Sonder Health Plans

Atlanta, GA

SONDER HEALTH PLANS

Care Management Program

2025

OVERVIEW

CMS has stated its commitment to **improving population health**. CMS defines population health as health behaviors and outcomes of a broad group of individuals, including the distribution of such outcomes affected by the contextual factors within the group. As part of this strategy, a population health management (PHM) approach addressing chronic disease, behavioral health and overall improvement of care management (CM) is employed.

As defined in the Social Security Act 1915(g)2, "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. There are four main principles of **care management (CM)**: care coordination, transitions of care, patient engagement and advocacy. The Triple Aim is a strategy focused on improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care. CMS has established health equity as a strategic priority and is empowering stakeholders to take a data-driven approach to measuring and improving population health. Care Management, specifically Chronic Care Management (CCM), are tools utilized to improve population health and assist with addressing health equity. Chronic care Management (CCM) is a critical component of care that contributes to better outcomes and higher satisfaction for members. CMS recognizes that providing CCM services takes time and effort.

Sonder Health Plan agrees that Chronic Care Management (CCM) or Care/Case Management (CM) is a vital part of the Health Plan Care Management Program. The goal of Care Management is to identify patients in need of case management services and refer eligible members to the appropriate programs. At Sonder we recognize that members with chronic conditions are at high risk for increased hospitalizations as well as increased mortality. It is our goal to serve as an advocate for our members and assure our members receive the appropriate level of care in the appropriate setting at the appropriate time. All members enrolled in a SNP plan will be auto-enrolled in the CM program. MA plan members will be enrolled on a case-by-case basis. No additional fees are charged for participation in Sonder Health Plan Case/Care Management Program, no prior authorizations or referrals are required.

PROGRAM OBJECTIVES AND GOALS

The SHP Care Management Program identifies members in need of additional support, education, or coordination of care with health management, social determinants of health, or behavioral health and refers to or coordinates the receipt of needed supports with and for members. Objectives of PH and the SHP CM Program are to improve Access to care; improve clinical outcomes; increase coordination of care and connections to community services; promote healthy behaviors; encourage preventive care & screening; and increase the utilization of appropriate health services. Together the CM will work with the member/caregiver and the member's integrated care team to support and assist the member in identifying and developing goals to assist the member with their identified needs. In addition, the CM staff is focused on improving member satisfaction and engagement in their care by providing education and member-centered support. The program will balance the needs of the member and their family with the efficacious and cost-effective use of resources. The goals of the program include:

- Reducing avoidable admissions for acute care
- Reducing emergency room visits
- Reducing re-admissions
- Improving clinical outcomes
- Increasing member quality of life and overall satisfaction
- Reducing duplication of services and avoidable costs
- Increasing utilization of preventive services

CASE MANAGEMENT SERVICES

The scope of services provided to members include but are not limited to:

A. Assessment of health status

B. Education on the CM program and their chronic condition which may include but not limited to dietary recommendations

C. Development of a care plan with health goals, barriers and self-management goals

D. Assessment of progress against the care management plans for the member, treatment plans, and evaluation of adherence with prescribed treatment, interventions, or regimens

E. Regularly scheduled contact with the Case Manager based on acuity

F. Assistance navigating and collaborating with the health plan, other practitioners, community resources and vendors regarding treatment plan

G. Support transition between levels of care including but not limited to: Hospital to Home; Hospital to SNF; and SNF to Home

H. Discussion with interdisciplinary team to review care plan and discuss interventions

I. Referral to PCP for preventive services

ELIGIBILITY CRITERIA

All SNP members will be enrolled in Case/Care Management. SNP members can opt out of the CM program by signing a "Refusal to Participate" form. However, SNP members will continue to be assigned a Case Manager, have an HRA completed during enrollment, annually, and/or upon changes in condition. SHP will utilize claims data as well as other monitoring tools that may signal the need for reassessment and changes to the member's care plan. MA members will be referred on a case-by-case basis, through hospital discharge planning, utilization management staff or other means of referral. Likewise, MA members can opt out of the CM program by signing a "Refusal to Participate" form.

ROLE OF THE CASE/CARE MANAGER (CM)

The CM collaborates with the member's Primary Care Provider (PCP), and the Interdisciplinary Care Team (ICT). The CM assesses the member, and in conjunction with the ICT, develops the plan of care, identifies barriers to care, identifies community resources to leverage as well as engages the member in their health goals. In developing this plan of care, the CM collaborates with the member/family to identify attainable goals that the member/caregiver can implement to improve the member's overall health status. The objective is to increase the member's self-confidence to self-manage through their participation in the goal setting process.

The Case Manager will assist the member with the following:

- Monitoring and problem solving
- Medication administration
- Skills and strategies to manage signs or symptoms
- Diet and physical exercise
- Coping with emotions (anxiety, depression, etc.)
- Reducing unhealthy behaviors (smoking, alcohol, etc.)
- Importance of keeping scheduled provider appointments
- Instruction and assistance with scheduling preventive services

DISCHARGE CRITERIA

Discharge from Case/Care Management will occur when:

- Majority of goals have been met (for non-SNP members)
- Eligibility ends
- Referred to Hospice
- Upon request (for non-SNP members)
- Member dies

Any discharged member can be re-admitted upon referral.