2024

Provider Administrative Guide

CLEVER CARE HEALTH PLAN | 7711 Center Ave Suite 100 Huntington Beach CA 92647

Clever Care Health Plan, Inc.

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Table of Contents

Table of Contents

OVERVIEW

Clever Care Health Plan, Inc., (Clever Care) is a Medicare Advantage Plan offering services in various states via designated affiliates. Clever Care is a Delaware corporation, whose business address is 7711 Center Ave Suite 100 Huntington Beach CA 92647. Clever Care was formed to address the provision of quality healthcare and services to its Medicare Advantage members.

Purpose Statement

Clever Care offers Medicare benefits with a unique set of supplemental services which blend traditional and modern methods of care to nurture the physical, mental, and spiritual wellbeing of its members.

Vision and Mission

To become the preferred health insurance solution for members, providers, and communities.

Goals

- Provide the preferred benefits to our members
- Become the preferred partner to our providers
- Grow to 150,000 MAPD members in 5 years

Strategy

Clever Care strives to provide the preferred supplemental benefits of our members which may include:

- Eastern Medicine services including acupuncture, Ayurveda, moxibustion massage therapy, and herbal supplement services.
- Offering wellness plans such as tai-chi and yoga.

Clever Care intends to become the preferred partner of network Providers by:

- Minimizing Primary Care Provider prior authorization requirements
- Offering PCP bonus Incentive rewards for quality improvement
- Providing fast and accurate claims payment
- Collaboratively developing its network of providers
- Encouraging practice growth with new patient referrals.

Summary

Clever Care seeks to provide a Medicare Advantage product that provides a holistic approach to care which blends ancient and modern medical practices in its approach to the health, healing, and recovery of its members.

MEDICARE ADVANTAGE OVERVIEW

Clever Care is a Medicare Advantage Plan offering a unique set of supplemental benefits to create a more holistic approach to providing care to Medicare beneficiaries. Clever Care offers a vast network of providers contracted with Clever Care. As a participating provider in the Clever Care network, the participating agreement will have a Reimbursement exhibit in addition to an exhibit identifying the CMS Required Medicare Advantage Terms and Conditions.

Clever Care's network of participating providers is the key to successfully managing care and outcomes of our beneficiaries. Clever Care believes that the holistic approach to care will be most successful when contracted hospitals, physicians and care givers work collaboratively to integrate all aspects of care.

Clever Care believes in aligning its values with individual practice styles to extend the provision of culturally sensitive benefits to all patients in a way that earns provider loyalty and respect as a trusted health care partner. This administrative guide is intended to demonstrate Clever Care's commitment to sharing information with participating providers and their staff to facilitate participation as a network provider.

Clever Care invites all network providers to participate in its quality management and assurance committees. Committee meetings are scheduled at convenient times and locations to encourage attendance. Clever Care's efforts will only be successful with network provider participation. If you would like to participate or have any suggestions, comments, or questions, or if you are interested in learning more about specific policies, please feel free to contact the Provider Services team through our main number at (657) 224-1888 Participating provider involvement will help create an efficient and coordinated system that ensures Clever Care members receive only the highest quality care and services.

MEDICARE MEMBER AND ENROLLMENT INFORMATION

Medicare offers a variety of ways in which beneficiaries can receive health care services. Beneficiaries can receive care through the original Medicare program or can choose to receive care by enrolling as a member of a Medicare Advantage plan such as the one offered by Clever Care. Beneficiaries receive information in the fall of each year to inform them of their care options.

Medicare beneficiaries can enroll in Medicare Advantage plans like Clever Care during certain time periods called election periods. Important election periods are:

- Annual Election Period (AEP): The AEP occurs from October 15 through December 7 every year. Medicare beneficiaries can enroll in, disenroll from, or switch to a Medicare Advantage plan during this time. The effective date of the change is January 1 of the following year.

- Initial Enrollment Period (IEP): This is the period when an individual is first eligible to enroll in Medicare. It is a seven-month period that begins three months before the month a beneficiary turns 65, includes the month the beneficiary turns 65, and ends three months after the month the beneficiary turns 65. Generally, individuals will have an IEP that is the same period as the Initial Enrollment Period for Medicare Part B, a seven-month period that begins three months before the month the individual meets the eligibility requirements for Part B and ends three months after the month of eligibility. Based on your enrollment date, CMS will determine when coverage begins.

- Special Election Period (SEP): CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. If a beneficiary has Part A coverage and obtains Part b coverage for the first time during the General Enrollment period (between January 1, and March 31 of each year), the beneficiary can also join a Medicare Advantage Plan at that time with coverage that begins on July 1st.

Additionally, CMS can perform a retro-enrollment or retro-disenrollment in limited circumstances. Clever Care follows CMS directives on member enrollment and disenrollment dates; If retroactivity occurs, this may have an impact on claims payments.

Once CMS confirms the beneficiary becomes a member of Clever Care's Medicare Advantage Plan, eligibility information is entered into the Clever Care system. Clever Care sends a welcome packet to each new member to confirm their enrollment. The new member welcome packet includes:

- An ID Card
- Benefits Summary
- An Evidence of Coverage (EOC) document
- Information on the Clever Care Member Portal

The Clever Care identification card provided to the member will include information such as the member's name, member number and basic information about the member's benefits. Members will also be informed about the Clever Care Member Portal which provides electronic access to all their membership, claims information, and plan administrative information to ease their access to care and information about their benefits under Clever Care. All members should present their member ID cards whenever receiving services.

CLEVER CARE PLANS

Clever Care is a licensed health plan organization. Clever Care has contracted with CMS to provide a Medicare Advantage Plan offering culturally sensitive supplemental benefits to eligible Medicare beneficiaries effective January 1, 2024.

Please see the Summary of Benefits document online at www.clevercarehealthplan.com for more information.

Clever Care's Medicare Advantage plan is designed to:

- provide a Medicare Advantage product that addresses a holistic approach to health, healing, and recovery.

- encourage member wellness by promoting the use of yoga and tai chi in addition to other forms of exercise.

- supplements western medicine with traditional eastern medicine practices including acupuncture, Ayurveda, and herbal supplements to keep the body in a physically and mentally balanced state that encourages health and well-being.

The Provider Self-Service Portal

Clever Care uses the EZ-NET Provider Portal to give providers dedicated and secure web-based access to healthcare information, including claims, eligibility, and authorizations. The Provider Portal is located on the Clever Care website, https://eznet.clevercarehealthplan.com/ which contains a full complement of online provider resources. The website features an online provider inquiry tool to reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

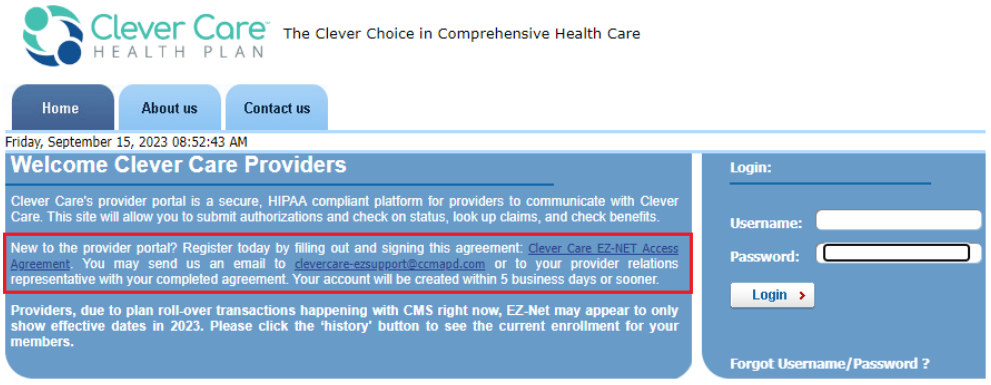
Online support services, such as:

- New user registration and activation, login, help, and username and password reset
- Forms to update provider demographics and information such as tax ID or group affiliation changes
- Provider panel reports
- Online daily PCP quality reports
- Hospital/inpatient admission, transfer and discharge reports
- Healthcare Effectiveness Data and Information Set (HEDIS) measures
- Interactive look-up tools and reference materials, such as:
    - Provider/referral directories
    - Member Eligibility Verification
    - Member Benefit Summaries
    - Prior-authorization submission and lookup tool for authorization history and approval status
    - Claims status submission and lookup tool
    - Reimbursement policies and related forms
    - Lookup procedures for COB, CPT codes, diagnosis codes and other general reference information
    - Provider administrative guides and quick reference cards (provider administrative guides are available two ways, via the provider website or through your local Provider Relations representative)

For support, email: clevercare-ezsupport@ccmapd.com or fax 657-276-4758

Clever Care also offers a dedicated Provider Services team to assist with prior-authorization and notification, health plan network information, member eligibility, claims information, and inquiries. The team can also accept any recommendations you may have for improving Clever Care processes and managed care programs. Additional information to assist providers in their day-to-day interaction with Clever Care is provided in the table below.

To register for the portal, open your preferred browser and follow this link: https://eznet.clevercarehealthplan.com/.



Quick Reference Information

Provider Services	Provider Portal: https://eznet.clevercarehealthplan.com/ Contact Provider Services at (562) 888-8801 Ext.3050
AT&T Relay Service	For English call 711
Prior-Authorization	May be submitted online, telephoned, or faxed to Clever Care: ▪ Telephone (714) 650-8770 ▪ Fax: (657) 276-4719 o Case Management: (714) 650-8770 o Home health, durable medical equipment, therapies, and discharge planning: (714) 650-8770 o Concurrent review clinical documentation: (714) 650-8770 o Behavioral health: (714) 650-8770 o Initial admission notifications and all other services: (714) 650-8770 Web: www.clevercarehealthplan.com • Data required for complete notification/prior authorization: o Member ID number o Legible name of referring provider o Legible name of individual referred to provider o Number of visits/services requested o Dates of service o Diagnosis o Current Procedural Terminology (CPT) code o Clinical Summary Documents • Notification is required o 14 days in advance for standard request o 3 days for expedited requests o **Please Call (714) 650-8770 for Expedited Requests** o Within one business day for all ER admits • Clinical staff are available during normal business hours from 8:00 a.m. to 5:00 p.m. PST Clinical information is required for prior-authorization (The Prior-authorization Request Form is also available online.)
Claims Submission: **Paper**	**Submit paper claims to:** **Clever Care Health Plan** **Attn: Claims Payment** **7711 Center Ave Suite 100** **Huntington Beach, CA 92647**
Claims Submission: **Electronic**	**Electronic Claims Payer ID:**

Clearinghouse	Payer Number
Office Ally	**CC168**
Office Ally Encounters	**CC16E**

Quick Reference Information	
	For help with claims and encounter submissions, contact the respective Clearinghouse. Timely filing is governed by the terms of the provider agreement.
Eligibility Verification	Clever Care provides an online resource designed to significantly reduce the time your office spends on eligibility verification, claims status and prior-authorization status at- https://eznet.clevercarehealthplan.com/ If you are unable to access the Internet, you may receive claims, eligibility, and prior-authorization status over the telephone at any time by calling our automated Customer Services number at the toll-free at (833) 388-8168
National Provider Identifier	**National Provider Identifier (NPI) –** The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique provider identifier for health care providers. All Clever Care participating providers must have an NPI number. The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care providers, such as the state in which they practice or their specialty. • Providers can apply for an NPI by completing an application. Online at https://nppes.cms.hhs.gov (Estimated time to complete NPI application is 20 min) • By downloading a paper copy at https://nppes.cms.hhs.gov. **Please send your NPI to:** **Clever Care Health Plan, Inc.** **Attention: Medical Necessity Provider Appeals** **7711 Center Ave Suite 100** **Huntington Beach CA 92647**
Medicare Advantage Participating Provider Appeals and Disputes	Medicare appeals are determined by the liable party, not by the initiator. The time frame to review your request will commence once your appeal is routed to the appropriate department. Please refer to the denial letter or Explanation of Payment (EOP) issued to determine the correct appeals process. **Medicare Participating Provider Standard Appeal** A formal request for review of a previous Clever Care decision where a determination was made with Provider liability was assigned (see original decision letter). **Clever Care Health Plan, Inc.** **Attention: Appeals Dept** **7711 Center Ave Suite 100** **Huntington Beach CA 92647** **Medicare Provider Payment disputes (Claims Re-review)** A formal request from a Provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial. **Clever Care Health Plan, Inc.**

Quick Reference Information	
	Attention: Medicare Payment Dispute Unit **7711 Center Ave Suite 100** **Huntington Beach CA 92647**
Medicare Member Appeals	Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or EOP issued to determine the correct appeals process to follow. All Medicare member liability appeals should be sent to: **Clever Care Health Plan, Inc,** **Attention: Appeals Dept** **7711 Center Ave Suite 100** **Huntington Beach CA 92647** A physician's signature is required on all appeals submitted on behalf of a member; otherwise, an Appointment of Representative form (AOR) is required. **EXPEDITED APPEALS** In the event that failure to provide the service is life- or limb-threatening or that waiting the standard appeal time frame would be harmful to the member, an expedited or fast appeal can be initiated by contacting us in one of the following ways: Medicare Complaints, Appeals and Grievances Department **Clever Care Health Plan, Inc.** **Attention: Appeals Dept** **7711 Center Ave Suite 100** **Huntington Beach CA 92647** **Phone: 1- 833-283-9888** **Fax: 1-657-276-4715** Please indicate if you are requesting an expedited appeal.
Provider Service Representatives	For more information, contact Provider Services at (562) 888-8801 ext. 3050 or your local Provider Relations representative.

Ongoing Provider Communications and Feedback

To ensure providers are up to date with information required to work effectively with Clever Care and our members, Clever Care provides frequent communications to providers in the form of broadcast faxes, Provider Administrative Guide updates, newsletters, and information posted to the Provider Portal on the Clever Care website.

PARTICIPATING PROVIDER INFORMATION

The Medicare Advantage Provider Network

Clever Care members obtain covered services by choosing a Primary Care Provider (PCP) who is part of the Clever Care network to coordinate their care. Members are encouraged to coordinate with their PCP

before seeking care from a specialist. PCPs may refer Members to a specialist for care as needed, and except for inpatient admissions or out of network care, they are not responsible for requesting prior authorizations for specialty care and services. Members may also self-refer for some specified services (routine and preventive care) for which no prior authorization is required. Members are encouraged to inform their PCP of their specialist and other self-referrals and to share related records with their PCP.

Except with respect to emergency services or any other services specifically set forth in this Provider Administrative Guide, Provider shall not refer a Member to an out-of-network provider for any Covered Services without first securing Clever Care's prior authorization in accordance with this Clever Care guidelines. Should a Provider fail or refuse to comply with the referral procedures set forth in the Provider Administrative Guide, Clever Care may, in addition to any other right or remedy under the Provider Agreement, retain from any amounts owed to Provider by Plan, amounts paid by Plan for such referred services to the other providers.

The Provider shall use his/her best efforts, consistent with sound medical practice, to refer Members only to Clever Care Network Providers for Covered Services. Provider shall ensure that appropriate case management and continuity of care between Provider and other respective health care providers and agencies to which Member may be referred is maintained.

Providers may not admit a member to a hospital, on a non-emergency basis, without first receiving prior authorization of Clever Care in accordance with this Provider Administrative Guide. Providers shall use his/her best efforts, consistent with sound medical practice, to admit Members only to Clever Care Network-designated hospitals for Covered Services.

Selecting a participating provider within the Clever Care Network will maximize the members' benefit and minimize their out-of-pocket expenses. If you need help finding a participating network provider, the Member Services prior authorization team is available to assist you. Please call Member Services 1-657-224-1888 for assistance.

Providers who believe they must refer a member to a provider outside of the Clever Care Network, must notify the Clever Care Member Services prior authorization team in advance of that request so assistance can be provided for the coordination of services for this Member. Failure to initiate this request may result in claims, denials, and member liability. However, this does not apply to urgent or emergency services. Please refer to the Prior-authorization requirements.

The Primary Care Provider Role

Members are required to select a PCP when enrolling in the Clever Care Plan and may request a change to their selected PCP at any time. Member-requested PCP changes will become effective the first day of the following month except in extenuating circumstances. Clever Care contracts with certain physicians that members may choose as their PCPs and some PCPs may be individual practitioners associated with a contracted medical group or an independent practice association.

Clever Care participating PCPs are generally physicians of internal medicine, family practitioners, gerontology, general practitioners, pediatricians, or obstetricians/gynecologists. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may also be designated as PCPs.

The PCP is a network physician who has responsibility for the complete care of his or her members, whether providing care directly or by referral to the appropriate provider of care within the network. The PCP, however, is NOT responsible for obtaining prior authorization for the referred covered services for members unless the referral is to a nonparticipating provider.

When coordinating member care, the PCP should refer the member to a participating provider within the Clever Care Network. To assist the specialty care provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialist

Any referral to a nonparticipating provider will require prior authorization from Clever Care or the services may not be covered. Contact Member Services at (833) 388-8168for questions or more information.

The Specialist Role

A specialist is any licensed provider (as defined by Medicare) providing specialty medical services to members. A PCP may refer a member to a specialist when medically necessary. Specialists must obtain prior authorization from Clever Care before performing certain procedures or when referring members to nonparticipating providers. Please refer to the Summary of Benefits or Evidence of Coverage documents for those procedures requiring prior authorization. You can review prior-authorization requirements online in the Provider Portal (https://eznet.clevercarehealthplan.com/) or call (714) 650-8770 for assistance.

After performing the initial consultation with a member, a specialist should:

- Communicate the member's condition and recommendations for treatment or follow-up care with the PCP
- Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan and any other pertinent information.
- If the specialist needs to refer a member to another provider, the referral should be to another Clever Care Network participating provider. Any referral to a nonparticipating provider will require prior authorization from Clever Care. Please refer to Prior authorizations.

Specialist as a PCP

In some cases, a specialist, physician assistant, nurse practitioner or certified nurse midwife under physician supervision may be a PCP. Specialists serving as a PCP must be authorized by the Clever Care's Case Management Department. Requirements and exceptions may vary by location or market. If you have any questions, contact the Provider Services. To download a copy of the Specialist as a PCP Form, go to www.clevercarehealthplan.com and click on Forms under Provider Resources & Documents.

Participating Provider Responsibilities

- Manage the medical and health care needs of Members, including monitoring and following up on care provided by other providers, providing coordination necessary for services provided by specialists and ancillary providers (both in and out-of-network), and maintaining a medical record that meets Clever Care standards.
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to members.
- Provide all services ethically, legally and in a culturally competent manner, and meeting the unique needs of members with special health care needs.

- Participate in the systems established by Clever Care to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements.
- Make provisions to communicate in the language or fashion primarily used by his or her assigned members.
- Provide hearing interpreter services upon request to members who are deaf or hard of hearing.
- Participate in and cooperate with Clever Care in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Clever Care.
- Comply with Medicare laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist, and provide information as requested, and maintain records for a minimum of 10 years.
- Participate in and cooperate with the Clever Care appeal and grievance procedures.
- Agree to not balance bill Members for monies that are not their responsibility or that should be paid for by another carrier (in the case of a dually eligible Members covered both by Medicare and Medicaid, federal law requires providers to bill only the Member's health plan or the state Medicaid agency for copayments or other cost-sharing amounts. Providers may not bill such members for cost sharing.)
- Continue care in progress during and after termination of a member's contract for up to sixty (60) days, or such longer period of time required by state laws and regulations, until a continuity of service plan is in place to transition the Member to another network provider or through the completion of care, or postpartum care for pregnant members in accordance with applicable state laws and regulations.
- Comply with all applicable federal and state laws regarding the confidentiality of patient records.
- Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens.
- Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act of 1990 (ADA).
- Support, cooperate and comply with Clever Care Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner.
- Inform Clever Care if a member objects to the provisions of any counseling, treatments, or referral services for religious reasons.
- Treat all members with respect and dignity, provide appropriate privacy, and treat member disclosures and records confidentially, giving members the opportunity to approve or refuse their release.
- Provide members with complete information concerning their diagnosis, evaluation, treatment, and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons.
- Advise members about their health status, medical care, or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered.
- When clinically indicated, contact members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings.
- Have a policy and procedure to ensure proper identification, handling, transport, treatment, and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection.
- Agree to maintain communication with the appropriate agencies such as local police, social services agencies, and poison control centers to provide high-quality patient care.
- Agree any notation in a member's clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of non-research-related care.

- Participate in the interdisciplinary care team meetings when necessary.
- If a member self-refers or a provider is referring to another provider, that provider is responsible for checking the Clever Care Network participating provider directory to ensure the specialist is in the Network. Referrals to Clever Care Network-contracted specialists may require prior-authorization, all referrals to non-participating providers outside the Clever Care Network require prior-authorization unless urgent or emergent services are needed. Some procedures performed by specialist physicians may require prior authorization. Please refer to the Summary of Benefits document for procedures that require prior authorization or call Member Services at (833) 388-8168. If you cannot locate a specialty provider in the Clever Care Network, contact Member Services at (833) 388-8168 for assistance. Authorization must be obtained from Clever Care before referring members to nonparticipating out-of-network providers. Additionally, certain services/ procedures require prior authorization from Clever Care.
- Provide advanced notification to members for services not covered by Clever Care or Medicare in accordance with Medicare requirements. Please refer to Prior authorizations.

Note: Clever Care does not cover the use of any experimental procedures or experimental medications, except under certain circumstances.

Care Transition Protocols and Management

Assisting with the management of care transitions is an important part of the Clever Care Case Management Program. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and includes changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the members with successful transitions. The Clever Care Case Management team is available to assist. Please contact (714) 650-8770 for assistance.

Care Transition Protocols

Transitional care management includes a comprehensive set of protocols that include logistical arrangements, providing education to the member and care giver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the member. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with goal of providing access to high quality, cost-effective medical care.

Personnel Responsible for Coordinating Care Transition

Managing transitions of care is the responsibility of the interdisciplinary care team (ICT). The composition of the team varies based on the complexity of the member's needs, the desires of the member and type of transition. The team consists of providers (including other case managers or social workers), the member and/or caregiver, and members of the Care Management team.

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The primary care provider (PCP) is responsible for coordinating and arranging referrals to the appropriate care provider. The provider network includes providers who have expertise in managing the health care needs of all members. Some of the provider types available in the network to manage the needs of members include but are not limited to:

- Geriatricians, physical medicine physicians and physiatrists
- Behavioral health providers and facilities
- Skilled nursing facilities
- Ancillary providers and facilities
- Cardiologists
- Endocrinologists
- Diabetic educators
- Dialysis centers
- Social workers and nursing professionals available through home health agencies

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the member.

When a member experiences a transition in care, it is the responsibility of the transferring provider to do the following:

- Notify the member in advance of a planned transition.
- Provide documentation to the provider or facility about the member to assist in providing continuity of care.
- Communicate and follow up with the member about the transition process.
- Communicate with the member about his or her health status and plan of care to prevent any gaps post transition.
- Provide a treatment plan or discharge instructions to the member prior to being discharged from one level of care to another.
- The referring physician or provider should provide the relevant patient history to the receiving provider.
- Any pertinent diagnostic results should be forwarded to the receiving provider.
- The receiving provider should communicate a treatment plan back to the referring provider.
- Any diagnostic test results ordered by the receiving provider should be communicated to the referring provider.

Clever Care assists members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent how case managers may work with providers and members to coordinate care and assist in the management of transitions:

- Communicates with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments.
- Arranging transportation
- Refer to external or internal programs.
- Coordinate care with behavioral health
- Arrange durable medical equipment (DME) and home health services.
- Coordinate and facilitate transitions to the appropriate level of care.
- Provide the member with disease specific education and self-management techniques.
- Contact members post discharge to reduce unnecessary readmissions.
- During interactions with the members, communicate support is available from Member Services to serve as a central point of contact and assist during any transition.

Enrollment and Eligibility Verification

All health care providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once a month for ongoing services. In an emergency, eligibility should be determined as soon as possible after the member's condition is stabilized. When a patient presents as a member, providers must verify eligibility, enrollment, and coverage by performing the following steps:

- Request the member's Clever Care Medicare ID card; if there are questions regarding the information, call Customer Service at the (833) 878-1704 to verify eligibility, deductibles, coinsurance amounts, copayments and other benefit information or use the online provider inquiry tool at www.clevercarehealthplan.com
- Copy both sides of the member's Clever Care Medicare ID card and place the copies in the member's medical record.
- Determine if the member is covered by another insurance or health plan to record information for coordination of benefits purposes.
- If you are a PCP, check your Clever Care Member Panel Listing via the Clever Care Provider portal to ensure assignment as the member's doctor.
- If the patient does not have an identification card, use the online provider inquiry tool at https://eznet.clevercarehealthplan.com/ or call Customer Service at (833) 388-8168.

Member Missed Appointments

Members may cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. Clever Care requires providers to attempt to contact members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the members about the importance of keeping appointments and to encourage the member to reschedule the appointment. Clever Care's goal is for members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

Noncompliant Clever Care Medicare Members

Clever Care recognizes providers may need help in managing non-compliant members. If you have an issue with a member regarding behavior, treatment cooperation, completion of treatment and/or not making or appearing for appointments, call Customer Service at (833) 388 8168.
A Member or Provider Services representative will contact the member by telephone, or a member advocate will visit the member to provide education and counseling to address the situation and will report the outcome of any counseling efforts to you.

Second Medical or Surgical Opinion

Members may request a second opinion if they:

- Dispute the reasonableness of a decision.
- Dispute the necessity of a procedure decision.
- Do not respond to medical treatment after a reasonable amount of time.

To receive a second opinion, members must:

- Obtain a second opinion from a provider within the Clever Care participating provider network.
- Be responsible for the applicable copayment.

Our Member Services staff at (833) 388-8168 can assist members and providers with identifying a participating provider for obtaining a second opinion.

Access and Availability

Participating providers must:

- Provide coverage for members 24 hours a day, 7 days a week.
- Ensure another on-call network provider is available to administer care when the PCP is not available.
- Not substitute hospital emergency rooms or urgent care centers for covering providers
- See members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment.
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility.

Access and Availability Standards Table

Type of Appointment (Medical or Behavioral)	Availability Standard
Patient Visit with Primary Care Provider	Within 10 business days
Specialist Appointment	Within 15 business days
Mental Health Provider not an MD	Within 10 business days
Appointment for other services to diagnose or treat a health condition	Within 15 business days
Urgently Needed Services **No** prior authorization required	Within 48 hours
Urgently Needed Services-Prior Authorization Required	Within 96 hours
Emergency	Immediately

Appointments for **urgent** medical or behavioral health care services shall be provided:

a. Within forty-eight (48) hours of a request for medical or behavioral health care services that do not require prior authorization.
b. Within ninety-six (96) hours of a request for medical or behavioral health care services that do require prior authorization.

Appointments for **non-urgent** care services shall be provided:

a. Within seven (7) days post discharge from an inpatient behavioral health admission for follow-up behavioral health treatment.
b. Within ten (10) business days for initial outpatient behavioral health treatment.
c. Within fifteen (15) business days of a request for ancillary services for the diagnosis or treatment of injury, illness, or other health condition.
d. Within ten (10) business days of a request for a primary care appointment.
e. Within fifteen (15) business days a request for a specialist appointment after the appropriate referral is received by the specialist.

After-Hours (PCPs ONLY):

The PCP provides, or arranges for, coverage of services, consultation, or approval for referrals twenty-four hours per day, seven days per week (24/7). After-hours coverage must be accessible using the medical office's daytime telephone number. After-hours coverage shall consist of an answering service, call forwarding, provider call coverage, or other customary means approved by Clever Care. The chosen method of 24/7 coverage must connect the caller to someone who can render a clinical decision or reach

the PCP for a clinical decision. A message directing the patient to hang up and call 911 or go to the nearest emergency room should also be included.

After hours Appointment Availability:

Clever Care monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the medical director for educational and/or counseling opportunities and are tracked for provider recredentialing. All providers and hospitals are expected to treat Clever Care plan members with the same dignity and consideration as afforded to their non-Medicare patients.

Covering Physicians

During a provider's absence or unavailability, the provider must arrange for coverage for his or her members. The provider will either: (i) make arrangements with one or more Clever Care network providers to provide care for his or her members or (ii) make arrangements with another similarly licensed and qualified non-network provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the members in question. In addition, the covering provider will agree to the terms and conditions of the network provider agreement, including any applicable limitations on compensation, billing, and participation. Providers will be solely responsible for a non-network provider's adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network provider providing substitute coverage to a Medicare member on the provider's behalf.

Reporting Changes in Address and/or Practice Status

Any changes in a provider's address and/or practice status can be submitted to Provider Relations at provider@ccmapd.com or reported to your local Clever Care Provider Relations Representative.

Clever Care Medicare Plan-specific Termination Criteria

The occurrence of any of the following is grounds for immediate termination of the Clever Care Professional Services Participation Agreement or an individual Provider:

- Provider's state or federal license or certificate to administer controlled substances is denied, modified, reduced, restricted, suspended, revoked, placed on provisional or probational status, or terminated (either voluntarily or involuntarily).
- Provider's authority to do business or other applicable license or accreditation necessary to perform any services contemplated by the Agreement is denied, modified, reduced, restricted, suspended, revoked, placed on provisional or probational status, or terminated (either voluntarily or involuntarily), including by a state or other governmental agency.
- Provider is no longer Medicare-eligible, Medicaid-eligible, or eligible to participate in any other government program.
- Provider's hospital medical staff privileges are denied, modified, reduced, restricted, suspended, revoked, or terminated (either voluntarily or involuntarily), except this does not include temporary suspensions of fewer than 31 days, which are imposed solely because of Provider's failure to timely complete medical records.
- Provider resigns during a hospital investigation related to Provider's medical staff privileges.
- Provider's professional liability coverage as required under the Agreement is reduced below required amounts or is no longer in effect.
- At any time, Provider fails to meet Plan's credentialing or re-credentialing, quality management or utilization management criteria, or fails to comply with Clever Care policies and procedures communicated to Provider, including this Provider Operating Guide also known as Provider Administrative Guide.

- Provider fails to provide material information or provides erroneous information on a credentialing or re-credentialing application.
- CMS or Clever Care makes a reasonable and good faith determination that such termination is necessary in order to protect the health, safety, or welfare of Members.
- Provider ceases to actively perform its business or dissolves.
- Provider is unable to pay its debts in the ordinary course of business.
- Provider files a petition in bankruptcy or an involuntary petition is filed against Provider which is not dismissed within 45 days of the filing.
- CMS or the state Department of Insurance or other state or federal agency with jurisdiction over Clever Care or Provider determines that it is improper for Provider to provide services in accordance with this Agreement and the parties cannot agree on an acceptable amendment to this Agreement within a time frame acceptable to the applicable state or federal agency or within 15 days after the determination of the agency, whichever is sooner;
- Provider pleads guilty or nolo contendere to or is convicted of any crime or is placed in a diversion program relating to the payment or provision of health care; or
- Provider is arrested on felony charges and Clever Care makes a reasonable and good faith determination that the nature of the charges is such that termination is necessary to avoid unnecessary risk of harm to Members that could occur during the pendency of the criminal proceedings.
  If Provider is a professional corporation, limited liability company, partnership, independent physician association or network and one of the events listed above occurs with respect to one or more individual shareholders, partners, employees, or contract Providers, the Agreement may be continued if Provider prohibits the affected individual(s) from providing services under this Agreement.
- Expiration or failure to renew Board Certification, as applicable.
- Appearance on Medicare Opt Out Provider listing.
- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the provider due to acts of omission or commission.
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the provider's office relative to inadequate access or other related issues that might cause a member injury.
- An office that is improperly kept, unclean or does not present a proper appearance.
- Failure to meet OSHA guidelines.
- Failure to meet ADA guidelines.
- Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines.
- Customer satisfaction ratings that drop below pre-established standards as determined by the Quality Management and Assurance Committee (QMAC) (this would include complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation, and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see Sanctioned Providers)
- Unfavorable inpatient- or outpatient-related indicators:
  - Severity-adjusted morbidity and mortality rates above established norms
  - Severity-adjusted length-of-stay above established norms.
  - Unfavorable outpatient utilization results
  - Consistent inappropriate referrals to specialists
  - Improper maintenance of high-risk patients, such as those members with diabetes and

hypertension
- Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community.
- Unfavorable malpractice-related issues
- Frequent litigious activity above and beyond what would be expected for a provider in that particular specialty.

Clever Care Network providers have 30 calendar days to appeal a termination. The Clever Care process is designed to comply with all state and federal regulations regarding the termination appeal process.

Incentives and Payment Arrangements

Financial arrangements concerning payment to providers for services to members are set forth in each provider's professional services participation agreement with Clever Care. Clever Care may also use financial incentives to reward providers for achieving certain quality indicator levels.

Clever Care does not use or employ financial incentives that would directly or indirectly induce providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Clever Care approves provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or with CMS Medicare Advantage regulations.

Laws Regarding Federal Funds

Payment's providers receive for furnishing services to members are derived in whole or part from federal funds. Therefore, providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the False Claims Act (32 USC 3279,et seq.); the Anti-Kickback statute (Section 1128B(b) of the Social Security Act); and the HIPAA Administrative Simplification Rules at 45 CFR Parts 160,162, and 164.

Prohibition Against Discrimination

Neither Clever Care nor its contracted providers may deny, limit, or condition the coverage or furnishing of services to members on the basis of payor source, race, color, creed, gender, religion, age, national origin (including those with limited English proficiency) ancestry, marital status, veteran status, sexual orientation or preference or any factor related to health status, including but not limited to the following:

- Medical condition including mental as well as physical illness.
- Utilization of Medical or Mental Health services or supplies
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
- Or Other unlawful basis including without limitation the filing by a member of any complaint, grievance, or legal action against the Provider or Clever Care.

Providers are expected to consider a member's literacy and culture when addressing Members and their concerns.

Provider Panel — Closing a Panel

When closing a provider panel to new Clever Care members or other new patients, providers must:

- Give Clever Care ninety (90) days prior written notice, via Provider Relations or submission using the online portal/provider website, the provider panel is closing to new members as of a specific closing date and accept new members until that closing date.
- Keep the provider panel open to members who were patients of that practice before the panel closed or before they were enrolled with Clever Care.
- Close the provider panel uniformly to all new Medicare patients, including all private payers and commercial or governmental insurers with whom the practice participates.
- Give Clever Care prior written notice when reopening the provider panel, including a specific reopening date.

Provider Panel — Transferring and Terminating Members

Clever Care will determine reasonable cause for transferring a member based on written request and documentation submitted by the provider. Providers may not transfer a member to another provider due to the costs associated with the member's covered services.

A provider may request termination of a member due to fraud, disruption of medical services or the member's repeated failure to make the required reimbursements for services. In such cases, the provider should contact Provider Services at (562) 888-8801 ext. 3050.

Reporting Obligations — Cooperation in Meeting CMS Requirements

Clever Care is required to provide information to CMS necessary to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise their choice in obtaining Medicare services.

Clever Care provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in Clever Care the previous two years).
- Information on member satisfaction.
- Information on health outcomes.

Providers must cooperate with Clever Care in its data reporting and audit obligations by providing Clever Care with any information required to meet these obligations in a timely fashion.

If an IPA fails to meet its reporting or audit obligations and a deficiency or issue is identified, Health plan will notify the IPA in writing, outlining the area(s) of deficiency and requesting the implementation of a Corrective Action Plan within a specified time frame, not to be less than thirty (30) calendar days. Failure on the IPA's part to fully correct the deficiency or issue within the specified timeframe, may lead to the imposition of a sanction(s). Sanctions may be imposed in a manner consistent with the impact of the deficiency on Members:

a. Exigent Sanctions. If any sanctions are deemed necessary because there is an immediate threat to the health of Health plan Members or access to Health Services, the Health plan can unilaterally impose sanctions, effective immediately without prior notice or opportunity to correct, as described pursuant to Section 7.2 and 7.5 of the IPA Agreement, Term and Termination and Article V of the Specialty Agreement, Term and Termination.

b. Non-exigent Sanctions. If any sanctions are deemed necessary because an administrative, financial, clinical and/or other issue, which does, or threatens to, seriously and adversely, impact Member care or access to care or Health Services, a sanction as described pursuant to Section 7.3

of the IPA Base Agreement, Term and Termination; Breach & Cure and Section 5.3 of the Specialty Agreement, Breach & Cure may be imposed.

Disciplinary Action and Termination. IPA acknowledges and agrees that under the Agreement, Health plan has the right to impose the sanctions set forth herein singly or in any combination:

a. De-delegation. Health plan may de-delegate a function assigned to the IPA that has led to an administrative, financial, clinical and/or other issue which does, or threatens to, seriously and adversely impact Member care or access to care or Health Services. In addition to de-delegating a function, Health plan will reduce the IPA's capitation payment based upon Health plan's costs associated with performing the previously delegated function. See Attachment C (Compensation), Section B (Delegated Activities Deductions) of Agreements.
b. Monetary Sanctions. Health plan may impose monetary sanctions for performance deficiencies or issues, in the same manner as provided in law, regulation for non-performance or non-compliance of contractual or regulatory requirements, which may be deducted from capitation payments at the discretion of Health plan. See Attachment C (Compensation), Section A (second paragraph) of Agreements.
c. Termination of Contract for Cause. The Agreement between the IPA and Health plan may be terminated for cause. See IPA base Article 7 of the IPA Base Agreement, Term & Termination and Section 5.3 of the Specialty Agreement.

Reporting Obligations — Certification of Diagnostic Data

Clever Care is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a member and provider, supplier, physician, or other practitioner (encounter data). Providers that furnish diagnostic data must certify (to the best of their knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Reporting Obligations — Authorization Submission

Clever Care has been working on streamlining the Authorization submission that we receive from our IPA's or Groups. To optimize the Authorization submission process, IPAs or Groups are required to submit Authorizations to Clever Care weekly in the file format specified HIPPA Compliance 278 or alternate format provided by Clever Care and upload it to the SFTP site.

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies, and procedures that come together in a system or agency or among professionals. Cultural competency assists providers and members to:

- Acknowledge the importance of culture and language.
- Assess cross-cultural relations.
- Embrace cultural strengths with people and communities.
- Strive to expand cultural knowledge.
- Understand cultural and linguistic differences.
- The quality of the patient-provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her provider and to adhere to recommended treatment.

Some of the reasons that justify a provider's need for cultural competency include but are not limited to:

- The perception that illness and disease and their causes vary by culture.

- The diversity of belief systems related to health, healing and wellness are very diverse.
- The fact that culture influences help-seeking behaviors and attitudes toward health care providers.
- The fact that individual preferences affect traditional and nontraditional approaches to health care.
- The fact that patients must overcome their personal biases within health care systems.
- The fact that health care providers from culturally and linguistically diverse groups are under-represented in the current service delivery system.

Cultural barriers between the provider and member can impact the patient-provider relationship in many ways, including but not limited to:

- The member's level of comfort with the practitioner and the member's fear of what might be found upon examination.
- The differences in understanding on the part of diverse consumers in the United States health care system.
- A fear of rejection of personal health beliefs.
- The member's expectation of the health care provider and of the treatment.

To be culturally competent, Clever Care expects providers serving members within their geographic locations to demonstrate the following:

Cultural Awareness

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior.
- The ability to modify one's own behavioral style to respond to the needs of others, while at the same time maintaining one's objectivity and identity.

Cultural Knowledge

- Culture plays a crucial role in the formation of health or illness beliefs.
- Culture is generally behind a person's rejection or acceptance of medical advice and treatment.
- Different cultures have different attitudes about seeking help.
- Feelings about disclosure are culturally unique.
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups.
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups.
- Resources such as formally trained interpreters should be offered to and used by members with various cultural and ethnic differences.

Cultural Skills

- The ability to understand the basic similarities and differences between and among the cultures of the persons served.
- The ability to recognize the values and strengths of different cultures.
- The ability to interpret diverse cultural and nonverbal behavior.
- The ability to develop perceptions and understanding of other's needs, values and preferred means of having those needs met.
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions.
- The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding.
- The ability to withhold judgment, action or speech in the absence of information about a person's

culture.

- The ability to listen with respect.
- The ability to formulate culturally competent treatment plans.
- The ability to use culturally appropriate community resources.
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters.
- The ability to treat each person uniquely.
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues.
- The ability to seek out information.
- The ability to use agency resources.
- The capacity to respond flexibly to a range of possible solutions.
- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process.
- The willingness to work with clients of various ethnic minority groups.

Marketing

Providers may not develop or use any materials that market Clever Care or the Clever Care plans without Clever Care's prior written approval. Under Medicare Advantage program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, providers can have plan marketing materials in their office as long as marketing materials for all plans the providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the Clever Care plans as long as the provider displays posters or notifications from all Medicare plans in which they participate.

Americans With Disabilities Act Requirements

The Clever Care policies and procedures are designed to promote compliance with the ADA. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair.
- Access to a lavatory that accommodates a wheelchair.
- Elevator or accessible ramp into facilities.
- Handicap parking clearly marked unless there is street side parking.
- Street-level access.

FIRST LINE OF DEFENSE AGAINST FRAUD AND ABUSE

General Obligation to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, Clever Care has a duty to help prevent, detect, and deter fraud, waste, and abuse. Clever Care is committed to detecting, mitigating, and preventing fraud, waste and abuse as outlined in its Corporate Compliance Program. As part of the requirements of the federal Deficit Reduction Act, each provider is required to adopt Clever Care policies on detecting, preventing, and mitigating fraud, waste, and abuse in all the federally and state funded health care programs in which Clever Care participates.

The Clever Care policy on fraud, waste and abuse prevention and detection is part of the Clever Care Corporate Compliance Program. Electronic copies of this policy and Clever Care Code of Business Conduct and Ethics can be found on the website at www.clevercarehealthplan.com.

Clever Care maintains several ways to report suspected fraud, waste, and abuse. As a Medicare Advantage provider and a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste, and abuse. To report suspected fraud, waste or abuse to the Clever Care Health Plan providers can access the Clever Care Confidential Fraud hotline at (833) 217-8645 or send an email to fwa@ccmapd.com. Providers also have the option to report online at https://clevercarehealthplan.com/report-fraud-waste-and-abuse/report-fraud-waste-and-abuse-form/.

To meet the requirements under the Deficit Reduction Act, you must adopt the Clever Care fraud, waste and abuse policies and distribute them to any staff members or contractors who work with Clever Care. If you have questions or would like more details concerning the Clever Care fraud, waste and abuse detection, prevention, and mitigation program, please contact the Clever Care Chief Compliance Officer.

Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste, and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibit fraudulent acts, including detection, prevention, investigation, and reporting. In this section, Clever Care educates providers on how to help prevent member and provider fraud by identifying the different types as the first line of defense.

Many types of fraud, waste and abuse have been identified, including the following:

Provider Fraud, Waste and Abuse

- Billing for services not rendered.
- Billing for services that were not medically necessary.
- Double billing
- Unbundling
- Upcoding

Providers can prevent fraud, waste, and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

Member Fraud, Waste and Abuse

- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

To help prevent fraud, waste and abuse, providers can educate members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent member fraud is as simple as reviewing the Medicare member ID card. It is the first line of defense against fraud. Clever Care may not accept responsibility for the costs incurred by providers rendering services to a

patient who is not a Clever Care member, even if that patient presents a Medicare member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage members to protect their cards as they would like a credit card or cash, carry their Clever Care member ID card at all times, and report any lost or stolen cards to Clever Care as soon as possible.

Clever Care believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with members to protect their Clever Care ID card can help prevent fraud, waste, and abuse. Clever Care encourages its members and providers to report any suspected instance of fraud, waste and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and Clever Care will make every effort to maintain anonymity and confidentiality.

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum Bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in health care fraud and simplifies the administration of health insurance.

Clever Care strives to ensure both Clever Care and contracted participating providers conduct business in a manner that safeguards patient/member information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the HIPAA privacy regulations.

Clever Care recognizes its responsibility under the HIPAA privacy regulations to only request the minimum necessary member information from providers to accomplish the intended purpose. Conversely, providers should only request the minimum necessary member information required to accomplish the intended purpose when contacting Clever Care. However, please note the privacy regulations allow the transfer or sharing of member information, which may be requested by Clever Care to conduct business and make decisions about care such as a member's medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need member information to perform their jobs. When faxing information to Clever Care, verify the fax number receiving is correct, notify the appropriate staff at Clever Care and verify the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing member information to Clever Care (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box, or department at Clever Care.

The Clever Care voicemail system is secure, and password protected. When leaving messages for Clever Care associates, providers should only leave the minimum amount of member information required to accomplish the intended purpose.

When contacting Clever Care, providers should be prepared to verify their name, address and Tax Identification Number or National Provider Identifier number.

MEDICAL RECORDS

Requirements Overview

Clever Care Network providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews.
- In conformity with good professional medical practice and appropriate health management
- Located at the primary care site for every Clever Care member.
- Kept in accordance with Clever Care and state standards as described in this administrative guide.
- Retained for 10 years from the final date of the contract or from the date of completion of any audit.
- Accessible upon request to Clever Care and/or downstream entities, any state agency, and the federal government

Clever Care will:

- Systematically review medical records to ensure compliance with standards. The health plan's Quality Management Committee oversees and directs Clever Care in formalizing, adopting, and monitoring guidelines.
- Institute actions for improvement when standards are not met.
- Maintain a record keeping system that is designed to collect all pertinent medical management information for each member.
- Make information readily available to appropriate health professionals and appropriate state agencies.
- Use nationally recognized standards of care and work with providers to develop clinical policies and guidelines of care for members.

Member Medical Records Standards

Clever Care requires medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year provided at no cost. Members or their representatives should have access to these records.

Clever Care medical records standards include:

1. Patient identification information — patient name or ID number must be shown on each page or electronic file.
2. Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
3. Date and corroboration — dated and identified by the author.
4. Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it.
5. Allergies — must note prominently:
6. Medication allergies
7. Adverse reactions
8. No Known Allergies (NKA)
9. Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children.
10. Immunizations — a complete immunization record for pediatric members aged 20 and younger

with vaccines and dates of administration

11. Diagnostic information
12. Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all member medical records.
13. Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact the care.
14. All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.
15. Medical information including medication and instruction to patient.
16. Identification of current problems
    - Serious illnesses
    - Medical and behavioral conditions
    - Health maintenance concerns
17. Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition.
18. Smoking/alcohol/substance abuse — notation required for patients aged 12 and older and seen three or more times
19. Consultations, referrals, and specialist reports — consultation, lab and X-ray reports must have the ordering physician's initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation.
20. Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted.
21. Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate.
22. Advance directive — must document whether the patient has executed an advance directive such as a living will or durable power of attorney.

Documentation Standards for an Episode of Care

When Clever Care requests clinical documentation from you to support claims payments for services, you must ensure the information provided to Clever Care:

- Identifies the member.
- Is legible.
- Reflects all aspects of care.

To be considered complete, documentation for episodes of care will include at a minimum the following elements:

- Patient identifying information.
- Consent forms
- Health history, including applicable drug allergies.
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports

- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the member's age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a member by a provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer.
- Contains information that identifies the member on each page in the medical record.
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers, or initials)

Other documentation not directly related to the member

Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Clever Care may request that you submit additional documentation, including medical records or other documentation not directly related to the member, to support the claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, Clever Care may:

- Deny the claim
- Recover and/or recoup monies previously paid on the claim

Section 1833(e) of the Social Security Act, states that Medicare payment can be made only when the documentation supports the service/item.

Clever Care is not liable for interest or penalties when payment is denied or recouped because the provider fails to submit required or requested documentation.

Patient Visit Data Records Standards

You must provide:

1. A history and physical exam with both subjective and objective data for presenting complaints
2. Behavioral health treatment, including at-risk factors:
    - Danger to self/others
    - Ability to care for self
    - Affect
    - Perpetual or Chronic disorders
    - Cognitive functioning
    - Significant social health
3. Admission or initial assessment must include:
    - Current support systems
    - Lack of support systems
4. Behavioral health treatment — documented assessment at each visit for client

status and symptoms, indicating:
    - Decreased
    - Increased
    - Unchanged
    - A plan of treatment, including:
        - Activities
        - Therapies
        - Goals to be carried out
        - Diagnostic tests
        - Evidence of family involvement in therapy sessions and/or treatment
5. Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
6. Referrals and results of all other aspects of patient care and ancillary services

Clever Care systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

Clever Care maintains a professional recordkeeping system for services to our members. Clever Care makes all medical management information available to health professionals and state agencies and retains these records for 10 years from the date of service.

Medical Record Review

Federal regulations require Medicare managed care organizations, and their agents review medical records to ascertain the quality of services provided to our members and to avoid over or under payment and verify documentation to support of diagnostic conditions. Medical Record Reviews are conducted under the direction of the Medical Director and the Quality Management Director. Results of the Medical Record Review are presented to the QI and the QMC.

Risk Adjustment Data Validation

Participation in risk adjustment data validation is required of all providers, and it is important that you are aware that medical records may be requested from your office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. These medical record reviews verify the accuracy of claim and encounter data and identify additional conditions not captured through this mechanism.

Clever Care may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under CFR 164.502 (Health Insurance Privacy and Accountability Act [HIPAA] implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the "general consent" of the member. A general consent form should be an integral part of your medical record file. More information related to risk adjustment can be found at www.cms.gov.

Clinical Practice Guidelines

Using nationally recognized standards of care, Clever Care works with providers to develop clinical policies and guidelines for the care of its membership. The Quality Management and Assurance Committee (QMAC) oversees and directs Clever Care in formulating, adopting, and monitoring guidelines.

Clever Care selects at least four evidence-based Clinical Practice Guidelines (CPGs) relevant to the Medicare member population. The guidelines are reviewed and revised by the Clever Care Quality Improvement Council at least every two years or whenever the guidelines change.

The Clever Care CPGs are located online at www.clevercarehealthplan.com. To access the CPGs, log in to the secure site with your username and password and select the Clinical Practice Guidelines link from the Clinical Policy and Guidelines section on the top navigation menu. A copy of the guidelines can be printed from the website.

Advance Directives

Advance directives are written instructions that:

- Give direction to health care providers as to the provision of health care
- Provide for treatment choices when a person is incapacitated
- Are recognized under state law when signed by a competent person

There are three types of advance directives:

- A durable power of attorney for health care (durable power) allows the member to name a patient advocate to act on behalf of the member
- A living will allow the member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a member's future mental health treatment if the member becomes unable to make those decisions. The instructions state whether the member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations

Clever Care advance directive policies include:

- Respecting the rights of the member to control decisions relating to his or her own medical care, including the decision to have provided, withheld, or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives; providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CRF 489 subpart I, including information on Chapter 765, F.S., and whether or not the enrollee has executed an advance directive. (42 CFR 438.3(j)(3))
- Advising members of their right to self-determination regarding advance directives
- Encouraging members to request an advance directive form and education from their PCP at their first appointment
- Assisting members with questions about an advance directive; no Clever Care employee may serve as witness to an advance directive or as a member's authorized agent or representative
- While members have the right to formulate an advance directive, a Clever Care associate, a facility or a provider may conscientiously object to an advance directive within certain limited circumstances if allowed by state law
- Having Member Services, Provider Relations and/or Health Care Management Services staff review and update advance directive notices and education materials for members on a regular basis
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians
- Clever Care or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
    - Describes the range of medical conditions or procedures affected by the conscience objection
    - Identifies the state legal authority permitting such objection

- Noting the presence of advance directives in the medical records when conducting medical chart audits

Providers must:

- Comply with the Patient Self-Determination Act requirements
- Make sure the first point of contact in the PCP's office asks the member if he or she has executed an advance directive
- Document in the member's medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the provider and the provider's discussion with the member, including the date when this discussion occurred. and action regarding the execution or nonexecution of an advance directive
- Ask members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/provider at the first point of contact
- Make an advance directive part of the member's medical record and put it in a prominent place.
    - The physician discusses potential medical emergencies with the member and/or family/ significant other and with the referring physician, if applicable.
    - If an advance directive has not been executed, the first point of contact at the PCP/provider's office will ask the member if he or she would like advance directive information. If the member desires further information, member advance directive education will be provided
- Not discriminate or retaliate against a member based on whether he or she has executed an advance directive

The requirements for advance directives, to include psychiatric advance directives, vary from state to state. Specific forms that meet compliance with each state can be found on the state's official website. Psychiatric advance directive information may be found at the following website:
https://www.nrc-pad.org/states/**california**-fa.

CREDENTIALING

Credentialing is the initial process through which Clever Care determines whether or not to grant network membership to a practitioner or healthcare delivery organization. Clever Care will collect, review and verify specific information regarding each applicant and determine whether the applicant meets the specific criteria set forth for such providers and approves or denies a provider's application for membership in Clever Care's provider network. The initial credentialing process will be completed in a timely manner (within 180 days) to ensure verification elements are current.

More specific information regarding Clever Cares Credentialing process can be found in the Clever Care Credentialing Plan and its policy and procedures.

Nondiscrimination Policy

Clever Care will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Clever Care will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process.

Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Clever Care will audit credentialing files annually to identify discriminatory practices in the selection of practitioners. Should discriminatory practices be identified through audit or through other means, Clever Care will take appropriate action(s) to track and eliminate those practices.

Scope and Applicability

This Credentialing Plan shall apply to the Licensed Independent Practitioners (LIPs) and Healthcare Delivery Organizations (HDOs) as set forth below:

It is the policy of Clever Care to implement a credentialing program to verify the professional qualifications of all participating providers prior to said providers rendering covered health services to members. Credentialing may be performed by Clever Care or its Contractors, e.g., MSO, delegates, hospitals.

Providers of medical services are categorized as either requiring credentialing through Clever Care, e.g., joining Clever Care via direct contract, or not requiring credentialing through Clever Care Health Plan, as they are credentialed through a delegated Contractor or network. (See Section 11 Delegation).

In instances where a provider is determined to require credentialing through Clever Care, Clever Care ensures that providers are thoroughly and appropriately credentialed in accordance with standards of the National Committee for Quality Assurance (“NCQA”) and all other state and federal regulations, as applicable, prior to rendering services to members, as set forth in the Clever Care Credentialing Plan.

The following providers are required to be appropriately qualified and credentialed by Clever Care prior to becoming participating providers in Clever Care’s network:

Credentialing Scope

Clever Care Health Plan has an established Credentialing Plan which sets forth the standards and criteria for its credentialing program. This section includes excerpts from Clever Care which includes more specific details as to the policies and procedures governing the Clever Care credentialing process.

I. Clever Care Health Plan credentials the following licensed/state certified independent health care practitioners:

a. Medical Doctor (MD)
b. Doctor of Osteopathic Medicine (DO)
c. Doctor of Podiatric Medicine (DPM)
d. Doctor of Chiropractic Medicine (DC)
e. Doctor of Dental Surgery (DDS)
f. Alternative Care Medicine (AC)
g. Behavioral Health Specialist (BH)
    i. Clinical Social Worker (CSW)
    ii. Psychiatrist (PSY)
    iii. Psychologist (PSY)
h. Acupuncturist (ACU)
i. Speech Therapist (ST)
j. Physical Therapist (PT)
k. Occupational Therapist (OT)
l. Audiologist (AUD)

II. Clever Care credentials the following Facilities also known as Health Delivery Organizations ("HDOs"):

a. Acupuncture Facilities
b. Adult Day Care Centers
c. Ambulance/Transportation Services
d. Behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting, including:
    - adult family care/foster care homes
    - ambulatory detox
    - community mental health centers (CMHC)
    - crisis stabilization units
    - intensive family intervention services
    - intensive outpatient – mental health and/or substance abuse
    - methadone maintenance clinics
    - outpatient mental health clinics
    - outpatient substance abuse clinics
    - partial hospitalization – mental health and/or substance abuse
    - residential treatment centers (RTC) – psychiatric and/or substance
e. Birthing Centers
f. Cancer Treatment Centers
g. Clinical Laboratories
h. Comprehensive Outpatient Rehabilitation Facilities (CORF)
i. Durable Medical Equipment (DME) Providers (including orthotic/prosthetics)
j. End-Stage Renal Disease Services Providers
k. Family and Fertility Planning Clinics
l. Federally Qualified Health Centers (FQHC)
m. Free-Standing Surgical Centers
n. Home Health Agencies
o. Hospices
p. Hospitals
q. Imaging Centers

r. Independent Diagnostic Testing Facilities (IDTF)
s. Night-Time Pediatrics
t. Outpatient Diabetes Self-Management Training Providers
u. Pharmacies (providing DME services)
v. Portable X-Ray Suppliers
w. PT/OT/SP/Audiology Groups
x. Rural Health Clinics (RHC)
y. Skilled Nursing Facilities
z. Sleep Centers
aa. Inpatient, residential, and ambulatory facility types
bb. Home Infusion Therapy Agencies

III. The following providers are not required to be credentialed:

Practitioners who practice exclusively within the inpatient setting and who provide care for members only as a result of members being directed to the hospital or another inpatient setting unless those health care professionals are separately identified in enrollee literature as available to enrollees:

a. Pathologist
b. Radiologists
c. Anesthesiologists (unless said practitioners see members in pain- management private practice)
d. Neonatologists
e. Emergency room physicians
f. Hospitalists
g. Practitioners who practice exclusively within free-standing facilities and who provide care for organization members only as a result of members being directed to the facility.
    1. Mammography centers
    2. Urgent-care centers
    3. Surgical centers
    4. Ambulatory behavioral healthcare facilities
    5. Psychiatric and addiction disorder clinics
h. Pharmacists who work for a pharmacy benefits management ("PBM") organization to whom the organization delegates Utilization Management functions.
i. Locum tenens and telemedicine consultants who do not have an independent relationship with the organization unless those health care professionals are separately identified in enrollee literature as available to enrollees.

Criteria for Licensed Independent Practitioners (LIP)

Each LIP must complete an Application with Credentialing Criteria as outlined in Attachment A with a signed attestation, which may be in an electronic format, within 180 days of the Decision Date or in accordance with Credentialing Authorities if it is a shorter time frame. Credentialing Criteria that require Primary Source Verification may only be verified by Clever Care Credentialing Department staff, or a contracted National Committee on Quality Assurance (NCQA) or accredited CVO entity. Each LIP must meet the following Credentialing Criteria, which must be verified and approved within 180 days of the Decision Date or in accordance with Credentialing Authorities if it is a shorter time frame:

- **Required medical or professional education and training.** MDs and DOs must graduate from allopathic or osteopathic medical school and successfully complete a residency program or other clinical training and experience as appropriate for specialty and scope of practice as determined by

the Credentialing Committee. DCs must graduate from Chiropractic College; DDSs or DMDs must graduate from dental school; and DPMs must graduate from podiatry school and successfully complete a hospital residency program. All mid-level practitioners must graduate from an accredited professional school and successfully complete a training program.

The highest level of education training must be Primary Source Verified. If Applicant claims to be board certified, Credentialing Entity will Primary Source Verify board certification from the most current edition of an NCQA approved source but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. At least annually, Clever Care must obtain written confirmation from the Board that it performs primary-source verification of education/training.

- **The Board Certification -** Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the Clever Care Health Plan:
    1. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties ("ABMS"), American Osteopathic Association ("AOA"), Royal College of Physicians and Surgeons of Canada ("RCPSC"), College of Family Physicians of Canada ("CFPC"), American Board of Foot and Ankle Surgery (ABFAS), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery ("ABOMS") in the clinical discipline for which they are applying.
    2. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
    3. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS.
    4. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
        i. As alternatives, MDs, DOs, DPMs and Oral Surgeons meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
            1. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC, ABPM, ABFAS, ABOMS) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten (10) consecutive years of clinical practice. OR
            2. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
            3. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in Clever Care's Network AND the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.

Practitioners meeting one of these three (3) alternative criteria (1, 2, 3) will be viewed as meeting all Clever Care education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC for board certification. These alternatives are subject to Clever Care review and approval. Reports submitted by delegate to Clever Care must contain sufficient documentation to support the above alternatives, as determined by Clever Care.

- **License, Certification or Registration** - Provider must hold a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals.

- **DEA or Controlled Dangerous Substance Certificate or Acceptable Substitute**. Unless the Applicant's practice does not require it, the Applicant must hold a current, valid, and unrestricted Drug Enforcement Agency ("DEA") and/or Controlled Dangerous Substances ("CDS") registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state. If provider do not have DEA or CDS Certificate, provider must fill out the DEA Alternative Arrangements Form or provide statement for controlled substances prescribe alternative arrangement.

- **Medicare/Medicaid Sanctions Review**. Regardless of the contracted line of business, for example, Medicare, Medicaid or Commercial the Applicant must not be ineligible, excluded or debarred from participation in the Medicare and/or Medicaid and related state and federal programs, or terminated for cause from Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the Office of Inspector General (OIG), the CMS Preclusion List or other disciplinary action by any federal or state entities identified by CMS. Credentialing Entity will, at a minimum, verify reported information for the most recent five (5) year period available from the Office of Inspector General (OIG), System for Award Management (SAM), and the CMS Preclusion list and Medicare opt out.

  * Applicants who have opted out of Medicare may not participate in Clever Care. This applies to all LIPs other than physical therapists, occupational therapists, and chiropractors are included in this requirement.

- **Work History**. The provider must supply the most recent five (5)-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six (6) months, the Practitioner must clarify the gap verbally or in writing.

- **Insurance or state-approved alternative**. Professional Liability Insurance - must be current at the time the file is ready for review and decision making.
  a. For Applicants with federal tort coverage, the Application need not contain the current amount of malpractice insurance coverage. An attestation from the Applicant or a copy of the federal tort letter meets the requirement.

- **Malpractice History.** Credentialing Entity must obtain written confirmation of the past five (5) years of history of malpractice settlements or judgements from the malpractice carrier or must query the NPDB. Malpractice claims history must be explained by the LIP and found acceptable by the Credentialing Entity.

- **Passing score on site visit.** If required by Credentialing Authorities, Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice, including staff interviews, and medical record-keeping assessments, as further documented in ATTACHMENT B, and must receive a passing score for the site assessment and medical record keeping assessment. Site visit must be completed prior to the Decision Date.

a. Any failed site visit will result in the Applicant being required to re-apply for Credentialing after at least six months have passed. The Credentialing Entity may agree to permit an Applicant to re-apply for Credentialing prior to the six months wait period if the Applicant can first demonstrate improvements in the areas previously found deficient by providing documentation of such improvements in an improvement action plan. If the Credentialing Entity accepts the improvement action plan, the Applicant must agree to allow the Credentialing Entity to conduct an office site visit of Applicant's practice as further documented in ATTACHMENT B and must receive a passing score for the site visit as part of the initial Credentialing Criteria.

- **Sanction and Limitation on Licensure**. In addition to primary source verification of license or certification will obtain information about the Applicant through a review of NPDB or FSMB and state licensing Board reports. Any finding that results in Material Restriction on the LIP from any state licensing authority may result in denial of Credentialing.

- **No prior denials or terminations**. At the discretion of the Credentialing Entity, the Applicant must not have been denied initial participation or had participation terminated (for reasons other than network need) by the Credentialing Entity or any Newly Merged Network within the preceding 24 months.

- **Hospital Staff Privileges**. Applicant must have full hospital admitting privileges, without Material Restrictions, conditions, or other disciplinary actions, at a minimum of one Participating (Network) hospital, or arrangements with a Participating LIP to admit and provide hospital coverage to Covered Persons at a Participating (Network) hospital, if the Credentialing Entity determines that Applicant's practice requires such privileges. The Applicant's attestation is sufficient verification of this requirement unless otherwise required by Credentialing Authority. The Credentialing Committee may recommend accepting a LIP to the Network if the restriction does not limit or impact the LIP's practice.

- **Affirmative responses to Disclosure Questions on the Credentialing Application**. Applicant is required to provide details on all affirmative responses to Disclosure Questions on the Credentialing Application, which may be reviewed by a Medical Director, and at the discretion of the Medical Director, may be reviewed by Credentialing Committee for a determination of LIP's acceptance into Credentialing Entity's Network.

- **CLIA Certificate or Waiver**. If the Applicant will be performing CLIA waived laboratory tests in the office setting, a current CLIA Certificate or Waiver must be included with the application. The CLIA Certificate or Waiver does not require verification.

- **NPI (National Provider Identifier)**. The Applicant must have a current NPI number.

- **Patient Age+ Limitations**. Patient age limitations and hours of practice shall be included in the application.

- **Application with attestation.** The Application must include a current attestation signed by the Applicant that is no older than 180 days at the time of review and decision-making.

- **Negative Information**. Negative information regarding the Applicant’s ability to provide services (any inability to perform the essential functions of the position with or without accommodation, illegal drug use, loss of license or felony convictions, loss of limitation of clinical privileges or

disciplinary action at all HDOs or organizations with which the Applicant has had privileges) must be explained in writing by the Applicant before being forwarded for review and decision-making.

Additional Participation Criteria and Exceptions for Non-Physician Credentialing

The Participation Criteria and Exceptions for Non-physician credentialing of Behavioral Health Practitioners, Nursing Specialists and Physician Assistants specific eligibility and verification criteria are set forth in Appendix A of the Clever Care Credentialing Plan.

Eligibility Criteria for Healthcare Delivery Organizations

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Clever Care may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If an HDO has satellite facilities that follow the same policy and procedures, Clever Care may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with Clever Care standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety.
List of acceptable Accrediting Agencies meeting Clever Care Criteria by HDO Provider Type:

HDO Type and Clever Care Approved Accrediting Agent(s) Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, HFAP, DNV/NIAHO, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Clinical Laboratories	CLIA, COLA
Dialysis Center	TJC, CMS Certification
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Portable x-ray Suppliers	FDA Certification
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC

Behavioral Health

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, TJC, CHAP, CARF, COA
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, DNV/NIAHO, TJC, COA, CARF
Outpatient Mental Health Clinic	HFAP, TJC, CARF, COA, CHAP
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC

Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	DNV/NIAHO, TJC, HFAP, CARF, COA

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	DNV/NIAHO, HFAP, TJC, CTEAM
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC, COA
Outpatient Substance Abuse Clinics	CARF, TJC

Recredentialing Applicable Licensed Independent Practitioners (LIPs) and Healthcare Delivery Organizations (HDOs)

Recredentialing of all Licensed Independent Practitioners (LIPs) and Healthcare Delivery Organizations (HDOs)occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each applicable practitioner and HDO applying for continuing participation in the Clever Care Network must submit all required supporting documentation.

ONGOING SANCTION MONITORING

To support certain credentialing standards between the recredentialing cycles, Clever Care has established an ongoing monitoring program. The Credentialing Department performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General ("OIG")
2. Federal Medicare/Medicaid Reports
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments
6. Clinical Quality Management Department (including data regarding complaints of both a clinical and nonclinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Clever Care Departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

Applicant responsibilities

During the Credentialing process the Applicant is responsible for timely completion of the Application, providing all requested information, and disclosing all facts that a Credentialing Entity would consider in making a reasonable Credentialing decision. Applicant or a Participating LIP or Participating Facility must inform Credentialing Entity of any material change to the information on the Application including but not limited to any change in staff privileges, prescribing ability, accreditation, ability to perform professional duties, change in OIG sanction or GSA debarment status or Material Restrictions on licensure. Failure to inform the Credentialing Entity immediately of a status change is a violation of this Credentialing Plan and the Participation Agreement and may result in immediate suspension or termination from the Network.

Throughout the credentialing process, the applicant or practitioner is responsible for:

a. Responding to requests for information made by Credentialing Staff, the Credentialing Committee, Peer Review Committee, the Quality Management and Assurance Committee, or the Board of Directors; and
b. Keeping Clever Care informed of any changes in his or her status relative to the criteria. For example, an Applicant should notify the Committee regarding any:
    (i) Judgment, settlement, or compromise in a professional liability action;
    (ii) Action limiting or suspending the practitioner's license to practice a profession, or his or her authority to prescribe medication;
    (iii) Federal Indictments where the practitioner has been named;
    (iv) Exclusion from the Medicare or Medicaid programs;
    (v) Cancellation of professional liability coverage; or
    (vi) Loss or significant curtailment of clinical privileges at a licensed hospital.
    (vii) Loss of or change in accreditation or certification status.

CONFIDENTIALITY OF APPLICANT INFORMATION

The Credentialing Entity believes information obtained in the credentialing process should be protected by the peer review privilege. Credentialing Entity will therefore maintain mechanisms to appropriately limit review of confidential credentialing information. Credentialing Entity will also contractually require Delegated Entities to maintain the confidentiality of credentialing information.

APPLICANT RIGHTS to Review Information Submitted

Applicants have the right to review certain information submitted in connection with their credentialing or recredentialing Application, including information received from any primary source and to correct erroneous information that has been obtained by Credentialing Entity. The Credentialing Entity will notify Applicant via phone call, fax or email of identification of any information that varies substantially from the information provided by the Applicant. At the time of notification, the Applicant will be advised where and within what time frame the Applicant must respond. Applicants must submit any corrections in writing as directed by the Credentialing Entity within 30 days of the Applicant's notification of the discrepancy, pending where the file is in process.

Applicant Right to be informed of application status.

Applicants also have the right to obtain information about the status of their Application upon their request. The Applicant can check on the status of an application by calling the Clever Care Health Plan at (657) 224-1888. The Credentialing Entity is not required to allow an Applicant to review personal or professional references, or other information that is peer review protected.

Notification of Credentialing Decisions

Applicants will be notified of the credentialing decision within 60 calendar days of the Credentialing Committee's decision and recredentialing denials within 60 days of decision date, notwithstanding this provision, credentialing time frames and notification will not exceed timelines required by the Credentialing Authority.

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Provider or HDO’s contract based on quality of care or professional conduct, a certified letter is sent to the Provider describing the adverse action taken and the reason for the action, including notification to the Provider of the right to a fair hearing when required pursuant to Laws or regulations.

Notification to Members of Provider Termination

Clever Care makes a good faith effort to provide at least forty-five (45) calendar days written notice of a primary care or behavioral health provider termination to all members who are currently assigned and have been patients of that primary care or behavioral health provider within the past three years before the termination effective date, regardless of the reason for the termination. Clever Care may provide member notification in less than thirty (30) days' notice as a result of a provider's death or exclusion from the federal health programs. When a termination involves a PCP, all members who are patients of that PCP are notified of the termination. More specific information regarding Clever Care's Credentialing process can be found in the Clever Care Credentialing Plan and its policy and procedures.

For contract terminations that involve specialty types other than primary care or behavioral health Clever Care makes a good faith effort to provide at least thirty (30) calendar days written notice before the termination effective date to all members who are seen on a regular basis, currently receiving care from, or have received care within the past three months from a provider being terminated.

QUALITY MANAGEMENT

Clever Care maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to members. The scope and content of the program reflects the demographic, epidemiologic, medical and behavioral health needs of the population served. The Quality Management Program goals include, but are not limited to:

- Develop and maintain QM resources, structure and processes that support the Clever Care's commitment to quality health care for our members
- Continuously improve the quality of care and service provided to members
- Improve the ability of Clever Care,- to deliver healthcare services and benefits to its SNP beneficiaries in a high-quality manner.
- Improve or maintain positive member and provider experiences through data analysis and implementing effective interventions
- Monitor and maintain full compliance with all applicable state, federal and accreditation requirements
- Implement a comprehensive Population Health Strategy that addresses:
    - Chronic Illness Management
    - Keeping Members Healthy
    - Managing Members with Emerging Risk
    - Patient Safety or Outcomes Across Settings
- Monitor for and maintain patient safety and promote safe clinical practices
- Establish and maintain effective credentialing and re-credentialing processes for providers that comply with state, federal and accreditation requirements
- Provide appropriate access to care by monitoring practitioner and provider access and availability reports.
- Provide oversight for all delegated activities to maintain compliance with all state, federal and accrediting organizations
- Communicate all Quality Improvement (QI) activities and outcomes through the QI process throughout the organization including the providers, Board of Directors, management, staff, members and the community.
- Cultivate a continuous Quality Improvement (CQI) management style that is woven throughout the organization with emphasis on the member, measurement of key performance indicators, empowerment of employees, and a commitment to the improvement of health care and services.
- Review provider's practice methods and patterns, morbidity/mortality rates, and all Grievances filed against a provider relating to medical treatment.

Members and providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to providers and members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The Clever Care QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review member complaints/grievances reported adverse events and other information to evaluate the quality of service and care provided to Clever Care members. Practitioners and providers must allow Clever Care to use performance data in cooperation with Clever Care quality improvement program and activities.

CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans using a star rating system. The CMS Five-Star Quality Rating System provides helpful information to consumers, families, and caregivers for comparing MA-PD plans based on a one to five rating:

★★★★★ equals excellent
★★★★ equals very good
★★★ equals good
★★ equals fair
★ equals poor

Many of the measures included in the CMS rating system are measures of preventive care and routine disease management. Some of these are listed below and are subject to change:

1. Staying Healthy — screening, tests, and vaccines:
   - Breast Cancer Screening
   - Colorectal Cancer Screening
   - Annual Flu Vaccine
   - Improving and Maintaining Physical and Mental Health
   - Monitoring physical activity
2. Managing Chronic Conditions:
3. Special Needs Plans (SNP) Care Management
4. Care for Older Adults: Medication Review, Functional Status Assessment and Pain Screening
5. Osteoporosis Management in Women who had a Fracture
6. Diabetes Care: Diabetes Eye Exam, Kidney Disease Monitoring, Blood Sugar and Cholesterol Control
7. Controlling Blood Pressure
8. Reducing the Risk of Falling
9. Improving bladder control
10. Care Coordination:
    - Transition of Care (which includes inpatient admission/discharge notification, patient engagement after inpatient discharge, medication reconciliation post discharge)
    - Follow-up after ED Visit for people with multiple high-risk chronic conditions
11. All-Cause Readmissions

The growing focus on quality health care and plan member satisfaction provides for CMS assesses Clever Care performance. The CMS assessment results in a star rating assigned to each plan. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Medicare beneficiaries who receive health care services through a MA-PD plan receive CAHPS surveys through the mail in late February.

The survey asks the Medicare beneficiary to assess his or her health and the care received from his or her primary care providers and specialists over the past six months. The survey includes questions regarding providers' communication skills and the member's perception about his or her access to needed health care services. Several questions directly correlate to a plan's CMS star rating. The survey questions ask the member to report his or her opinion about access to care and the health plan's customer service. It also asks the member to rate the communication received from his or her providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations with a MA contract. CMS randomly samples Medicare beneficiaries from each participating MA plan. Two years after the initial HOS survey, the same Medicare beneficiaries are surveyed again. The results are part of the effectiveness of care component of the HEDIS rates for the MA plan.

12. Drug Safety
    - Medication Adherence for Diabetes Medication
    - Medication Adherence for Hypertension
    - Medication Adherence for Cholesterol
    - Statin Use for People with Diabetes

The rating system empowers consumers, families and caregivers with information to compare MA- PD plans. The measures of the rating system include preventive care and routine disease management. This information gives consumers, families and caregivers results to make an educated decision about their health care needs. The ratings are posted online and may be accessed at www.medicare.gov Please note there are separate ratings for Part C (medical) and Part D (prescription drug) services.

Clever Care encourages participating providers to help improve member satisfaction by:

- Ensuring members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this administrative guide
- Educating members and talking to them during each visit about their preventive health care needs and disease management goals
- Ensuring providers answer any questions members have regarding newly prescribed medications
- Ensuring members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral
- Allowing time during the appointment to validate members' understanding of their health conditions and the services required for maintaining a healthy lifestyle
- Referring members to the Member Services department and recommending they speak to a case manager

Committee Structure

Clever Care maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

Quality Management and Assurance Committee (QMAC)

The purpose of the Corporate Quality Management and Assurance Committee (QMAC) is to provide a forum for members of the committee to review, coordinate, and direct the Clever Care Quality Improvement Program. This enables interdepartmental leadership and oversight of key quality improvement activities and processes, including Medicare specific policies and procedures. This work supports improved quality of care and services, and improved member health outcomes.

Responsibilities:

- Review and approve Quality Management (QM) Trilogy Documents: Program Description, Work Plan, and Annual QI Evaluation
- Review standardized reports (at least annually) reflecting progress towards goals, actions taken, improvements
- Analyze, review, and make recommendations regarding Clever Care, implementation, measurement, and outcomes of the clinical/service Quality Improvement Projects (QIP) and Chronic Care Improvement Programs (CCIP)
- Review, monitor and evaluate program compliance against Clever Care, Inc., State, Federal and

CMS standards
- Review overall regional and corporate quality program effectiveness including, but not limited to, member and provider satisfaction, quality of care, and accessibility and availability of care and services

Quality Management Committee

The purpose of the health plan Quality Management Committee (QMC) is to maintain quality as a cornerstone of Clever Care culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC's responsibilities are to:

- Establish strategic direction and monitor and support implementation of the Quality Management Program
- Establish processes and structure that ensures accreditation compliance
- Review and accept Corporate and Local QM Policies and Procedures, as appropriate
- Analyze, review, and make recommendations regarding Clever Care, implementation, measurement, and outcomes of clinical/service quality improvement studies
- Coordinate communication of quality management activities
- Review HEDIS® and CAHPS® data and action plans for improvement.
- Review, monitor and evaluate program compliance against State, Federal and accreditation standards
- Review and approve the annual quality management program description and work
- plan; which determines and describes the program's overall effectiveness; considers the adequacy
- of resources, committee structure, practitioner participation and leadership involvement in the QM program and determines whether to restructure or change the QM program for the subsequent year based on its findings.
- Provide oversight and ensure compliance of delegated services
- Assure inter-departmental collaboration, coordination and communication of quality improvement activities
- Measure compliance to medical and behavioral health practice guidelines
- Monitor continuity of care between medical and behavioral health services
- Monitor accessibility and availability with cultural assessment
- Publicly make information available to members and practitioners about network hospitals' actions to improve patient safety
- Make information available about the QM program to members and practitioners
- Assure the availability of Quality Management program minutes to the appropriate state regulatory agency, as applicable

Assure practitioner involvement through direct input from the Quality Management and Assurance Committee (QMAC) or other mechanisms that allow practitioner involvement. The QMAC provides applicable advice and input to the corporate committee with oversight over the development and updating of clinical practice guidelines (CPGs); and identifies opportunities to improve services and clinical performance by establishing, reviewing/updating clinical practice guidelines based on review of demographic and epidemiologic information to target high volume, high cost, high risk, problem prone conditions. In addition, the QMAC conducts a systematic process for network maintenance through the credentialing/recredentialing process. The QMAC gives advice to the Clever Care health plan administration in any aspect of Clever Care's policies or operations affecting network providers or members

and provides oversight of the peer review process and drug utilization reviews The QMAC also provides guidance and feedback regarding technology assessment

The QMAC's responsibilities are to:

- Utilize ongoing peer review system to assess levels of care and quality of care provided
- Monitor practice patterns in order to identify appropriateness of care and for improvement/risk prevention activities
- Review and provide input, based upon the characteristics of the local delivery system; approve evidence-based clinical protocols/guidelines to facilitate the delivery of quality care and appropriate resource utilization
- Review clinical study design and results
- Develop and approve action plans/recommendations regarding clinical
- quality improvement studies;
- Consider/act in regard to physician sanctions
- Review, and provide input, to credentialing /re-credentialing policies and procedures; and clinically oriented Quality Management policies and procedures, Utilization
- Management policies and procedures;
- Disease/Case management policies and procedures
- Review and provide feedback regarding new technologies
- Oversee compliance of delegated services

Peer Review Committee (PRC)

The Peer Review is responsible for evaluating the appropriateness of care rendered by Clever Care's contracted providers and reviewing provider's practice methods and patterns. The PRC evaluates provider performance and trends in quality of care and service issues. The PRC develops and analyzes Plan-wide audits. The PRC may also serve as Clever Care's provider advisory council providing input and recommendations to Clever Care concerning, but not limited to, the clinical guidelines adopted, QM Trilogy documents, Credentialing report, PIPS, process improvements, quality indicators, performance measures, HEDIS, and Provider Satisfaction Survey tools and results.

Credentialing Committee

The health plan Credentialing Committee (CC) has been delegated authority of the credentialing program by the health plan Quality Management and Assurance Committee. It is responsible for the oversight of the credentialing program, decisions regarding the credentialing and recredentialing of the practitioners and providers contracted with the health plan, and oversight of organizations for which credentialing has been delegated

The CC's responsibilities are to:

- Conduct reviews for all providers who apply for participation in Clever Care;
- Review all participating providers for recredentialing purposes, including the review of any quality or utilization data/reports;
- Report providers approved or not approved for participation and report decisions to the Quality Management and Assurance Committee or the Peer Review Committee;
- Approve or deny for participation providers submitted by delegated credentialing activity;
- Review and update credentialing policies and procedures;
- Report to the Medical Advisory Committee physician corrective actions and sanctions imposed based upon recredentialing activity;
- Oversee delegated credentialing relationships.

HEALTH CARE MANAGEMENT SERVICES

Clever Care continuously seeks to improve the quality of care provided to its members. Clever Care encourages and expects all providers to participate in health promotion and disease prevention programs. Providers are encouraged to collaborate with Clever Care in efforts to promote healthy lifestyles through member education and information sharing.

Providers must fully comply with:

- Health care management services policies and procedures
- Quality improvement and other performance improvement programs
- All regulatory requirements

The health care delivery system is a PCP-centric model that supports the role and relationship of the Primary Care Provider (PCP). The model includes direct contracts with PCPs, hospitals, specialty physicians and other providers as required to deliver Medicare benefits, additional benefits and Clever Care programs for members with complex medical needs. All contracted providers are available to Clever Care members by PCP or self-referral for the services identified below. There are no sub networks that limit the choice of specialist referrals based on selection of PCP.

The model requires all members to select a PCP upon joining Clever Care. Members who do not choose a PCP are assigned one. Clever Care works with the member, the physician and the member's representative, as appropriate, to ensure the PCP is suitable to meet the member's special needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

Self-Referral Guidelines

Clever Care members may self-refer for the following services:

- Wellness and Supplemental benefits
- Influenza and pneumococcal vaccinations
- All preventive services (e.g., routine physical examinations, prostate screening, and preventive women's health services, such as Pap smears)

Except for the services listed above, emergent or out-of-area urgent care and dialysis services, in general, Clever Care members must obtain services within the Clever Care provider network or obtain a prior-authorization for covered services outside the network. As a contracted provider with Clever Care, you are responsible for either referring within the network or obtaining prior authorization from Clever Care.

Referral Guidelines

PCPs may only refer members to Clever Care contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the member's ongoing primary care relationship. If you believe the required specialty is not available within the contracted network, contact Provider Services at (714) 650-8770. Providers must obtain prior authorization from Clever Care before referring members to non-network providers. Referring a Clever Care member out-of-network will result in the claim denying with member liability unless urgent, emergent, out of area renal dialysis or if prior authorization was obtained from Clever Care.

Providing Non-Covered Services Advanced Notification
For services that require prior authorization or are non-covered by Clever Care (i.e. statutory exclusion), it becomes extremely important that Clever Care authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Clever Care prior authorization protocols, Clever Care may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The Centers for Medicare & Medicaid Services (CMS) issued guidance concerning Advance Notices of Non-Coverage. The ABN is an FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS (page 4) the ABN is given to beneficiaries enrolled in the Medicare Fee- For-Service (FFS) program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from Clever Care.

Prior authorization

Certain services/procedures require prior authorization from Clever Care for participating and non-participating PCPs and specialists. Please refer to the list below or the Prior authorization Lookup tool online or call Provider Services at (714) 650-8770 for more information. You can also access information concerning prior authorization requirements on our website at:
https://eznet.clevercarehealthplan.com/

The following are examples of services requiring prior authorization before providing the nonemergent or urgent care services:

- Procedures performed by Specialists
- Behavioral health partial hospitalization
- Skilled Nursing Facility (SNF)
- Home health care
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital outpatient surgery or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions for medical and mental
- Transplant evaluation and services
- Durable Medical Equipment (DME)
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Referrals outside of the Clever Care network
- Requests for non-covered services under the Medicare program such as non-emergency transportation, or day care services.

For services that require prior authorization or are non-covered by Clever Care (i.e., statutory exclusion), it becomes extremely important that all authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered

services. In such cases when the network physician fails to follow authorization protocols, Clever Care may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied, and the member cannot be held financially responsible. Therefore, your failure to provide an appropriate coverage determination could result in a denial of payment for the non-covered service.

Please contact Clever Care prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Medicare Member in the event of non- coverage. As a Contracted Provider with Clever Care, you are prevented from billing the Medicare Member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

Medically Necessary Services and Medical Criteria

Multiple clinical and coverage determination guidelines are utilized to review the appropriateness of a service that has been rendered or requested to determine the care is reasonable and necessary for the diagnosis or treatment of illness or injury, provided in the most appropriate level of care, and is not furnished for the convenience of the member or provider. The clinical guidelines used may include any of the following based on the type of request: CMS (Centers for Medicare & Medicaid Services) National and Local Coverage and Benefit Guidelines, current editions of InterQual® Level of Care, MCG™ Guidelines (formerly Milliman Care Guidelines®), Clever Care Medical Policies and Clinical Utilization Management Guidelines to review the medical necessity and appropriateness of physical health services, unless superseded by state requirements or regulatory guidance. Clever Care Behavioral Health Medical Necessity Criteria are utilized for all behavioral health services, unless superseded by state or federal requirements or regulatory guidance. The Medical Policies and Clinical Utilization Management Guidelines are developed by the Clever Care Technology Assessment Committee (TAC). Criteria for review of behavioral health issues are reviewed by the Behavioral Health Clinical Advisory Committee, a subcommittee of TAC. In addition to policies developed and or approved through MPTAC, the Health Plan's medical reviewers use criteria developed by Delegated Specialty Healthcare Networks for review of selected service requests in some markets.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

Criteria and guidelines are reviewed and approved annually by members of the Quality Management and Assurance Committee and updated when appropriate. Input from the medical community is solicited and utilized in developing and updating policies. Policies and procedures for application of medical necessity criteria are reviewed and approved annually by the Quality Management and Assurance Committee.

Getting the best care in the most appropriate setting is key to achieving the best outcomes for Clever Care members. These members rely on their health care professionals and Clever Care to help coordinate this important aspect of their care. To do this, timely communication is essential.

Ensuring that you provide the correct and complete clinical information at the correct time when requesting a medical necessity review of clinical information is needed.

If the information provided does not support medical necessity, the service cannot be approved under Medicare law. Please provide the necessary information to justify the services you are requesting at the time of the request to allow for an appropriate decision to be made. Any service determined to require a clinical review will be processed in accordance with:

- Section 1861(a)(1)(A) of the Social Security Act, which states that Medicare payment can only be made for services/items that are medically necessary and reasonable.
- Section 1833(e) of the Social Security Act, which states that Medicare payment can be made only when the documentation supports the service/item.

UM criteria is made available to practitioners upon request. If a medical necessity decision results in an adverse determination, practitioners are welcome to discuss the denial decision with a Medical Director. For additional information, to speak to a Medical Director, obtain UM criteria or for any inquiries, contact may be made via the Provider Portal, by calling the Member Services Department at (657)224-1888 or by calling the number on the members' identification card.

HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Clever Care requires prior authorization of all inpatient elective admissions. The referring primary care or specialist physician is responsible for prior authorization.

The referring physician identifies the need to schedule a hospital admission and must submit the request to the Clever Care UM department.

Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the need for inpatient services or at least 72-hours prior to the scheduled admission. This will allow Clever Care to verify benefits and process the prior authorization request. For services that require prior authorization. Clever Care makes case-by-case determinations that consider an individual's health care needs and medical history, in conjunction with nationally recognized standards of care.

Electronic submission using the Provider portal is the preferred method for the submission of prior authorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for members covered by Clever Care plans. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool).

- **Initiate prior authorization requests online**, eliminating the need to fax. The Provider Portal allows detailed text, photo images and attachments to be submitted along with your request.
- **Make inquiries** on previously submitted requests via phone, fax, the portal or other online tool.
- **Instant accessibility** from almost anywhere including after business hours.
- **Utilize the dashboard** to provide a complete view of all UM Requests with real time status updates including email notifications if requested using a valid email address.
- **Real time results** for some common procedures with immediate decisions.
- **Access the website** under Authorizations and Referrals via the Provider Web Portal.

For an optimal experience with **Clever Care's Provider Portal** use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari.

The hospital can confirm that a prior authorization is on file by calling Member Services at (833) 388-8168. Please refer to the Provider Inquiry Line for more information). If coverage of an admission has not been approved; the facility should call Member Services at (833) 388-8168. Clever Care will contact the referring physician directly to resolve the issue.

When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the prior authorization nurse.

The prior authorization nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the prior authorization nurse will assist the physician in identifying alternatives for health care delivery as supported by the medical director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, a Clever Care authorization reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the member's needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the medical director will contact the requesting physician to discuss the case.

If the prior authorization documentation is incomplete or inadequate, the prior authorization nurse will notify the referring provider to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the member and provider.

Member liability for inpatient admissions will be assigned only:

- When the denial is issued prior to the services being rendered
- When the Important Message from Medicare is delivered in accordance with CMS guidelines
- When inpatient services were rendered by a nonparticipating facility, were not prior authorized and are not considered services covered under Clever Care

Participating providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

Emergent Admission Notification Requirements

Clever Care prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify Clever Care of emergent admissions within one (1) business day. Clever Care Utilization Management Services staff will verify eligibility and determine benefit coverage.

Clever Care is available 24 hours a day, 7 days a week to accept emergent admission notification at Utilization Management Services at the(833) 253-8373.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, a Clever Care reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, Clever Care will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the medical director denies coverage of the request, the appropriate denial letter will be mailed to the member and provider, including the appropriate appeal rights.

Nonemergent Outpatient, Specialty, and Ancillary Services Prior Authorization and Notification Requirements

Clever Care requires prior authorization for coverage of selected nonemergent outpatient, specialty, and ancillary services. Requests for prior authorization with all supporting documentation should be submitted immediately upon identifying the need for the request (fourteen (14) days advance notification for standard requests and three (3) days advance for expedited requests). To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number and fax number of physicians performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one (1) business day. Urgent and emergent admissions require notification within one (1) business day by the Provider. The Clever Care utilization review clinician determines the member's medical status through communication with the hospital's Utilization Review department. The appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the medical director who renders a decision regarding the coverage of the hospitalization. Diagnoses meeting specific criteria are referred to the medical director for possible coordination.

Affirmative Statement About Incentives

Clever Care, as a corporation and as individuals involved in Utilization Management (UM) decisions, is governed by the following statements:

- UM decision-making is based only on the appropriateness of care and service and existence of coverage.
- Clever Care does not specifically reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting, or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for Clever Care UM decision-makers do not encourage decisions that result in underutilization or create barriers to care or service.

Discharge Planning

Discharge planning is designed to assist the provider in the coordination of a member's discharge when acute care (hospitalization) is no longer necessary. Clever Care utilization management nurse will assist providers and hospitals with the discharge planning process in accordance with requirements of the

Medicare Advantage program. At the time of admission and during the hospitalization, the Clever Care case manager will discuss discharge planning with the provider, member and/or member advocate.

When the provider identifies medically necessary and appropriate services for the member, Clever Care will assist the provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care.

Hospital-Acquired Conditions

A Hospital-Acquired Condition (HAC) is a medical condition or complication that a patient develops during a hospital stay, which was not present at admission. Examples of HAC include but are not limited to:

- A pattern of substandard care that is likely to result in future dangers to members
- Failure to comply with accepted ethical and professional standards of behavior
- An action that represents a clear and serious breach of accepted professional standards of care, such that the continued care of members by the provider could endanger their safety or health
- Potential quality of care issues related to underutilization or overutilization

Clever Care Quality Management staff will review the identified or potential quality of care issue, request medical records, supporting documentation and other information as appropriate relevant to the case. The medical director will make a determination.

Clever Care will review and analyze the quality-of-care issues quarterly and identify opportunities for improving care and making recommendations for quality improvement actions. On an annual basis, Clever Care reports quality of care issues to the corporate Quality Improvement Committee. The Credentialing department uses quality of care reports to evaluate practitioners during the recredentialing process. As appropriate and required, Clever Care will report incidents to federal, state, and contractual entities as required. Please contact the Clever Care local Quality Management department when you identify potential incidents.

Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information in accordance with the Medicare Advantage program and provisions of HIPAA concerning members' rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, disease management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received from Clever Care to ensure no misrouted PHI is included. Misrouted PHI includes information about members whom a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as

long as it is retained. In no event are providers or facilities permitted to misuse or re-disclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Clever Care Provider Services to report receipt of misrouted PHI.

Emergency Services

Clever Care does **not** discourage members from using the 911 emergency system nor deny access to emergency services. Emergency services are provided to members without requiring prior authorization. Any hospital or provider calling for prior authorization for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; and/or (3) serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services, including the police, fire and Emergency Medical Services (EMS) departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

When a member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the member's chart the results of the emergency medical screening examination. Clever Care will compensate the provider for the screening, evaluations and examinations that are reasonable and calculated to assist the health care provider to determine whether or not the patient's condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the member at the treating facility prevails and is binding on Clever Care. If the emergency department is unable to stabilize and release the member, Clever Care will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the member is medically stable and the facility is capable of rendering the required level of care.

If the member is admitted, the Clever Care concurrent review nurse will implement the concurrent review process to ensure coordination of care.

Post-stabilization Care Services

Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient's condition. Prior authorization is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicare rate. Clever Care will adjudicate emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.

Access to Care Routine and Nonemergency Services

For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 10 business days, unless the member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for nonurgent primary medical care, the request-to-appointment time must be no greater than 10 business days, unless the member requests a later time medical, including dental care outpatient appointments for urgent conditions, must be available within 48-hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 15 business days, unless the member requests a later time. For outpatient scheduled appointments, the time the member is seen must not be more than 30 minutes after the scheduled time, unless the member is late. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 15 business days, unless the member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 48 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

Urgent Care

Clever Care requests its members to contact their PCP in situations when urgent, unscheduled care is necessary. Prior authorization with Clever Care is not required for a member to access an urgent care center.

MEMBER MANAGEMENT SUPPORT

Medicare covers a diverse group of people. Most are over 65, but 15 percent (nearly 7 million) are people under 65 who have a disability. Almost half (47 percent) have modest or low incomes, and over one-third (36 percent) of the Medicare population has three or more chronic conditions. Medicare also covers many people who have a cognitive or mental impairment (29 percent of the Medicare population).

A significant portion (17 percent) of the Medicare population is also enrolled in Medicaid. These beneficiaries are known as dual-eligible.

Appointment Scheduling

Clever Care, through its participating providers, ensures members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a member's needs and requests in a timely manner. The Primary Care Provider (PCP) should make every effort to schedule members for appointments using the PCP Access and Availability guidelines.

Interpreter Services

Clever Care provides our members with free interpreter services. Services are available 24 hours a day, 7 days a week and include over 150 languages, as well as services for members who are deaf or hard of hearing. To arrange interpreter services for a member in your care, call Member Services at (833) 388-8168.

Health Promotion

Clever Care strives to improve healthy behaviors, reduce illness and improve the quality of life for our members through comprehensive programs. Educational materials are developed or purchased and disseminated to our members, and health education classes are coordinated with community organizations and network providers contracted with Clever Care.

Clever Care manages projects that offer our members education and information regarding their health. Ongoing projects include:

- Creation and distribution of health education tools used to inform members of health promotion

issues and topics
- Health Tips on Hold (educational telephone messages while the member is on hold)
- Health education programs offered to members
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community-based organizations to enhance opportunities for members

Case Management

The Clever Care Case Management Program is a member-centric, integrated continuum of care model that strives to address the totality of each member's physical, behavioral, cognitive, functional, and social needs.

The scope of the Case Management Program includes but is not limited to:
- Member identification using a prospective approach that is designed to focus case management resources for members expected to be at the highest risk for poor health outcomes
- Initial and ongoing assessment
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the member as determined by initial and ongoing assessments
- Coordination of care with PCPs and specialty providers
- Member education
- Facilitation of effective member and provider communications
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Member satisfaction and quality of life measurement

Using a prospective systematic approach, members with a risk of poor health outcomes are identified and targeted for case management services. This continuous case finding system evaluates members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Case management resources are focused on meeting listed members' needs by using a mix of standardized and individualized approaches.

A core feature of the Case Management Program is the emphasis an integrated approach to meeting member needs. The program considers the whole person, including the full range of each member's physical, behavioral, cognitive, functional and social needs. The role of the case manager is to reach out and engage members of identified risk populations and to follow them across health care settings, to collaborate with other health care team members to determine goals and to coordinate access to resources and monitor utilization of resources. The case manager works with the member to identify specific needs and interfaces with the member's providers and care givers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from members, family/caregivers and in some cases providers, establishes the basis for identification of problems. Areas identified during the assessment that may warrant intervention include but are not limited to:
- Conditions that compromise member safety

- Poor or inconsistent treatment/medication adherence
- Current treatment plan has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Comorbid conditions
- History of high service utilization
- Use of inappropriate services
- Medical/psychological/functional complications
- Health education deficits
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the member's optimal care path, as well as the member's wishes, values, and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the member and providers to develop and implement an individualized care plan. As a provider, you may receive a call from the case manager, or a copy of the member's care plan may be sent to you.

If you identify a member as a possible candidate for case management services and wish to have them evaluated to see if they qualify, you can call in the referral for evaluation to (714) 650-8770 or the number on the members identification card and ask for someone in the Case Management department. The case management department is available Monday-Friday from 8am to 5pm PST.

Member Satisfaction

Clever Care periodically surveys members to measure overall customer satisfaction, including satisfaction with the care received from providers. Clever Care reviews survey information and shares the results with network providers.

Members are also surveyed by CMS twice a year through the CAHPS and HOS surveys. The results of both CMS surveys are part of the Medicare Advantage plans' HEDIS and star ratings. Clever Care encourages its participating providers to encourage members to actively participate in their health care, to receive preventive services timely and to improve their quality of life by following the provider's treatment plan. See the Centers for Medicare & Medicaid Services Star Ratings section of this administrative guide.

CLAIM SUBMISSION AND ADJUDICATION PROCEDURES

Claims — Billing and Reimbursement

Clean claims for Clever Care members are generally adjudicated within sixty (60) calendar days from the date Clever Care receives the claim. For nonclean claims, the provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Clever Care and the information required from the provider in order to adjudicate the claim. Clever Care produces and mails an Explanation of Payment (EOP) on a daily basis. The EOP delineates for the provider the status of each claim that has been paid or denied during the previous week.

Clever Care members must **not** be balance billed for services rendered as outlined in the participating provider agreement and the Attachment A rate sheet. Clever Care members are also not held liable for non-covered services where the provider failed to provide advanced notice of non-coverage via the organization determination process. Reimbursement by Clever Care constitutes payment in full except for applicable copays, deductibles and coinsurance. These amounts will be indicated in the EOP and direction provided based on whether Clever Care is responsible for processing both the primary and secondary claims or not. In instances where Clever Care is only responsible for processing primary claims, the provider should bill the state Medicaid agency or appropriate third-party insurer responsible for the remaining portion of the claim.

Providers must use HIPAA-compliant billing codes when billing. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating provider agreement will not be required to replace such billing codes. Clever Care follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with HIPAA. Clever Care will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim "Corrected Claim." Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim, due to the original claim not being considered a clean claim.

Claim Status

Providers should access the Clever Care online claim status inquiry tool on the Provider Portal https://eznet.clevercarehealthplan.com/EZ-NET60/Login.aspx https://eznet.clevercarehealthplan.com/ or may call Customer Services at (714) 650-8770 to check claim status.

Provider Claims

Providers should submit claims to Clever Care as soon as possible after service is rendered. Claims should be filed using the CMS-1500 (08-05) or UB-04 CMS-1450 claim forms or filed electronically.

Billing Differences for Medicare Advantage

CMS-1500 (08-05)

Box 9, 9A-D	Other Insurance, including Medicaid
Box 25	Federal Tax ID number
Box 33	State Medicaid number

Hospitals

Hospitals should submit claims to the Clever Care claims address as soon as possible after service is rendered, using the standard UB-04 form or by filing electronically.

UB-04/CMS 1450

Box 5	Federal Tax ID Number
Box 51a	Clever Care Unique Provider ID Number
Box 51b	State Medicaid Number
Box 51c	Medicare ID Number

Coordination of Benefits

Clever Care and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Clever Care members. When Clever Care is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if Clever Care does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts from Members.

Clever Care will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Clever Care will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Clever Care handles the filing of liens and settlement negotiations both internally and externally via its vendors.

Electronic Submission

Clever Care encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within the timely filing limits noted below from the date of discharge for inpatient services or from the date of service for outpatient services.

Electronic claims submission is available through
Clearinghouse.
Providers have the option of submitting claims electronically through EDI

The advantages of electronic claims submission are as follows:

- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims

To initiate the electronic claims submission process or obtain additional information, please contact the Clever Care EDI Hotline at 1 (657)224-1888.

EDI Submission for Corrected Claims

For corrected professional (837P) claims submitted via EDI claim professional, providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:

7 – Replacement of Prior Claim 8 – Void/Cancel Prior Claim

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the NUBC website at www.nubc.org

Indicator Placement:
Loop: 2300 (Claim Information)
Segment: CLM 05-03 (Claim Frequency Type Code) Value: 7, 8

For corrected institutional (837I) claims submitted via EDI, providers should use one the following Bill Type Frequency Codes to indicate a correction was made to a previously submitted and adjudicated claim:

0XX5 – Late Charges Only Claim
0XX7 – Replacement of Prior Claim
0XX8 – Void/Cancel Prior Claim

Note: A full definition of each code can be referenced on Pages II-111 through II-114 of the Ingenix UB04 Billing Manual.

Indicator Placement:
Loop: 2300 (Claim Information)
Segment: CLM 05-03 (Claim Frequency Type Code) Value: 5, 7, 8

Paper Claims Submission

Providers also have the option of submitting paper claims. Clever Care uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by Clever Care staff for claims information, allowing more timely and accurate response to provider inquiries

Providers must submit a properly completed UB-04 or CMS-1500 (08-05) within ninety (90) days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third-party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUCC, Clever Care now requires the use of the new CMS-1500 (08-05) for the purpose of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, Clever Care now requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.

CMS-1500 (08-05) and UB-04 CMS-1450 must include the following information (HIPAA-compliant where applicable):

- Member's ID number
- Member's name
- Member's date of birth
- ICD-10 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
- Itemized charges
- Days or units

- Provider tax ID number
- Provider name according to contract
- Clever Care provider number
- NPI of billing provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing provider when applicable
- State Medicaid ID number, as applicable
- Coordination of Benefits/other insurance information
- Authorization/prior authorization number or copy of authorization/prior authorization
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

Clever Care cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the provider with an explanation of the reason for the return. Clever Care will not accept claims from those providers who submit entirely handwritten claims.

Paper claims must be submitted within the timely filing limits noted below from the date of service: Submit paper claims to the following address:

MARKET	SUBMIT PAPER CLAIMS TO:
California	Clever Care Healthcare Plan, Inc. 7711 Center Ave Suite 100 Huntington Beach CA 92647

Encounter Data

Clever Care has established and maintains a system to collect member encounter data. Due to reporting needs and requirements, network providers who are reimbursed by capitation must send encounter data to Clever Care for each member encounter. Encounter data can be submitted through EDI submission methods. The preferred submission of encounter data is through Office Ally- Payer ID **CC16E**. Encounter data must be submitted to the Plan on a weekly basis, within 1 week of claim adjudication.- Encounter Data acceptance rates should be 99% or higher, with encounter data rates that meet CMS expectations.

The encounter data will include the following:

- Medicare member ID number
- Medicare member name (first and last name)
- Medicare member date of birth
- Provider name according to contract
- Clever Care provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider tax ID number and state Medicaid ID number, if applicable.

Encounter data should be submitted to the address provided on the previous page.

Through claims and encounter data submissions, Healthcare Effectiveness Data and Information Set (HEDIS) information is collected. This includes but is not limited to the following:

- Preventive services (e.g., immunization, mammography, Pap smears)
- Prenatal care (e.g., low birth weight, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by the Clever Care utilization and quality improvement staff, coordinated with the medical director, and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.

Claims Adjudication

Clever Care is dedicated to providing timely adjudication of provider claims for services rendered to members. All network and non-network provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Institutional claims should be submitted using EDI submission methods or an UB-04 or CMS-1450 and provider claims using the CMS-1500. Clever Care must also comply with state regulations regarding the payment of claims.

Providers must use HIPAA-compliant billing codes when billing Clever Care. This applies to both electronic and paper claims. When billing codes are updated, the provider is required to use appropriate replacement codes for submitted claims. Clever Care will not pay any claims submitted using noncompliant billing codes.

Clever Care reserves the right to use code-editing software to determine which services are considered part of, incidental to, or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria is applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, providers must adhere to the following time limits:

- Submit claims within the number of days specified for each market from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified for each market from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims submitted after the market specific timely filing deadline will be denied.
- In no case will Clever Care pay any claim initially submitted more than twelve (12) months after the date of service or pay a Clean Claim submitted more than twelve (12) months after the date of service.

After filing a claim with Clever Care, review the daily EOP. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the Clever Care Provider Portal at https://eznet.clevercarehealthplan.com/ or by calling Customer Services at (833) 878-1704. If the claim is not on file with Clever Care, resubmit your claim as soon as possible and within ninety (90) days from the date of service, or by the timely filing requirement for your market. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice management vendor.

Clean Claims Payment

A clean claim is a request for payment for a service rendered by a provider that:

- Is submitted in a timely manner
- Is accurate
- Is submitted on a HIPAA-compliant standard claim form, including a CMS-1500 or CMS-1450 or successor forms thereto or the electronic equivalent of such claim form
- Requires no further information, adjustment or alteration by the provider or by a third party in order to be processed and paid by Clever Care

Clever Care produces and mails an EOP on a weekly basis, which delineates for the payment the status of each claim that has been adjudicated during the previous payment cycle. Upon receipt of the requested information from the provider, Clever Care should complete processing of the clean claim within- sixty (60) calendar days.

Paper claims determined to be unclean will be returned to the billing provider along with a letter stating the reason for the rejection. Electronic claims determined to be unclean will be returned to the Clever Care contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, Clever Care will pay at least ninety-five percent (95%) of all clean claims from practitioners either in individual or group practice or who practice in shared health facilities within- sixty (60) calendar days of the date of receipt. Clever Care will pay or deny all other claims within sixty (60) calendar days of the receipt of the request. The date of receipt is the date Clever Care receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or other form of payment.

Provider Reimbursement

Electronic Funds Transfer and Electronic Remittance Advice

Clever Care offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Clever Care payments electronically through direct-deposit to their bank account. In addition, providers can select from a variety of remittance information options, including:

- HIPAA-compliant data file for download directly to your practice management or patient accounting system.
- Paper remittance printed and mailed by Clever Care.

Some of the benefits providers may experience include:

- Faster receipt of payments from Clever Care.
- The ability to generate custom reports on both payment and claim information based on the criteria specified.
- Online capability to search claims and remittance details across multiple remittances.
- Elimination of the need for manual entry of remittance information and user errors.
- Ability to perform faster secondary billing.

To register for ERA/EFT, please visit https://www.payspanhealth.com/nps.

Primary Care Provider Reimbursement

Clever Care reimburses PCPs according to their contractual arrangement.

Specialist Reimbursement

Reimbursement to network specialty care providers and network providers not serving as PCPs is based on their contractual arrangement with Clever Care.

Specialty care providers must obtain Clever Care approval prior to rendering or arranging any treatment procedure that is beyond the specific treatment authorized or beyond the scope permitted under this program. Initial consultations resulting from patient self-referral do not require authorization but are limited to a specific CPT code set of services.

Specialty care provider procedure services will be covered only when there is documentation of appropriate notification or prior authorization, as appropriate, and receipt of the required claims and encounter information by Clever Care.

Reimbursement Policies

Reimbursement policies serve as a guide to assist providers in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Clever Care benefit plan. These policies can be accessed on the Provider Portal at https://eznet.clevercarehealthplan.com/

The listing of a service, procedure, item, etc. as covered under a member's benefit plan is not a determination that a provider will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Providers must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, Clever Care policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Clever Care may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Clever Care reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Clever Care strives to minimize these variations.

Clever Care reserves the right to review and revise its policies periodically when necessary. When there is an update Clever Care will publish the most current policy at; https://eznet.clevercarehealthplan.com/

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, prior authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

Level 1: Benefit Coverage
Level 2: Medical necessity or clinical criteria

Level 3: Reimbursement Policy and regulations
Level 4: Payment methodology as determined by contract / requirements.

Review Schedules and Updates

Reimbursement Policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements. Additionally, updates may be made at any time if Clever Care is notified of a mandated change or due to a Clever Care business decision. When there is an update, we will publish the most current policy at; http://www.clevercarehealthplan.com/ https://eznet.clevercarehealthplan.com/

Medical Coding

The Claims department ensures that correct coding guidelines have been applied consistently throughout Clever Care. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition

Clever Care allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by provider contracts, or state, federal or CMS requirements. There are seven CPT sections:

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Temporary codes for emerging technology, services or procedures

Various procedure codes are located in particular CPT categories, although the procedure may not be classified within that particular category (e.g., venipuncture is located in the CPT Surgical Section, although it is not a surgical procedure).

Overpayment Process

Refund notifications may be identified by two entities, Clever Care Claims Department, or the provider. The Claims Department researches and notifies the provider of an overpayment by requesting a refund check. The provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified by Clever Care, the Claims Department will notify the provider of the overpayment. The provider will submit a Refund Notification Form along with the refund check. If a provider identified the overpayment and returns the Clever Care check, please include a completed Refund Notification Form specifying the reason for the return. This form can be found on the Provider Portal at https://eznet.clevercarehealthplan.com/. Submission of the Refund Notification Form will allow Clever Care to process and reconcile the overpayment in a timely manner. Please ensure that the notice references the claim number under which the overpayment was made. For questions regarding the refund notification procedure, please call Customer Service at (714) 650-8770.

Clever Care uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-

widening array of edits and rules as well as consistency of payment for providers by ensuring correct coding and billing practices are being followed. Using sophisticated auditing logic, the code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single beneficiary. If a provider has any questions regarding the payment of a claim, they may call the Customer Service line at (714) 650-8770 to speak to a Claims Department supervisor.

Administrative Appeals

Please reference the notification letter received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the member can be held liable for any payments (member liability).

Member Liability Appeals

If a provider appeals a decision rendered with member liability, then the appeal follows the CMS Member Liability Appeals process and is processed by the Medicare Complaints, Appeals and Grievance (MCAG) department. See Medicare Member Liability Appeals process.

Provider Liability Appeals

A provider liability appeal is a request for Clever Care to review a decision by Clever Care Utilization Management Services to deny payment (without member liability) for services already rendered. To submit a request for appeal, send in a copy of the explanation of payment received along with all medical records. The provider is responsible for sending in all necessary information, after which time the appeal will be reviewed and a determination rendered based on the information provided.

Claim Correspondence

Claim Correspondence is different from a Payment Dispute. Correspondence is when Clever Care requires more information in order to finalize a claim. Typically, Clever Care makes the request for this information through the claim development letter. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, Clever Care will use it to finalize the claim.

The following table provides examples the most common Correspondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
Rejected Claim(s)	First check with Clearinghouse when your claim was submitted electronically but was never paid or was rejected. Clever Care is available to assist you with setup questions and help resolve submission issues or electronic claims rejection
EOP Requests for Supporting Documentation (Sterilization/	Submit a claim correspondence form, a copy of your EOP and the supporting documentation to: Claims Correspondence

Type of Issue	What Do I Need to Do?
Hysterectomy/Abortion Consent Forms, itemized bills, and invoices)	7711 Center Ave Suite 100 Huntington Beach CA 92647
EOP Requests for Medical Records	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence 7711 Center Ave Suite 100 Huntington Beach CA 92647
Need to submit a Corrected Claim due to errors or changes on original submission	Submit a Claim Correspondence form and your corrected claim to: Claims Correspondence 7711 Center Ave Suite 100 Huntington Beach CA 92647 Clearly identify the claim as corrected. Clever Care cannot accept claims with handwritten alterations to billing information. Clever Care will return claims that have been altered with an explanation of the reason for the return. A corrected claim must be received within 90 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to Clever Care to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI EOP.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a Claim Correspondence form, a copy of your EOP and the COB/TPL information to: Claims Correspondence 7711 Center Ave Suite 100 Huntington Beach CA 92647
Emergency Room Payment Review	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence 7711 Center Ave Suite 100 Huntington Beach CA 92647

Provider Payment Disputes Process

If you believe Clever Care has not paid for your services according to the terms of your provider agreement, submit a request using the Provider Dispute Resolution Request Form located on the Provider Portal under References and Forms at https://eznet.clevercarehealthplan.com/.

Providers will not be penalized for filing an appeal or payment dispute. Submit provider liability appeals/payment disputes to:

Provider Payment Dispute Unit
7711 Center Ave Suite 100
Huntington Beach CA 92647

The Provider Disputes Unit will receive, distribute, and coordinate all payment disputes and appeals.

1. Submit a written request with supporting documentation, such as an EOP and a copy of the claims or denial letter received along with other written documentation; a full explanation of the dispute is required and must be submitted within 120 days of when Clever Care notice of initial determination was generated or Clever Care will not accept the request; the provider is responsible to submit all necessary documentation at the time of the request.

2. The Clever Care UM Department conducts the review, and/or the health plan medical director reviews the second level dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.

3. An internal review is conducted, and results communicated in a written decision to the provider within 60 calendar days; the written decision includes:
    - A statement of the provider's dispute
    - The reviewer's decision along with a detailed explanation of the contractual and/or medical basis for such decision
    - A description of the evidence or document that supports the decision

PROVIDER COMPLAINT AND GRIEVANCE PROCEDURE

Clever Care has a formal process for the handling of disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see "Provider Payment Disputes." For Medicare member liability appeals, see "Medicare Member Appeals." Providers may access this process by filing a written grievance. Provider grievances will be resolved fairly and consistent with Clever Care policies and covered benefits.

Providers are not penalized for filing complaints. Supporting documentation should accompany the complaint and be forwarded to Clever Care Office.

Attention: Administrative Provider Plea /Appeals Clever Care
7711 Center Ave Suite 100
Huntington Beach CA 92647

COORDINATION OF BENEFITS

Clever Care and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When Clever Care is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim or redirecting the provider to bill the appropriate insurance carrier. If Clever Care does not become aware of the resource until sometime after payment for the service was rendered it will pursue post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

Clever Care will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, Clever Care will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched post-payment to determine likely cases based on information obtained through communications with members and providers. Clever Care handles the filing of liens and settlement negotiations both internally and externally via its subrogation or delegated vendors.

Clever Care requires members to cooperate in the identification of any and all other potential sources of payment for services.

Any questions or inquiries regarding paid, denied, or pended claims should be directed to Customer Services at (833) 388-8168.

Provider Obligations Denial Notification for Member complaints, appeals and grievances Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS) and Clever Care requirements concerning issuing letters and notices. This includes advanced notice of denials that will result in member liability or cost in accordance with Medicare guidelines for Medicare Advantage Plans.

Skilled Nursing Facilities and Home Health Agencies

The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice that is issued to Medicare Advantage members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility or home health services. This notice explains the determination that continued coverage after a specific effective date will no longer be covered by Clever Care. A NOMNC should be issued to a Medicare member at least two days prior to discharge, or in advance of the last two covered visits. This notice informs the member his or her stay or visits no longer meet coverage criteria and will end in two days or after two visits. In most cases, the notice is required to be issued by the provider, and Clever Care is required to ensure proper delivery and that the member's signature is obtained. The member's

signature is not an agreement with the denial; however, it is documentation he or she has received the notification. If a member refuses to sign the notice, the provider may contact the member's representative to have that person sign. If no representative is available, the provider may annotate the notice to indicate the refusal and document that notification was provided to the member, but the member refused to sign. If in-person notification cannot be provided to a representative, he or she can be contacted telephonically to advise him or her of the notice and their appeal rights. If agreed by both parties, the notice can then be emailed or faxed (in accordance with HIPAA privacy and security requirements). The notice should be annotated by the person providing the notification to the representative indicating the date, time, person name, relation to the member, telephone number called, and that the notice was read to the representative, including all appeal rights. If a member (or representative) elects to exercise his or her right to an immediate review, the member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The provider is responsible for submitting any documents or medical records as requested by the QIO or Clever Care Medicare Complaints, Appeals and Grievance department within the time frame indicated on the request.

Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary's rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the member or representative and provide them with a copy at that time. The hospital is also responsible for ensuring the member can comprehend the contents of the notice before obtaining the signature. It is the responsibility of the hospital to explain the notice, if necessary, and be able to answer any questions about the notice the member or representative may have. Notices should not be delivered while the member is receiving emergency treatment but should be delivered once the patient is stable. If a member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise him or her of their appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). In addition, prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the member or representative in person. If the notice is being given on the day of discharge, the member must be provided at least four hours to consider his or her rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge, either verbally or in writing, before that person leaves the hospital.

Provider Obligations — In-office Denials

In the event a member disagrees with the provider's decision about a request for service or a course of treatment or is requesting or in need of services that are not covered by Clever Care or Medicare. At each patient's encounter with a Clever Care member, the provider must notify the member of his or her right to receive, upon request, a detailed written notice from Clever Care regarding the member's services. The provider must request Clever Care to provide a detailed notice of a provider's decision to deny a service in whole or part; in turn, Clever Care must give the member advanced written notice of the determination, by following the prior authorization process (outlined below).

For services that require prior authorization or are non-covered by Clever Care (i.e., statutory exclusion), it becomes extremely important that Clever Care authorization procedures are followed. If a member elects to receive such care the member cannot be held financially responsible unless notified in advance of the non-covered services. In such cases when the network physician fails to follow Clever Care authorization protocols, Clever Care may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

The Centers for Medicare & Medicaid Services (CMS) have established guidelines concerning Advance Notices of Non-Coverage (ABN). The ABN is an FFS document and cannot be used for Medicare Advantage denials or notifications. Per CMS (page 4) The ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service (FFS) program. It is not used for items or services provided under the Clever Care Medicare Advantage (MA) Program or for prescription drugs provided under the Clever Care Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If there is any doubt about whether a service is not covered, please seek a coverage determination from Clever Care.

A written coverage determination will help ensure that a claim for non-covered care from a contracted provider is paid accurately. According to CMS, if the appropriate written notice of denial of payment is not given to the Medicare Advantage member regarding a non-covered service, the claim may be denied, and the member cannot be held financially responsible. Therefore, your failure to provide an appropriate coverage determination could result in a denial of payment for the non-covered service.

Please contact Clever Care prior to services being rendered to comply with this requirement and ensure appropriate claims payment and allow you to bill the Member in the event of non- coverage. As a Contracted Provider with Clever Care, you are prevented from billing the Clever Care Member for any service that is deemed non-covered if you have not ensured this advanced notification has been issued.

Provider Obligations — Prior authorization

Providers are responsible for obtaining prior authorization from Clever Care before performing certain procedures, when rendering non-covered services or when referring members to noncontracted providers. Please refer to the Summary of Benefits document for those procedures that require prior authorization or the Provider Portal or call Member Services at (833) 388-8168. Clever Care will render a determination on the request within the appropriate timeframe and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Medicare members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Clever Care and the provider will not generate a member denial letter.

- An initial *organization* determination is any determination (e.g., an approval or denial) made by Clever Care for coverage of medical services (Part B-covered services).
- An initial *coverage* determination is any determination (e.g., an approval or denial) made by Clever Care for coverage of prescription drugs (Part D-covered services).

Clever Care Complaints, Appeals, Grievances and Disputes

Distinguishing between Provider and Member Complaints, Appeals & Grievances

Clever Care has separate and distinct processes for requests to reconsider a Clever Care decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Member liability denials are subject to the Medicare Complaint, Appeal & Grievance (MCAG) process as outlined in the Member Appeals and Grievances section. Disputes between the Clever Care as the Health Plan and the Provider that do not involve an adverse determination or liability for the Member would follow the Clever Care Participating Provider Appeals and Dispute or Non-Participating Provider Payment Dispute processes.

Providers must cooperate with Clever Care and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Clever Care to make an expedited decision. Your participation in, along with the member's election of the Clever Care Medicare Advantage plan, are an indication of consent to release those records as part of the health care operations.

Medicare Member Liability occurs when Clever Care has determined that a Member is responsible for payment as the service(s) are determined to be not covered under Clever Care to which they are enrolled or is considered Member cost-share. Any time a member liability denial letter is issued, the Member Appeals process should be followed and NOT the Provider Appeals process.

Member liability is assigned when:

- the Integrated Denial Notice (IDN) is issued as per the Medicare Managed Care Manual Chapter 13 Appeal rights with subsequent review by the Independent Review Entity (IRE).
- Notice of Medicare Non-Coverage (NOMNC) is issued as per the Medicare Managed Care Manual Chapter 13 Appeal rights with rights to pursue an appeal via the Quality Improvement Organization (QIO) or Clever Care directly.
- an Explanation of Benefits (EOB) indicates there is member responsibility assigned to a claim processed.
- an Explanation of Payment (EOP) indicates there is member responsibility assigned to a claim processed.

Participating Provider Liability occurs when Clever Care has determined that the Participating Provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment. Participating Providers are prohibited from billing a Clever Care Member for services unless Clever Care has determined Member liability and issued the appropriate notices as above.

Non-Participating Provider Liability is when Clever Care has determined that the Non-Participating Provider has failed to follow Medicare processing guidelines. Non-Participating Providers are prohibited from billing a Clever Care Member for services unless Clever Care has determined Member liability and issued the appropriate notices as above and has procedures for Non-Participating Provider to follow.

Clever Care Participating Provider Complaint and Appeals

Participating Provider Appeals follow the standard Clever Care process for provider appeals. Clever Care participating providers may initiate provider appeals under the Provider Complaint and Appeal Procedures. The processing of a provider's appeal may vary depending on whether or not it involves a

review of medical necessity. The Provider Complaint and Appeals Procedures contain alternative steps, based on product and state, as necessary to comply with regulatory and accreditation requirements.

The Provider Complaint and Appeal Procedures are designed to permit Clever Care to examine issues fully and fairly before completion of Clever Care's internal review process. Special processes apply to appeals that involve utilization review decisions on clinical benefits. Clever Care typically determines provider appeals within sixty (60) days (for utilization review cases) or sixty (60) days (for other cases) when sufficient information is received to make a decision.

Medicare Participating Provider Standard Appeal

A formal request for review of a previous Clever Care decision where medical necessity was not established and where Provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility All requests must be:

- Submitted in writing
- Submitted within 180 days from the Clever Care decision letter date
- Include a cover letter with:
    - Member Identifiable information
    - Date(s) of service in question
    - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Clever Care's original decision
    - Include necessary attachments:
    - Copy of the original Clever Care decision
    - All applicable medical records

NOTE: Clever Care will not request additional records to support the provider's appeal argument and expects the provider to submit the necessary information to substantiate their request for payment.

Appeals should be mailed to:

Clever Care Health Plan
Attention: Medical Necessity Provider Appeals
7711 Center Ave Suite 100
Huntington Beach CA 92647

Providing the above information will enable Clever Care's Participating Provider Appeals team to properly and timely review requests within thirty (30) calendar days. Requests that do not follow the above may be delayed.

Medicare Participating Provider Administrative Plea/Appeal

A formal request for review of a previous Clever Care decision where a determination was made that the Participating Provider failed to follow administrative rules and Provider liability was assigned (see original decision letter) where services have already been rendered.

Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.

Provider Administrative Appeals Responsibility All requests must be:

- Submitted in writing

- Submitted within 120 days from the Clever Care decision letter date
- Include a cover letter with:
  - Member Identifiable information
  - Date(s) of service in question
  - Specific rationale as to why the administrative rules were not followed and requires an exception to be made or extenuating circumstance that warrants a re- review of the request for provision of payment.
- Include necessary attachments:
  - Copy of the original Clever Care decision
  - All applicable medical records

NOTE: In the event Clever Care waives the administrative requirement, should your request require a medical review, Clever Care will not request additional records to support the providers argument and expects the provider to submit the necessary information to substantiate their request for payment.

Requests should be mailed to:

Clever Care Health Plan
Attention: Medical Necessity Provider Appeals
7711 Center Ave Suite 100
Huntington Beach CA 92647

Providing the above information will enable Clever Care's Participating Provider Appeals team to properly and timely review requests within thirty (30) calendar days. In the event Clever Care waives the administrative requirement, the request will be transferred to the appropriate area for review under that process and applicable timeframes.

Requests that do not follow all of the above may be delayed.

Medicare Provider Payment disputes (Claims Re-review)

A formal request from a Provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial and claims payment determinations have already been rendered.

All Payment Disputes must be:

- Submitted in writing
- Submitted within 120 days from the Clever Care original payment
- Include a cover letter with:
  - Claim Identifiable information
  - Specific rationale as to why the payment made is not appropriate or needs adjustment
- Include necessary attachments:
  - Copy of the original Clever Care payment (EOP)
  - All applicable medical records or other attachments supporting additional payment

NOTE: Clever Care will not request additional information and expects the provider to submit the necessary information to substantiate their request for additional payment

Disputes should be mailed to:

Clever Care Payment Dispute Unit
7711 Center Ave Suite 100
Huntington Beach CA 92647

Providing the above information will enable Clever Cares Claims Department to properly and timely review requests. Requests that do not follow all of the above may be delayed.

Clever Care Non-Participating Provider Payment Disputes

Non-Participating Provider Payment Disputes

If, after a claim has been adjudicated, a non-participating provider contends that Clever Care's decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the Non-Participating Provider Payment Dispute Resolution Process can be utilized. Notification will be provided to the Non-Participating Provider at each step of the process.

Clever Care Non-Participating Provider Appeals Rights

If a claim is partially or fully denied for payment, the non-participating provider must request a reconsideration of the denial within sixty (60) calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed Waiver of Liability form must be included. To obtain this form, please go to: The purpose of the Waiver of Liability form is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the non- participating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing and mailed.**

Please mail the appeal to this address:

Clever Care Health Plan
Attention: Medical Necessity Provider Appeals
7711 Center Ave Suite 100
Huntington Beach CA 92647

Clever Care Member Complaints, Appeals and Grievances

Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a health plan, provider, facility or Quality Improvement Organization (QIO) by a Member made orally or in writing. There are two procedures for resolving Member complaints: The Member **appeals** process and the Member **grievance** process. All member concerns are resolved through one of these mechanisms. The Member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Clever Care to reconsider and change an initial coverage/organization determination (by Clever Care or a provider) about what services, benefits or prescription drugs are necessary or covered, or whether Clever Care will reimburse for a service, benefit, or a prescription drug.

A Member appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Clever Care denies it, the member has the right to appeal the decision. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Clever Care or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Clever Care concerning reimbursement for a health care service
- An adverse initial organization determination by Clever Care concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by Clever Care or a provider concerning authorization for prescription drugs

Appeals should be sent to:

Clever Care Health Plan
Attention: Medical Necessity Provider Appeals
7711 Center Ave Suite 100
Huntington Beach CA 92647

All Member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

Participating Provider Responsibilities in the Member Appeals Process

Physicians can request standard service or expedited appeals on behalf of their members; however, if not requested specifically by the attending, an Appointment of Representative Form may be required to submit an appeal on behalf of a Member. The Appointment of Representative Form can be found online and downloaded on the Provider Portal or at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.

- When submitting an appeal, provide all medical records and/or documentation to support the appeal at that time. Please note that if additional information is requested, it will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process

Appeal timeframes

Members or their Authorized Representatives have sixty (60) days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended if good cause can be shown.

- For standard pre-service appeals, issues must be resolved within thirty (30) calendar days from the date the request was received.
    - If the normal time period for an appeal could jeopardize the member's life, health, or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals are generally resolved within 72 hours unless it is in the member's interest to extend this time period.

For appeals related to Part B drugs, issues must be resolved within seven (7) calendar days from the date the request was received. Timeframes cannot be extended for Part B drugs.

- For payment appeals, service and payment issues must be resolved within sixty (60) calendar days from the date the request was received. All payment appeals must be submitted in writing.

Further Appeal Rights

If Clever Care is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- Clever Care will forward the appeal to an Independent Review Entity (IRE) contracted with the federal government. The IRE will review the appeal and make a decision:
  - Within 72 hours if expedited**
  - Within 30 days* if the appeal is related to authorization for health care
  - Within in 7 days for Part B drugs
  - Within 60 days* if the appeal involves reimbursement for care
  - Prescription drug appeals are not forwarded to the IRE by Clever Care but may be requested by the member or representative; information will be provided on this process during the Clever Care Medicare member appeals process

- If the IRE issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ)
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court

❖ Some plans may have different turnaround times due to state requirements.
❖ Payment and Part B drugs requests cannot be expedited.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to the expedited member appeal process. The Centers for Medicare Medicaid Services (CMS) has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When a Clever Care member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than noon of the first working day after the member receives the Notice of Discharge and Medicare Appeal Rights. The QIO will make a decision within one full working day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Clever Care continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days.

If an MA member misses the deadline to file for an immediate QIO review, then he/she may request an expedited appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

Clever Care Member Grievance

A Member grievance is the type of complaint a member makes regarding any other type of problem with Clever Care or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Clever Care must accept grievances from members orally or in writing within sixty (60) days of the event. Clever Care must make a decision and respond to the grievance within 30 days*. A member can request an expedited grievance, in which case Clever Care has 24 hours to respond. An expedited grievance can only be initiated if Clever Care refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination. Clever Care can request up to fourteen (14) additional days to respond to a grievance with good reason.

*Some plans may have different turnaround times due to state requirements.

Resolving Clever Care Member Grievances

If a Clever Care member has a grievance about Clever Care, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Clever Care Health Plan
Attention: Medical Necessity Provider Appeals
7711 Center Ave Suite 100
Huntington Beach CA 92647

Provider Portal

Clever Care Self-Service Website and the Provider Inquiry Line

The Clever Care self-service website at https://eznet.clevercarehealthplan.com/EZ-NET60/Login.aspx https://eznet.clevercarehealthplan.com/ provides a host of online resources**,** such as the **Online Provider Inquiry Tool** for real-time claim status, eligibility verification and prior-authorization status. You can also submit a prior-authorization request. Detailed instructions for use of the Online Provider Inquiry Tool can be found on the website.

Provider Services

To support our providers and members, Clever Care has established the Customer Service Unit (CSU) to assist with questions and concerns about the Clever Care plans. The CSU is comprised of subject matter experts and specializes in first-call resolution for provider and member inquires. Clever Care CSU representatives can help:

- Resolve payment disputes, appeals and other claims issues
- Verify claims status, member eligibility, prior-authorization requirements, and the status of health care services
- Identify participating Clever Care providers for referring members to specialty services
- Refer members for interpreter services, transitions, care coordination, transfers, and terminations
- Support noncompliant members (e.g., members who repeatedly miss appointments, members who are noncompliant with their treatment plans, etc.)

The CSU is available Monday through Friday from 8:00 a.m. until 8:00 p.m. Pacific Standard time at (657) 224-1888. Information is available through the automated system, or you can be transferred to the appropriate department for other needs, such as authorization questions.

Clever Care members have the right to timely quality care and treatment with dignity and respect. Each member receives a copy of the Explanation of Coverage which outlines the member's rights and responsibilities. Providers must respect the rights of all Clever Care members.

Members have the right to:

- Be treated with dignity, respect, and fairness at all times.
- Receive information about the Clever Care Health plan, services, practitioners, providers and member rights and responsibilities.
- Receive information in a way that works for them (in languages other than English spoken in Clever Care service area, in Braille, large print or other alternate formats).
- Ensure the privacy of their medical records and personal health information.
- Choose a plan provider.
- Receive care from a women's health care provider.
- Have timely access to their providers and to receive services from specialists when appropriate,
- Obtain information from providers and be advised about all medically appropriate or necessary treatment options available for their condition, regardless of cost or benefit coverage.
- Participate fully in decisions about their health care and be informed about any risks involved in their care.
- Refuse treatment, leave a hospital or medical facility or stop taking medications; the member must accept responsibility and the consequences of his or her decision.
- Complete an advance directive (living will or power of attorney) to help them with decisions related to their health care if they are unable.
- Voice complaints or appeals about the Clever Care plan or the care provided.
- Make recommendations regarding the Clever Care's member rights and responsibilities policy.
- Receive information about appeals and grievances members have filed against Clever Care in the past.
- Receive information about the Clever Care plan, plan providers, drugs, health care coverage and costs, including an explanation about any bills received for services or drugs not covered.
- Request information regarding provider compensation by Clever Care.
- Receive a written or binding advance-coverage determination for health care services, even if the care is requested from a nonparticipating provider.

Members have the responsibility to:

- Be familiar with their coverage and the rules they must follow to obtain health care.
- Notify Clever Care if they have additional health insurance coverage.
- Notify providers when seeking care that they are Medicare members and present their Clever Care Medicare member ID cards.
- Provide the health plan, doctors, and practitioners with accurate information to render care and follow the treatment plans and instructions they agreed to with the provider.
- Understand their health problems and participate in identifying mutually agreed-upon treatment goals to the extent possible.
- Treat their doctor, their doctor's staff and Clever Care employees with respect and dignity.
- Not be disruptive in the doctor's office.
- Pay their copayment for covered services.
- Notify Clever Care if they have questions, concerns, problems, or suggestions (Members may call Member Services at (833) 388-8168 and TTY users should call 711.)

Providers are also required to adhere to Centers for Medicare & Medicaid Services (CMS) and Clever Care requirements concerning issuing letters and notices.

BENEFITS

Summary of Benefits Tables

Clever Care Member benefits are summarized in the Summary of Benefits. To view the Summary of Benefits tables, click the link below for the appropriate market.

MARKET	CLICK THE LINK TO ACCESS THE BENEFITS TABLES
California	www.clevercarehealthplan.com

Notations regarding some benefit categories are listed below. Please note availability and limitations of Clever Care Medicare Advantage supplemental benefits may vary by product and market. Please refer to the appropriate Summary of Benefits documents listed above for detailed information.

Prior-authorization requirements are described in later sections and in detail on the Clever Care provider website. All services from noncontracted providers with the exceptions of urgent and emergent care and out-of-area dialysis require prior-authorization.

The medical benefits are further explained in the following sections:

Emergency Care

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Clever Care covers emergency services if they are:

- Furnished by a provider qualified to provide emergency services
- Needed to evaluate or stabilize an emergent medical condition in accordance with the prudent layperson standard

Members with an emergency medical condition should be instructed to call 911 and/or go to the nearest emergency room or hospital. Prior authorization for an emergency medical condition is not required.

Urgently Needed Care

Members needing urgent care (but not emergent care) are advised to call their PCP, if possible, prior to obtaining services. Prior authorization is not required.

Urgently needed services are defined as those that are covered but are not emergent services and are provided:

- When the member is temporarily absent from the Clever Care service area and such services are medically necessary and immediately required
- As a result of an unforeseen illness, injury, or condition
- If it is not reasonable given the circumstances to obtain the services through a Clever Care network provider

Under unusual and extraordinary circumstances, services may be considered urgently needed services when the member is in the service area but the appropriate provider within the Clever Care provider network is temporarily unavailable or inaccessible.

Out-Of-Area Dialysis Services

Members may obtain medically necessary dialysis services from any qualified provider when they are temporarily absent from the Clever Care service area and cannot reasonably access contracted Clever Care dialysis providers. Members can obtain dialysis services without prior-authorization or notification when outside of the Clever Care service area.

Clever Care suggests members advise Clever Care if they will temporarily be out of the service area, so a qualified dialysis provider may be recommended.

Hospital Services

There are two types of admissions:

- Elective inpatient admissions — prior authorization is required for all elective inpatient admissions
- Emergency admissions — admitting physicians must notify us within 24 hours or by the next business day of the admission

Clever Care Utilization Management, in coordination with admitting physicians and hospital-based physicians, is in charge of:

- Coordinating and conducting continued-stay coverage reviews
- Providing appropriate referrals for extended-care facilities
- Coordinating coverage of all services required for adequate discharge

Utilization Management assists with coordinating services in the discharge planning process, as well as coordinating the required follow-up by the appropriate providers.

Preventive Services

The following preventive services are offered to members with no member copayment or cost sharing:

- Preventive visit
    - Annual physical examination (in addition to the Medicare preventive visits)
    - You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with diagnosis code V70.0
        - Welcome to Medicare exam
        - Annual wellness exam
    - Bone mass measurements
    - Colorectal screening
    - Diabetic monitoring training
    - Cardiovascular disease testing
    - privacy screening
    - Pap smear, pelvic exams and clinical breast exams
    - Prostate cancer screening exams
    - Abdominal aortic aneurysm screening
    - Diabetes screening
    - EKG screening
    - Flu shots
    - Glaucoma tests
    - Hepatitis B shots
    - HIV screenings

- Medical nutrition therapy services
- Pneumococcal shots
- Smoking cessation (counseling to stop smoking)
- Depression screening

Domestic Violence Services

It is especially important that network providers be vigilant in identifying members who may have been subjected to domestic violence. Domestic violence screening tools are included. are included on the next page of this administrative guide. Member Services can help members identify resources to protect themselves from further domestic violence. Providers should report all suspected domestic violence.

State law requires reporting of child abuse. Such reporting can be done anonymously. Report any injuries from firearms and other weapons to the police. Report suspected child abuse or neglect immediately.

State law encourages individuals to report suspected cases of elder or partner abuse, neglect, or exploitation that occurs in the community. Report suspected elder or partner abuse immediately to the state's Division of Aging and Community Services or to the particular county Adult Protective Services office. An individual can access the National Domestic Violence Hotline number by calling 1-800 799 7233. For text telephone assistance, call 1-800-787-3224.

State law provides immunity from any criminal or civil liability as a result of good faith reports of child abuse or neglect. Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to $1,000 or imprisonment up to six months.

DOMESTIC VIOLENCE SCREENING TOOLS

Domestic Violence — Framing Statements

- Because violence is so common in many people's lives, I have begun to ask all my members about it.
- I'm concerned that someone hurting you may have caused your symptoms.
- I don't know if this is a problem for you, but many of the people I see as members are dealing with abusive relationships.

Domestic Violence — Direct Verbal Questions

- Are you in a relationship with a person who physically hurts or threatens you?
- Did someone cause these injuries? Was it your partner or spouse?
- Has your partner or ex-partner ever hit you or physically hurt you? Has he or she ever threatened to hurt you or someone close to you?
- Do you feel controlled or isolated by your partner?
- Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
- Has your partner ever forced you to have sex when you did not want to? Has your partner ever refused to practice safe sex?

Domestic Violence – New Member

- Option 1:
  - Have you ever been hurt or threatened by your friend, spouse or partner?
  - Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse or partner?
  - Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse or partner during this pregnancy?
  - Have you ever been raped or forced to engage in sexual activity against your will?
- Option 2:
  - Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?
- Option 3:
  - Have you ever been forced or pressured to have sex when you did not want to?
  - Have you ever been hit, kicked, slapped, pushed, or shoved by your friend, spouse or partner?

Sexual Abuse

It is required that each provider contact your local state agency when sexual abuse is suspected.

SUPPLEMENTAL BENEFITS

Supplemental benefits are those benefits offered by Clever Care in addition to the basic Medicare services offered through the original Medicare Part A and B program. Clever Care offers limited supplemental benefits to covered members as outlined in the Summary of Benefits documents. Please refer to the applicable Summary of Benefits for specific supplemental benefits being offered by Clever Care, as well as any limitations and requirements to utilize specific vendors for services. Providers will not be reimbursed for supplemental benefits that they are either not contracted for or that are required to be rendered by a specific vendor under is Clever Care has arranged for a specific vendor to provide these services. Members cannot be billed for non-covered services unless notified in advance. See Provider Obligations — In-office Denials.

Supplemental benefits vary by plan, product, and state. Below is a list of supplemental benefits Clever Care may choose to offer each calendar year in certain states and plans. Please refer to the Summary of Benefits documents for details on which plans cover certain supplemental benefits.

- Routine eye examinations, eyeglasses, and contact lenses
- Routine hearing examinations and hearing aids up to a defined benefit limit.
- Dental examinations, cleanings, and other services up to a defined benefit limit.
- Coverage of Over the Counter (OTC) items
- Nonemergency transportation
- Acupuncture services
- Eastern Medicine Services including Ayurveda, massage, moxibustion, and herbal therapies.
- Fitness programs which include Yoga and Tai Chi Classes
- All plans have a Maximum Out-of-Pocket (MOOP) limit for medical services. The MOOP does include out-of-pocket costs for Part B drugs but does **not** include Part D (pharmacy prescriptions) cost-sharing amounts. Once a member reaches his or her MOOP limit, all covered medical services will be covered at 100 percent for the remainder of the year.
- Telemonitoring is available in all plans.
- Out-of-country emergency care

Providers **contracted with the delegated provider network** associated with that supplemental benefit must bill that vendor directly.

Providers **not contracted with the delegated provider network** to render such a benefit, please note you will only reimbursed or able to bill a member for non-covered services if you have provided the member with advanced notice of non-coverage. Please note that contracted providers are required to provide a coverage determination for services that are not covered by the member's plan that is issued by Clever Care.

This will ensure that the member will receive a denial of payment and accompanying appeal rights. As per the Medicare Advantage HMO & PPO Provider Guidebook CMS has stated that the use of an Advanced Beneficiary Notice or a similar document (as used with Medicare Fee for Services beneficiaries) is not sufficient in many instances for use with Medicare Advantage members. Therefore, you are required to seek a coverage determination from Clever Care prior to rendering such services.

Providers are encouraged to call the Customer Service number on the back of the member ID card with any questions around services that may or may not be covered.

Note: Not all supplemental benefits are available in all states and for all plans, and some limitations and restrictions apply. Additionally, some supplemental benefits are only available from a specific set of delegated providers of these benefits.

Dental Services
Some Clever Care plans include preventive and other dental services that are covered by Clever Care through a contracted dental vendor, which supplement the dental services covered as emergency services. The Clever Care Medicare Advantage supplemental dental health benefits complement its medical plan emphasizes prevention, quality and cost-effectiveness. Clever Care works with contracted dental providers to ensure access to the full range of preventive, primary and specialty oral health services. Please see the Summary of Benefits documents for more information on dental benefits.

Optometry and Audiology Services
Some of Clever Care plans include coverage of routine vision and hearing services, including:

- Routine yearly visual exams
- Screening for glaucoma
- Refraction exams for eyeglasses or contacts
- Eyeglasses and contact lenses
- Routine Hearing exams
- Hearing aid devices

Contracted network providers, assisted by the Clever Care, coordinate benefits for lenses and hearing aid devices when covered by Clever Care. Please see the Summary of Benefits documents for more information on vision and hearing benefits.

Over-The-Counter Items
Some of our plans include coverage of OTC items and health-related supplies. Please see the Summary of Benefits documents for more information on these benefits

Nonemergent Transportation
In many markets and benefit plans, Clever Care provides nonemergent transportation through a contracted vendor. In other markets, these services must be arranged through the Clever Care Case Management Program. See the Summary of Benefits documents for more information. Some plans have coverage of trips for members to obtain the preventive services.

Annual Physical Exam
Clever Care plans allow for an Annual Physical Examination (in addition to the Medicare preventive visit or the new to Medicare exam). Please see the Summary of Benefits documents for more information on these benefits

Eastern Medicine Services
Eastern Medicine Services including Acupuncture, Ayurveda, massage, moxibustion, and herbal therapies Please see the Summary of Benefits documents for more information on these benefits

PRESCRIPTION DRUG COVERAGE

All Clever Care plans include coverage of Medicare Part D prescription drugs, as well as those covered under Medicare Part B.

Part D Prescription Drugs

Medicare Part D prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Part D prescription drugs covered by Clever Care are listed in the Clever Care Medicare formulary. The formulary includes all generic drugs covered under the Part D program, as well as many brand-name drugs, nonpreferred brands and specialty drugs. One can view a copy of the formulary on the Clever Care website at www.clevercarehealthplan.com. From the Provider Resources & Documents library, select Pharmacy Tools, then Medicare Formulary or request a copy from the Provider Relations department. Some of these drugs have prior-authorization or step-therapy requirements or quantity limits. Providers may request authorization for a drug or coverage of a drug not on the formulary by contacting the MEDIMPACT at (800) 926-3004. Members should obtain Part D covered drugs from a network pharmacy pursuant to a physician's prescription.

Please refer to the formulary when prescribing for Clever Care Members. Though most medications on the formulary are covered without Prior Authorization, a few agents will require you to obtain an authorization. For Clever Care Part B, contact MEDIMPACT at (800) 926-3004. For Clever Care Part D, contact MEDIMPACT at (800) 926-3004.

Prescription Drugs by Mail Order

Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, members should allow up to two weeks for mailing and processing.

If a member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call the MEDIMPACT at (800) 926-3004. They will assist with obtaining an emergency supply of the member's medication until he or she receives the new mail-order supply.

Members are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the Clever Care network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of- pocket payment difference to the member. The member pays one copayment for each 31-day supply or a reduced copayment for a 62- or 93-day supply when obtaining maintenance drugs via mail order.

Part B Prescription Drugs

Prescription drugs covered under the Medicare Part B benefits are very limited. These include the following:

- Injectable medications provided incidental to a physician's service
- Drugs administered through covered durable medical equipment, such as a nebulizer or infusion pump in the home
- Certain oral cancer medications
- Antiemetic drugs administered within 48 hours of chemotherapy
- Immunosuppressive drugs prescribed following a Medicare-covered organ transplant

- Erythropoietin for individuals undergoing chronic renal dialysis
- Parenteral nutrition for members with a permanent dysfunction of the digestive tract

Other drugs may be covered under Part B in certain limited situations. Many Part B drugs, and injectable medications provided incidental to a physician's service require prior authorization from Clever Care. Please call the Member Services at (714) 650-8770for additional information.

Covered Vaccines

CMS and Clever Care, through the Clever Care plans, cover vaccines and vaccine administration for Medicare recipients. Listed below are the vaccine benefits covered under Medicare Part B, Medicare Part D and those covered under either Medicare Part B or Part D coverage.

Vaccines and Vaccine Administration Coverage Under Medicare Part B (Medical) Benefits

Medicare Part B benefits include the following routine immunizations:

- Pneumococcal pneumonia vaccine
- Influenza virus vaccine
- Hepatitis B vaccine

Claims for Medicare Part B benefits should be submitted to Clever Care for processing and reimbursement at:

Claims Department
Clever Care Health Plan, Inc.
7711 Center Ave Suite 100
Huntington Beach CA 92647

Vaccines and Vaccine Administration Coverage Under Medicare Part D (Pharmacy) Benefits

Medicare Part D generally covers vaccines not available under Medicare Part B. Medicare Part D vaccines are included in the Clever Care Medicare Formulary located online at www.clevercarehealthplan.com. From the Quick Tools link, select Pharmacy Tools, then Medicare Formularies. Providers who do not have access to a vaccine list using the online formulary can call the prescription into a participating pharmacy. If the vaccine is administered in a network pharmacy, the pharmacy will transmit the claim to the Pharmacy Benefit Manager for processing and reimbursement.

Providers who have a supply and administer the vaccine in their office should collect the member's copay at the time of service and submit the claim for the vaccine and administration on a CMS 1500 (08-05) form to:

Claims Department
Clever Care Health Plan, Inc.
7711 Center Ave Suite 100
Huntington Beach CA 92647

Vaccines Covered Under Either Part B (Medical) or Part D (Pharmacy) Benefit Coverage

Vaccines administered directly related to the treatment of an injury or direct exposure to a disease or condition would be covered under Part B. Vaccines administered for prevention of an illness and not covered under Medicare Part B (influenza or pneumococcal) would be covered under Part D. Vaccines that may be Part B or Part D are:

- Hepatitis A vaccine
- Anthrax vaccine
- Rabies vaccine
- Tetanus toxoid, tetanus-diphtheria toxoids

For reimbursement of a vaccine and vaccine administration that could be either Part B or Part D, indicate the reason for immunization (injury and/or direct disease exposure or prevention of an illness) on a CMS 1500 (08-05) claims form and submit to:

Claims Department
Clever Care Health Plan, Inc.
7711 Center Ave Suite 100
Huntington Beach CA 92647

Additional information can be found on the CMS website under the Medicare Learning Network General Information page at www.cms.hhs.gov/MLNGenInfo.

Coverage Determinations for Part D Prescription Drug Benefits

Coverage determinations: The first decision made by a plan regarding the prescription drug benefits an enrollee is entitled to receive under Clever Care, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.

A coverage determination is any decision Clever Care makes regarding:

- A decision about whether to provide or pay for a Part D drug, including a decision not to pay because the drug is not on Clever Care's formulary, the drug is determined not to be medically necessary, the drug is furnished by an out-of-network pharmacy or Clever Care determines the drug is otherwise excluded, but the member believes it may be covered by Clever Care
- Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the member's health
- A decision concerning a tiering exception request
- A decision concerning a formulary exception request
- A decision on whether a member has satisfied a prior-authorization or other utilization management requirement

Two decisions govern the need for prescription drugs the member has not yet received:

- A standard decision made within the standard 72-hour time frame
- An expedited decision made within 24 hours

An expedited decision can only be requested if the member or any physician believes waiting for a standard decision could jeopardize the member's life, health or ability to regain maximum function. This is called the expedited criteria.

The member or a physician can request an expedited decision. If a physician requests an expedited decision or supports a member in asking for one and if the physician indicates the situation meets the expedited criteria, Clever Care will automatically provide an expedited decision within 24 hours from the initial request.

Formulary Exceptions

If a prescription drug is not listed in the Clever Care formulary, please check the updated formulary on the Clever Care website. The website formulary is updated frequently with any changes. In addition, providers may contact the Clever Care Member Services at MEDIMPACT at (800) 926-3004 to be sure a drug is covered. If the Member Services department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.

- The patient or prescribing physician may ask Clever Care to make an exception (a type of coverage determination) to cover the non-formulary drug. If the member pays out-of-pocket for a non-formulary drug and requests an exception that Clever Care approves, Clever Care will reimburse the member. If the exception is not approved, the member may appeal Clever Care's denial. See the Member Liability Appeals section for more information on requesting exceptions and appeals.

In some cases, Clever Care will contact a member who is taking a drug that is not on the formulary. Clever Care will give the member the names of covered drugs used to treat his or her condition and encourage the member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, members who recently joined a Clever Care plan may be able to get a temporary supply of a drug they are taking if the drug is not on the Clever Care formulary.

Transition Policy

Members who are new to Clever Care plans may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as prior authorization or step-therapy. Current members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their providers to decide if they should switch to a different drug Clever Care covers or request a formulary exception in order to get coverage for the drug (as described above).

During the period of time members are talking to their providers to determine the right course of action, Clever Care may provide a temporary supply of the nonformulary drug if those members need a refill for the drug during the first 90 days of new membership in a Clever Care plan. For current members affected by a formulary change from one year to the next, Clever Care will provide a temporary supply of the nonformulary drug for members needing a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and Clever Care provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits (but is otherwise considered a Part D drug), Clever Care will cover at least a one time, 30-day supply (unless the prescription is written for fewer days). After Clever Care covers the temporary 30-day supply, Clever Care generally will not pay for these drugs again as part of the transition policy. Clever Care will provide the member and the provider with a written notice after it covers a temporary supply. The notice will explain the steps the member can take to request an exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new member is a resident of a long-term care facility (like a nursing home), Clever Care will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, Clever Care will cover more than one refill of these drugs during the first 90 days a member is enrolled in our plan. If the member has been enrolled in Clever Care for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step-therapy or dosage limits, Clever Care will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member requests a formulary exception.

This policy also applies to current Clever Care members who experience a change in the level of their care. For example, if a member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the member may receive a temporary transition supply of the nonformulary drug for up to 31 days, unless the prescription is written for fewer days.

Please note the Clever Care transition policy applies only to those prescription drugs that are Part D drugs.

Medication Therapy Management

The **Medicare Modernization Act of 2003** requires Medicare Part D prescription drug plans to include medication therapy management (MTM) services delivered by a qualified health care professional, including pharmacists. MTM services target beneficiaries who have multiple chronic conditions (such as diabetes, asthma, hypertension, hyperlipidemia, and congestive heart failure), take multiple medications or are likely to incur annual costs above a predetermined level. Clever Care supports MTM in a variety of ways:

- Medication Management Services for Clever Care Members
- In-House Consults by Clever Care Pharmacists

Reimbursement Policies

Reimbursement policies serve as a guide to assist providers in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Clever Care benefit plan. These policies can be accessed at www.clevercarehealthplan.com. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Providers must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, Clever Care policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Clever Care may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Clever Care reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or State contracts, or State, Federal, or Centers for Medicare and Medicaid Services (CMS) requirements. Claims System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Clever Care strives to minimize these variations.

Clever Care reserves the right to review and revise its policies periodically when necessary. When there is an update Clever Care will publish the most current policy at. https://eznet.clevercarehealthplan.com/

Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy.

Neither payment rates nor methodology are considered to be conditions of payment.

- **Level 1: Benefit Coverage**
- **Level 2: Medical necessity or clinical criteria**
- **Level 3: Reimbursement Policy and regulations**
- **Level 4: Payment methodology as determined by contract / requirements.**

Review Schedules and Updates

Reimbursement Policies go through a review at least every two (2) years for updates to state contracts, or state, federal or CMS requirements. Additionally, updates may be made at any time if Clever Care is notified of a mandated change or due to a Clever Care business decision. When there is an update Clever Care will publish the most current policy at https://eznet.clevercarehealthplan.com/

Medical Coding

The Claims Department ensures that correct coding guidelines have been applied consistently throughout the enterprise. Those guidelines include, but are not limited to:

- Correct modifier use
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements
- Analysis of codes, code definition and appropriate use

Reimbursement by Code Definition

Clever Care allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are seven CPT sections:

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Temporary codes for emerging technology, services or procedures

Various procedure codes are located in particular CPT categories, although the procedure may not be classified within that particular category (e.g., venipuncture is located in the CPT Surgical Section, although it is not a surgical procedure.

Delegation
Clever Care Health Plan has established a Delegation Oversight Program to build structure around the requirements to audit, monitor, communicate, train, and monitor functions that have been delegated. Not all contractual arrangements require direct oversight; only delegated administrative or health care service functions. All First-Tier entity relationships are managed by an operational business owner, based on the function delegated.
Clever Care is responsible for the compliance of its First Tier, Downstream or Related (FDRs).

As part of the Clever Care Compliance Program, Clever Care must conduct certain compliance validation activities prior to the signing of the delegation agreement by the CEO.

The Compliance Department is responsible for reviewing the new First Tier entity's Compliance Program, obtaining a completed Compliance Attestation and for screening the potential entity against the OIG/GSA Excluded Persons lists prior to contract effectuation.

When a new First Tier entity is in the contract negotiation with Clever Care, the business owner is responsible for notifying the Compliance Department.

The Compliance Department must conduct a pre-delegation review of a new First Tier entity to confirm they have an effective compliance program and, at a minimum, includes the following core elements:

1. Compliance policies & procedures, standards of conduct including disciplinary standards and documented distribution to workforce and all covered entities.
2. Fraud, waste and abuse and compliance training for new employees and annually thereafter.
3. Routine screening of persons involved against the OIG/GSA Excluded Persons lists.
4. Effective communications; Regulation and guidance distribution, and mechanisms for confidential FWA and non-compliance reporting
5. System for auditing, monitoring and corrective actions and retaliation safeguards.
6. Oversight of their downstream entities
7. Record retention of at least 10 years
8. HIPAA Privacy and Security Requirements

The Clever Care business owners are responsible for implementing delegated functions with the new First-Tier entity. As part of this implementation process, policies and procedures to be used by the First-Tier entity must be reviewed and approved by the business owner and the Compliance Department prior to contract effectuation.

The Compliance Department is responsible for coordinating oversight activities in collaboration with the business owners and the First-Tier Entity.

All findings of non-compliance must be reported to the Compliance Officer and will require immediate corrective actions. If findings are severe, the contract effectuation must be postponed until validation audits of the corrective action are confirmed by the Compliance Department.

For delegation of provider credentialing and care management, the Quality Department performs a pre-delegation audit of the credentialing practices prior to contract effectuation.

Clever Care may delegate functions to contract providers that are NCQA-Accredited Organizations or NCQA-Certified Programs. In the event Clever Care delegates to a contract provider that is NCQA accredited or certified, Clever Care is not required to conduct a pre-delegation evaluation, annual evaluation, and annual audit. Both the NCQA-Accredited Organizations and NCQA-Certified Programs designations are awarded to organizations that meet the requirements set forth by the NCQA. NCQA-

Accredited organizations include health plan accreditation, managed behavioral health organization accreditation, disease management accreditation, utilization management, provider network accreditation, case management accreditation and other accreditation programs. NCQA-Certified programs include credentialing verification organization certification, disease management certification, health information products certification, physician hospital quality certification, and utilization management and credentialing certification. Clever Care will verify accreditation/program certification as a part of its pre-delegation assessment.

Once pre-delegation audits are complete and findings are favorable, the Chief Executive Officer may sign the contract. It defines the responsibility of each business owner for oversight of vendors as they relate to Clever Care Health Plan, Inc, insurance products. Delegation and oversight procedures are defined in accordance with the Centers for Medicare and Medicaid Services (CMS) and the applicable State Insurance Commissioner guidelines and are reviewed annually. This policy applies to delegation oversight responsibilities as they relate to providing or administering health care services for members of Medicare Part C, D or Qualified Health Plan benefits. For additional requirements on delegation and oversight activities related to Clever Care delegates and sub delegates with managed care responsibilities of Credentialing/Re- credentialing, Customer Services, Quality Improvement and Utilization Management, please see Credentialing Delegation and Oversight Policy**.**

Evaluations and comprehensive assessments of the delegated entities' performance pre- and post-delegation must be conducted to prevent, detect and correct issues of compliance in accordance with regulatory requirements. Evaluations also serve to assess the vendor's ability to prevent, detect, and correct issues of non-compliance as well as an assessment of the vendor's ability to implement and monitor Corrective Action Plan(s) (CAP) as needed. Evaluations must also include a review of compliance policies and the code of conduct (COC) to ensure that for First Tier, Downstream and Related Entities (FDRs), compliance policies, COC and procedures are distributed to all associates within ninety (90) days of the time of hire or contracting, annually thereafter and whenever policies/COC revised or updated. Clever Care Health Plan Hhh(hereafter, Clever Care) business owners responsible for the contract, or specific delegation activities, are responsible to validate compliant monitoring and oversight of vendors. This responsibility includes ensuring staff are adequately trained and qualified to assess the delegates' activities. If the contracted vendor is unable or unwilling to fulfill delegated responsibilities according to Federal/State mandates and Clever Care requirements, as indicated in the contractual provisions, Clever Care shall not execute a contract, or when applicable, shall terminate the delegation agreement after making a concerted effort to bring the vendor into full compliance.

Risk Assessment

1. On an annual basis, each vendor is evaluated to determine the level of risk the entity poses to Clever Care.
2. The level of risk determines the next steps:
    a. High Risk Level
        i. Depending on the results of the Compliance Officer’s review of the risk assessment, an onsite audit may be conducted.
        ii. If an onsite audit is not conducted, a desktop audit will be performed to review workflows, policies and procedures and any other pertinent documentation.
    b. Moderate Risk Level
        i. Depending on the results of the compliance officer's review of the risk assessment, a desktop audit may be conducted to review workflows policies and procedures and any other pertinent documentation.
        ii. Ad-hoc audits and monitoring thereafter, either onsite or desktop will be performed as necessary.

c. Low Risk Level
    i. Vendors assessed as low risk will be subject to the completion of attestation and training requirements.
    ii. Ad-hoc audits, either onsite or desktop, will be performed as determined necessary.
d. Ad-Hoc audits
    i. Either desktop or onsite audits will be conducted as necessary.

Claims Delegation
Clever Care follows CMS requirements contained in the Medicare Managed Care Manual Chapters, Parts 422 Title 42 of the Code of Federal Regulations.

Clever Care will ensure that delegated entities develop and maintain claims operational and processing procedures that allow for accurate and timely payment of claims, taking into consideration proper application of benefit coverage, eligibility requirements, and which meet all applicable federal regulatory requirements.

The Claims Director is responsible for the Claims Delegation Oversight of the relationship, regular performance reports and routine conference calls to discuss operational activities and compliance with CMS guidelines.

To be delegated for Claims Administration, Medical Groups, IPAs, and/or Vendors must do the following:

- Have a capitation contract with Clever Care and be in compliance with the financial reserve requirements of the contract.
- Protect the confidentiality of all PHI as required by Law.
- Have processes in place to identify and investigate potential Fraud, Waste, and Abuse.
- Have a Claims Administration delegation pre-assessment completed by Clever Care to determine compliance with all applicable State and Federal regulatory requirements for Claims Administration.
- Correct deficiencies within timeframes identified in the correction action plan (CAP) when issues of non-compliance are identified by Clever Care.
- Must have an automated system capable of providing Clever Care with the Encounter Data required by the state in a format readable by Clever Care.
- Agree to Clever Care's contract terms and conditions for Claims Delegates.
- Submit timely and complete Claims Administration delegation reports as detailed in the Delegated Services Addendum to the applicable Clever Care contact.
- Within (45) days of the end of the month in which care was rendered, provide Clever Care with the Encounter Data required by the state in a format compliant with HIPAA requirements.
- Provide additional information as necessary to load Encounter Data within (30) days of Clever Care's request.
- Comply with the standard Transactions and Code Sets requirements for accepting and sending electronic health care Claims information and remittance advice statements using the formats required by HIPAA.
- Comply with all applicable Federal and State Laws.
- When using Clever Care's contract terms to pay for services rendered by Providers not contracted with IPA or group, follow Clever Care's Claims Administration policies and guidelines, such as the retroactive authorization policy and guidelines for Claims adjustments and review of denied Claims.
- A Medical Group, IPA, or Vendor may request Claims Administration delegation from Clever Care Provider Network Manager. Clever Care will ask the potential delegate to submit policies and

procedures for review and will schedule an appointment for pre-assessment. The results of the pre-assessment are submitted to the Delegation Oversight Committee (DOC) for review. The final decision to delegate Claims Administration is based on the Medical Group, IPA, or Vendor's ability to meet Clever Care, State and Federal requirements for delegation.

Encounter Reporting

Each capitated FDR delegated for Claims payment is required to submit encounter data for all adjudicated Claims. The data is used for many purposes, such as the quality improvement program and HEDIS reporting.

The encounter data reporting specifications are provided by Clever Care during the FDR orientation process.

Designated Claims staff are responsible for reviewing monthly FDR reports and encounter files to ensure claims payment accuracy, claims payment timeliness, and claims processing accuracy. Claims staff will review claims reports submitted by FDRs for:

A. Claims processing timeliness
B. Claims processing accuracy
C. Claims payment accuracy

Credentialing Delegation

Clever Care ensures that any organization/entity with delegated credentialing authority for practitioners and other healthcare delivery organizations have written policies and procedures for the selection and evaluation of providers. Policies and procedures must conform to credential and re-credentialing requirements set forth by the Centers for Medicare and Medicaid Services (CMS), state regulatory requirements, and contractual agreements.

Clever Care conducts oversight audits with the delegated entity on an annual basis. The Delegation Oversight Committee via the Compliance Officer submits written results of to the delegated entity, including corrective or a corrective action if deficiencies are noted. The Delegation audit results are reported to the Compliance Officer.

Clever Care may, in accordance with the terms of the contract, revoke or amend the Credentialing Delegation Agreement and assume responsibility for all or part of the delegated credentialing functions.

In the event that Clever Care delegates to an FDR that is NCQA accredited or certified, Clever Care is not required to conduct a pre-delegation evaluation, annual evaluation, and annual audit. Both the NCQA-Accredited Organizations and NCQA-Certified Programs designations are awarded to organizations that meet the requirements set forth by the NCQA. NCQA-Accredited organizations and comply with CMS requirements.

Clever Care will conduct regular audits of FDR entities with delegated credentialing authority for practitioners and other healthcare delivery organizations. Audits will include elements to ensure, at a minimum, consistent compliance with the requirements set forth in the Delegated Credentialing and Re0credentialing policy.

Clever Care will issue a report of audit findings and require corrective action plans for any area found to be non-compliant. Corrective actions are monitored by the Quality Management Department staff to ensure all required activities are completed to resolve issues in a timely manner.

MSO/IPA Delegation

A. Pre-delegation Assessment Process: Prior to proceeding with delegation of responsibilities to an FDR, Clever Care will conduct a pre-delegation assessment to determine, among other things, the FDR's ability to implement all proposed delegated activities.
    1. Preliminary notification of prospective delegation:
        i. The Business Owner, or requestor of the delegation, contact the potential FDR regarding a prospective contract.
        ii. The Business Owner assesses if Clever Care and the potential FDR agree to the terms of delegation.
        iii. The Business Owner makes initial contact with all appropriate areas and ensures proper approvals are received. This includes all necessary subject matter departments, as well as legal and the Compliance Officer.
        iv. The Business Owner notifies the Compliance Officer of the prospective delegation by completing and submitting the pre-delegation application form. The notification must include the following and be submitted at least 60 calendar days prior to implementation of the delegated function(s):
            1. The services and/or functions to be performed by the FDR;
            2. The services and/or functions to be performed by Clever Care;
            3. The impact of services and/or functions to be performed by the FDR on Star Ratings measures (both current and potential future measures);
            4. The name of the FDR contact person;
            5. The phone, fax, and email addresses of the FDR contact person;
            6. The mailing address of the FDR, including all site locations
        v. The name and contact information of the Business Owner;
        vi. The date of anticipated contract implementation, proposed service levels (performance standards) and reporting responsibilities of the FDR
        vii. Sub-delegate information, where applicable
        viii. Clever Care may delegate functions to FDRs that are NCQA-Accredited Organizations or NCQA-Certified Programs. In the event that Clever Care delegates to a FDR that is NCQA accredited or certified, Clever Care may conduct a modified pre-delegation evaluation, annual evaluation, and annual audit. Both the NCQA-Accredited Organizations and NCQA-Certified Programs designations are awarded to organizations that meet the requirements set forth by the NCQA. NCQA-Accredited organizations include health plan accreditation, managed behavioral health organization accreditation, disease management accreditation, utilization management, provider network accreditation, case management accreditation and other accreditation programs. NCQA-Certified programs include credentialing verification organization certification, disease management certification, health information products certification, physician hospital quality certification, and utilization management and credentialing certification. Clever Care will verify accreditation/program certification as a part of its pre-delegation assessment.

Standard Prior Authorization Requests

Clever Care shall audit the FDR for timely review of prior authorization requests and to ensure notification of the member, and the provider as appropriate, of the decision as specified in the timeliness standards included in this policy. Decisions are made with consideration for the clinical urgency of the situation and medical necessity. The FDR must have an established process to accept oral pre-service organization determination requests for standard requests.

Clever Care shall assess that the determination of coverage is made by Appropriately Qualified Health Care Professionals and based on the Medicare National Coverage Determinations and/or Local Coverage Determinations, and relevant medical records in collaboration with the treating physician.

Clever Care will audit that the FDR accepts all organizational determination requests for a service from the member, the member's authorized representative, or the member's treating physician. If additional records or other information is required to approve the request, the FDR shall make at least three reasonable attempts to obtain the information. If the staff are unable to obtain the information, the FDR physician advisor will conduct the outreach to the provider in an attempt to obtain the necessary information. If the required documentation for approval is not received near the end of the timeframe, and the request is from a non-contracted provider, the timeframe will be extended for an additional 14 days. The member is notified in writing with their right to file an expedited grievance prior to the expiration of the review timeframe. All attempts and extensions of timeframes are documented in the FDR medical management system.

The FDR shall provide notice to the member using the most efficient manner of delivery to ensure the member receives the notice in time to appeal the decision. If the member has an authorized representative, a copy of the notice should be sent to the representative.

The FDR will approve or deny a standard organization determination request and notify the member and provider as expeditiously as the member's health condition requires but no later than 14 calendar days of the receipt of the request. Standard Part B drug organization determinations will have a turnaround time of 72 hours, extensions cannot be taken for Part B drugs.

If the FDR decides to deny a requested service or item, in whole or in part, or discontinues or reduces a previously authorized ongoing course of treatment, it shall give the member written notice of its determination and the reason for the decision in easy-to-understand language. The organization determination is reviewed by a physician or other appropriate health care professional with sufficient expertise, including Medicare coverage criteria.

If the FDR fails to provide the member with a timely notice of an organization determination, this failure itself constitutes an adverse organization determination and may be appealed.

Expedited Prior Authorization Requests

The FDR must have an established process to accept oral pre-service organization determination requests for expedited requests. The FDR identifies and enters requests into the authorization management system and routes the request to the utilization management department. Requests for nursing facility placement and discharge from the hospital after hours and on the weekend, are routed to the on-call nurse for resolution. Expedited outpatient requests received after 5:00 p.m. on Friday are resolved Monday to meet the 72-hour timeframe.

If a physician requests an expedited review, the FDR will verify with the requesting provider that the service requires an expedited response and review accordingly. However, if a member requests an expedited review, the Medical Director may determine if the request meets the "Expedited Criterion." If not, the member will be notified in writing (Right to an Expedited Grievance) within 72 hours that their request has been downgraded to the Standard review process and a decision will be made not later than 14 calendar days from receipt.

The 72-hour review period begins when the request is received by the FDR, regardless of whether or not the provider is contracted. If additional records or other information is required to approve the request, the FDR shall make reasonable attempts to obtain the information taking into consideration business hours, alternate methods of contact, and exigency of the request. If staff are unable to obtain the information, a plan physician will conduct outreach to the provider. If medical documentation is required from a non-

contract provider, the FDR will make the request within 24 hours of the initial request for the expedited determination. Regardless, the FDR is responsible for adhering to the timeframes and notice requirements.

If the FDR fails to provide the member with a timely notice of an organization determination, this failure itself constitutes an adverse organization determination and may be appealed.

Expedited organization determinations are processed, and an attempt is made to notify the member verbally within 72 hours of the date/time of request. When the member is verbally notified, written notice is sent within 3 calendar days. If the member cannot be verbally notified, written notice is sent in a manner that the member will receive the notice within 72 hours. Expedited Part B drug organization determinations will be completed within 24 hours of the request, an extension cannot be taken for Part B drugs.

If the FDR extends the 72-hour time frame by up to 14 calendar days, Clever Care notifies the member in writing of how the delay is in the best interest of the member. The members are also notified in writing of their right to an expedited grievance if they do not agree with the extension.

If the FDR fails to provide the enrollee with timely notice, this failure itself constitutes an adverse organization determination and may be appealed.

All authorization requests are considered time sensitive.

Utilization Management (Authorization) Delegation
Internal UM Lead UM Nurse is responsible for day-to-day oversight and monitoring of the audit processes and applicable timeframes for reporting. The Lead UM Nurse is responsible for reviewing monthly reporting and identifying any needed corrective actions under the direction of the UM Director.
The UM Nurse is responsible for applying clinical criteria and approving requests or forwarding to the appropriate professional for review within the applicable timeframes.

Monitoring
The UM Director of Care Management, with the Lead UM Nurse, will supervise audits of the FDR's capacity to execute delegated care UM management tasks before entering into a contract and, at least once a year thereafter. This is in conjunction with the annual risk assessment process, ensuring that FDRs operate in compliance with CMS regulations. When deemed necessary, an on-site audit of an FDR may be conducted to verify its ongoing ability to meet Clever Care's established performance standards, as well as compliance with CMS, State and Federal regulations, and any pertinent accreditation criteria, including those set by the National Committee on Quality Assurance (NCQA), where applicable.

The UM Department evaluates the quality of care and service provided to the members and practitioners by delegate/vendor organizations through continuous oversight of the delegate/vendors' performance, program, regular reports, and corrective action/focus improvement plans as applicable.

FDRs, as applicable, are required to validate their performance of utilization management, the monitoring of their processes and their adherence to their policies and procedures.

The FDR shall not provide incentives for the denial, limitation or discontinuation of health care services.

The UM Department monitors performance indicators at a minimum annually and communicates routinely with FDRs.

The UM Department performs focused reviews and administers corrective action plans as warranted. The FDR is evaluated for compliance with contracts, standards and performance.

a. The Auditor will conduct the pre-delegation assessment and evaluate the potential FDR's ability to perform the Delegated Services including, but not limited to, the following:
    i. FDR's demographics
    ii. Individual components and requirements related to the Delegated Services
    iii. Experience, ability, and willingness to perform in accordance with all proposed contractual and policies and procedure requirements related to the Delegated Services
    iv. Policies and procedures related to the delegated services, including coordination with Clever Care's other FDRs, provider, and pharmacy networks, etc.
    v. Personnel credentials
    vi. Resources
    vii. Technology and Equipment (ability to capture data and generate reports)
    viii. Availability of staff and access to providers within their network
    ix. Deficiencies
    x. Sub-delegation
    xi. OIG/SAM exclusion list initial check of all their employees and monthly thereafter
    xii. Other items as needed and/or assigned

Delegation Oversight Committee

Once the pre-delegation form is received, the Delegation Oversight Committee ("DOC"), comprised of representatives from Legal, Compliance, Medical Management, and Provider Contracting Leadership will meet with the Business Owner to determine the level of need for the FDR.

Compliance Auditor Review

a. Once approved by the DOC, a Compliance Auditor ("Auditor") will be assigned to the FDR. The Auditor will work with the Business Owner to ensure that all elements of delegation have been reviewed, the audit has been performed and that any Corrective Action Plans ("CAPs") are on track for completion. The Business Owner has ultimate responsibility for CAP remediation.
b. The Auditor will conduct the pre-delegation assessment and evaluate the potential FDR's ability to perform the Delegated Services including, but not limited to, the following:
    i. FDR's demographics
    ii. Individual components and requirements related to the Delegated Services
    iii. Experience, ability, and willingness to perform in accordance with all proposed contractual and policies and procedure requirements related to the Delegated Services
    iv. Policies and procedures related to the delegated services, including coordination with Clever Care's other FDRs, provider, and pharmacy networks, etc.
    v. Personnel credentials
    vi. Resources
    vii. Technology and Equipment (ability to capture data and generate reports)
    viii. Availability of staff and access to providers within their network
    ix. Deficiencies
    x. Sub-delegation
    xi. OIG/SAM exclusion list initial check of all their employees and monthly thereafter
    xii. Other items as needed and/or assigned

    Each FDR and each individual delegated service are subject to a pre-delegation audit.

c. A score of less than 100% on any individual pre-delegation assessment will result in CAPs for each non-passing Delegated Service.
d. Scores on pre-delegation assessments for each Delegated Service shall not be combined to determine

whether all Delegated Services are to commence.

The Compliance Officer will schedule a pre-delegation audit for all potential Delegated Services 60 calendar days in advance based on business need.

- New entity or site – a desktop audit or an onsite audit will be conducted, except in the case of the credentialing function.
- Expansion of service – a desktop audit may be conducted.

It is the responsibility of the Business Owner to facilitate audit material submissions in partnership with the Auditor. All delegation materials must be delivered to the Compliance Officer within 30 calendar days from the scheduled audit start date.

The Auditor completes the applicable audit and will make findings and require a CAP for any area receiving a score of less than 100%.

The Auditor will notify the Business Owner of all findings and CAPs.

The Business Owner and the Auditor will discuss the findings and CAPs, if any, and develop a timeframe and step-action plan for successful and timely resolution of the CAP.

The Business Owner schedules an orientation with the FDR and conducts an orientation, which includes:

a. Clever Care overview
b. Clever Care Mission Statement
c. Clever Care responsibilities
d. Compliance requirements
e. Star Ratings requirements and performance expectations
f. Education regarding fraud, waste, and abuse
g. FDR responsibilities
h. Delegated services
i. Type and frequency of reporting to Clever Care
j. Process by which Clever Care evaluates the FDR's performance
k. Other topics as determined by Clever Care

Financial Oversight:

FDR Capitation Models
Clever Care employs a variety of Capitation reimbursement models; only organizations or individuals with a significant number of Members to spread the financial risk are approved for capitation contracts.

Financial Viability of Capitated FDRs
Clever Care is obligated to monitor the financial status of the groups to whom it has given financial risk. This is a contractual and business responsibility. Clever Care uses all reasonable methods to prevent placing an organization at risk for more than they are able to manage. Clever Care works to ensure there is little risk to any Providers who would look to the FDR for payment of Claims. Prior to the initial contracting under a capitation model with an FDR, Clever Care assesses the FDR's financial condition by reviewing the two most recent years audited financial statements and year-to-date unaudited financial statements for the current year.

Physician Incentive Plan (PIP):
For Providers/Provider groups with substantial financial risk (any organization that could be adversely or positively affected financially by the referral volume of its Members), Clever Care is required to disclose additional documentation. FDRs with substantial financial risk must provide information to Clever Care including:

- Mode of payments to Providers and any payment plans considered to be PIPs
- Evidence of stop-loss protection
- Evidence of annual Member satisfaction surveys

Financial Reporting Requirements of FDRs:
Once contracted, Clever Care expects all FDRs, identified as bearing substantial financial risk on the PIP, to submit the following documents to Clever Care:
Complete quarterly financial statements including:

- Balance Sheet
- Income Statement
- Statement of Cash Flows
- Audited annual financial statements

FDRs delegated for Claims may have additional reports required to assist Clever Care in fulfilling its financial oversight responsibilities.

Joint Operations Meetings:
Joint Operations Committee Meetings: Clever Care is available to meet as needed to address operational or contractual issues. On a quarterly basis, Clever Care tries to meet with each of its FDRs that operate under a capitation model. The purpose of the meetings is to:

- Identify any operational difficulties between the FDR and Clever Care and determine plans for a remedy;
- Educate one another on changes to either the FDR or Clever Care; and
- Provide an opportunity for staff to meet their counterparts in order to facilitate more productive interactions
- Encounter Reporting
- Each capitated FDR delegated for Claims payment is required to submit encounter data for all adjudicated Claims. The data is used for many purposes, such as the quality improvement program and HEDIS reporting.
- The encounter data reporting specifications are provided by Clever Care during the FDR orientation
- process.

If any area of deficiency or non-compliance is identified through any internal or external sources, e.g., member or provider complaint, readiness assessment, regular reports, oversight reviews, and ongoing monitoring, the Compliance Officer will require an FDR to respond to and submit a CAP.

- Such CAP may result in either weekly or monthly focused audits.
- When the FDR demonstrates three (3) months of consecutive compliance, the FDR will then be placed back on their regular review schedule.
- The DOC may assess sanctions, up to, and including, contract termination, against an FDR, if such FDR fails to submit the requested CAP for a material deficiency adversely impacting a member in the time or the manner required by Clever Care, or the FDR fails to meet the deadlines for compliance in the time or manner required by Clever Care.
- The Compliance Officer will have up to thirty (30) calendar days to review any rebuttals and

provide a response. An FDR that does not agree with the final resolution, after the rebuttals have been reviewed, may file a provider complaint.

Sub-Delegation Oversight Process

To ensure the Compliance Officer has oversight of all sub-delegate arrangements and is in compliance with all contractual requirements, the Compliance Officer will monitor sub-delegation through the audit of the FDRs. The sub-delegation attestation will be reviewed and signed during the FDR audit and more frequently if required by Clever Care.

Each FDR is required to attest if they use sub-delegates to perform Delegated Services.

a. FDRs that sub-delegate Delegated Functions are required to provide a list of all sub- delegates and their functions at the time of contract, and at such time as a new sub-delegate is added.
b. FDRs that have sub-delegates must provide evidence of a Business Associates Agreement holding the sub-delegate to all contractual obligations as outlined in the agreement between the FDR and Clever Care.

Revocation of Delegation

1. Delegation may be revoked in incidences where Clever Care or a Governmental Authority determines that the FDR has not performed satisfactorily, including failing to implement a CAP or quality improvement plan. Clever Care can also terminate the Delegation Agreement at any time for cause related to egregious deficiencies.
2. The QIC may approve complete or partial de-delegation of activities to an FDR.
3. All sanctionable offenses will be escalated to the Compliance Committee for further actions.
4. The FDRs will not further delegate any function to any other person and/or entity except upon Clever Care's prior written consent.
5. Upon revocation/termination of Delegation Agreement, the performed Delegated Services will be conducted by Clever Care or will be delegated to another person and/or entity.

Reporting

Reporting of Key Performance Indicators

In addition to conducting annual audits of its Delegates and Sub-Delegates, Clever Care requires that the Delegates and Sub-Delegates submit reports on key performance indicators for each delegated or sub-delegated or outsourced function to regularly monitor compliance with all applicable laws, rules, regulations, contractual requirements and Clever Care policies and procedures. The reporting requirements and frequencies are summarized below:

Function	Reporting Requirements	Minimum Frequency of Reporting
Utilization Management	Utilization Management Program Description	Annually
	Utilization Management Metrics and Work Plan (HICE Format)	Semi-Annually
	Part C Report	Quarterly
	ODAG, Table 1	Monthly

Complex Case Management	Complex Case Management Program Description	Annually
	Case Management Metrics and Work Plan (HICE Format)	Semi-Annually
Credentialing	Credentialing Reports (HICE Format)	Quarterly
Claims Processing and Provider Dispute Resolution	Monthly Timeliness Reports (MTRs) Direct Member Reimbursement (DMR) Table 4 *Both sets of data are captured in the MTR report template	Quarterly
	Provider Dispute Report	Quarterly
	ODAG Table 3 Dismissals, Table 13 *Both sets of data are captured in the Claims ODAG report template	Monthly
Documentation to Support Annual Delegation Oversight Audits	Other documentation, such as Delegate and Sub-Delegates' policies and procedures, are collected at the time of audit	Annually

Delegates are required to send regular reports to Clever Care that meet the Clever Care defined requirements.

1. Data shall be presented that is specific to Clever Care members and separated by market if the delegate is contracted for more than one Clever Care market.
2. Delegation oversight activities will include review of the timeliness and completeness of reporting activities. Failure to submit accurate, complete, and timely reports may result in termination of the delegation agreement.
3. Delegates are responsible for oversight of any sub-delegates and to collect and submit data from them as part of their reporting responsibility.
4. The Quality Improvement Committee will provide feedback to the delegate by the Delegation Oversight Director/Manager, and in collaboration with the Health Services Department designee once the committee has completed its review of the data submission.

The Clever Care or Delegate Health executive tasked with oversight for each delegated function is responsible for raising and discussing relevant Delegate or Sub-Delegate oversight issues with the applicable committee, which issues include, but are not limited to:

- Trending and analysis of key performance indicators.
- Results of annual audits.
- Progress against any CAPs issued.
- Recommendations for de-delegation, should poor performance persist.
- Recommendations for removing individual practitioners from the Clever Care network should the credentialing process identify persistent concerns.

All UM Delegates are to provide the following:
A. No later than the end of the first quarter of the calendar year, the delegate shall provide:

1. Annual Utilization Management Program Description;
2. Annual Utilization Management Program Evaluation of the prior calendar year's activities;
3. Utilization Management Work Plan for the current calendar year;

Note: If UM program-related information is included in the Quality Improvement Program Evaluation and Work Plan a separate document is not required. These documents shall be presented to the Quality Improvement Committee for review and approval. The Quality Improvement Committee may ask for revision to the Work Plan based on the previous year's evaluation to ensure the needs of the Clever Care Health Plan population are being met.

4. Copies of any reviews of subdelegated entities conducted during the reporting period. The delegated entity must demonstrate its own oversight activities and at a minimum a formal annual review of the subdelegates to assess compliance with federal, state, NCQA and Clever Care requirements. The delegated entity is responsible for ensuring that the subdelegates' reports include the same elements required of the delegate and that they are sent to Clever Care.

B. Quarterly reports are submitted to the Quality Improvement Department and include the following:

1. Inpatient Discharges/1000 Members;
2. Inpatient ALOS;
3. Percentage of Members receiving inpatient services;
4. Percentage of Members receiving institutional services such as skilled nursing and rehabilitation;
5. Percentage of Members receiving Ambulatory Services; and
6. Readmission Within 30 Days of Discharge.

C. Monthly reports are submitted to the Quality Improvement Department and include:

1. Member authorization logs;
2. Number of provider appeals with outcome;
3. Number of UM Reviews by type and place of service;
4. Number of UM Approvals by type and place of service;
5. Number of UM Denials by type and place of service;
6. UM Timeliness by decision type.

Behavioral Health Delegates
In addition to the reporting requirements specified in A, B, and C above, Behavioral Health Delegates must also submit the following quarterly reports:

1. Chemical Dependency Inpatient Discharges/1000 Members;
2. Chemical Dependency Inpatient ALOS;
3. Mental Health Inpatient Discharges/1000 Members;
4. Mental Health Inpatient ALOS.

Pharmacy Benefit Manager Delegate Monitoring
Pharmacy specific oversight will include audits conducted by the Pharmacy Department staff that consist of the following:

A. **EOB Accuracy Audit:** To confirm the accuracy of EOB letters sent to members from the PBM.
B. **Coverage Determination Audit:** To confirm the accuracy of CDs performed by PBM personnel according to good clinical judgment, current CMS approved prior authorization criteria, step therapy, formulary exception requests and quantity limits and any additional restriction that may be approved by CMS. Also, to confirm the timely and accurate communication of such coverage determinations to the prescriber and to the member.
C. **Mail Order Turnaround Time Audit:** To confirm that all mail order prescriptions requiring the intervention of a pharmacist shall be shipped within 5 business days.
D. **Manual Claims Audit:** To confirm that manual claims from the PBM have been adjudicated in a timely manner and decision rationale is appropriate.
E. **Plan Finder – Website Formulary Audit:** To validate that the Medicare Plan Finder reflects the correct formulary details.
F. **Transition Audit:** To assure that PBM is sending transition letters to members accurately, and in a timely manner, and that a letter regarding the same drug is also sent to the member's physician.
G. **Daily Denials Review:** Clever Care clinical pharmacists will review drug coverage denials on a daily basis. Such claims that have not been subsequently resolved are followed up by the pharmacist and resolved.
H. **External Financial Review:** Clever Care shall retain an external reputable pharmacy auditing firm at a frequency of the lesser of every two (2) years or in the last year of a PBM contract. This review shall determine that prices/discounts/rebates applied to drug transaction for members were applied correctly according to existing contract terms and conditions, including CMS pass-through requirements.
I. **MTMP Audit**: To ensure that monthly MTMP eligible members are being contacted and processed appropriately (opted out, deceased, etc.) based on evaluation comments in Assurance. No less than quarterly, the clinical pharmacist audit a sample of completed MTMPs to ensure recommendations made by MMS (Medication Management Systems) pharmacists are clinically appropriate for our members based on our formulary and quality initiatives and also verify that the member appropriately qualified to be MTMP eligible based on the CMS submitted criteria.
J. **Network Pharmacy Credentialing:** Clever Care shall delegate Network pharmacy credentialing to the contracted PBM.
    1. The PBM will include approved credentialing criteria in its pharmacy provider auditing program
    2. No less than yearly Clever Care will review the PBM's Pharmacy Credentialing policy to ensure the processes and requirements are appropriate to ensure credentialed and re-credentialed pharmacies are in good standing with all local and federal entities before inclusion in any pharmacy network.

K. **PBM Member Eligibility Monitoring:** To ensure proper prescription claim adjudication will occur at the point-of-sale member eligibility loaded at the PBM should match member eligibility as defined by Clever Care.
    1. No less than quarterly there will be a compare of the PBM eligibility file against the Clever Care eligibility file. If a variance is noted Clever Care's eligibility department will perform an analysis to determine if the variance is appropriate or requires resolution.

More Specific information and details can be found in Clever Care Health Plan policies and procedures, administrative guides, and manual, and related documents.

GLOSSARY OF TERMS

Appeal: Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a member is entitled to receive or any amounts the member must pay for a covered service. These procedures include reconsiderations by Clever Care, the Part D Quality Improvement Council, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the provider administrative appeals/dispute process.

Basic benefits: services covered for all Medicare beneficiaries under Medicare Part A and Part B. All Medicare Advantage members receive all basic benefits, including all health care services covered under Medicare Part A and B programs, except for hospice services. Clever Care also provides supplemental benefits not covered by fee-for-service Medicare.

CMS: Centers for Medicare & Medicaid Services; the federal agency responsible for administering the Medicare program.

Contracting hospital: a hospital that has a contract to provide services and/or supplies to Medicare members.

Contracting medical group: a group of physicians organized as a legal entity for the purpose of providing medical care with a contract to provide medical services to Medicare members.

Contracting pharmacy: a pharmacy that has a contract to provide Medicare members with medications prescribed by network providers in accordance with the Clever Care contract.

Coverage determination — the first decision made by Clever Care regarding the benefits prescription drug benefits an enrollee is entitled to receive under Clever Care, including a decision not to provide or pay for a Part D drug, a decision concerning an exception request and a decision on the amount of cost sharing for a drug.

Covered services: those benefits, services or supplies that are:

- Provided or furnished by providers or authorized by Clever Care or its providers
- Emergency services and urgently needed services that may be provided by non-participating providers
- Renal dialysis services provided while members are temporarily outside the service area
- Basic and supplemental benefits

Emergency medical condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency services: covered inpatient or outpatient services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition in accordance with the prudent layperson standard.

Experimental procedures and items: procedures and items determined by Clever Care and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Clever Care will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare. Section 1862(a)(1)(E) of the Social Security Act, prohibits payment for procedures that are deemed experimental and/or investigational in nature.

Exceptions: An exception request is a type of coverage determination request. Through the exception process, the member can request an off-formulary drug, an exception to the Clever Care tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or prior-authorization requirement).

Fee-for-service Medicare: a payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare).

Grievance: a complaint or dispute other than one involving an organization determination. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are: waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Home health agency: a Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a member's home when medically necessary, when members are confined to their home and when authorized by Clever Care.

Hospice: a Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.

Hospital: a Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Hospitalist: a member of a growing medical specialty who has chosen a field of medicine that specifically focuses on the care of the hospitalized patient. Before selecting this new medical specialty, hospitalists complete education and training in internal medicine. As a key member of the health care team and an experienced medical professional, the hospitalist takes primary responsibility for inpatient care by working closely with the patient's primary care physician during the member's inpatient stay.

Independent practice association: a group of physicians that function as a contracting medical provider/group but in which the individual member physicians operate their respective independent medical offices.

Medicaid: the federal health insurance program established by Title XIX of the Social Security Act and administered by states for low-income individuals.

Medically necessary: medical services or hospital services determined by Clever Care to be:

- Rendered for the diagnosis or treatment of an injury or illness
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards
- Not furnished primarily for the convenience of the member, the attending provider or other provider of service

Clever Care makes determinations of medical necessity based on peer-reviewed medical literature, publications, reports, and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Clever Care. Section 1862(a)(1)(A) of the Social Security Act, states that Medicare payment can only be made for services/items that are medically necessary and reasonable.

Medicare — the federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals.

Medicare Part A: Medicare Part A covers hospital insurance benefits, including inpatient hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.

Medicare Part A premium: Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island or local government employment to be insured, they do not have to pay a monthly premium. If members do not qualify for premium-free Part A benefits, members may buy the coverage from Social Security if they are at least 65 years old and meet certain other requirements.

Medicare Part B: optional, supplemental medical insurance requiring a monthly premium. Medicare Part B covers physicians (in both hospital and nonhospital settings) and certain nonphysician services. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood products not covered under Part A.

Medicare Part B premium: a monthly premium paid to Medicare (usually deducted from a member's Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive covered services, whether members are covered by a Medicare Advantage plan or by original Medicare.

Medicare Part C: optional coverage that can be selected by the Medicare beneficiary. Coverage under Part C is provided by health maintenance organizations. The health maintenance organization must provide all Part A and B services in its plan and may offer additional benefits to the beneficiary.

Medicare Part D: the prescription drug coverage provided by a Medicare Advantage (MA) plan or by a stand-alone Prescription Drug Plan (PDP) contracted with CMS. The MA plan or PDP may charge the beneficiary premiums and cost sharing for this coverage. Clever Care offers MA-PD plans in specific markets.

Medicare Advantage (MA) agreement: the agreement between Clever Care and the Centers for Medicare & Medicaid Services (CMS) to provide Medicare Part C and other health plan services to Clever Care members.

Medicare Advantage (MA) plan: a policy or benefit package offered by a Medicare Advantage Organization (MAO) in which a specific set of health benefits are offered at a uniform premium level of cost sharing to all Medicare beneficiaries residing in the corresponding service area. An MAO may offer more than one benefit plan in the same service area. The Clever Care plan is an MA plan.

Member: a Medicare beneficiary entitled to receive covered services who has voluntarily elected to enroll in the Clever Care plan and whose enrollment has been confirmed by CMS.

Noncontracting medical provider or facility: any professional person, organization, health facility, hospital or other person or institution that is licensed and/or certified by the state and/or Medicare to deliver or furnish health care services; and that is neither employed, owned, operated by nor under contract with Clever Care to deliver covered services to Medicare members. Also known as non-participating provider or facility.

Provider: any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services. This individual or organization has a contract directly or indirectly with Clever Care to provide services directly or indirectly to Medicare members pursuant to the terms of the participating provider agreement.

Provider liability appeal: a request for Clever Care to review a decision by the Clever Care UM department for services already rendered and denied without Medicare member liability.

Provider payment dispute: a request for Clever Care to review the claim adjudication as the provider feels payment was not rendered as per the contractual agreement between Clever Care and the provider.

Primary Care Provider (PCP): a provider physician selected by a member to coordinate the member's health care. The PCP is responsible for providing covered services for Medicare members and coordinating referrals to specialists. PCPs usually practice internal medicine, family practice or general practice medicine.

Service area: a geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for each Medicare Advantage plan is located in the Summary of Benefits document.

Needed services: those covered services provided when the member is temporarily absent from the Medicare Advantage service area, or under unusual and extraordinary circumstances, services provided when the member is in the service area but the member's PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.

Provider Manual Review and Updates

This provider manual will be periodically reviewed and updated as needed but not less than once every 2 years.

A summary of changes to the Manual will be posted on the Clever Care Health Plan website and communicated to all providers.

Material changes to the manual impacting the providers in Clever Care's network or its delegated providers shall provide for a forty-five (45) calendar day review of the proposed change prior to implementation and the effective date of the change unless these material changes are as a result of changes in state and federal law or regulation or impact the safety and wellbeing of Clever Care Health Plan members.

Provider authorization to adjust claims and create claim offsets

Please submit this completed authorization form with all supporting documentation to ensure proper processing of your request to adjust claims as detailed below. The adjustments will result in overpayments being withheld from future claims payments.

Provider name:	
Provider NPI:	
Provider tax identification number:	
Provider contact information:	

Cost Containment project number (if applicable):	
Document identification number (if applicable):	
Total recoupment dollar amount:	

Please list claim information below if the Cost Containment letter or other supporting claim/member detail is not provided with this request.

Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:
Recoupment reason:			
Claim number:	Member number:	Service dates:	Recoupment amount:

Recoupment reason:

If your request for recoupment exceeds the space provided, please attach an excel file that includes all the data noted above. For questions related to the completion of this form, please call Customer Services at 1-657-224-1888.

I authorize Clever Care to proceed with adjusting the claims as listed on this form or per separate document that supports this request.

Print name

Signature

Mail this form to:

Clever Care Health Plan

Attn: Payment Disputes

7711 Center Ave Suite 100

Huntington Beach CA 92647

Note: Do not use this form if you are submitting a refund check. If you would like to submit a refund, please use the refund notification form below or on the provider website. Instructions for the form and how to mail a check are found in the Overpayment Refund Notification form attachment.

OVERPAYMENT REFUND NOTIFICATION FORM

In order for an overpayment refund to be processed in a timely manner, please submit a completed form with all refund checks and supporting documentation. If the refund check you are submitting is a Clever Care check, please include a completed form specifying the reason for the check return.

Provider Name/Contact Contact Number Provider ID **Provider Tax ID __ Subscriber ID** **DCN Number (Displayed on CCU Letter)**
Member Name ____ Member Account Number Date of Service: [to] **Total Billed Charges: $___**

Total Check Amount: $____

Claim Number(s):

Reason for Refund or Check Return:

□ Health Plan Letter
□ Contract Rate Change
□ Duplicate Payment
□ Incorrect Member
□ Incorrect Provider
□ Negative Balance
□ Other Health Insurance/Third-Party Liability
□ Payment Error
□ Billed in Error/Adjusted Charge
□ Other:

All refund checks should be mailed with a copy of this form to:

Clever Care Health Plan, Inc
Attn: Cost Recovery Unit
7711 Center Ave Suite 100
Huntington Beach CA 92647

Once the Clever Care Cost Recovery Unit has reviewed the overpayment, you will receive a letter explaining the details of the reconciliation. Thank you for completing this Overpayment Refund Notification Form.