Contracting Spotlight

Community-Based Organization Network Partner: Western New York Integrated Care Collaborative (WNYICC) is a Community Care Hub leading a network of eight Area Agencies on Aging, one Center for Independent Living, and 30 community-based organizations serving individuals of all ages in western and central NY.

Health Plan Partner: WNYICC launched a regional project with a large regional Medicare Advantage (MA) plan in CY2020 to provide post-discharge home-delivered meals.

Complementary Health Care Providers: The success of the contract agreement with a major regional MA plan allowed WYNICC to coordinate with hospital discharge planners and their regional health information organization (RHIO) to receive daily notification of member admissions to solicit referrals and document meal delivery by their network through a centralized data system managed by WNYICC.

Interventions Offered: Under the initial intervention, WNYICC provided a custom, post-discharge home-delivered meals program for hospitalized members that included hot home-delivered meals and medically tailored meals. WNYICC also incorporated patient satisfaction surveys to facilitate member feedback to the health plan.

After successful demonstration of organizational capacity, their contract expanded to include chronic care management, expanded meal benefit, a social isolation intervention, medical nutrition therapy, and evidence-based programs (including chronic disease, falls, diabetes, and caregiver focused interventions).

Financial Model: WNYICC integrates with the major regional MA plan provider practices that are participating in value-based payment models, which require the healthcare provider to operate on a capitated risk-based payment model. WNYICC is paid for some services on a fee-for-service basis. For CY2021, WNYICC began providing chronic care management services which are paid on a per member per month (PMPM) basis, for persons that are actively receiving care management services.

Key Features: WNYICC was founded via grant funding from the Health Foundation of Western and Central New York. WNYICC has a master service agreement with the major regional MA plan and subcontracts with their many CBO partners. The WNYICC network of CBO partners includes eight Area Agencies on Aging, one Center for Independent Living, United Way, Meals on Wheels, food banks, county health departments, and a range of other community-based direct service providers, serving the entire western New York region.

WNYICC relies on a complex network of home-delivered meals providers, including large and small independent meal providers, to provide meals to all regions covered by the network (including rural areas).

WNYICC has successfully secured additional contracts with Medicaid managed care plans, other Medicare Advantage plans, commercial plans, and Medicaid long-term care plans. They have integrated with local physician groups and hospitals that are participating in value-based contracts with Medicare and Medicaid to deliver a range of community-based interventions.

Contracting Spotlight

Community-Based Organization Network Partner: The Mid-America Regional Council (MARC), the Area Agency on Aging (AAA) of the Kansas City Metropolitan Statistical Area (MSA), provides services to older adults and persons with disabilities in two states, nine counties, and 119 cities. The Department of Aging and Adult Services at MARC serves a five-county region on the Missouri side of the MSA.

MARC serves as the Community Care Hub for a network of community-based organizations (CBOs) addressing health-related social needs and the coordinated delivery of home and community-based services.

Health Plan Partnership: MARC worked through extensive negotiations with a prominent local health plan in the Kansas City metro area to provide care transitions, evidence-based programs, and a community-based care management intervention to high-risk members in its commercial plans and members enrolled in a new Medicare Advantage plan. These interventions are now included in the CY2021 Medicare Advantage (MA) plan benefits following a successful bid to CMS. The agreement also includes the health plan's largest medical provider group.

Interventions Offered: Key features of the benefit allow MARC, through their CBO network, to provide community-based case management, including a comprehensive in-home assessment, care plan development, medication reconciliation model (using the evidence-based HomeMeds intervention), and resource navigation services to address SDOH.

Financial Model: MARC is reimbursed by the health plan based on a contracted fee schedule. For the commercial plan membership, MARC submits an invoice, which is reimbursed. For Medicare Advantage, a claim is filed for each member receiving services.

Key Features: MARC receives referrals from the health plan directly and works with the provider group's outpatient clinic practices to conduct outreach to plan members. MARC also conducts direct outreach to members.

MARC operates a centralized referral management system to ensure that there is a streamlined process to conduct the interventions, support of bi-directional data exchange, and a closed-looped referral system. The contract period began in January 2021, thus data will be forthcoming.

Contracting Spotlight

Community-Based Organization Network Partner: Community Care Solutions (CCS) is an Alabama non-profit corporation that was formed by the Southern Alabama Regional Council on Aging (SARCOA).

CCS, a Community Care Hub, deploys targeted interventions that include a range of direct care transitions and care management services, delivered through a regional network of Area Agencies on Aging (AAAs) and direct service providers in each region.

Health Plan Partner: CCS holds a care coordination contract with a major Medicare Advantage plan to address needs of the health plan members across four AAA regions in southeast and central Alabama, serving 18 counties (mix of rural and urban).

Complementary Health Care Providers: In addition to the contract with the major Medicare Advantage (MA) plan, CCS holds contracts with local hospitals and physician groups.

Interventions Offered: Under this value-based, risk-bearing contract, CCS deploys an intensive community-level case management intervention for moderate and high-risk Medicare Advantage members. The contract includes outreach services and intensive case management for high utilizers and super-utilizer beneficiaries enrolled in the health plan, measured and evaluated based on required quality measures.

Financial Model: The CCS contract with the MA plan is structured as a capitated per member per month (PMPM) payment model. This is a risk-bearing arrangement (downside risk), with CCS required to meet various goals to keep the full PMPM payment. As the lead entity, CCS bears all risk on behalf of their CBO network partners; they also hold the CBOs to performance standards on risk of exclusion from a sub-contract.

Key Features: The statewide network of AAAs each individually secured NCQA accreditation for LTSS case management. Since each AAA in the State has full NCQA accreditation, the MA plan is able to fully delegate all related case management activities to the CBO partner, according to NCQA regulatory requirements.

The MA plan pays CCS for care coordination services. When a member requires a SDOH intervention, CCS will seek public or community resource funding for identified service needs. If there is a public or community resource are available, CCS leverages this resource to deliver the SDOH intervention. If public funding is not available, the MA plan determines whether to pay for the recommended SDOH service (typically through a covered benefit).