KEY TRENDS ACCELERATING OPPORTUNITIES FOR INNOVATION IN HEALTHCARE & SOCIAL SERVICE PARTNERSHIP & PAYMENT MODELS

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Five Key Trends of Significance for Community-Based Service Organizations

1. Macro factors are moving the **whole healthcare sector** towards addressing drivers of health beyond clinical care
2. For government sponsored programs, **Managed Care is now the dominant model**
3. Healthcare stakeholder investment in HRSN and SDOH is part of a deliberate and sustained push from healthcare's largest funders (e.g., federal / state government) = **this is not a fad**
4. Supporting **capacity to adequaltey address HRSN demand** is a significant challenge – and opportunity
5. Healthcare organizations are most likely to make meaningful investments in approaches that **demonstrate tangible, near-term value for their organization**

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Up to 80% of health outcomes are driven by factors outside of clinical care – the traditional domain of the healthcare system

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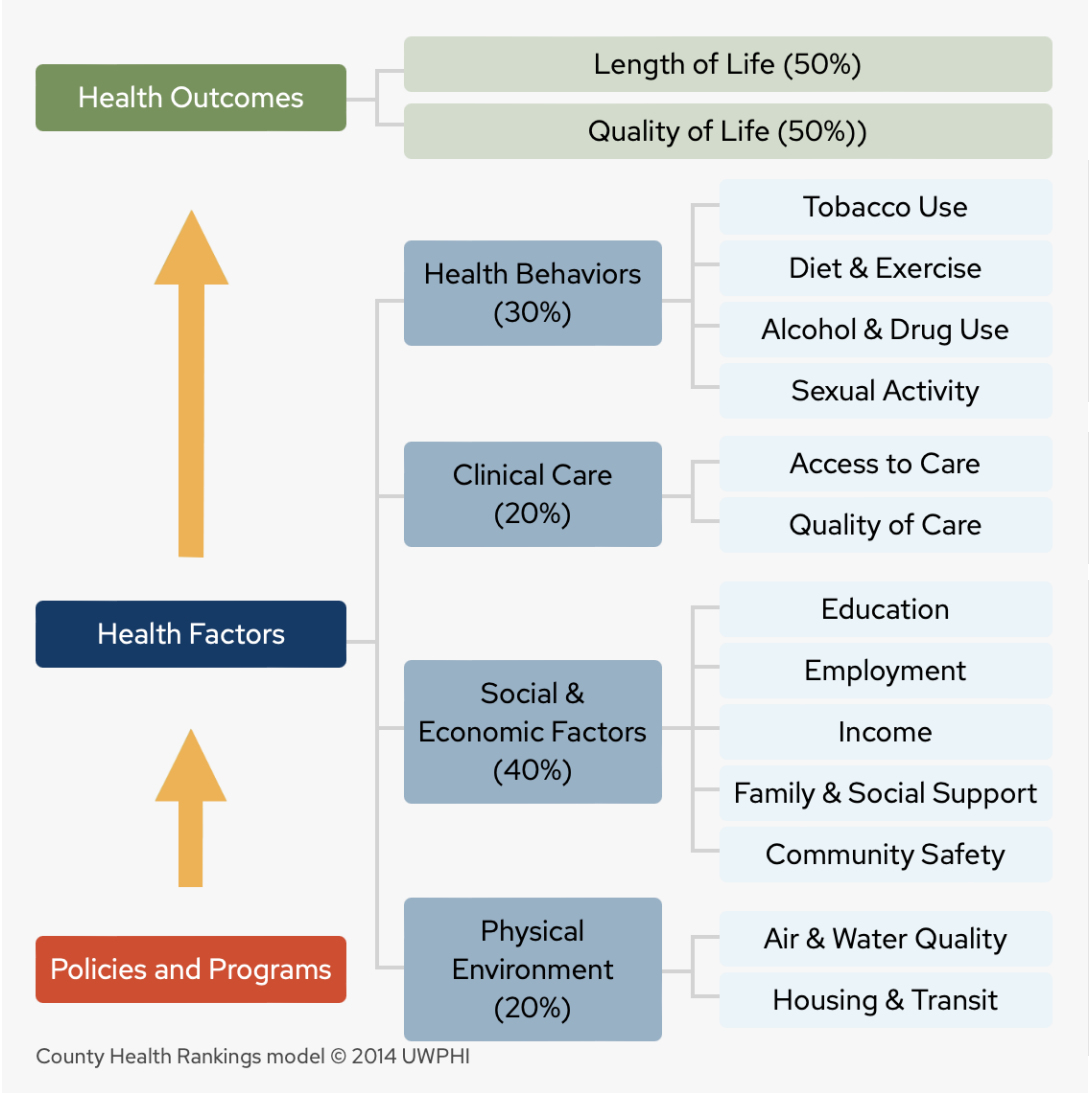
County Health Rankings & Roadmaps Model[1]



Traditional Domain of:

Public Health

Healthcare System

Government / Social Safety Net

1. University of Wisconsin, Population Health Institute – access here

A confluence of factors are driving the need for healthcare system stakeholders to rationalize their role related to social, behavioral, and environmental drivers of health

Public health funding shortfall

$4.5 billion

Public health funding gap to provide a minimum standard of foundational capabilities

Coronavirus Aid, Relief and Economic Security (CARES) Act, H.R. 748 (2020)

Growth in alternative payment models

15%

Increase (2015 – 2020) in the share of health care payments flowing through alternative payment models

Health Care Payment Learning & Action Network

Increase in Medicaid managed care

43 States

Use capitated managed care to deliver services to Medicaid enrollees, representing 72% of beneficiaries nationwide[3]

Kaiser Family Foundation

Increased awareness of health inequities

$320 billion

Estimated actuarial cost to the health system due to inequity, rising to $1 trillion by 2040 if left unaddressed

Deloitte Insights

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Managed Care has Become the Dominant Model for Both Medicaid and Medicare – *Meaning that Private Insurers are Managing Populations for a Capitated Fee*

Medicare

- Among the 57.6 million Medicare beneficiaries with both Part A and Part B coverage in 2021, approximately two-thirds were in Medicare managed care (Medicare Advantage or other private plans) or ACO models
- $361 Billion spent in FY 2021

Medicaid

- Managed care is also the dominant delivery system for Medicaid enrollees; $420 Billion spent in FY 2021
- Nationally, 72% of Medicaid members were enrolled (57 million people in 2020) in comprehensive managed care organizations (MCOs)
- At present 43 states and the District of Columbia use some capitated managed care model to deliver services in Medicaid

1. MedPAC: July2021_MedPAC_DataBook_Sec5_SEC.pdf
2. Kaiser Family Foundation, access here

Healthcare – and Medicaid specifically – are increasingly recognizing the role of and deepening commitments to health-related social needs.

Medicaid

- **1115 Waivers** for social determinate of health provisions are **approved in 19 states**, with applications **in 16 additional states pending**[1]
- A January 4, 2023 **CMS State Medicaid Director Letter** opens the door to states wishing to comprehensively address social drivers of health as In Lieu of Services, using managed care authority, without the need for a waiver[2]

Hospitals

- Starting in CY2024, hospitals participating in the Hospital Inpatient Quality Reporting Program are **required to report on two measures related to screening for social determinates of health**[3]

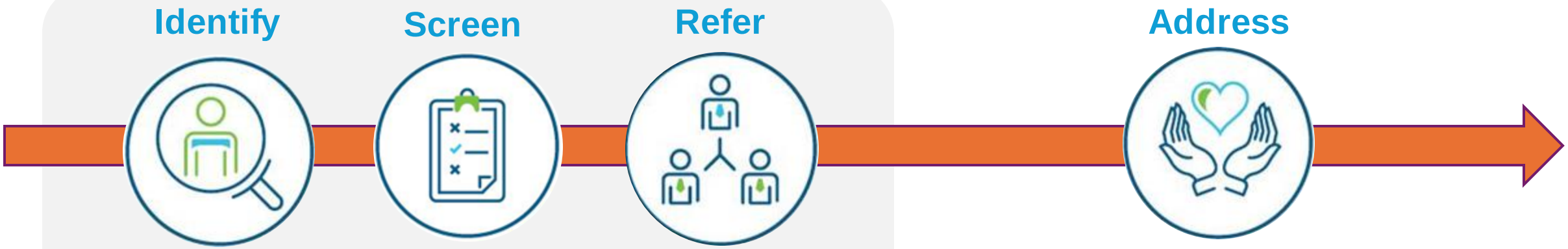
Physicians

- The CY2024 Medicare Physician Fee Schedule (PFS) proposed rule includes **new payment opportunities for social determinate of health screening and community health integration services**[4]

1. Kaiser Family Foundation, access here
2. https://www.medicaid.gov/federal-policy-guidance/downloads/smd23001.pdf
3. Health Quality Innovation Network, Quick Start Guide: Screening for Social Determinants of Health
4. https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-advances-health-equity

And yet, policy reform focused on the first stages of addressing health-related social needs increases demand without adding service capacity (i.e., supply)

Continuum of Addressing Health-related Social Needs



- Common Medicaid Requirements related to screening and navigation (used in 25+ states)[1]
- More straightforward to implement – similar to screen and refer approach used in clinical care
- Requires knowledge of and communication with community-based providers that address health-related social needs

- Advanced Medicaid Requirements (used in < 5 states)[1]
- Fewer external markers of provider quality, program model fidelity
- Requires robust partnerships with a new type of provider
- Community-based providers unfamiliar with Medicaid billing; unaccustomed to fee-for-service payment model

1. Mannat Health, In Pursuit of Whole Person Health: A Review of Social Determinants of Health (SDOH) Initiatives in Medicaid Managed Care Contracts and 1115 Waivers

Several forces are driving the need for capacity building to scale SDOH solutions

- Social determinants of health can drive as much as **80% of health outcomes**[1]
- Value-based payment systems are **increasing the pressure on plans and providers** to deliver outcomes and contain costs
- Many **states are expanding their requirements for MCOs** to address social determinant of health needs beyond screening and referrals [2]
- **Over 90% of states** require MCOs to screen beneficiaries for unmet social needs and provide referrals to community services [3]
  - Increased referrals are **driving an imbalance** between demand and capacity to deliver services
  - **Lack of reimbursement** inhibits supply-side capacity

Value-Based Payment Models Can Support More Meaningful CBO Engagement with Managed Care Organizations (MCOs)

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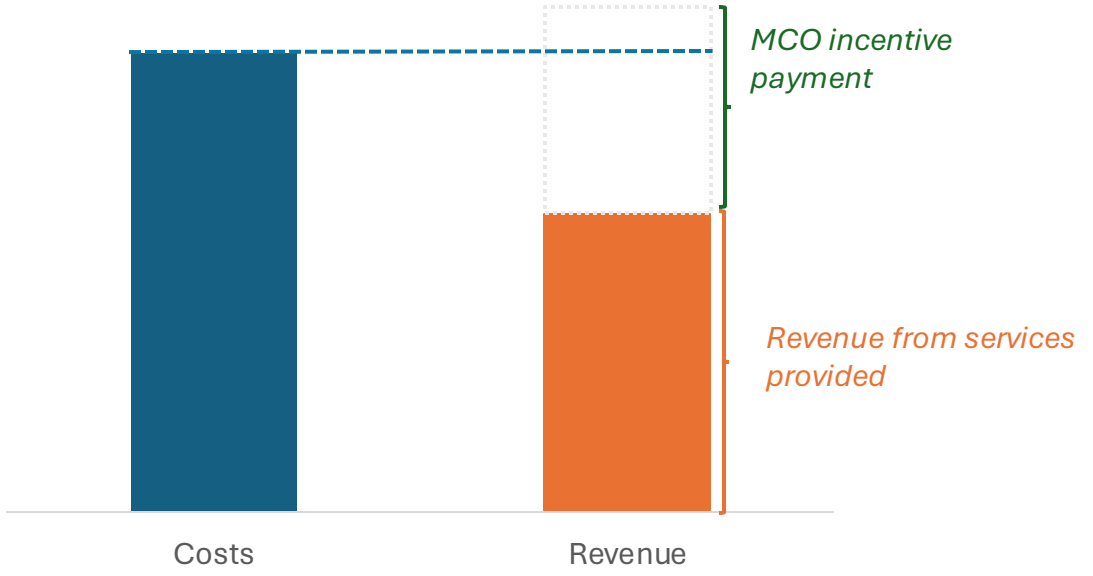
Value Based Financing Model

MCO pays the service provider, generally a community-based organization (CBO), for services and offers an **incentive payment** if certain performance outcomes are met



Revenue cushion allows CBO to scale services and ensure high quality necessary to achieve anticipated outcomes

Funding Gap. Even if they are able to access payments (i.e., fee-based reimbursement for services) CBOs typically operate programs at a financial loss – requiring philanthropic or other support to fill the gap in

1. Start-up expenses, and/or
2. Ongoing operations

Mutually Prioritized Outcomes. If the service provider achieves member or population-based outcomes that are meaningful to the MCO, this performance can trigger incentive payments that fully or partially close the revenue gap

Value Based Contract Terms. Ideally maintain some level of reimbursement for services (FFS) and provide a mechanism for the service provider to earn performance-based payments if targets are met (with a mutually agreed upon reporting, assessment, and payment schedule)