Department: Health Services	**Number:** HS-017
Title: **Utilization Management Compliance with CMS Provider Time and Distance Requirements**	
Original Effective Date 12/30/2024	**Latest Revision Date:** 12/30/2024

Purpose:

The purpose of this policy is to ensure that Sonder Health Plans ("SHP") enrollees have access to providers and care that meet or exceed the CMS reasonable time and distance standards. When reviewing provider prior authorization ("PA") requests, Sonder Health Plans ("SHP") staff will adhere to the applicable regulatory and Health Services Department ("HSD") guidelines and prioritize use of in-network providers when available to reduce enrollee cost sharing. This policy applies to Utilization Management ("UM") in the HSD within SHP.

Definitions:

- **Enrollee:** a person who is eligible for coverage, is enrolled in Medicare and/or Medicaid, and receives their benefits through Sonder Health Plans. The term enrollee and members are used interchangeably in this document.
- **Medicare Advantage Plan:** A type of Medicare health plan offered by private companies that contract with Medicare to provide Part A and Part B benefits.
- **Provider Network:** A list of approved healthcare providers, including primary care physicians, specialists, hospitals, and other healthcare facilities, contracted by SHP to provide services to enrollees.
- **Time and Distance Standards:** CMS-established maximum time and distance limits within which enrollees may have access to specific types of healthcare providers based on their geographical location (state and county) and one of five county type classifications. Counties are classified as large metro, metro, rural, micro, or CEAC (Counties with Extreme Access Considerations).

Policy Statement:

Sonder Health Plans maintains an adequate provider network to support access to covered services for its enrollees and to meet the maximum time and distance standards set forth by CMS for Medicare Advantage plans. The HSD is committed to maintaining utilization review processes that incorporate these and other applicable regulatory requirements. This includes ensuring access to primary care, specialty care, and other essential health providers within specified time and distance limits from our members' residences and approving out of network provider services when an in-network provider is not available for a requested service that meets coverage standards and medical guidelines.

Procedures:

1. The Utilization Management Team's Responsibilities:
    a. Reviews prior authorization requests, including medical documentation, detailing the medical necessity of the services to be provided by non-network providers.
    b. Determines if the member meets the applicable eligibility and coverage criteria and if prior authorization is required for the service requested.
    c. Assess if the service can be provided by in-network providers that meet the CMS time and

distance standards to perform the service. If yes, the request may be denied and notification, along with in-network provider options, will be provided in accordance with SHP and CMS guidelines.

d. If no in-network providers are available, or if the requested service is specialized and not readily available within the network, continue review for the non-par provider.
    i. Review medical necessity based on established guidelines, clinical evidence, and plan criteria.
    ii. Assess the cost-effectiveness of the service and member cost share.
    iii. If service is determined to be medically necessary, escalate for final decision by the Medical Director and/or VP HS or current HSD process. SHP may also assess if a Single Case Agreement can be completed with the provider.
e. Follow applicable SHP, HSD, and/or regulatory guidelines for notification of approval or denial of the request.

2. Provider Accessibility
    a. Locating An In-Network Provider:
        i. Utilize the CMS Provider and Facility Health Service Delivery (HSD) Tables to search for the State (GA) and the county that the member resides in. Then, select the provider type or facility type to identify and document the CMS time and distance requirements.
        ii. Review the SHP online provider directory to complete a search of available providers and their location in relationship to the member's address based on the HSD criteria in the step above.
        iii. Determine if there is an in-network provider available within the required time and distance limits.
        iv. If there is an in-network provider available within the required time and distance limits, the requesting provider (who is ordering the service) may be contacted to re-direct the request to an in-network provider.
    b. If an in-network provider is unavailable, follow the steps outlined above.
3. Time and Distance Standards:
    Provider Services maintains information on time and distance standards information for the network. If a member needs to be redirected to a new provider and time and distance needs to be validated, the Health Services staff may check with Provider Services for possible options. Current information about CMS specific time and distance standards can be found at:
    https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/HSDNetworkSubmissionInstructionsCY2019.pdf

File: "C:Sonder Health Plans, Inc\HealthServices - Documents\UM\UM Desktop Tools\Physician Denial Language Spreadsheet 12.05.24.xlsx"

Attachment(s): N/A

Statutory Reference(s):

Federal:

- 42 CFR § 422.112(a)(1)
- 42 CFR § 422.116
- CMS Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance (updated December 2023)

Contract Reference(s): N/A

Element Reference(s): N/A