Department: Health Services – Case Management	**Number:** HS-029
Title: Care Management Program	
Original Effective Date: 1/1/2021	**Latest Revision Date:** 6/3/2025

PURPOSE:

To outline the policies and procedures for the Care Management Program (CMP) for Sonder Health Plan (SHP) Medicare Advantage (MA) plans, and Special Needs Plans (SNPs) to ensure compliance with Centers for Medicare & Medicaid Services (CMS) requirements, Special Needs Plan Models of Care (SNP-MOC's), and other applicable federal and state regulations. The CMP aims to provide high-quality, member-centered case management services that address the medical, social, and behavioral needs of enrollees.

DEFINITIONS:

- **Case Management**: A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's comprehensive health needs.
- **Special Needs Plan (SNP)**: A type of Medicare Advantage plan tailored for individuals with specific characteristics or health conditions, such as dual eligibility, institutionalization, or chronic conditions.
- **Dual Eligible**: An individual entitled to Medicare Part A and/or Part B and eligible for Medicaid benefits.
- **Care Plan**: A document outlining the specific healthcare services, goals, and timelines tailored to an individual's needs.
- **Special Needs Plan Model of Care (SNP-MOC):** A comprehensive care management plan required for SNPs, mandated by the Centers for Medicare & Medicaid Services (CMS). It outlines how the plan will:

  I. Identify and assess the needs of members.
  II. Coordinate care across providers.
  III. Manage chronic conditions or other special health needs.
  IV. Ensure high-quality and cost-effective care delivery.

POLICY STATEMENT:

The SHP CMP is committed to providing care that meets the health, social, and behavioral needs of enrollees while complying with applicable federal and state regulations. The program supports CMS's objectives for improving health outcomes, enhancing beneficiary experience, coordination of care and ensuring cost-effective care delivery.

PROCEDURES:

I. Assessment

A. Make a good faith effort to conduct a CMS compliant Health Risk Assessment that identifies the enrollee's medical, psychosocial, functional, and cultural needs within 90 days after enrollment and annually thereafter, or more frequently based upon CMS statutes, state law, or SNP-MOC requirements.

B. Develop a person-centered care plan in collaboration with the member's caregivers, healthcare providers and others as requested by the member.
C. Document measurable goals, needed services, and timelines for achieving health outcomes.

II. Implementation

A. Coordinate with the member's interdisciplinary care team to deliver services identified in the care plan.
B. Facilitate access to specialists, community resources, and ancillary services as needed.

III. Monitoring and Evaluation

A. Conduct periodic reviews of the care plan based on the member's changing needs and health outcomes.
B. Utilize data analytics to track program effectiveness and compliance with CMS and state requirements.

IV. Communication

A. Maintain open and timely communication among members, caregivers, providers, and case managers.
B. Provide regular updates to members and their Integrated Care Team regarding changes to the members' care plans; provide on-going member centered care coordination, support, and education regarding health care needs and diagnoses.

Attachments:

N/A

Statutory Reference(s):

Federal:

- 42 CFR Part 422: Centers for Medicare & Medicaid Services (CMS).
- Medicare Managed Care Manual, Chapter 16b2