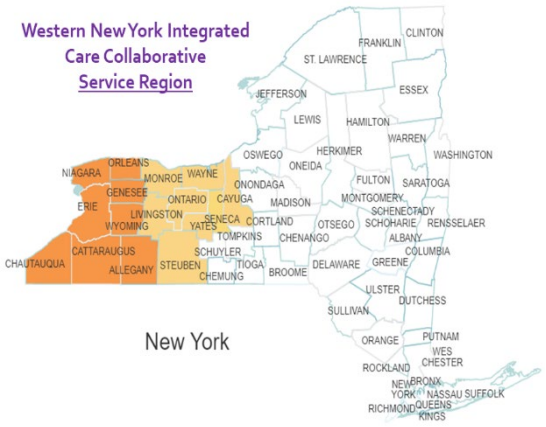
Community Care Hub Spotlight

Innovative Partnership between a Community Care Hub and Medicare Advantage Plan

Addressing health-related social needs (HRSNs) requires partnership between health care systems and community-based organizations (CBOs). CBOs can play a strategic role in helping health care systems address HRSNs. They have longstanding relationships with community members addressing health and social service information and referrals, promoting health and well-being through service coordination and delivery, and reducing social isolation.

The Western New York Integrated Care Collaborative (WNYICC) is a community care hub formed in 2016. Its network members include two health departments, one independent living center, eight area agencies on aging, and 43 social care agencies.



In 2018 Independent Health, a regional nonprofit health plan serving eight counties in western New York, approached WNYICC to facilitate access to the Diabetes Prevention Program for approximately 65,000 members in their Medicare Advantage plan, Independent Health. WNYICC responded by building a strategic partnership with Independent Health and offering an added service, diabetes self-management, for individuals who were already diagnosed with diabetes.

Opportunity

Independent Health and WNYICC built on early successes with the diabetes prevention and diabetes self-management programs, expanding partnership opportunities to include the launch of:

- Meals program in 2020
- Chronic Care Management (CCM) Medicare benefit and Healthy IDEAS pilot and expansion of meals program in 2021
- New billing codes for Community Health Coaching (CHC) previously known as CCM/Healthy IDEAS in 2022
- Falls prevention and caregiver programs in 2023

Best Practice Model

The partnership between WNYICC and Independent Health began through the formation of a joint operating committee/workgroup that meets weekly. The workgroup discusses each program's referral process, marketing, and communication strategies, as well as WNYICC and their partner CBOs' strategy, any escalation of incidents, provider outreach, billing and outcomes, and other reporting. In addition, communications and marketing materials are co-branded to reflect the value of the partnership and increase program visibility and credibility.

Impact

Outcomes from the partnership between WNYICC and Independent Health resulting in increased access to health and social service programs are illustrated in Exhibit 1.

Exhibit 1. 2022 Program Outcomes

Post-Discharge Meal Program Outcomes

- 695 participants received meals
- 18,094 meals delivered
- 79% increase in meals compared to 2020 and 2021
- 73% of participants report that meals helped to prevent a hospital readmission

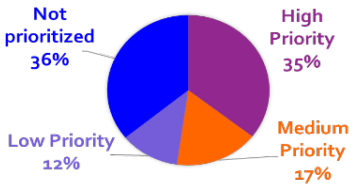
Healthy IDEAS

- 85% of participants improved either PHQ-9 or UCLA Loneliness score by 15%
- 76% of participants increased their physical and/or social activity through the program
- 57 referrals made to clinical providers: primary care physician, mental health providers, or registered dietitian

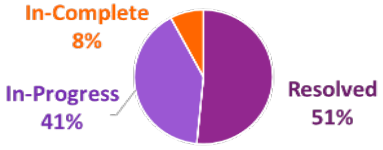
Community Health Coaching

- 46% had needs with Physical Environment/Housing
- 46% had needs with Food/Nutrition
- 40% had needs with Transportation
- 38% had needs with Community/Social
- 16% had needs with Economic Stability
- 70% had needs with Health Education/Literacy
- 31% had needs with Health Care System

- 275 Areas of Concerns / Social Determinant of Health Barriers across 15 participants



- 128 high or medium priority concerns with goals to resolve areas of concern
- 15 participants Jan 2022- May 2023 with an average of 8 goals per participant
- 92% resolved or in-progress; 8% incomplete



- 25 active participants: April 2023
- 100% of completers increased vegetable intake
- 92% made changes in eating habits
- 62% increased amount of physical activity
- 67% of those at risk for malnutrition improved to normal nutrition status.

- 40 referrals (all self-referrals) through Independent Health Servicing Team
- 32 participants assigned to coach
- 27 completed at least 1st appointment
- 36% signed up for PERS unit
- 44% completed MyMobility Plan (CDC planning tool)
- 3 enrolled in evidence-based fall prevention program

Sustainability

Sustainability is supported through the inclusion of programs within Medicare Advantage funding mechanisms. Exhibit 2 reflects the funding stream Independent Health uses to cover WNYICC programs.

Exhibit 2. Programs by Medicare Advantage Funding Mechanism

Program	Funding Mechanism for IH
Post-Discharge Meal Delivery Program	Supplemental Benefit
Community Health Coaching	Program, extension of IH case management
Healthy IDEAS	Program, extension of IH BH case management
Falls Prevention	Supplemental Benefit
Caregiver Support	Program, extension of IH case management
Diabetes Prevention Program	Medicare Part B Benefit
Diabetes Self-Management Training	Medicare Part B Benefit
Medical Nutrition Therapy	Medicare Part B Benefit (i.e. DM/CKD) & added Supplemental Benefit for any other diagnosis

Independent Health worked with WNYICC to develop billing processes. Healthcare Common Procedure Coding System (HCPS) billing code S5170 (home delivered prepared meal) is used and includes modifiers for Modified, Alternate (frozen), and Rural rates.

Health coaching programs use billing codes such as:

- **0591T**: Individual Assessment and Care plan: flat fee, not time-based
- **0592T**: Monthly Coaching/Care Coordination: up to 6-12 months
  - 30-minute units; up to 3 units (90 minutes)/month
- **S9451** Exercise workshops: 2 units:
  - Enrollment and attendance at 1 session
  - Completes program (attendance at ~67% of sessions)
- **98962** Health education workshops: 2 units (units same as S9451)
- **Z-Codes** used to distinguish programs.
  - Community Health Coaching: Diagnosis codes vary – from referral (chronic condition)
  - Healthy IDEAS: Z73.89 – Other problems related to life management difficulty
  - Falls Prevention: Z91.81 – History of falling (at risk of falling)
  - Caregiver Support: Z74.1 – Need assistance with personal care / secondary diagnosis: Y93.F9 – Activity, other caregiving

Lessons Learned

1. WNYICC and Independent Health recognize the value of partnership. The partnership provides Independent Health with access to more than 50 local and trusted CBOs known by community members. The partnership has resulted in one-stop contracting, billing, and referral processes, as well as increased coordination and use of in-home interventions and supports needed by members. WNYICC and Independent Health, by working together, impact health and social service outcomes of many members across western New York.
2. Medicare Advantage plans like to bill via claims. It allows the claim to show up on the member's Explanation of Benefits (EOB) and allows the health plan to better track services and impact. Hubs that can file claims will be better positioned to contract. Hubs also want to make sure they have a revenue cycle management process in place.
3. Negotiating the contract is just one step. The hub and health plan should work together to determine how to increase referrals and ensure beneficiaries know about the benefits/programs the hub provides.

For More Information see below:

www.independenthealth.com

www.wnyicc.org