

# Success Stories

## *Building Collaborative Contracts with Health Care: Region IV Area Agency on Aging and Corewell Health*

Since 2016, The John A. Hartford Foundation and USAging's Aging and Disability Business Institute have played a pivotal role in recognizing and honoring the achievements of community-based organizations (CBOs) that partner and contract with health care entities. They honor CBOs through The John A. Hartford Foundation Business Innovation Award,<sup>1</sup> which recognizes innovative and transformative approaches to addressing health-related social needs.

Region IV Area Agency on Aging (Region IV AAA) in St. Joseph, MI, is one of the runners up for the 2023 award. The award recognizes Region IV AAA's Community of Care for Older Adults with Complex Care Needs contracts with Corewell Health. These contracts are testaments to the power of collaboration and demonstrate excellence in innovative and transformative programming, significantly impacting the lives of older adults living in southwest Michigan. This Success Story is a beacon of hope, inspiring future partnerships and transformative opportunities.

### About the Partners

#### Region IV AAA

Region IV Area Agency on Aging<sup>2</sup> was established in 1974 and is designated to receive Older Americans Act funds for planning, developing and managing various programs and service delivery contracts. Region IV AAA strives to ensure that older adults and people with disabilities can live as self-sufficiently as possible in the setting of their choice with a mission of offering options

for independent living. The agency provides a full range of home and community-based long-term supports and services (LTSS), mainly through contracts and purchase agreements with local provider organizations and it monitors these partners for quality assurance and client satisfaction. Its Medicare services include primary care, behavioral health counseling, medical nutrition therapy, chronic care management, transitional care management and other Care Transitions Programs (CTP) and codes in a Medicare direct bill model is under contract with health care partners. Other services include private pay/cost share care management and service arrangements, volunteer engagement, caregiver support, health promotion programs and technology training. Region IV AAA serves people aged 60 and above and people aged 18 and up with disabilities, focusing on those in greatest socioeconomic need and experiencing health care disparities. Region IV AAA serves as a Community Care Hub (CCH) for more than 100 CBOs addressing social care needs.

#### Corewell Health

Corewell Health<sup>3</sup> is Michigan's largest nonprofit health care system, created in 2022 by a merger of Spectrum Health and Beaumont Health. Corewell Health provides health care and coverage, operating 21 hospitals and over 300 outpatient locations, and is affiliated with over 12,000 independent and employed physicians and advanced practice providers. Corewell Health's core principle is to help people be well to live their healthiest life possible.<sup>4</sup>

## About the Contract

Community of Care for Older Adults with Complex Care Needs (CoC) is a partnership between Region IV AAA, Corewell Health South and a network of CBOs, with Region IV AAA serving as the CCH. The CoC project embeds AAA social care staff in medical care teams to overcome social determinants of health (SDOH) barriers, improve health and reduce costs for older adults with multiple chronic conditions. Region IV AAA serves as the hub of connectivity to the ecosystem of this CBO network.

In partnership with Corewell Health, Region IV AAA hosted a Community Convening meeting of medical and social care professionals, CBOs, Home and Community Based Services (HCBS) providers, older adults and caregivers to develop a Community of Care Transformation strategy that would address the needs of older adults with complex care needs. The result was the creation of the CoC, which aims to address fragmentation within the health care ecosystem and incorporate strategies to address SDOH issues. LTSS demands and caregiver needs are also critical to improving health outcomes while integrating community-based care into the health care delivery system. Region IV AAA shared the top SDOH barriers facing CoC patients: mental health, home environment, nutrition education and incomplete advanced care plans.

The CoC partnership links social care clinicians with medical clinicians in an integrated team and creates patient-tailored interventions using the 4Ms of Age-Friendly Care<sup>5</sup> (what matters, medication, mentation and mobility), the four evidence-based elements of high-quality care. CoC aims to address health-related social needs (HSRN) by integrating social care and medical care in a Primary Care First<sup>6</sup> practice and a rural health clinic. Region IV AAA holds two contracts for this project: a fee-for-service (FFS) contract for the rural health clinic and FFS work to transition its Primary Care First practice contract to a value-based upside/downside risk-based contract.

## CoC Value Expectations (goals)



**Stabilized Health for Seniors** who have Multiple Chronic Conditions



**Reduced Cost of Care Overall:**  
Right Care, Right Setting, Right Time  
Reduced Hospitalization & ED visits,  
Increased Primary Care



**Increased Caregiver and Social Support**



**Sustainability through Establishment of Payment Model** (Contracts executed)

Beyond referrals and warm handoffs, CoC uses an innovative approach to structurally link AAA social care clinicians with medical clinicians to create an integrated team that meets patients' social and medical needs with a unified care plan. This partnership serves older adults aged 60 and older with a complexity score of 14 or more and highly utilizes inpatient and emergency department services. Patient complexity scoring measures several criteria to identify people with complex health and social needs, including the number and kind of chronic physical and behavioral conditions, the number of times they use the emergency department and are admitted to a hospital, type of health insurance and age.<sup>7</sup> The CoC uses a tool embedded in the Electronic Privacy Information Center (EPIC), a health care software program, to determine a complexity score based on coexisting conditions and challenges associated with managing interactions among various conditions and medications.

The CoC team (AAA and Corewell staff) holds weekly in-person care conferences to create tailored interventions for each patient based on patient-identified goals, utilizing the 4M’s approach to care, which focuses on patients’ individualized strengths and goals. Through in-home care management and motivational interviewing, SDOH barriers are identified, the network of CBOs engaged, and long-term services and supports are incorporated to overcome the obstacles to improved health and reach patient goals. This results in a structurally connected Community of Care that addresses patients’ social and clinical care needs, resulting in improved health, reduced costs and funding mechanisms for project sustainability.

## Funding

Corewell Health and Region IV AAA applied for and received a planning grant and implementation grant from the Michigan Health Endowment Fund to launch this work, establish a partnership and utilize Medicare billable codes to support the CoC beyond the initial grant-funded launch to create project sustainability. Medicare billable codes fund CoC Chronic Care Management (CCM) services and an independent data analysis of pre-and post-health care costs demonstrates value to our health care partner. Additionally, Corewell Health contracted with Region IV AAA to provide CCM services for two physician practices. The CoC Medicare billable codes and the two CCM contracts with Corewell provide Region IV AAA with a growing revenue stream and diversify its service and income portfolio, allowing for a more significant mission impact.

### Fee for Service Billable Codes

Billing Code	Code Description	Summary Requirements
HCPCS G0506	Comprehensive Assessment & Care Planning	<ul style="list-style-type: none"> <li>▪ Patient enrolled in person</li> <li>▪ Systematic assessment &amp; care planning personally performed by the billing provider</li> <li>▪ Add-on code to the standard E&amp;M code (99212-99215), AWV or IPPE initiating visit</li> </ul>
CPT 99490	Standard CCM	<ul style="list-style-type: none"> <li>▪ 20+ minutes of care management outside of office visits performed by clinical staff</li> <li>▪ Care plan established and regularly reviewed</li> </ul>
CPT 99439 (New in 2021)	Non-complex Add-on	<ul style="list-style-type: none"> <li>▪ Additional 20 minutes of "non-complex" CCM</li> <li>▪ Reportable up to 2x per month (after 99490)</li> </ul>
CPT 99487	Complex CCM	<ul style="list-style-type: none"> <li>▪ 60+ minutes of care management outside office visits</li> <li>▪ Care plan created and/or significantly revised</li> </ul>
CPT 99489	Complex Add-on	<ul style="list-style-type: none"> <li>▪ Billed incrementally for each additional 30 minutes spent beyond the first 60 minutes for Complex CCM case</li> </ul>

The funding for the CoC has revealed a progressive transition from grant funding to sustainability through Medicare billable codes to evolving toward a value-based payment model with shared risk and shared savings.



## Impact and Outcomes

An independent evaluation of the CoC program shows that the Region IV AAA and Corewell Health partnership and the CoC program demonstrate clear success.

Ninety-three patients enrolled in the program for at least six months showed an 86 percent reduction in unplanned inpatient hospital stays, a 63 percent reduction in emergency department transition to an inpatient stay, an 80 percent reduction in the length of hospital stay and a 100 percent reduction in emergency department transition to a nursing home. In addition, 83 percent of CoC patients report having a caregiver and 93 percent of these caregivers indicate they now feel supported in their caregiving role due to the CoC program.

The total cost of savings six months after the CoC program was 1.7 million dollars. Other outcomes indicating success are the CoC:

- Allows providers and patients to prioritize care goals and create a plan for chronic diseases requiring more attention.
- Utilizes subject matter experts on health-related social needs to achieve disease-related goals resulting in a longitudinal care plan.
- Provides a more proactive and personalized approach to complex needs.
- Improves patient and caregiver satisfaction.
- Reduces total per capita costs by efficiently using community-based services and reducing inpatient and emergency department utilization, skilled nursing facility admissions and outpatient services.
- Increases touchpoint time with patients.
- Expands the team for team-based care.
- Reimburses the team for non-face-to-face work.
- Improves quality outcomes and patient satisfaction scores.

*“Utilizing a care model that integrates social and medical care clinicians as one patient-centered team has generated significant value for our patients, caregivers and care teams. With this model, each team member better understands the patient/caregiver’s goals and challenges. The care plans are enhanced with needed perspectives that improve outcomes and reduce costs.”*

**Melinda Gruber**, Vice-President,  
Continuing Care Services, Corewell Health

## Lessons Learned

The CoC partners learned that embedding AAA social care staff in medical teams improves health outcomes for older adults and reduces health care costs. Health systems, funders and health care payors do not need to reinvent what already exists and should realize that it is critical to build on and integrate existing AAA and CBO infrastructure. Relationships are also essential, as building trust and demonstrating value to your health care partner is paramount. Face-to-face care conferencing drives greater impact. This partnership launched one week before COVID-19 shutdowns. AAA and Corewell staff collaborated remotely throughout the pandemic with good but mixed results. Once in-person weekly care conferences were established, a sense of a one-team approach to the work escalated and patient impact scores increased significantly.

## The Future

Amid a growing focus on addressing health-related social needs and AAAs innovative strides in health care contracting, the CoC emerges as a pioneering model. This business innovation strategically integrates AAA social care clinicians into medical teams, fostering a synergistic approach to social and medical care. Developed in collaboration with the local health system and a network of community-based organizations, CoC has been instrumental in resolving social determinants of health barriers and improving patient and caregiver outcomes while effectively reducing health care costs for complex older adults.

AAA staff log into each physician practice's instance of EPIC and use the AAA's electronic communication tool for CBO connectivity. This challenges scalability because the AAA staff needs to log into multiple systems for this project. Region IV AAA and Corewell Health plan to expand CoC work by developing an interoperable referral platform to reduce duplication for AAA staff and reach the broader network of CBOs.

A FFS model demonstrates the potential for scale in a value-based payment arrangement. CoC partners are exploring that model for future growth and maximum community impact.

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## Endnotes

1. The John A. Hartford Foundation Business Innovation Award - Aging and Disability Business Institute
2. [About - Area Agency On Aging \(Region IV AAA\)](#)
3. [About | Corewell Health](#)
4. Ibid.
5. [Age-Friendly Care \(johnhartford.org\)](http://johnhartford.org)
6. Primary Care First is a voluntary, five-year payment model designed by the Centers for Medicare & Medicaid to improve the quality and accessibility of primary care, especially for patient with complex chronic conditions. <https://www.cms.gov/priorities/innovation/innovation-models/primary-care-first-model-options>
7. [https://www.ihl.org/sites/default/files/Report\\_Measuring-Complexity-Standardized-Measures-for-Complex-Care.pdf](https://www.ihl.org/sites/default/files/Report_Measuring-Complexity-Standardized-Measures-for-Complex-Care.pdf)

## About the Aging and Disability Business Institute

The mission of the Aging and Disability Business Institute (Business Institute) is to build and strengthen partnerships between aging and disability community-based organizations (CBOs), CBO networks and the health care system. Led by USAging in partnership with the most experienced and respected organizations in the aging and disability networks, the Business Institute provides CBOs with the tools and resources to adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Funded by the U.S. Administration for Community Living, the Business Institute is the home of the Center of Excellence to Align Health and Social Care, which funds and supports community care hubs and the CBO networks that they lead. Learn more at [aginganddisabilitybusinessinstitute.org](http://aginganddisabilitybusinessinstitute.org).