Department: Health Services	**Number:** HS-014
Title: **Health Services Committee Policy, Procedure, and Charter**	
Original Effective Date:	**Latest Revision Date:** 12/30/2024

Purpose:

The purpose of this document is to establish the formal Charter, Policy, and Procedure for Sonder Health Plans ("Sonder," "SHP") Health Services Department's Health Services Committee ("HSC"). The HSC will oversee the quality of care, appropriate utilization of services, clinical guideline adherence, and compliance with CMS regulations to ensure optimal healthcare outcomes and resource use for SHP members. The HSCHSC is also responsible for oversight of SHP's Clinical Operations, including Utilization Management and Population Health (comprised of Case Management and Disease Management) that reside in the Health Services Department ("HSD").

Definitions:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) -** a survey that produces comparable data on the patient's experience of care that allow objective and meaningful comparisons between MA and PDP contracts on domains that are important to consumers. The survey data are publicly reported by contract.
- **Centers for Medicare & Medicaid Services (CMS)** - the U.S. federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program(CHIP). CMS also works with the health care community to improve quality, equity, and outcomes in the health care system.
- **Healthcare Effectiveness Data and Information Set (HEDIS®)** - A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.
- **Health Services Committee ("HSCHSC"):** oversees SHP's Clinical Operations, including Utilization Management, and Population Health (comprised of Case Management and Disease Management). All references to the Utilization Management (UM) Committee, as cited from CMS regulations or other sources, is understood to have the same meaning as the Health Services Committee in this document.
- **Quality Improvement Committee**: The committee assigned by the Board of Directors to oversee the Health Services Committee and other SHP subcommittees.

Scope:

This Charter applies to all members of the HSC, including physicians, clinical staff, administrative staff, internal and external advisors. The committee is responsible for decision-making related to SHP's Clinical Operations, including Utilization Management and Population Health (comprised of Case Management and Disease Management), policy development, and performance improvement across all covered services under SHP.

Authority:

The HSC operates under the delegated authority of SHP's Executive Leadership Team and the Board of Directors. It has the authority to:

- Develop, approve, and review clinical and utilization management policies.

- Make decisions on medical necessity, utilization, and service authorization.
- Approve performance improvement initiatives and monitor quality outcomes.

Policy Statement:

The purpose of the SHP Health Services Committee is to oversee, guide, and evaluate delivery of clinical and medical services provided by SHP. The committee is led by a SHP Medical Director in accordance with 42 CFR § 422.137 and ensures that SHP's Clinical Operations adhere to federal and state requirements. The committee performs the functions as described below to promote high quality and cost-effective healthcare delivery to members.

Procedures:

I. CMS Membership Requirements:

A. In compliance with 42CFR § 422.137, SHP's Health Services Committee is comprised of and includes:

1. A majority of committee members who are practicing physicians.
2. At least one practicing physician who is independent and free of conflict relative to the MA organization and MA plan.
3. At least one practicing physician who is an expert regarding care of elderly or disabled individuals.
4. Members representing various clinical specialties (for example, primary care, behavioral health) to ensure that a wide range conditions are adequately considered in the development of the SHP's utilization management policies.
5. At least one member with expertise in health equity effective January 1, 2025. Expertise in health equity includes educational degrees or credentials with an emphasis on health equity; experience conducting studies identifying disparities amongst different population groups; experience leading organization-wide policies, programs, or services to achieve health equity; or experience leading advocacy efforts to achieve health equity.

II. Committee Composition: Based on the CMS guidance above, SHP has designated the following key HSC roles:

A. Chairperson: An SHP Medical Director appointed by the SHP Board of Directors and/or SHP executive leadership.

B. VP of Health Services and/or Director of Health Services

C. Physicians from various specialties

D. Health Equity Representative

E. Internal or External Experts: As needed, internal or external subject matter experts may be invited to provide additional clinical or operational insight.

III. Term of Membership:

Committee members serve renewable 2-year terms. New members are appointed by the SHP Chief Medical Officer.

IV. Meeting Frequency and Quorum:

A. The HSC will meet at least annually, with additional meetings scheduled quarterly, or more frequently as necessary.

B. At least 50% of voting members must cast a vote either during a scheduled meeting or electronically within 7 days following the meeting to make policy decisions, or approve actions related to Utilization Management.

V. Decision-Making Process:

A. Decisions will be made by majority vote. In the event of a tie, the Chairperson will cast the deciding vote.

B. In urgent cases, the Chairperson may call for an ad-hoc meeting or seek a consensus decision via electronic communication.

VI. Responsibilities: The Health Services Committee responsibilities include those mandated by CMS as well as those delegated by SHP's Executive Leadership and/or SHP's Board of Directors and include:

A. At least annually, reviewing the policies and procedures for Utilization Management, including prior authorization, used by Sonder. This review considers:

1. The services to which the utilization management applies.
2. Coverage decisions and guidelines for Traditional Medicare, including NCDs, LCDs, and laws; and
3. Relevant current clinical guidelines.

B. Approving only utilization management policies and procedures that:

1. Use or impose coverage criteria that comply with the requirements and standards relating to basic benefits at 42 CFR § 422.101(b).
2. Comply with the requirements and standards at 42 CFR § 422.138 for prior authorization policies.
3. Comply with the standards in 42 CFR § 422.202(b)(1) on practice guidelines and utilization management guidelines.
4. Apply and rely on medical necessity criteria that comply with § 422.101(c)(1).

C. Revising SHP's Utilization Management policies and procedures as necessary to comply with the standards in 42 CFR § 422.137, including removing requirements for UM for services and items that no longer warrant UM.

1. As required by CMS, SHP will not use any UM policies and procedures for basic or supplemental benefits on or after January 1, 2024, unless those policies and procedures have been reviewed and approved by the UM committee.

D. Clearly articulating and documenting processes to determine that the requirements have been met for SHP's Health Services Committee Composition (as described in 42 CFR § 422.137(c)(1) through (4), including the determination by an objective party of whether disclosed financial interests are conflicts of interest and the management of any recusals due to such conflicts.

E. Documenting in writing the reason for its decisions regarding the development of UM policies and make this documentation available to CMS upon request.

F. Beginning in 2025, annually conducting a health equity analysis of the use of prior authorization, and ensuring the analysis, reports, metrics, and criteria are aligned with the guidance in 42 CFR § 422.137(d)(6).

G. Ensuring the public posting of the results of the health equity analysis of the utilization management policies and procedures on the Sonder Health Plan's website and ensuring it meets the requirements at 42 CFR § 422.137(d)(7) by July 1, 2025, and annually thereafter.

H. Reviewing trends and reports regarding Part D medications as provided by the Sonder Pharmacy Benefit Manager.

I. The oversight of Care Management and Utilization Management programs to ensure goals are met as outlined in the Goals and Objectives of the Care Management and Utilization Management Program Description. This includes:

1. Reviewing utilization data based on industry and internally derived benchmarks, readmission rates, emergency department visits, outpatient procedures, and high-cost services to identify trends, overutilization, or underutilization.

2. Reviewing utilization of services, such as members who visit their primary care physician within 30 days of discharge from an inpatient setting.

3. Developing performance improvement initiatives to improve quality of care, reduce inefficiencies, and enhance member outcomes based on review of performance data, such as CAHPS/HEDIS scores, member satisfaction, and grievances.

4. Performing case reviews to include the review of complex or disputed cases to ensure decisions are based on medical necessity, clinical appropriateness, and utilization guidelines. This might also include reviewing pre-authorizations and concurrent review requests as well as appeals.

J. The review and approval of evidence-based clinical guidelines and protocols for the management of specific conditions. These guidelines will be regularly updated to reflect current best practices. If the Plan modifies an adopted clinical practice guideline or nationally recognized protocol, and that modification applies to all members, that change is approved by the Health Services Committee, communicated to the Quality Improvement Committee, and is updated on the Sonder Health Plan website. Provider Network representatives may also provide this information in written form when visiting the provider in person.

VII. Delegation:

A. The Health Services Committee delegates to the Health Services Department, the responsibility of distributing approved and adopted policies, procedures, and clinical guidelines, and/or guidance based on those approved and adopted documents, as needed, to applicable stakeholders, such as internal SHP staff, members, and providers. This delegation includes making updates to the Sonder Health Plan Provider Handbook and ensuring they are published on the SHP website as applicable.

VIII. Compliance and Regulatory Oversight:

A. The HSC will ensure all policies, procedures, and activities comply with CMS regulations, including those related to utilization review, member protections, and performance reporting. The HSC will participate in CMS audits, as needed, and ensure appropriate corrective action is taken if areas of non-compliance in the HSD are identified.

IX. Meeting Agenda:

A. The Chairperson, or his/her designee, will develop the agenda to include topics including, but not limited to:

1. Review of utilization trends and key metrics
2. Discussion of CMS regulation and updates and their implications for SHP
3. Review and approval of SHP Clinical Operations policies.
4. Case reviews
5. Identification of performance improvement areas.

B. Agenda and any required materials will be distributed to HSC members prior to the meeting.

X. Documentation and Reporting:

A. Meeting minutes will be taken during each meeting, documenting decisions, actions, and follow-up items. Minutes will be distributed to committee members within 10 business days post-meeting.

B. The HSC Chairperson, or his/her designee, will submit a quarterly report to the Quality Improvement Committee, SHP Executive Leadership Team and the Board of Directors summarizing committee actions, decisions, utilization trends, and any performance improvement recommendations.

C. The HSC will provide an annual review of its activities, including policy changes, performance improvements, and areas for further development. This review will be submitted to SHP's Quality Improvement Committee, SHP Executive Leadership Team, and the Board of Directors.

XI. Accountability and Reporting Structure:

A. The HSC is accountable to SHP's Executive Leadership and Board of Directors. All committee actions and recommendations must be aligned with SHP's overall mission to provide high-quality, cost-effective care, while maintaining compliance with CMS standards and improving healthcare outcomes for members.

XII. Charter Amendments:

A. This Charter, Policy, and Procedure document will be reviewed annually and may be amended as necessary by a majority vote of the HSC members. Amendments will also reflect any changes in CMS regulations or other applicable regulations.

Attachment(s): N/A

Statutory Reference(s):

Federal:

- The "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" Final Rule reported in the Federal Register on 04/12/2023.
- HPMS Memo "Additional Operational Instruction on the Utilization Management Committee Structure" dated 11/15/2023.
- HPMS Memo "Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)" dated 02/06/2024.
- The "Medicare Program; Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program for Contract Year 2024 – Remaining Provisions and Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (PACE)" – 04/23/2024.
- CMS Regulations at 42 CFR Part 22 as referenced throughout this policy.

Contract Reference(s): N/A

Element Reference(s): N/A

Related Policy(s): N/A