud, waste and abuse, Corporate Compliance, conflicts of interest, antidiscrimination, etc.

ix. **Chief Clinical Informatics Officer (CCIO)**
CCIO is a board certified physician and informaticist responsible for the management and integrity of clinical data, its incorporation into Clover Health's technical platform, and it is used in Clover Health applications that support clinical programs and quality improvement activities. This includes traditional population management tools (which track member clinical outcomes) and a focus on how Clover Health's tools support evidence-based clinical care.

x. **Director of Internal Monitoring**
The Director of Internal Monitoring partners with internal Business Leads to ensure a sampling of processor/vendor accuracy occurs monthly and that remediation activities occur for unsatisfactory results or trends. The Director also reviews ODAG Universes Tables monthly to mine opportunities and promote clean, audit-ready universe tables.

xi. **Director, Grievances and Appeals**
The Director Of Grievances and Appeals manages the teams handling appeals and grievances from our beneficiaries and providers and collaborates with our clinicians to ensure case reviews are completed according to Medicare guidelines. He/she works closely with Operations on trend analyses to ensure implementation of improvement actions based on opportunities identified. As Lead of Grievance and Appeals, he/she is responsible for driving the vision, strategy, and oversight for Clover Health's Appeals department. The Lead directs day-to-day activities of the Appeals and GrievanceUM teams in continuing to build and refine complex, highly-regulated processes in order to improve the health outcomes of our members.

xii. **Lead, Medical Management**
The Lead of Medical Management manages the teams handling of authorization requests from our beneficiaries and providers and collaborates with our clinicians to ensure case reviews are completed according to Medicare guidelines. He/she works closely with Operations on trend analyses to ensure implementation of improvement actions based on opportunities identified. As Lead of Medical Management, he/she is responsible for driving the vision, strategy, and oversight for Clover Health's Appeals department. The Lead directs day-to-day activities of the UM teams in continuing to build and refine complex, highly-regulated processes in order to improve the health outcomes of our members.

xiii. **Director, Network Engagement/Provider Relations**
The Director of Network Engagement/Provider Relations has experience in contracting and network development. He/she reports to the CEO and is in charge of network and third party partnerships and growth. He/she or their designee is a member of the Delegation Oversight committee.

xiv. **Chief Financial Officer (CFO)**
The CFO is a Bachelor/Master level professional in economics/business administration with commensurate experience in finance in a managed care environment. He/she reports to the CEO. The CFO is responsible for ensuring that financial resources are adequate to support Quality Improvement program initiatives. The CFO is responsible for overseeing the financial stability of Clover Health through effective management of fiscal

resources. The CFO is responsible for coordinating preparation of the quarterly financial statement reports and the audited annual financial statements to meet CMS Fiscal Soundness reporting requirements.

xv. VP Sales and Marketing

The VP Sales and Marketing is a Bachelor/Master level professional or an individual with commensurate experience in sales of commercial and government sponsored programs and who understands the cultural background of the community that Clover Health serves. He/she reports to the CEO. He/she participates as a member of the Quality Improvement Committee. His/her responsibilities are to hire, train and manage a group of marketing representatives, coordinate presentations, create lead opportunities for sales, oversee and coordinate the production of enrollment and beneficiary materials that are in compliance with CMS marketing and communications requirements.

xvi. Credentialing Manager

The Credentialing Manager is a Bachelor level person or an individual with commensurate experience in the credentialing process. He/she reports to the Head of Network Management. He/she participates in the Credentialing Committee meetings. His/her responsibility is to oversee activities related to receiving the credentialing and recredentialing applications, conducting primary source verification and preparing the files for the Credentialing Committee. He/she is responsible for the monitoring and audit of credentialing delegates.

xvii. VP Pharmacy Operations

The VP Pharmacy Operations is a licensed Pharmacist with experience in managed care and delegation. He/she reports to the CFO and is a member of the Medical Management, Quality Improvement and Delegation Oversight committees. His/her responsibilities include ensuring compliance with Part D requirements for prescription drug plans, facilitating the Medication Therapy Management program, facilitating the analysis of pharmacy utilization management and quality improvement initiatives. The VP Pharmacy Operations provides primary oversight of the PBM, CVS/Caremark, and other delegates.

xviii. VP Insurance Operations

The VP of Insurance Operations oversees, develops and implements

strategies to ensure high quality, timely and efficient claims service throughout the organization. This individual ensures full compliance with Medicare guidelines, provider contracts and member benefits. This individual also ensures collaboration across the organization and is a member of the Medical management and Delegation Oversight Committees.

xix. Manager, Stars Quality Improvement Analytics

The Manager, Stars Quality Improvement Analytics reports to the Director, Clinical Quality Improvement and is responsible for clinical engagement and interventions of the organizations' beneficiaries and providers related to Stars. He/she oversees strategy implementation and through data analysis works to improve Stars Measures (i.e., HEDIS, HOS, CAHPS, Administrative Part C and D) and oversees reporting and data collection. He/she is a member of the Quality Improvement Committee and Stars Steering Committee.

xx. Associate Manager, Clinical Quality and Process Improvement

The Associate Manager, Clinical Quality and Process Improvement and their team are responsible for supporting the effectiveness of the Clover Health Quality and Process Improvement Program as well as evaluation, design, and implementation of best practice business and quality improvement processes to improve Clinical Operations service and business efficiency. They analyze data related to workflow, processes, and reporting to evaluate and improve the efficiency and performance of business processes. The Associate Manager supports the implementation of continuous process and value improvement including design and deployment for Clinical Quality Improvement initiatives to support the CMS Medicare Stars program and Quality Improvement Program (per MMCM Ch 5 requirements).

xxi. External/Network Practitioners

An important component of Clover Health’s Quality Improvement Program is the active participation of the provider network. The expertise and input of contracted providers is critical to improving the quality of care and service beneficiaries receive. Contracted practitioners and providers are made aware of the MAPD Quality Improvement Program and various quality initiatives related to HEDIS, HOS, CAHPS, through the provider portal on the Clover Health website. Participation in the Quality Improvement program is promoted through several mechanisms but not limited to provider participation on the Credentialing and other committees, as applicable.

b. Quality Improvement Program Resources

Resources available to the Quality Improvement Program that contribute to the Quality Improvement function include various Clover Health departments. Because Quality Improvement is an organization wide endeavor, additional Clover Health resources participate in organizational quality improvement (and additional identified, as needed). These include the following:

- Chief Executive Officer
- President and Chief Technology Officer
- Chief Information Officer
- Chief Compliance Officer
- Chief Clinical Informatics Officer
- Chief Scientific Officer
- Senior and Executive Vice Presidents
- Medical Directors
- Medical Management/Review staff
- Appeals/Grievances staff
- Coordination of Care staff
- Network Management staff
- Provider Relations staff
- Claims department staff
- Customer Service staff
- Pharmacy department staff
- Compliance staff
- Credentialing staff
- Information Systems staff
- Sales and Marketing staff
- Data Science staff
- Information Technology staff
- Clinical Quality Improvement staff

The Clinical Quality Improvement team has the following full-time employee (FTE) positions dedicated solely to Quality Improvement Activities:

- Director, Clinical Quality Improvement (1 FTE)
- Manager, Stars Quality Improvement Analytics (1 FTE)
- Associate Manager, Clinical Quality and Process Improvement (1 FTE)
- Stars Strategy Analyst Associate (1 FTE)
- Stars Operations Analyst Associate (1 FTE)
- HEDIS Audit Associate (1 FTE)
- Associate Manager, Clinical Quality and Process Improvement (1FTE)

c. Data Sources

Clover Health clinical quality improvement staff are provided with multiple resources for data collection, mandatory reporting and quality improvement initiatives. Clover Health's Information Technology (IT) system collects, integrates, stores, groups, and reports data from all components of its network necessary to implement the MAPD Quality Improvement Program and to assess its effectiveness. The IT system is central to Clover Health's efforts to manage patient care and to assess and improve healthcare quality and outcomes for its MAPD beneficiaries. Data sources include, but are not limited to:

- Claims/encounters
- Beneficiary health surveys (Health Risk Assessment, BH/SA screening)
- Beneficiary grievances/appeals
- Provider complaints/appeals
- Pre-authorization and concurrent review data
- Beneficiary experience data (CAHPS and other surveys)
- Provider experience data
- Telephone access data
- Data from medical record reviews generated from audits and HEDIS
- Access and availability data (GeoAccess)
- Electronic medical record information (CCDAs) and laboratory results

Data collection, management and analysis is carried out by Clover Health's staff such as nurses, business analysts, reporting analysts and clinical auditors with the appropriate background and qualifications required by the task such as data management, computer programming, data analysis, and clinical expertise.

Clover Health staff use cross functional/departmental meetings in order to involve relevant staff in root cause analysis and care areas requiring improvement. Clover Health's meeting technology allows staff to conduct and participate in web-based meetings throughout Clover Health's multiple regions, and travel funds are allocated when necessary to allow face-to-face contact. All staff are equipped with personal computers and phones with speaker and conference call capabilities. A broad and diversified Quality Improvement committee structure encourages member input, provider participation, leadership involvement, and integration of information and decision making across functional areas and departments. All employees have slide presentation software to facilitate information sharing and formal presentations.

Quality Improvement staff receive training throughout the year to increase knowledge and skills. HEDIS training and resource manuals are provided to Quality Improvement employees annually. Training on the use of analytic tools is provided to Quality Improvement Analytics staff ad hoc to facilitate more sophisticated Quality Improvement analysis. Training on performance feedback and evaluation, interviewing, and other topics are provided by Human Resources to Quality Improvement managers to assist them in providing effective leadership.

7. Committee Roles and Responsibilities

The Clover Health Quality Improvement Program is accomplished through the following committees, in conjunction with health plan personnel resources.

a. Governing Body

Clover Health Insurance Board Of Directors (BOD):
The BOD is the governing body for Clover Health plan and oversees Clover Health's functions, including the Quality Improvement program. The CMO is responsible for representing the Quality Improvement Program to the BOD. The CMO also provides feedback from the BOD to the members of the Quality Improvement Committee (QIC).

The BOD has delegated responsibility for oversight and coordination of the Quality Improvement Program to the Quality Improvement Committee. The CMO is responsible for the overall function and direction of the Quality Improvement Program. The BOD meets quarterly.

The BOD reviews the program's core documents annually as evidence of oversight. Quality Improvement updates are also given to the Board throughout the year. The Board will have access to the Quality Improvement Committee for discussion purposes.

The Board of Directors will:

- Appoint Quality Improvement Committee membership and review membership on an annual basis;
- Review, evaluate and approve the Quality Improvement Program Description, Quality Improvement Work Plan, Quality Improvement Program Evaluation, and Quality Improvement Committee memberships at least annually;
- Oversee that the Quality Improvement Program and Quality Improvement

Work Plan are implemented effectively and result in meaningful improvements in care and service;
- Review Quality Improvement workgroup recommendations, actions taken and improvements made;
- Provide the resources necessary to accomplish the Quality Improvement program; and
- Provide oral and written feedback, when indicated.

b. Quality Improvement Committee (QIC)

The Quality Improvement Committee is a multi-disciplinary committee that is responsible to support, coordinate, and facilitate the Quality Improvement Program for Clover Health MAPD. The Quality Improvement Committee reviews, analyzes, recommends and approves all Quality Improvement activities. The Quality Improvement Committee monitors and supports the implementation of the Quality Improvement Program and Work Plan. The CMO serves as the chairperson of the Quality Improvement Committee and provides quarterly reports to the Board of Directors.

Committee Composition

- Chief Medical Officer (Chair)
- Director, Clinical Quality Improvement (Co-chair)
- SVP, Health Plan Operations
- Chief Clinical Informatics Officer
- Chief Scientific Officer
- EVP, Complex Care
- Associate Manager, Clinical Quality and Process Improvement
- UM Medical Director
- Medical Director(s)/Clinical leadership
- Lead Medical Management and Appeals or designee
- Director Network Engagement/Provider relations or designee
- Chief Compliance Officer or designee
- VP Pharmacy Operations or designee
- VP Clinical Programs/Operations
- Manager, Stars Quality Improvement Analytics
- VP, Pharmacy or designee
- Credentialing manager or designee
- Stars Quality Analysts (2)
- HEDIS Audit Associate (1)

Accountability and Responsibilities of the Quality Improvement Committee include, but are not limited to:

- Annual Document Review and Approval:
- MAPD Quality Improvement Program Description
- Quality Improvement Work Plan
- Quality Improvement Program Annual Evaluation
- Chronic Care Improvement Program
- Clinical Quality Policy/ProcedureApprove and prioritize the Quality Improvement projects to undertake
- Integrate all departments and functions relative to the goals and objectives of the Quality Improvement Program
- Oversee the quality of care and service delivered to enrollees, practitioners, and organizational providers through review and analysis of Quality Improvement activity reports
- Develop and monitor the implementation and effectiveness of the Quality Improvement program through the Quality Dashboard that includes key care and service performance indicators
- Adopt new and revised clinical practice guidelines, medical necessity criteria, and medical and behavioral health policies as recommended by Quality Improvement Committee subcommittees
- Direct and guide the Quality Improvement Program through the review and analysis of data and the prioritization of actions to be taken to address opportunities for improvement
- Review and monitor the status of planned Quality Improvement activities on the Quality Improvement work plan
- Review beneficiary/provider individual and aggregate data to identify areas for improvement.
- Serve as the coordinating body that reviews and approves the actions and recommendations of subcommittees that report to it
- Report key performance indicators, action plans and program evaluations to the Board of Directors on a quarterly basis
- Monitor the effectiveness of interventions implemented to improve care and service
- Recommend policy decisions
- Receive input from practicing practitioners
- Approve, disapprove, and recommend corrective actions, up to and including revoking delegation status, of any health plan function under Clover Health’s contract with CMS
- Monitor the continuous improvement of the delivery of quality health care

and service

Quorum

In addition to the chairperson (who holds the tie-breaking vote), at least 50% of committee members or their designees must be present at each meeting to constitute a quorum. Meetings may be held in which a quorum is not present, but voting may not take place. Meeting minutes reflect decisions, and are signed and dated. The minutes are distributed to committee members for review prior to approval at the next meeting. Quality Improvement Committee documentation is considered confidential and is electronically stored in a private, secured folder.

Frequency of meetings

The Quality Improvement Committee meets monthly or at least ten (10) times per year

c. Medical Management Committee (MMC)

The Medical Management Committee is a sub-committee of the Quality Improvement Committee and is responsible for the review, analysis, and recommendations for improvement in the areas of Utilization Management, Care Management, Coordination of Care, Chronic Care and Health Promotion. The MMC reports quarterly or more frequently to the Quality Improvement Committee. The UM Medical Director or designee serves as the chairperson for the MMC.

Committee Composition

- UM Medical Director
- Chief Medical Officer
- Manager, Medical Management
- Director, Appeals and GrievancesMedical Director(s)/Clinical program leadership
- Behavioral Health Lead
- UM Medical Director(s)
- Director, Clinical Quality Improvement
- VP Pharmacy Operations or designee
- VP Insurance Ops or designee
- VP Clinical Programs/Operations
- Chief Clinical Informatics Officer
- Complex Care Medical Director

Accountability

- Annual Document review and approval: UM Program Description, UM Program Evaluation, UM Workplan and MMC Committee charter
- Conducts annual review and updates of UM decision making criteria and the biennial review and update of clinical practice guidelines
- Evaluates the consistency of UM decision-making by all clinical reviewers through annual inter-rater reliability audits
- Analyzes beneficiary and provider satisfaction with the UM process through analysis of survey data, complaints, denial and appeal trends
- Monitors under- and over- utilization of services by monitoring utilization by product line, place of service, and provider specialty compared to thresholds, health plan goals and national benchmarks and implements actions for improvement
- Reviews and analyzes data on healthcare outcomes and assesses utilization management practices for selected cases and diagnoses
- Develops, reviews, updates and approves all Medical Management policies and procedures in accordance with regulatory requirements
- Establishes performance goals and benchmarks for utilization management and effectiveness of care measures and Star measures
- Provides oversight for all pharmacy related utilization reports and Part D Stars performance measures
- Reviews and provides oversight for all behavioral health related utilization reports and performance
- Monitors provider and organizational performance on HEDIS effectiveness of care and use of services measures, HOS measures, Star Measures and CAHPS clinical measures.
- Reviews outcomes, identifies barriers and develops interventions for program/service improvement relative to: preventive health, screening, health promotion, care management, readmission rates, discharge planning, and excessive use of ED among others.
- Closely monitors the progress of improvement plan and adjusts processes and activities as needed
- Reviews, evaluates, revises, approves and disseminates information regarding new technologies and treatment protocols, guidelines and clinical criteria to PCPs and specialists

Frequency of Meetings

- The MMC meets monthly.

d. Credentialing Committee (CRC)

The Credentialing Committee is a sub-committee of the Quality Improvement Committee and is the principal peer review committee in accordance with the provisions of the HealthCare Quality Improvement Act of 1986, as amended. The Quality Improvement Committee delegates the authority for initial peer review, approval of provider and institutional credentialing/recredentialing, and approval of credentialing delegated entity processes. The Credentialing Committee evaluates and approves or denies the credentialing of new and re-credentialing applicants through a peer review process. Peer review evaluation is performed by the Committee on files where items of negative information such as licensure sanctions and/or high malpractice claims volume and/or high malpractice claims payments and/or other negative information or issues are identified. Based on the review a decision is made to accept or not accept the applicant as a provider, or in the case of an existing provider, to recredential the provider for three years, or not.

Membership of the committee includes a minimum of seven participating network providers who represent a cross-section of specialities from Clover Health's provider panel and designated Clover Health personnel who serve in an advisory capacity to the committee and are not voting members of the committee.Clover Health's Credentialing Committee reports quarterly or more frequently to the Quality Improvement Committee.The CMO serves as the chairperson of the CRC.

<u>Committee Composition</u>

- Chief Medical Officer (Chairperson)
- Credentialing Manager or designee
- Director, Clinical Quality Improvement
- Six (6) Network physicians
- One (1) Hospital physician

<u>Accountability</u>

Annually review and approve written policies and procedures for credentialing that involve:

- committee responsibilities;
- designated responsibility of the CMO and approvals of the credentialing process;
- criteria established for the approval of new practitioners/providers and

re-credentialing of existing practitioners/providers;
- processing and approval of files that meet Clover Health's criteria and those that do not;
- the imposition of corrective action up to restriction, suspension, or termination of a credentialed practitioner;
- an appellate process for instances where restriction, suspension or termination of a practitioner is imposed;
- assess individual applicants and re-applicants, validating qualifications and credentials in accordance with approved criteria, policies and procedures;
- approve and maintain accurate minutes of Credentialing Committee meetings
- perform as the Peer Review Committee when potential quality of care or conduct issues are identified in connection with a practitioner or organizational provider;
- review submissions to NPDB and State regarding terminations and quality of care issues;
- review and monitor credentialing/re-credentialing process and files from delegates

Frequency of Meetings
The CRC meets monthly or more frequently as needed. Ad-hoc and virtual meetings may be scheduled as needed/required.

e. Pharmacy and Therapeutics Committee (P&TC)

Function
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 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. A majority of the P&T Committee members are actively practicing pharmacists and physicians. At least one P&T Committee practicing pharmacist and one practicing physician is an expert in the care of elderly or disabled persons. Only P&T Committee

members have voting rights for decisions regarding drug coverage on Medicare Part D Drug Lists. 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.

f. Delegation Oversight Committee (DOC)

Function

The Delegation Oversight Committee is a sub-committee of the Compliance Committee and is responsible for conducting oversight of all delegated and contracted activities to outside vendors/entities that impact MA beneficiaries. Oversight is conducted to monitor and ensure compliance with contractual, MAPD regulatory requirements and Clover Health policies and procedures.

The Director of Regulatory Audits serves as the chairperson of the DOC.

Committee Composition

- VP of Clinical Programs/Operation
- Director, Clinical Quality Improvement
- Director Network Engagement/Provider Relations or designee
- Chief Compliance Officer or designee
- VP Pharmacy Operations or designee
- Credentialing Manager
- Delegates Representatives

Accountability

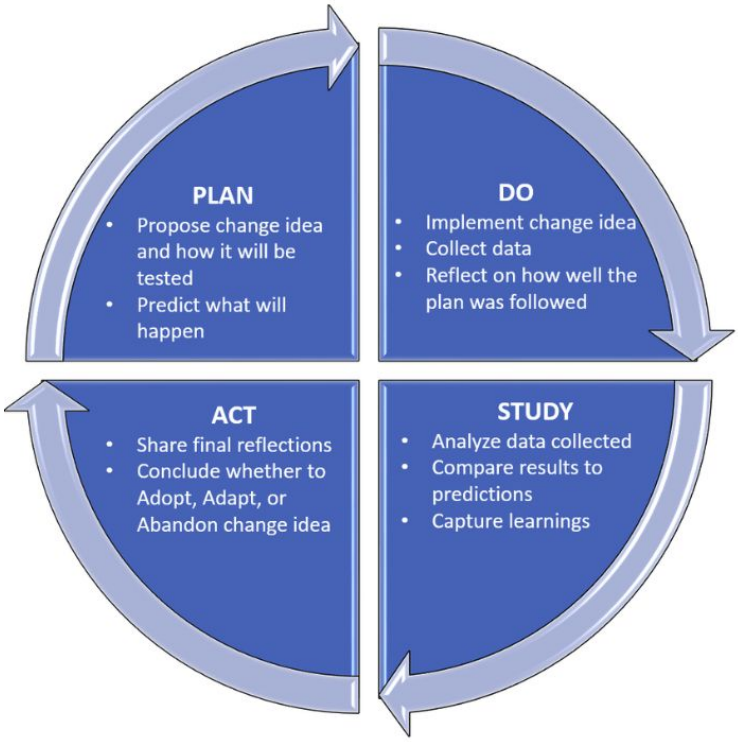
- Reviews and approves all delegation policies and procedures
- Analyzes results of pre-delegation and annual oversight audits and makes recommendations to the Compliance Committee regarding delegate’s performance
- Provides ongoing oversight of all delegated entities through analysis of quarterly reports corresponding to delegated functions
- Implements corrective action plans if performance standards are not met and monitors effectiveness of corrective actions
- Conducts annual desktop audits
- Makes recommendations to the Compliance Committee regarding termination of delegated contracts

Frequency of Meetings
The DOC meets monthly.

8. Quality Improvement Methodology and Process

Clover Health follows the Plan, Do, Study, Act (PDSA) quality improvement model to ensure that continuous performance improvement activities are conducted in a systematic manner. The PDSA cycle is iterative, repeating itself on a continuous basis. This iterative process ensures that Clover Health identifies opportunities for improvement and selects improvement strategies effectively, and ensures success through a feedback loop and continual adjustment.

Clover Health completes the following steps using the PDSA model:



a. Plan

Develop a plan for improvement; document the anticipated outcome; identify the steps needed to execute the plan.

Clover Health designs improvement projects to correct problems and improve performance based on annual goals and objectives. Clover Health also initiates projects when internal surveillance and monitoring identify opportunities for improvement. The various areas of surveillance and monitoring are covered

under the Quality Improvement program scope and program activities are discussed later in this document. Clover Health's planning step includes the following activities:

- Analyse the sources of performance variation and identify root causes of undesirable performance.
- Select interventions to address the root causes and improve performance
- Establish goals/objectives and data indicators to monitor performance
- Develop a data collection plan

Analyze the sources of performance variation/root causes:
Clover Health begins performance improvement planning by analyzing the root cause barrier issues related to low performance and isolating root causes of problems. Various tools may be used to accomplish this analysis, such as flowcharting, cause and effect diagraming, five-why analysis, etc. Causes are then prioritized to determine the sequence and timing for addressing them.

Select Interventions:
Clover Health selects interventions that will address root causes of problems and improve performance. The organization strives to use system interventions to change performance rather than strictly focusing on isolated individual deficiencies. For example, Clover Health establishes or updates clinical practice guidelines to be followed by providers based on recommendations from expert credible sources and evidence based medicine. This ensures that the entire healthcare system changes to achieve the desired outcome and that success is not dependent on any one individual for compliance. When serious deficiencies in employee or provider performance are identified, they are referred to the appropriate entity for follow up, e.g. customer Service Director, Medical Director, quality improvement committee, etc.

When prioritizing opportunities, the Quality Improvement Committee considers the potential to impact beneficiary health or beneficiary or provider satisfaction, the prevalence of the condition or volume of service, and if significant improvement can be expected. The Quality Improvement Committee prioritizes opportunities using the following methodology:

- Prioritizing Methodology for HEDIS Effectiveness of Care and Star Measures
- Those Medicare HEDIS measures that demonstrate a decrease from previous years' results, or that fall below the national mean or the CMS 4.5 Star Threshold, if the measure is used for the CMS Star Rating System, are identified as potential priorities.

- Prioritizing Methodology for CAHPS/HOS MEASURES/INDICATORS
- Those Medicare CAHPS measures that fall below the national mean or the CMS 4.5- Star Threshold, if the measure is used for the CMS Star Rating System are identified as potential priorities.
- Prioritizing Methodology for Key Clinical and Service Indicators
- Those key clinical and service measures that do not meet goal and impact beneficiary or provider satisfaction are identified as potential priorities.

Based on the availability of resources, organizational priorities, and regulatory requirements, the Quality Improvement Committee makes the final determination of which measures are selected as priorities for quality improvement initiatives. The Quality Improvement Committee may direct that task forces be formed to ensure quality initiatives are appropriately supported by key stakeholders,administrative staff and/or clinicians who are knowledgeable of the issues. The task forces are charged with identifying barriers to reaching goals, developing actions, and assisting in the implementation of those actions.

Establish Project objectives and performance indicators:
Clover Health establishes specific performance indicators to monitor whether projects are successful and goals are achieved over time. To ensure that indicators are useful measures of improvement/success Clover Health selects measures that are supported by current clinical knowledge/research, are capable of objectively measuring performance outcomes (e.g. health and functional status, clinical care, customer satisfaction, etc.) are defined in clear and unambiguous terms and include numerator/denominator specifications. Clinical and service indicators are carefully selected to reflect industry recognized measures such as HEDIS and other measures that reflect important aspects of care and service. A population-based assessment is utilized whenever feasible to promote improved health outcomes for the MA population.

Once priorities have been established, barrier analysis is conducted to determine the root cause or causes that are preventing Clover Health from achieving its goals. The purpose of the barrier analysis process is to identify the primary underlying problems (root causes) to ensure appropriate interventions are designed to eliminate or reduce those problems. Data mining and analytical tools are to be utilized in order to identify factors/individuals/ departments/policies and other barriers affecting the outcomes.

Root cause analysis is performed by a team of subject matter experts. Various work groups will be instituted such as: HEDIS/HOS, Member Experience, and Medical Management Work Groups to facilitate the root cause analysis. The CMO, Medical Director and the UM Medical Director are involved in those work groups as appropriate.

Improvement actions are designed taking into consideration the unique aspects of the membership (such as culture, age, education, etc.). Strategies for overcoming the barriers are proposed and a work plan for implementing the strategies, including specific action items and timelines is established.

Develop a data collection plan:
Clover Health develops a data collection plan for each project to ensure that data collection occurs on a timely basis and is accurate, valid and reliable. The data collection plan includes:

- Data source.
- Quantitative outcome performance indicator specifications to be collected (numerator and denominator) Note: Clover Health may also establish anecdotal ad hoc measures that will be used to monitor short term performance.
- Frequency and time periods for data collection.
- Data validation methods to ensure data is complete, accurate, valid and reliable.

b. Do

Execute the plan on a small scale to test the plan.

After Clover Health has completed the planning step, the organization implements interventions to improve areas of clinical care, service, and operations that demonstrate undesirable performance variation. Clover Health may choose to test interventions on a small scale first, such as through a pilot test, or proceed with full implementation.

Once improvement actions have been designed to specifically address identified barriers, and the action plan has been approved by the Quality Improvement Committee, the Director, Clinical Quality Improvement facilitates implementation of the action plan with the responsible parties. The Quality Improvement Committee ensures that appropriate staff are informed of Quality Improvement initiatives that impact their areas of responsibility and that providers are

educated about initiatives that impact their practice or services. The Quality Improvement Committee also ensures that initiatives are supported with appropriate materials and staff.

c. Study

Evaluate feedback to determine if the outcome was achieved

Immediately after Clover Health has implemented new interventions, the Quality Improvement Committee oversees the re-measurement of indicators to assess the effectiveness of the actions. These indicators include the original measures used to identify the need for improvement as well as any other important indicators that have been identified during the barrier analysis, action development, and implementation phases. Quantitative data/feedback and process measures are used to evaluate the initial impact on performance and make any necessary refinement to interventions. Quantitative results are analyzed and trended against previous performance established performance goals, standards or benchmarks (where benchmark data exists) in order to evaluate change over time and may be illustrated using charts, graphs or tables. Whenever possible, qualitative (root cause) analysis is conducted to identify the deficiencies or processes that may present barriers to improvement or cause failure to reach a stated performance goal or standard. Root cause analysis helps drive the design of targeted interventions to eliminate or reduce those problems. Root cause analysis is performed by a team of subject matter experts who have knowledge and experience of the process.

Monitoring frequency is established by indicator and is generally determined based on the urgent or routine need for data, as well as the need for continuous data for analysis and follow- up actions, such as with HEDIS and Star measures.

Over time, Clover Health uses outcome performance indicators to evaluate the effectiveness of interventions and ensure that pre-established goals and objectives are met. The organization uses reports of key quantitative performance measures (established during the Quality Improvement planning stage) to gauge progress. Based on an analysis of the re-measurement results, the Quality Improvement Committee may determine the topic is no longer a priority because goals have been achieved, regulatory requirements have changed, or organizational priorities have changed. The Quality Improvement Committee may also determine the topic continues to be a priority and directs continued action.

d. Act

Take action based on the study. Make the plan permanent or start the cycle again to make needed adjustments

Clover Health studies improvement project results over time to determine if interventions have been effective and goals/objectives met. If improvement has not occurred, Clover Health evaluates whether adjustments to existing initiatives should be made or new improvement projects should be initiated. If a pilot test has been determined to be successful, Clover Health will take steps needed to support full-scale implementation, e.g., system training, policy and procedure development, etc.

The PDSA process is an iterative process in that when Clover Health identifies that current processes need refinement or new opportunities for performance improvement exist, the PDSA process again enters the planning stage.

9. Quality Improvement Work Plan

As part of the Clover Health Quality Improvement Program, the organization develops an annual Quality Improvement Work Plan for each calendar year. The work plan functions as a guide to Clover Health Medicare Advantage clinical and non clinical quality improvement activities for the upcoming year and details each planned quality improvement activity with a brief description, timeframe for completion, the area or individual responsible for the activity, applicable regulatory requirements, and numerical objectives. Clover Health updates the work plan throughout the year to track progress of activities and to address any additional needs identified in the course of the year. The work plan is reviewed and approved by the Quality Improvement Committee and the Board of Directors annually.

10. Quality Improvement Evaluation

Clover Health conducts an annual Quality Improvement Program Evaluation which includes information about the following:

- Review of progress and status of annual goals.
- Evaluation of the effectiveness of each quality improvement activity.
- Evaluation of the effectiveness of the CCIP.
- Evaluation of the progress achieved on Star measures.
- Review of trends on clinical and service quality indicators.
- Evaluation of the improvements occurring as a result of quality improvement efforts.

- Identification of areas of deficiencies and recommendation for new interventions
- Evaluation of the overall effectiveness of the Quality Improvement Program.
- Evaluation of adequacy of staff resources.
- Evaluation of the program structure and processes

Based on the annual program evaluation, the prior year's Quality Improvement Program and Work Plan are revised, and a new Quality Improvement Program and Work Plan for the coming year are developed to guide and focus the work for the next year.

This information is also shared internally with Clover Health's staff through staff meetings and internal communications.

All documents related to the Quality Improvement Program, Work Plan and Program Evaluation, policies and procedures, reports, studies, minutes and all related documentation are stored and made available to CMS upon request.

11. Process and Outcome Measures

The following process and outcome measures are collected and reported on varying frequencies, from monthly to annually depending on the business needs, the nature of the indicator as per what it measures and the availability of data. These measures are collected, analyzed and reported by a team of professionals with knowledge in data management and analysis and with clinical expertise.
Results are presented at various committees (Medical Management, Quality Improvement) and shared with beneficiaries and providers as appropriate via mechanisms such as the member and provider communications or the Clover Health website.

a. HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by many health plans to measure performance on important aspects of care and service. Some HEDIS measures are used to calculate a health plan's Medicare Star rating which is reported to consumers. This empowers consumers to reliably compare and make informed choices about the managed health care plan they would like to join.

Annually, Clover Health participates in HEDIS reporting for its MAPD population.

The performance measures in HEDIS are related to many significant public health issues such as cancer, heart disease, smoking, asthma and diabetes and it includes measures such as “Effectiveness of Care”, “Access to/Availability of Care” and “Utilization and Relative Resource Use”. HEDIS is sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA). Clover Health uses these measures as one way to evaluate the effectiveness of the health plan performance as well as any interventions put into place to improve performance.

Clover Health’s staff collects, consolidates and reports HEDIS hybrid and administrative rates. Administrative and hybrid data is reported and collected through Change Health, a certified HEDIS measure software vendor. Clover Health contracts with Change Health to collect medical records and conduct data abstraction for the hybrid measures. Throughout the chart chase, medical records are overread by a Clover Health HEDIS team RN to ensure vendor abstraction quality and to initiate new medical record chases when appropriate. Administrative and chart review data is consolidated and final determinations are made as per the beneficiary being compliant, non-compliant or excluded from the denominator. To ensure HEDIS measures are accurately reported, data files and documentation are reviewed by an NCQA certified auditor vendor Healthy People. HEDIS rates are calculated and reported via the IDSS (Interactive Data Survey System) to NCQA and CMS via the Patient Level Detail file.

HEDIS results are compared to available regional, national and/or state benchmarks and prior year’s results through statistical testing. A HEDIS Team is led by the Director of Clinical Quality Improvement, Manager, Stars Quality Analytics and includes representatives from Quality and various stakeholders such as Medical Management and Care Coordination. Based on HEDIS results and statistical comparison against benchmarks and prior years’ results, the HEDIS Team identifies areas for improvement. Once barriers are selected, the HEDIS Team prioritizes them, identifies root causes and barriers whether related to data collection, provider or beneficiary behavior, and devises activities for improvement. Results and action plan are presented at the Stars Steering, Medical Management, and Quality Improvement Committees for additional input and approval of plan of action, semi-annually.

b. CAHPS Member Experience Survey

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a member experience and satisfaction survey as well as a major component of STARS. Clover Health contracts with a Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS Survey approved survey vendor, SPH Analytics.The Medicare CAHPS survey is a measurement tool that asks MAPD beneficiaries to report on and evaluate their experiences with health care in areas of customer service, access to care, interactions with providers and pharmacy services. Results are submitted by the vendor to CMS.

CAHPS® composite measures are compared to national/State benchmarks by a Member Satisfaction Team led by the Director of Clinical Quality Improvement And with representatives from Stars team, and across Clover Health including Medical Management, Pharmacy, Provider Services and Customer Services, etc. Further analysis and comparisons are carried out at the individual question level to identify poor performance areas and conduct root cause analysis. Results and action plans are presented at the Quality Improvement Committee for feedback and approval.

c. Health Outcomes Survey (HOS)

The HOS is a health functional status survey administered annually to a random sample of 1,200 (or maximum available) Medicare beneficiaries by an NCQA certified survey vendor. The survey is designed to assess a health plan's ability to maintain or improve the physical and mental health of its Medicare beneficiaries over time. The survey is administered to a different baseline cohort each year and then two years later, the same cohort is surveyed again, allowing for the assessment of "outcomes". It includes the Veterans RAND 12-item Health Survey, supplemented with additional case-mix adjustment variables and four HEDIS® Effectiveness of Care measures.

The Clover Health HOS Team, comprised of representatives from Quality Improvement and Medical Management and led by the Director, Clinical Quality Improvement analyze baseline and cohort follow-up results and performance trends to include a comparison of Clover Health's performance with state and national results. The HOS Team identifies opportunities for improvement and develops an improvement plan. Results are presented annually to the Quality Improvement Committee and recommendations for improvement are selected and approved.

12. Quality Improvement Program Components

The following are brief descriptions of the various components of the Quality Improvement Program.

a. Preventive Health and Wellness

The goal of Clover Health's preventive health and wellness activities is to improve the quality of health by encouraging MAPD beneficiaries to pursue healthy lifestyles by obtaining needed immunizations and screenings and empowering them to actively participate in the management of their physical and mental health and chronic conditions.

Effectiveness of the Preventive Health and Wellness program is monitored through HEDIS and other measures that include but are not limited to:

- Breast cancer screening
- Colorectal cancer screening
- Influenza vaccination
- Diabetes dilated retinal exam, kidney monitoring, and blood sugar control
- Measure results are analyzed for opportunities to improve the overall health of beneficiaries.

b. Coordination of Care

The Clover Health Coordination of Care program is designed to help members manage their chronic conditions, reduce their chances to be admitted to the hospital, provide continuity of care and improve their health outcomes and quality of life. Coordination of Care occurs through a variety of programs which may include:

- Telephonic Care Coordination-Telephonic care coordination is provided to beneficiaries who need help in coordinating their care whether it be due to their multiple comorbidities, complex social needs, difficulties accessing care, or other concerns. Beneficiaries are identified through self-referral or are referred by a physician or another department at Clover Health. Reports followed by the team lead on metrics such as member engagement, completion of tasks can then be followed to look for opportunities to improve the overall health of beneficiaries.
- Health Risk Assessment- Clover Health will collect from newly enrolled beneficiaries, within 90 days of enrollment, a Health Risk Assessment (HRA). For existing beneficiaries, a Health Risk Assessment will be administered annually. The Health Risk Assessment will be self-administered (via online form or paper form mailed to all members), or answered telephonically (with someone recording the answers). The Health Risk Assessment information is

used to identify barriers to care and care coordination needs, including major beneficiary health and functional challenges. Reports on initial and annual HRA completion rates and subsequent number of beneficiaries identified for coordination of care needs will be reported to the Quality Improvement Committee to support appropriate triage/referral to existing clinical and care coordination programs.

- Clover Assistant- Clover Health has developed a point of care tool that is offered to network primary care physicians to better identify member needs and allow Clover Health to support PCPs in providing high-quality evidence-based care. This tool allows Clover Health to communicate bidirectionally with providers to confirm beneficiary conditions, care plans, remind providers of individual member preventive health and wellness needs, and prompt action where members may not be receiving evidence-based clinical management. Metrics such as successful tool usage will be reported to the Medical Management Committee and can allow opportunities to improve provider engagement and patient outcomes.

c. Clinical Practice Guidelines

Evidence-based clinical practice guidelines related to preventive health and chronic conditions are developed based on national guidelines and benchmarks. These are adopted and reviewed annually by the Medical Management Committee. All guidelines reflect the most current view of the relevant medical community as reflected in the scientific evidence; professional standards and expert opinion from recognized sources. They include the following:

- Diabetes care
- Cardiac care
- Heart failure
- Cholesterol management
- Hypertension management
- Depression screening
- Substance abuse screening and counseling
- Tobacco cessation
- Adult obesity
- Asthma
- COPD
- HIV/AIDS
- Prevention for adults
- Osteoporosis
- Osteoarthritis

- Lower back pain
- Colorectal cancer screening

Clinical practice guidelines are available to providers upon request to the Quality Department and they are posted in the provider portal at www.cloverhealth.com. Information on updated guidelines is made available to providers through direct mailings and on the web.

Adherence with clinical practice guidelines is assessed yearly through HEDIS measurement and performance is evaluated at the plan and practitioner/medical group level.

d. Utilization Management

The UM Program is designed to ensure that medically appropriate services are provided to all beneficiaries through a comprehensive framework that promotes the provision of high quality, cost effective, medically appropriate healthcare services in compliance with the beneficiary benefit coverage and in accordance with applicable regulatory requirements. The UM program has reporting metrics to monitor and improve upon the quality and appropriateness of utilization of medical services provided by participating physicians, hospitals, and other ancillary providers. These UM quality metrics, reported through the Medical Management Committee and summarization up to QIC, may include but are not limited to:

- UM decision making and notification timeliness
- Inpatient average length of stay (ALOS)
- Unplanned admission rates
- Readmission rates
- Over and under-utilization monitoring
- Inter-Reviewer Reliability (IRR) Testing
- Member and provider UM experience data
- Emergency department visit rate

e. Pharmaceutical Management

Pharmacy services are delegated to CVS/Caremark Part D Services.

CVS/Caremark's Clinical Quality Assurance Program is designed to encourage safe and effective drug utilization, enhance beneficiaries' health outcomes, and promote cost-effectiveness. The program is built upon the requirements of the National Committee for Quality Assurance (NCQA), Utilization Review

Accreditation Commission (d.b.a. American Accreditation Healthcare Commission) (URAC), the Centers for Medicare & Medicaid Services (CMS) and other applicable regulatory organizations.

Additionally, quality improvement and oversight for key Stars Medication Adherence metrics are monitored, tracked and trended with identified areas of quality improvement acted on by the Clinical Quality Improvement team.

Part D Program Goal

The goal of the QA Program is to ensure that beneficiaries receive access to high-quality prescription drug coverage and quality service, and to reduce the risk of fraud, waste and abuse within the Part D prescription benefit. The goal is accomplished through the following:

- Provide therapeutically appropriate drug intervention and formulary management recommendations to Clover Health
- Support beneficiaries' timely access to the drugs prescribed by their practitioners
- Promote targeted prescriber communication identifying clinically based, cost-effective therapy options for their patients covered by Medicare Part D that helps improve safety, adherence and health care outcomes
- Promote the regular review of data related to complaints/grievances, drug utilization review (DUR, concurrent DUR, retro DUR), medication error identification and reduction (MEIR) processes, UM program, formulary processes, and fraud, waste and abuse (FWA) in order to identify opportunities to meet or exceed industry or regulatory benchmarks for Medicare Part D.
- Monitor the effectiveness of QA practices intended to respond to opportunities identified by the review of various quality metrics to help improve member safety, timely and appropriate access to covered medications, regulatory compliance for formulary processes, and reduce unnecessary cost, waste or abuse of the Part D prescription benefit

Drug Utilization Review (DUR)

CVS Caremark Part D Services utilizes data provided from the Acumen Patient safety website in monitoring the effectiveness of its clinical programs. The Acumen Patient safety data website is accessed no less than monthly to review and download relevant plan-specific data for its Prescription Drug Program Sponsors (PDPS).

Multiple DUR processes are in place to evaluate prescriptions received by Clover Health beneficiaries for safe, appropriate use. Some reviews are performed before a beneficiary receives medication (UM, cDUR, Plan design/formulary edits) and others retrospectively (rDUR). Each process has unique attributes to contribute to safe and effective medication therapy while reducing unnecessary cost and mediation waste.

- Concurrent DUR: Conducted at the point of service and covers areas such as appropriate dosage, duplicate therapy, contraindications, age and/or pregnancy precautions.
- Retrospective DUR: Conducted retrospectively through review of utilization profiles of drugs that either should be avoided, should be used instead, or the dosage or frequency is not appropriate.
- Alerts are sent by Clinical Pharmacists to prescribing physicians.

Medication Safety and Monitoring

The Safety and Monitoring Solution (SMS) focuses on utilization of high-risk drug classes, such as controlled substances (CSs), by using indicators that suggest inappropriate use or misuse of CSs such as poly-pharmacy, “provider shopping,” morphine milligram equivalent dose (MME) and high total targeted drug claims volume. Algorithms with a graduated risk score identify highest- risk plan beneficiaries and profiles are generated. On a monthly and quarterly basis, CVS clinical pharmacists evaluate controlled substances claims and any available supporting data to identify potential medication misuse and inappropriate claims for appropriate intervention. If it is observed that there are safety concerns, letters are sent to the prescribing practitioner(s) noting the observation and requesting verification of drugs prescribed along with medical diagnosis codes. The SMS is intended to complement a Clover Health's general program management initiatives and can be included as one component of the requirements under Chapter 9 of the Prescription Drug Benefit Manual relating to fraud, waste and abuse.

Enhanced Safety and Monitoring Solution

The Enhanced Safety and Monitoring Solution (ESMS) provides a more extensive range of interventions for those cases that continue to show evidence of inappropriate or unexplained utilization despite interventions applied in the Core Safety program. Cases are referred to the ESMS for further review. This review includes a secondary level of analysis that can culminate in one or more of the following interventions:

- Inclusion of the beneficiary in the beneficiary/practitioner lettering campaign.

This is a multi-letter campaign designed to promote awareness of the medication history to both the beneficiary and each practitioner who has written a prescription with the overall goal to change beneficiary behavior in line with current pain management guidelines

- Provide case documentation or support for client CMS Medicare Drug Integrity Contractors (MEDICs) reporting if deemed appropriate. CVS Caremark Part D Services collaborates with Clover Health to review the need for this intervention on a case- by-case basis
- Provide prescribers with toolkits designed to provide education and assistance in managing patients with pain
- Implement member-specific utilization management edits (MSUME)

CVS/Caremark Part D Services provides Clover Health quarterly reporting and presents a summary of findings during Clover Health's Quality Improvement Program Committee meetings.

f. Medication Therapy Management Program

The Medication Therapy Management (MTM) program is delegated to Clinical Support Services (CSS). The program is designed to optimize the therapeutic outcomes for targeted beneficiaries by improving medication use and reducing adverse drug events.

For the 2020 benefit year, beneficiaries are eligible for the program if they are taking 8 or more Medicare Part D covered maintenance drugs, have 3 or more chronic conditions and who are likely to spend more than $4,255 in a given year. The chronic conditions targeted are: asthma, copd, diabetes, depression, osteoporosis, chronic heart failure, hiv and cardiovascular disorders such as high blood pressure, high cholesterol or coronary artery disease.

Pharmacists contact the beneficiary and conduct a comprehensive medication review, suggest changes when appropriate and work with Clover Health case managers and prescribing physicians to coordinate medication therapy. The program is an opt-out program.

This measure is defined as the percent of Medication Therapy Management (MTM) program enrollees who qualified for the program and who received a Comprehensive Medication Review (CMR) during the reporting period. Results and progress of the percentage of qualified members that received a CMR are reported quarterly to the Medical Management Committee to track progress

towards achieving five star ratings for this measure. The committee will request corrective action plans, should the goals not be reached.

Clinical Support Services provides Clover Health with dashboard reporting, access to their web-based portal and supplies Clover Health with annual MTM program reports for submission to CMS through the HPMS site.

g. Credentialing and Recredentialing

A significant part of Clover Health's Quality Improvement Program is the appropriate and regular credentialing of providers (physicians, health care professionals, facilities and ancillary facilities) in compliance with N.J.A.C. 11:24C-1 et seq and 42CFR§422.204. The Credentialing Committee establishes and approves policies and procedures that delineate standards for identifying competent and qualified physicians and other providers in accordance with regulatory requirements and accreditation standards. The Committee uses the standards to determine eligibility for participation in Clover Health's network. The goal is to develop a network of participating providers that demonstrates Clover Health's commitment to continuously improve the quality of health care delivered to its beneficiaries.

All providers participating with the health plan must submit their qualifications through an application for verification, review and approval by the Credentialing Committee. In that application providers must attest to the correctness and completeness of the information they provide. Qualifications for physicians and other healthcare professionals include, but may not be limited to, current licensure, valid DEA or CDS, education and training, work history, board certification, hospital/facility privileges, malpractice history, and history of any sanctions and suspensions. Clover Health or its delegated entity conducts primary source verification of license, education and training and/or board certification through the use of industry-recognized verification sources. Clover Health conducts secondary source verification of credentials information through widely accepted and appropriate sources, as per CMS guidance. Providers, through the application, attest to the existence of any physical and/or mental health problems, history of chemical dependency, loss of license and/or hospital privileges. PCPs must also attest that their physical offices are in compliance with ADA requirements.

Re-credentialing is performed on every network provider every three years. To ensure the quality and safety of care between credentialing cycles, the program

performs continuous monitoring through the Practitioner Data Bank looking for sanctions and/or limitations on licensure, opt-in/opt- out of Medicare, as well as any Medicare or Medicaid sanctions. In addition, Clover Health monitors provider performance related to potential quality of care issues, including beneficiary complaints, results of quality reviews, performance indicators, utilization management and re-verification of hospital privileges.

Clover Health makes every effort to ensure practitioners are treated fairly and has established a comprehensive appeals process for practitioners for whom their privileges or network participation is reduced, suspended or terminated. These actions may or may not be taken as a result of quality deficiencies. In addition, Clover Health will:

- Provide a written explanation to the practitioner of the reasons for termination and his/her right to a hearing
- Not terminate a practitioner for advocating on behalf of a beneficiary, for filing a complaint, for appealing a decision or for requesting a hearing
- Notify licensing and/or disciplinary bodies when a practitioner is suspended or terminated for quality deficiencies
- Ensure that all processes are administered in compliance with federal requirements

Clover Health has written policies and procedures for the assessment of medical and behavioral health organizational providers prior to initial contracting and at least every three years thereafter. The credentialing process includes submission of a completed application document and assessment of accreditation status. A site visit is conducted for organizational providers who are not accredited, or in lieu of a site visit, Clover Health may accept a copy of the CMS or state quality review indicating a successful/passed inspection within the past three years.

h. Access and Availability

Clover Health has established access and availability performance standards for its network and other aspects of operations to ensure that all services for beneficiaries are available and accessible according to 42 CFR § 422.112. Clover Health's network access and availability requirements, and monitoring of these requirements, include but are not limited to:

- Availability: Clover Health has established geographic availability standards for primary care, specialty care, behavioral health practitioners and organizational providers, such as hospitals, to ensure its network is sufficient

to support beneficiary needs. Clover Health monitors geographic availability on a continuous basis, with a comprehensive annual analysis, to identify potential network deficiencies that may require recruitment efforts.

- Accessibility: Member complaint data, as well as CAHPS survey questions, and other access data are analyzed to evaluate opportunities to improve network access and availability. In addition, Clover Health tracks and acts upon any complaints related to office access for members with disabilities.

i. Network Adequacy

Clover Health monitors the quality of its provider network as per CMS network adequacy requirements. This includes assessing whether there is a sufficient number of providers, across various specialties.Clover Health utilizes Quest Analytics to monitor any adverse accessibility impacts to changes in the provider network. If necessary, Clover Health then initiates corrective actions which may include contracting with additional providers and/or facilities. Clover Health manages benefits with parity in most plans for network versus non-network, as is primarily a PPO plan.

To assess the cultural/ethnic and linguistic adequacy, Clover Health actively monitors grievances and member requests. While this is not a CMS-mandated network adequacy requirement, if deficiencies are reported, additional contracting may subsequently occur to bolster the network.

To address volume needs, Clover Health may contract with additional provider(s), when available, in primary care,any needed specialties, or arrange for necessary ancillary services to be provided by out-of-service area providers.

j. Potential Quality of Care Concerns

Clover Health monitors, identifies, investigates, and takes necessary action to resolve potential quality of care issues, including sentinel events and on-going concerns. When Clover Health detects or suspects a potential issue, Clover Health will initiate an investigation and refer to appropriate stakeholders/committees.

Important single events, levels of performance, patterns, or trends vary significantly and undesirable from those expected; or
A sentinel event has occurred. A sentinel event is defined as an unexpected occurrence involving death or serious injury, or significant risk of death or serious injury.

Incidents that potentially affect the quality of care rendered to Clover Health members are tracked, trended and evaluated in order to recommend corrective actions, where necessary, and to verify the problems identified are resolved and education is provided accordingly.

k. Coordination with Behavioral Health Care

Clover Health manages behavioral healthcare services to enhance continuity of care among Clover Health members. Behavioral Healthcare Services include but are not limited to: Inpatient, Intensive Outpatient, Residential Treatment, Chemical Dependency, and outpatient care. Routine reports are submitted to the appropriate committee(s) that include: behavioral health network provider adequacy, members engaged by internal Behavioral Health team, members engaged by TeleDoc services for Behavioral Health, and performance on behavioral health HEDIS.

Special emphasis on the Behavioral Health Quality Improvement program is given to monitor the continuity and coordination of care for members with Behavioral Health conditions, as well as to identify areas for evidence-based expansion of Behavioral Health services. Coordination of care extends to include help accessing and affording care.

Members seen by the Behavioral Health program are either proactively identified (e.g. with significant burden of Behavioral Health conditions, after a Behavioral Health hospitalization), by referral from network providers or Clover Health clinical teams), or by member self-referral.

l. Beneficiary and Provider Experience

Beneficiary experience is monitored and analyzed utilizing survey results and other sources of beneficiary experience data such as inquiries, complaints, grievances and appeals. Surveys include but are not limited to: CAHPS member experience, care coordination program satisfaction survey, and HOS member experience surveys. Survey responses by question type and by composite measure are correlated with beneficiary complaint, grievance and appeal data to identify opportunities for improvement. Summary of analysis and activities for improvement are presented at the Quality Improvement Committee for monitoring and quality improvement opportunities.
Provider experience is monitored through the collection and analysis of complaints and appeals on an ongoing basis and is correlated with other

experience data, as applicable. All information is utilized to enhance Clover Health's collaborative relationship with network providers.

m. Customer Service

Clover Health has established performance standards for customer service and monitors the service on an ongoing and annual basis to assure that beneficiaries and practitioners have prompt access to Customer Service staff. Clover Health monitors to ensure that beneficiaries with unique linguistic or translation needs have appropriate and timely access to translation services as well as TTY for hearing impairment support. Clover Health has Spanish-speaking Customer Service representatives and also has a Member Advocacy Service to assist beneficiaries. Clover Health monitors beneficiary access to Customer Service via the following:

- Average speed of answer (ASA)
- Abandonment rate
- Customer Service Star measure rating
- Foreign Language Interpreter and TTY Availability Star measure ratings (Part C and Part D)

n. Delegation Oversight

Clover Health conducts ongoing delegation oversight activities, including monitoring of required deliverables and annual delegation audits of delegates. Compliance with deliverables such as required reporting is monitored through oversight of the Delegation Oversight Committee and its delegate coordinators, on a monthly basis. Clover Health has a formal process for conducting pre-delegation assessments of potential delegates, and conducts ongoing monitoring of delegated activities carried out by contractors.

Clover Health ensures that a delegation agreement is in place and that it includes the delegate's and Clover Health's responsibilities and accountability, frequency of reporting and provides for revocation of the delegation contract or other remedies for inadequate performance. Clover Health has specific written procedures for monitoring and evaluating the delegated functions, maintains oversight responsibility of delegated activities and retains the right to modify or withdraw the nature of the contractual relationship, including the termination of the contract and/or termination of the delegated activities as specified in the agreement.

The Delegation Oversight Committee monitors delegate performance to ensure

that the vendor or delegate's activities adhere to regulatory requirements, Clover Health policies and procedures, and meet applicable contractual performance. In the event a delegate does not meet performance standards, the committee requires that corrective actions be implemented and provides ongoing oversight to ensure resolution of performance issues. Delegate reports are submitted at least semi- annually to the Delegation Oversight Committee and Compliance Committee.

o. Beneficiary Safety

Clover Health is committed to beneficiary safety; it is of utmost importance to Clover Health. Promoting beneficiary safety encompasses monitoring and trending activities that includes:

- Maintaining a safety conscious provider network through diligent credentialing;
- Monitoring quality of network practitioners through the investigation and resolution of beneficiary quality of care complaints and adverse events;
- Monitoring of drug interactions and contraindications through the DUR program;
- Monitoring of appropriate prescribing and drug utilization;
- Conducting peer review of suspected instances of substandard quality health care delivery;
- Monitoring appropriate discharge planning;
- Monitoring over and under-utilization.

Individual cases or a significant trend of issues that may represent urgent or emergent situations are acted upon immediately to ensure beneficiary safety. Quality of care and other relevant issues are submitted to the Credentialing Committee as part of the ongoing monitoring of network quality and safety.

p. Behavioral Health Program

Clover Health offers both telephonic and in-home Behavioral Health services to enhance coordination of care with both inpatient and outpatient Behavioral Health providers including psychiatrists and therapists, and in community-based Behavioral Health settings. The Behavioral Health program also provides assistance with accessing additional financial resources (e.g Medicaid) to improve access to care. The team helps members address barriers leading to food insecurity and housing instability. Clover Health provides access to telehealth behavioral health services to all beneficiaries.

q. Beneficiary Rights and Responsibilities

All beneficiaries are granted certain rights and responsibilities which must comply with federal and state laws. Among their rights are the following:

- Be treated with respect and fairness
- Be provided with information
- Participate in decision making regarding their health
- Voice a grievance or complaint
- Formulate advance directives
- Have access to medical records
- Refuse treatment and be informed of the consequences

The list of rights and responsibilities is provided to beneficiaries at the time of enrollment and annually thereafter. When adverse determinations regarding benefits are made, Clover Health communicates the member rights in appealing the determination. Training on member's rights is provided to customer service and other staff who deal with members as part of their position. The same list of rights and responsibilities is distributed to new practitioners at the time of contracting.

r. Beneficiary Grievances and Appeals

Clover Health's Quality Improvement Program monitors appeals/grievances through regular reporting and ongoing monitoring by the Quality Improvement Committee. This includes CMS required quarterly reporting and monitoring for trends and variances. Committees review operational reports which monitor turnaround times, categories and types of appeals/grievances, and types of resolution. Quality of care issues may be escalated through the complaints process or internal referral to the Clinical Quality Improvement team for investigation and forwarded to the appropriate physician/committees for resolution.

Beneficiary grievances/complaints and appeals are key performance indicators of beneficiary experience and satisfaction. Clover Health has established written policies and procedures for thorough, appropriate, and timely resolution of beneficiary grievances/complaints and appeals. The substance of grievances and appeals and actions taken are documented in the Grievances and Appeals data management systems. Beneficiary grievances are received, classified and responded to within 30 days of receipt for standard grievances and within 24 hours for expedited. Standard appeals must be resolved within 30 calendar days and expedited appeals must be resolved within 72 hours. Grievances and

appeals are analyzed by category/type in conjunction with other beneficiary experience data in order to identify areas of dissatisfaction, determine root causes and implement improvement action plans.

Quality of Care complaints are complaints by a beneficiary related to the quality of services received and treatment from practitioners, facilities and ancillary organizations. These complaints are reviewed by a Clover Health quality nurse and/or the CMO. Medical records are requested, reviewed and a final recommendation as per the severity of the complaint is made.

s. Monitoring of Adverse Events

The Institute for Healthcare Improvement defines adverse events as: "unintended physical injury resulting from or contributed to by medical care (including the absence of indicated medical treatment), that requires additional monitoring, treatment, or hospitalization, or that results in death." Clover Health has established an organization-wide process for the identification, reporting, analysis and implementation of corrective or follow-up actions to resolve potential and actual adverse events. Adverse events may be identified and reported by any Clover Health employee related to a beneficiary event in an outpatient, inpatient, and other relevant settings (e.g., pharmacy, home) that impacts the beneficiaries' safety and health. Adverse event information is reported to the Quality Improvement department for review and follow-up, which may include review with a Clover Health Medical Director. Data is collected, reviewed, and analyzed in aggregate for trends and opportunities for improvement.

Potential quality of care issues are reviewed by the Director, Clinical Quality Improvement, together with the CMO, and evaluated as per their level of severity. Appropriate actions are taken.

t. Cultural Competency/Health Literacy/Racial Disparities

Clover Health works to ensure all beneficiaries receive equitable and effective treatment. Key priorities of Clover Health include:

- Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost, to each patient/consumer with limited English proficiency, at all points of contact, in a timely manner during all hours of operation.
- Provide patients/consumers in their preferred language both verbal offers and written notices informing them of their rights to receive language

assistance services.

- Assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff; family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
- Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Beneficiaries who speak a language other than English have access to a language line whenever they need to interact with Clover Health. All beneficiaries enrolled in CA@Home programs have access to translation services and materials available in Spanish, which is the predominant non-English language among Clover Health's beneficiaries. Additionally, Clover Health provides materials in the language where there is 5% population that speaks that language in a service area, per CMS regulations. All other materials are translated and provided upon request, including large print and braille.

u. Community Engagement

Clover Health works with numerous community organizations in order to coordinate support services for Clover Health members such as Senior Centers, County Offices on Aging, Community-based Adult Services Centers, transportation, housing, prescription assistance, and hospice care.

v. Confidentiality

Clover Health is committed to ensuring the privacy and confidentiality of individually identifiable protected health information of our beneficiaries. Confidentiality is the responsibility of every Clover Health employee. Clover Health has developed and enforced confidentiality, privacy and security policies and processes to comply with applicable federal and state regulations including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA). All new and existing employees, other persons on Clover Health's workforce, and others, as determined by Clover Health, such as practitioners, are trained on the Clover Health privacy and confidentiality policies and procedures upon hiring, or upon appointment to a committee/work group. All external, non-employee members and guests of any Clover Health quality committee or work group are required to sign a confidentiality agreement annually regarding the confidentiality of member, provider and Clover Health information discussed and reported at any committee. Access to physical and

computerized files is limited to business need and such access is removed when an employee (or any other person working on Clover Health's behalf) terminates from Clover Health.

Clover Health Quality Improvement and Credentialing committee minutes are confidential and privileged. Minutes are maintained in confidential, secure files within the respective business Quality Improvement teams. In addition, documents containing member data are treated in a confidential manner.

Clover Health's Quality Improvement Program documents are subject to Clover Health's policies and procedures for handling confidential information and are confidential pursuant to state and federal statutes. All privacy and security policies and procedures are maintained and updated at least annually, and more often as regulatory requirements are updated by the Clover Health Compliance Director/Compliance Officer

w. In-Home Care Program

Clover Health offers its most complex members in New Jersey with frequent hospitalization for ambulatory care sensitive conditions, frailty, and advanced illness access to In-Home Primary care services at no additional charge. Many of these members are homebound. These services include in-home access to physicians, nurse practitioners, nurses, social workers, and medical assistants. Visits are up to 60 minutes in length and include both urgent visits and care transitions visits. Network providers can refer members to the In-Home Care program, as can Clover Health clinical staff. Members are also identified for In-Home Care using algorithms designed to identify members meeting program clinical criteria.

x. Supportive Care Program

Clover Health offers members with limited life expectancy access to additional supportive care services including social worker and nurse practitioner services in the home. Services include: (1) Care coordination, including communication of both urgent and chronic care needs to PCPs and other relevant specialists; (2) Financial and social services support; (3) Counseling and education of patients and families, including with regard to disease self-management and advanced care planning; (4) Management of pain and other symptoms causing suffering in physical, emotional, and spiritual domains. Network providers can refer members to the Supportive Care program, as can Clover Health clinical staff. Members are also identified for Supportive Care using algorithms designed to

identify members meeting program clinical criteria.

y. Claims Payment Processes

Clover Health's Quality Improvement program monitors claims payment processes, including turnaround time and volume of claims processed and claims adjusted through ongoing report monitoring by the Quality Improvement Committee. Clover Health also reviews the Office of Inspector General (OIG) disbarment reports in order to monitor provider eligibility for payment.

z. Health Information Systems

Clover Health integrates information from multiple data sources in order to maintain internal health information systems. Clover Health's health information includes the following data:

- Medical and behavioral health claims payment data;
- Enrollment/eligibility data;
- Prescription encounter data;
- Health risk assessment data;
- Chronic care improvement program data;
- Care coordination data;
- Medical management data;
- Complaints/appeals/grievances data;
- Credentialing data;
- Lab encounter data;
- Provider data;
- Customer service data;
- Member satisfaction/experience surveys.

Data is used in identification of opportunities for improvement, planning and implementation of Quality Improvement activities, and analysis of Quality Improvement activities. Quality Improvement Program data and documentation is maintained throughout the year and is available to CMS upon request for audit and quality program oversight purposes.

In compliance with CMS requirements, Clover Health participates in an independent annual data validation audit. The audit is conducted by a data validation contractor who is certified on the CMS required elements. Additionally, Clover Health contracts with an NCQA certified auditor for data validation annually for the HEDIS project as required to ensure that data reported is valid and reliable. Data quality issues that are identified through

Quality Improvement activities and oversight are addressed in order to improve data quality on an ongoing basis.

Clover Health follows established procedures for collecting and reporting data related to HEDIS, part C and D reporting, and CAHPS and HOS surveys to ensure accuracy, validity and reliability. These are covered earlier in this document under these topic areas.

13. Chronic Care Improvement Program

Clover Health offers a Chronic Care Improvement Program (CCIP) per Section 1852(e) of the Social Security Act which requires that Medicare Advantage organizations (MAO) have an ongoing Quality Improvement Program that includes a CCIP for each contract as described in 42 CFR §422.152(a)(2). For 2020, Clover Health is continuing its focus and work in 'Improving oral medication adherence in diabetics' for the CCIP.

The CCIP employs a continuum based approach to health care delivery and member education to achieve program goals. Clover Health identifies eligible members who may benefit from participation in the CCIP through its various data sources, such as medical and pharmacy claims, encounters, laboratory, or health risk assessments. Clover Health mines these and other data sources to identify members who meet defined eligibility criteria.

The CCIP serves to:

- Identify members with the chronic condition of diabetes;
- Support the relationship between physician and patient in the management of their medication adherence compliance;
- Identify red flag barriers to care that prohibit patient from adhering to their prescribed medication regimen and determine structural interventions to reduce barriers;
- Reduce cost of treatment for diabetes through the use of evidence-based practices and member empowerment.

Members who participate in the CCIP are monitored using quality improvement metrics specific to the CCIP. Clover Health utilizes the Plan-Do-Study-Act (PDSA) quality improvement model for the CCIP. The effectiveness of the CCIP will be evaluated through measurement of the following health outcomes for participants:

- Quality indicators

- Improved operational systems post-intervention to assess the effectiveness of its CCIP with intervention and processes modification, as necessary;

Clover Health conducts the CCIP as required by CMS. Areas for improvement may be mandated by CMS or identified from analysis of multiple data sources that are considered relevant to the chronic condition focus being studied, including HEDIS measures, Star measures, CAHPS and HOS surveys. Clover Health uses the designated CMS CCIP template for documentation, which includes a description of the basis for selection; anticipated outcomes; data sources; and program design (population identification, evidence based medicine, care coordination approach, education, outcome measures and interventions, rational, measurement methodology, timeline, and communication sources). Clover Health attests to CMS according to the required reporting timeframes. The Clinical Quality Improvement team is charged with providing regular reports to the Quality Improvement Committee on the progress of the CCIP.

Clover Health makes information on the status and results of ongoing projects available to CMS upon request. On an annual basis, Clover Health submits information to CMS attesting that the CCIP project is in progress and ongoing as well as any CCIPs to be implemented in the upcoming year.

14. Star Rating

Clover Health closely monitors performance on all Star Rating measures against CMS benchmarks. Through its work groups, Clover Health identifies areas for improvement, conducts root cause analysis to detect barriers to achieving performance goals and implement actions for improvement.

15. CMS Part C and Part D Reporting Requirements

Clover Health cooperates fully with all required regulatory reporting and external audits, including audits by CMS and their contractors. By cooperating with this reporting, Clover Health makes quality outcome measures available to CMS that will be used in Clover Health's Medicare Star ratings and enable members to compare health plan coverage options and select between them.

Based on the Medicare contract, Clover Health is required to submit data to CMS on a monthly, quarterly or annual basis related to its Part C and Part D contracts. Clover Health delegates reporting of some sections of Part C data to HealthEdge/Health and DentaQuest and reporting of Part D data to

CVS/Caremark and utilizes Clover Health data to report on Part C data generated and processed at Clover Health. Clover Health ensures that all its delegated vendors are knowledgeable in Medicare's technical specifications and have the processes in place to produce CMS' required reports. Clover Health closely monitors its delegated vendors' submissions through random sample audits and trend analysis, and monitors its internal reporting capabilities through random sample audits.

Clover Health's Compliance Department carefully reviews the Part C and Part D reporting requirements each year and works with the operational departments and delegated entities responsible for maintaining the source systems where the data reside. A standardized template and other supplemental documents are created and maintained, which carefully outline the programming codes used to extract data as well as the reporting, archiving and data validation processes. Each department/delegate gathers the data elements based on the Part C and D reporting requirements, then conducts data validation prior to submitting the data to the Compliance Team. The data is again reviewed for accuracy and submitted by the Compliance Team to CMS via HPMS. On an annual basis an external data validation audit is conducted by a CMS certified data validation contractor to ensure that Clover Health's reporting of Part C and Part D health and drug plan data that are reliable, valid, complete, comparable, and timely. Clover Health uses the CMS Data Validation Standards as a guide to develop and maintain a quality assurance process for all reporting measures. Every operational department/delegate conducts validation during each step of the data extraction and reporting processes. For example: The programming codes are tested against the Part C and D reporting technical specifications, then the final output is validated and attested to by the operational departments before submitting to the Compliance Team. Finally, the Compliance Department will validate for accuracy and assurance that the data elements represent CMS's reporting requirements prior to submission through HPMS.

Should any deficiency be identified through the Part C or D reporting requirements or the process for compiling those requirements, the Compliance Department immediately addresses that issue with the appropriate operational department. The root cause for the deficiency is identified, and a corrective action plan is implemented and monitored to ensure that the deficiency is resolved and does not recur.

16. Quality Improvement Program Documentation

Clover Health will store the Quality Improvement Program Description, applicable attachments and Medicare Advantage Quality Improvement Program Evaluations on the organizational Intranet site, Confluence, where it is available to all employees. This information will also be made upon request and during onsite audits. The Quality Improvement program description is also available to members and providers, upon request.

17. Approval

The Quality Improvement Program Description will be reviewed and approved by the designated Quality Improvement committees and the Clover Health Insurance Board Of Directors.

Committee Approval	**Approval Date**
Quality Improvement Committee	12/20/2019
Board of Directors	04/15/2020

Reviewed and approved for distribution

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Chairman, Board of Directors

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Date