Sonder Health Plans
Atlanta, GA

Utilization Management Program 2025

SECTION A – INTRODUCTION, MISSION, OBJECTIVES AND SCOPE

The Utilization Management Program Description ("UMPD" or "UM Program") summarizes the philosophy, structure and standards that govern Health Services, utilization management/ utilization review ("UM/UR" or "UM") responsibilities and functions of Sonder Health Plans (SHP). The UM Program provides a structure to monitor the efficiency and quality of UM services to ensure member access to quality medical, surgical, and behavioral health care. P o licies and procedures supplement this description and further explain specific Program implementation.

I. UTILIZATION REVIEW

Utilization Management (UM) activities are supported by objective, evidence–based, nationally recognized medical policies, clinical guidelines, and criteria. These policies, guidelines and criteria promote delivery of appropriate care to SHP members in the most appropriate setting at the appropriate time. Medical Directors, nursing and pharmacy staff work closely with health care providers to optimize health care outcomes.

II. MISSION AND SCOPE

SHP's mission is to help people live healthier lives and help make the health system work better for everyone. The Program offers UM services and products designed to improve the individual member experience, improve population health, improve the provider experience, and reduce the costs of health care.

The UM Program provides a structure to monitor and facilitate the delivery of high quality, individualized care to members. The Program includes end-to-end processes such as:

- Coordinator Intake/Notification
- Clinical Coverage Review/Prior Authorization/Prospective/Pre-Service Review
- Inpatient Care Management/ Concurrent Review
- Discharge Planning/Post-Acute Care
- Pharmacy Management

III. OBJECTIVES & GOALS

SHP seeks to attain the goals of improving the member experience, improving quality of care, reducing the costs of health care, and improving the provider experience. Attaining these goals will result in healthier populations, in part because of new designs and programs that better identify problems and member-oriented solutions that connect members to care before acute or emergency care may be needed, and outside of acute health care settings.

UM Program-focused objectives are to:

- Assure fair and consistent UM decision- making.
- Provide appropriate training and development opportunities to UM Staff;
- Standardize the implementation of the UM Program;

- Monitor staff participation in inter-rater reliability testing and evaluate/address outcomes;
- Monitor and evaluate the efficiency and effectiveness of processes through analysis and review of various metrics, including but not limited to timeliness and accuracy of decision- making, communication of decisions and satisfaction with UM processes;
- Ensure that mental health parity requirements are appropriately fulfilled; and
- Maintain compliance with applicable laws, regulations, and accreditation requirements.

UM Program goals for 2025 include:

- Maintain or decrease admission and readmission rates for SHP membership
- Maintain or decrease SNF days/ 1,000 for SHP membership
- Decrease ED visits/ 1,000 for SHP membership
- Completion of authorization determinations within applicable timeframes
- Completion of notification within applicable timeframes
- Identification and implementation of process efficiencies

SECTION B – PROGRAM OVERSIGHT

I. MEMBER CARE

The primary care provider and other collaborative providers are responsible for managing all aspects of the member's health care needs. All members select a primary care provider at the time of enrollment and are encouraged to establish and maintain a relationship with the provider. The member is instructed to contact the primary care provider whenever medical or behavioral health care is needed. The primary care provider is informed about the patient's needs and can make informed, appropriate decisions regarding treatment. The care management team provides assistance with navigating the health care system, as requested by individual members.

II. HEALTH SERVICES COMMITTEE

Health Services Committee

The Health Services Committee (HSC) is responsible for oversight of the Utilization Management program and the development and maintenance of the scope and processes for UM Reviews.

Functions of the HSC include, but are not limited to the following:

I. Oversight of the UM Program
II. Review and approval of services added to and removed from prior authorization review lists.
III. Oversee development and implementation of UM Review processes to include:
    a. Assign processes to submit and adjudicate UM requests.
    b. Processes to ensure appropriate clinical review of UM cases; and
IV. Promote compliance with regulatory and accreditation medical management

requirements, as applicable.

v. Review and provide feedback on utilization management quality improvement activities, including, but not limited to the annual UM Evaluation; and

vi. Maintains approved records of all committee meetings.

The composition of the Health Services Committee (HSC) includes a SHP Medical Director, Community physicians, and the SHP Vice President and/or Director of Health Services. The Health Services Committee meets at least annually or more frequently if needed.

SECTION C – DESCRIPTION OF PROGRAM REVIEWS & SERVICES

Intake/ Notification

The Intake process includes receipt of provider/practitioner/member communications that notify SHP of planned and unplanned services as required by provider contract or member benefit plan. The Intake process supports other varied processes within SHP including referral into case and disease management programs, admission notification and prior authorization. The Intake process involves obtaining member demographic information, physician/provider identifying information, requested services, hospital/facility identifying information and network status of providers and facilities. The Intake process uses the information to confirm member eligibility, provider network status, build case files for the specific member and distributes the case files to the appropriate UM staff to initiate the clinical review process. Once a determination is made, notifications are communicated in accordance with applicable state, federal or accreditation requirements.

Medical Necessity Review

Medical Necessity Review by the UM clinical staff includes review and application of objective, evidence-based clinical criteria to members' clinical information on a case-by-case basis and benefit plans to determine benefit coverage for requested services in accordance with members' health benefit programs prior to delivery of the requested services. The primary goal is to provide consistent application of clinical criteria to member clinical information as informed by member benefit document language in adjudicating benefit coverage. The UM clinical staff determines benefit coverage consistent with applicable laws and accreditation requirements, as required. The staff uses applicable member benefit plan documents, nationally recognized clinical guidelines and criteria, i.e., Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Cases requiring clinical review are forwarded to UM nurses and/or physicians for review. UM Medical Directors offer peer-to-peer conversations with ordering physicians as needed if determinations are adverse or whenever requested by ordering physicians within 2 business days. All clinical adverse determinations are made by physicians.

Prospective or pre-service review are reviews that UM service conduct at the request of providers or members for services that are not on the Prior Authorization list. UM staff conduct the reviews prior to delivery of the service. The basic elements of pre- service review include member eligibility verification, benefit interpretation and may include review of medical necessity and appropriateness of care for making UM determinations regarding

inpatient and outpatient services. The reviews are conducted by physicians or clinical peer reviewers if potential outcomes include clinical adverse determinations.

Inpatient Management/Concurrent Review/Discharge Planning/Post-Acute

The Inpatient and Skilled Nursing Facility (SNF) UM nurses review facility admissions on a case-by-case basis using objective, evidence-based clinical criteria to determine if the admissions are medically necessary under the provisions of the applicable health benefit plan. Nurses consult with the Medical Director to review cases if potential outcomes include clinical adverse determinations. Notice of all review determinations are communicated in accordance with applicable state, federal or accreditation requirements.

Post-Service Review

Post-service review assesses the appropriateness of medical services on a case-by-case basis after the service has been provided but prior to payment for services. Post- service reviews are based on established review guidelines and includes:

- Review of medical necessity;
- Appropriateness of level of care;
- Identifying claims issues;
- Eligibility determination;
- Initiation of appropriate follow-up actions for utilization and quality issues; and
- Identifying appropriateness and administrative issues such as physician notification, emergency status of admission.

Pharmacy Management

The purpose of SHP's UM program is to support appropriate processes for reviewing requests for the coverage of pharmaceutical products for which SHP has instituted clinical review criteria. All denials for standard and automated coverage decisions are administered by a licensed physician or licensed pharmacist in good standing and without restriction.

External Review Services

External review services are available through relationships with independent external review organizations or individual clinicians. Board–certified, licensed physician consultants from specialty areas of medicine, surgery, chiropractic, and podiatry are available to review individual cases as required by state mandate, regulatory agency guidelines and any voluntary external review program. A reviewing physician may not perform a review on one of his/her patients, the patients of his/her partners, cases in which he/she has had previous involvement or cases in which he/she has proprietary interest. When specific requirements of specialty or state licensure exist, or if there needs to be "independent" reviews for an appeal or peer review, consultants will be obtained through one of the contracted External Review Organizations. The internal medical director will make the final determination based on the consultation with the External Review Organization's recommendation.

SECTION D – DEPARTMENTAL ROLES & RESPONSIBILITIES

The staffing model that supports the UM Program consists of clinical, non-clinical, and administrative personnel. Distinct job functions, with defined roles, responsibilities, and accountabilities have been developed. The Program ensures that all physicians hold active unrestricted licenses. Peer clinical reviewers have an active unrestricted license as well as education, training, or professional experience in medical or clinical practice that is appropriate to render a clinical opinion for the conditions, procedures and treatment that will be reviewed. Key positions include the following:

- Chief Medical Officer: Provides clinical leadership for SHP Health Services.
- Vice President, Medical Management: Provides guidance and oversight for the services and benefits within scope of the UM Program.
- Director of Health Services: Provides guidance and oversight of the UM Program.
- Director of Pharmacy: Provides guidance and oversight and is responsible for all clinical aspects of the UM program for the pharmacy benefits.
- Clinical Review Medical Directors: Accountabilities include providing prior authorization reviews or prospective/pre-service decisions for requested healthcare services, including reviewing for network gap exceptions; and participating in the concurrent review processes to assist with coverage review of the facility setting.
- UM Nurses: Support the management of health care delivery by determining benefit coverage for requested services in accordance with member benefit programs and applicable criteria. Staff who conduct initial clinical reviews are health professionals who possess active, unrestricted licensure and/or appropriate certifications. Nurses review against the benefit plans and medical policy, CMS NCDs and LCDs or other applicable criteria.
- Health Services Coordinators: Non-clinical staff members who receive initial review requests and notifications and may perform initial screening of certain emergent or scheduled services. Assist in notification of coverage decisions.
- Clinical Pharmacists and pharmacy staff: Perform UM services for pharmacy benefits.

SECTION E – CLINICAL REVIEW CRITERIA, DEVELOPMENT AND APPROVAL

Clinical coverage decisions are based on the eligibility of the member, state and federal mandates, the member's EOC or summary plan description, medical policy, medical technology assessment information, and CMS NCDs and LCDs and other evidenced-based clinical literature. Determinations are made using evidence based clinical criteria to guide length of stay and level of care reviews. Application of clinical review criteria is integral to the UM processes of clinical coverage review and inpatient concurrent review. SHP may use clinical criteria from third party sources such as MCG Care Guidelines. Third party criteria will also be made available to providers and members as required by law and permitted by the third party. SHP may also develop clinical review criteria with review and input from appropriate providers and based on current clinical principles and processes and evidence-based practices.

Pharmacy clinical programs and criteria are developed by SHP clinical pharmacists. Selection of drug products and development of program criteria include review of peer-

reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data; published clinical practice guidelines, comparisons of efficacy, side effects, potential for off label use, and thorough SHP claims data analysis.

Program review also includes a comprehensive efficacy comparison as well as the type and frequency of side effects and potential drug interactions among alternative drug products and will consider the likely impact of a drug product on patient compliance when compared to alternative products, and evaluation of the benefits, risks, and potential outcomes for members. At least annually, medical literature is reviewed to determine if criteria need to be modified based on new evidence for medications with clinical review criteria. Ad hoc reviews may be performed at any time when questions concerning any indication are raised by clinical staff or through the appeals process.

SHP applies objective, evidence-based clinical criteria for Behavioral Health (BH) and Substance Use Disorders (SUD) when making benefit coverage determinations while taking into account individual needs and the local delivery system. The clinical criteria are based on guidance produced by government sources, professional societies, and published research. In addition to making benefit coverage determinations, the clinical criteria inform discussions about evidence-based practices and discharge planning. SHP uses CMS National and Local Coverage Determinations (NCDs/LCDs) and Medicare Benefit Policy Manual; MCG Care Guidelines, APA Psychological and Neuropsychological Testing Billing and Coding Guide; and American Society of Addiction Medicine (ASAM) criteria used to make clinical determinations for behavioral health and substance-related disorder benefits.

SHP is committed to meeting the requirements of the Mental Health Parity and Addiction Equity Act and applicable state laws (collectively MHPAEA) ensuring that mental health parity exists between medical/ surgical (M/S) and mental health/substance use disorder (MH/SUD) processes and that the non-quantitative treatment limitations for MH/SUD benefits are comparable to and no more restrictive than those for M/S benefits.

SECTION F – ADDITIONAL ASPECTS OF THE UM PROGRAM

SHP operates quality programs outside of the UM Program to improve the quality of care accessible to SHP members and the overall member experience. Quality programs include transition of care, readmission management and population health services.

Appeals

The SHP Appeals & Grievances Department manages appeal requests for SHP. Policies and procedures describe the specific appeals processes including required turnaround times, administrative requirements, letter content, and reviewer requirements. When applicable, appeals processes meet Department of Labor (DoL) regulations. State laws are followed if they are more stringent than the DoL regulations. Clinical input into the appeal process is provided by Medical Directors.

Transition of Care or Special Circumstances

SHP new members might be receiving treatment from non-contracted physicians. Policies for transition of care allow a member to continue his/her health care with the non-contracted physician, under certain circumstances and for a defined period of time. After that time, the member is assisted in finding a contracted physician who can provide the required care.

Care Management

Hospitalized members who have complex discharge planning needs or who may be at risk for a readmission, for post-discharge support, or other disease management needs may be referred to SHP CM program designed to improve the members' health and well-being and provide general health education.

Second Opinion

A member or member's PCP may request a second opinion if:

- The member/PCP believes that they are not responding to the current treatment plan in a satisfactory manner following a reasonable lapse of time for the condition being treated.
- The member/PCP disagrees with the opinion of their physician regarding the reasonableness or necessity of a surgical procedure or the treatment plan for a serious injury or illness.
- The member will need surgery or is diagnosed with a major non-surgical condition and/or requires diagnostic/therapeutic procedure(s).

Upon request for a second opinion:

- SHP Plan and/or the PCP will offer the member a choice of network physicians/providers. In those instances, in which a network physician/provider is not available, the process for referring a member to a non-network physician/provider is followed. Non-network physicians/providers should be selected within the SHP geographic service area. If the member does not seek a second opinion through the PCP, the PCP will be informed by the Plan of a request for a second opinion.
- Diagnostic testing, requested as part of the second opinion, must be completed by a network provider and authorized, as appropriate, through the Health Services Department.
- The consulting (second opinion) physician/provider must personally examine the member and provide the PCP with a copy of the consultation report and written opinion.
- Upon review of the consultation report and written opinion, the Medical Director, in consultation with the PCP, will make the final judgment concerning the treatment regarding the obligation of the Plan for further care.

The Medical Director may approve a "third" opinion if indicated. The consulting (third opinion) physician/ provider must personally examine the member and provide the PCP with a copy of the consultation report and written opinion. Upon review of the consultation report and written opinion, the Medical Director, in consultation with the PCP, will make the final judgment concerning the treatment regarding the obligation of the Plan for further care.

SECTION G – OTHER

UM PROCESS IMPROVEMENT

UM process improvement is a structured approach to maintain consistent application of UM processes. It is designed to provide an objective and assessment of the UM Program by measuring the adherence to policies and procedures, licensing/regulatory standards, and customer services. Process improvement reviews include:

- Process audits;
- Inter-rater reliability assessments;
- Participation in activities to meet accreditation and regulatory requirements; and
- Development of targeted, relevant action plans for continuous process improvement activities.

Medical directors, who are responsible for benefit coverage determinations and medical necessity determinations, participate in inter-rater reliability exercises, no less than annually. Results for inter-rater reliability programs are monitored and tracked for improvement opportunities.

Measurement and Reporting

Measurement and reporting are designed to support adherence to operational, regulatory and accreditation requirements. Reporting includes clinical, operational, and key performance metrics to ensure a comprehensive and balanced value approach.

Key performance indicators are monitored that reflect the impact of the Program activities. Measures include, but are not limited to:

- Timelinessof decision-making,
- Notification of decisions,
- Communication regarding UM activities with contracted practitioners & members, as applicable,
- Under and over utilization,
- Satisfaction with UM processes.

When possible, data is collected centrally and systematically from the UM systems. Self-reported measures are subject to audit. The process is structured to ensure that methodologies are consistently applied, and that data are appropriately interpreted.

DELEGATION OF UTILIZATION REVIEW FUNCTIONS

When UM activities are delegated to another organization, an evaluation of the organization's capacity to perform the proposed delegated activities is performed prior to entering into a delegation agreement. Pre-delegation evaluations may include, but are not limited to:

- The formal, written agreement or description of delegated activities;
- The delegated organization's UM plan documents and related policies and procedures;
- The delegated organization's annual UM evaluation; and
- Activity reports, files, and other relevant documentation, as applicable.

The delegated organization's ongoing ability to perform delegated activities is evaluated at least annually. Reports of selected activities are reviewed on a periodic basis. As applicable, opportunities to improve performance are monitored on a regular basis. The delegation

oversight is the responsibility of SHP.

CONFIDENTIALITY

The UM Program is designed to comply with the applicable policies of SHP, including the Code of Conduct, and those related to Ethics and Integrity. Through application of the policies related to Privacy, the Program seeks to retain the trust and respect of our customers and the public in handling of private information including health, financial, and other personal information in the conduct of our activities.

All employees, contracting practitioners, providers, and agents of SHP are required to maintain the confidentiality of member protected health information, including member demographic information, medical records, peer review and quality improvement records. All information used for UM activities is maintained as confidential in accordance with federal and state laws and regulations, including HIPAA Privacy requirements. Reasonable efforts are made to limit access to protected health information and other personal information to the minimum necessary to conduct operations.

CONFLICT OF INTEREST

All employees are prohibited from engaging in any activities that conflict with the responsibilities of SHP. Employees receive information and training on conflict of interest upon hire and must disclose any real or potential conflicts of interest to SHP. If SHP does not waive conflict of interest, employees must eliminate the conflict or resign from their position within SHP.

FINANCIAL COMPENSATION

Financial compensation plans for professionals who make utilization decisions are not based on the quantity or types of adverse decisions rendered and do not contain incentives, direct or indirect, for any type of UM decision. Financial incentives for clinical decision-`makers do not encourage decisions that result in under or over utilization of care or service.

ANNUAL EVALUATION

To determine if it remains current and appropriate, an annual evaluation of the UM Program is conducted. The annual UM evaluation reviews the Program structure, the Program scope, and member and practitioner experience. Recommendations resulting from the process of evaluating the UM Program are incorporated into the UM Program Description for the following year.