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LIMITLESS HORIZONS

Healthcare Partners 101 for Community-Based Organizations



Presentation by:

St. Louis Integrated Health Network &
Limitless Horizons

Agenda

Overview of Providers and Payers

Medicare, Medicaid, ACOs, and more!

Terminology and Translation

The Role of the CCH and Next Steps

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Your Trusted Partner in Advancing Health Equity

Presenter Introduction



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Let’s See Who’s in the Room

What is the Role of Payers and Providers?

Healthcare Payers

Healthcare payers manage the payment for healthcare services, along with details on insurance coverage, provider network development, and approval of services for the members enrolled in their plans. Their financial model is increasingly focused on **value-based care.**

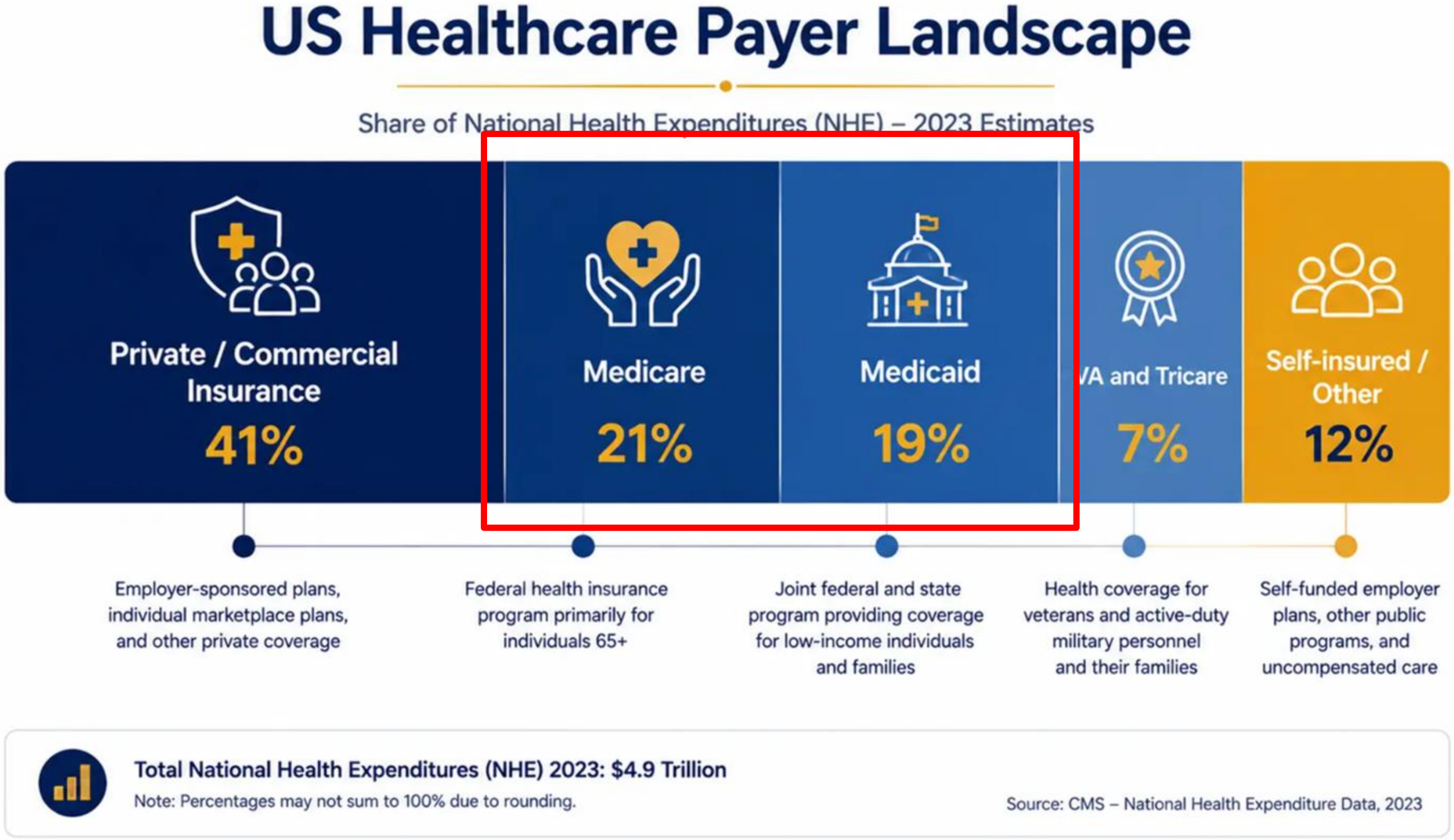
Healthcare Providers

Healthcare providers focus on provision of care to individuals seeking services. Their financial model has historically been based in **fee-for-service** arrangements.

Who Actually Pays for Healthcare?

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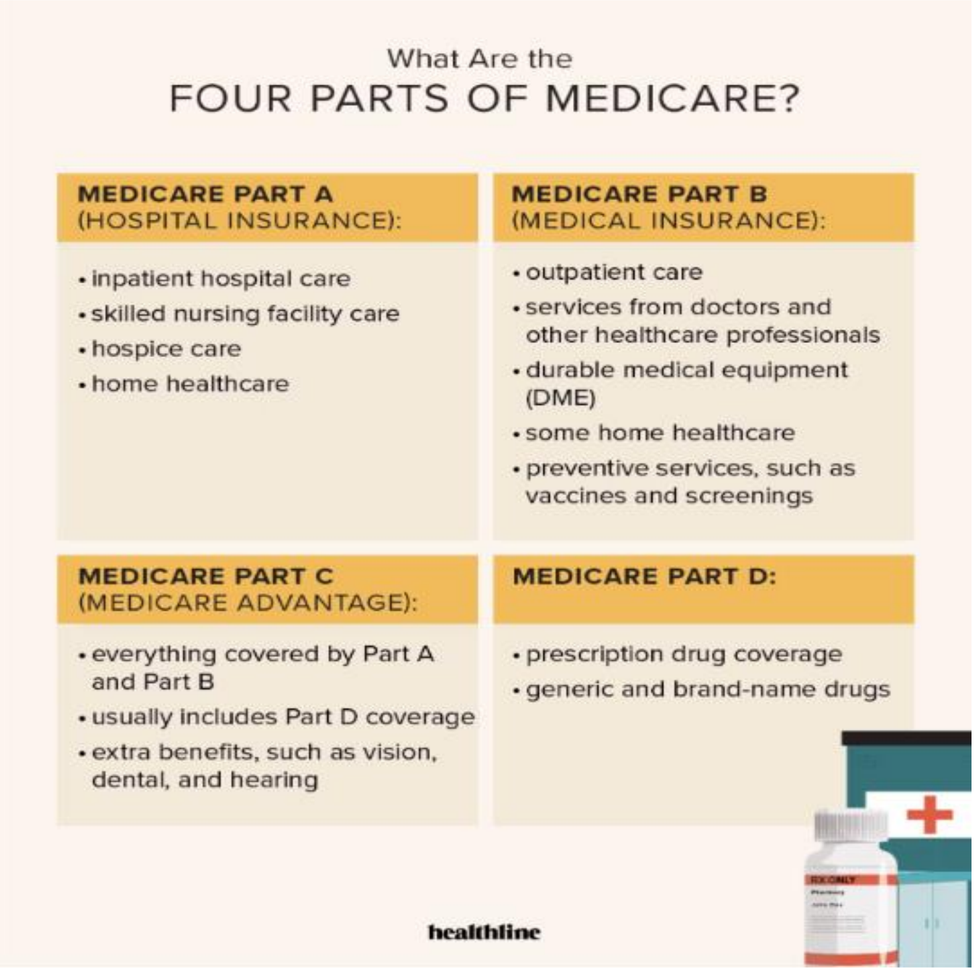
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Medicare

Medicare's Role

- **Federal program administered primarily by uniform nationwide rules**, eligibility criteria, and benefits structures.
- Covers **eligible individuals aged 65 and older**, as well as **younger people with specific disabilities, End-Stage Renal Disease, or ALS**.
- **Increasingly connected to value-based care efforts** that reward providers for patient health outcomes rather than the volume of services provided.

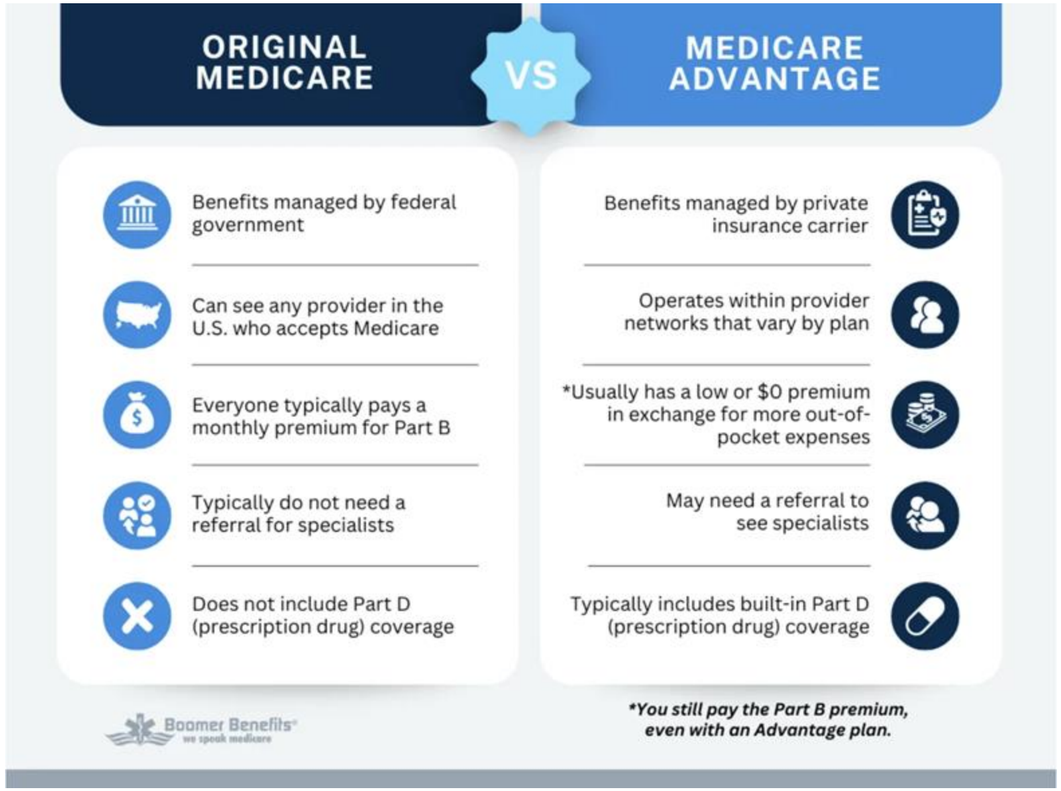


**Individuals choose to enroll in either Parts A and B (and typically D) that is known as Traditional Medicare, or they can enroll in Part C (Medicare Advantage), along with Part D plans.

Why It Matters to CBOs

Medicare's transition to payments aligned with value-based care introduces opportunities for CBOs to partner with Medicare payers and providers to prevent costs through provision of social services.

Part C: Medicare Advantage



Resources: https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage

AARP Medicare Advantage from UnitedHealthcare

aetna medicare solutions

Figure 4

Share of Medicare Advantage Enrollees in Plans with Extra Benefits by Benefit and Plan Type, 2026

	Individual Plans (n=21.4 million)	Special Needs Plans (n=8.2 million)
Eye exams and/or eyeglasses	99%	97%
Dental	98%	93%
Hearing exams and/or aids	95%	92%
Fitness	91%	93%
Over the Counter Benefits	68%	98%
Meal Benefit	65%	81%
Acupuncture	44%	38%
Remote Access Technologies	43%	39%
Transportation	22%	73%
Bathroom Safety Devices	21%	60%
In-Home Support Services	10%	38%
Caregiver Support Services	7%	32%
Telemonitoring Services	2%	1%

Note: Dental includes plans that only provide preventive benefits, such as cleanings. Analysis excludes employer group health plans (EGHPs). Individual plans are plans open for general enrollment and exclude EGHPs and SNPs.

Source: KFF analysis of CMS Medicare Advantage Enrollment and Benefit Files, 2026.

KFF

Resources: https://www.kff.org/medicare/medicare-advantage-in-2026-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/

Why It Matters to CBOs

Medicare Advantage plans can offer benefits beyond Original Medicare, creating opportunities to align with community-based services. Plans also have incentives to manage costs and improve quality and outcomes, creating potential CBO partnership opportunities. Benefits and requirements vary by plan.

Medicaid (MO HealthNet)

Medicaid's Role

- Federal-state health coverage program
- Covers generally low-income individuals and eligible children, pregnant women, adults, older adults, and people with disabilities
- Pays for healthcare and long-term services and supports
- Increasingly supports efforts to improve outcomes beyond traditional clinical settings

Managed Care Health Plan



MC English
MC Español

You will get your MO HealthNet coverage through one of the **Managed Care Health Plans**: Healthy Blue, United Healthcare, or Home State Health if you are a:

- Parent or guardian with a child under age 19 in the home
- Child (birth through age 18)
- Adult age 19-64 without a disability
- Pregnant woman (including your newborn child)

Review the **Managed Care Guide** for more information about your program.

También está disponible una versión en español de la Guía de atención administrada: **Su Guía de Managed Care**.

Fee-For-Service Program



FFS English
FFS Español

You will get your MO HealthNet coverage through the Fee-For-Service program if you are a:

- Person with a disability
- Senior (age 65 or older)
- Blind or visually impaired adult
- Woman (under age 65) with breast or cervical cancer

Review the MO HealthNet **Fee-For-Service Guide** for more information about your program.

También está disponible una versión en español de la guía de pago por servicio: **Su guía del programa Pago Por Servicio de MO HealthNet**

Source: https://dss.mo.gov/mhd/benefits

Why It Matters to CBOs

Understanding how Medicaid works can help identify where your services may align with healthcare priorities and potential partnership opportunities.

Inside Missouri Medicaid:

How Managed Care, Fee-for-Service Create Different Opportunities

Managed Care

Value-Added Benefits and Social Supports

- Managed care plans may offer *value-added benefits* beyond standard Medicaid-covered services – things like transportation to the grocery store, home-delivered meals, car seats, etc.
- Plans may also connect members to social and community supports that address needs affecting health
- These services can create opportunities for CBOs to support areas such as food and nutrition, transportation, housing-related needs, care coordination, and other social needs

Fee-for-service

Covered Services & Community Supports

- Payment is generally tied to specific Medicaid-covered services provided by enrolled providers
- Some services that CBOs provide may be directly reimbursable if they are covered Medicaid services and applicable provider requirements are met (e.g., care coordination)
- Other social and community services may not have a direct reimbursement pathway through Fee-for-Service

Inside Missouri Medicaid:

How Managed Care, Fee-for-Service Create Different Opportunities

How is it determined who has managed care and who has fee for service?

States make a determination based on a variety of factors, including ability to manage costs, capabilities of managed care providers, and more, on which populations and services will be enrolled in managed care and which will be enrolled in FFS.

Carved into managed care: Most physical healthcare and many behavioral health services for children, families, pregnant women, and adults ages 19-64 without disabilities

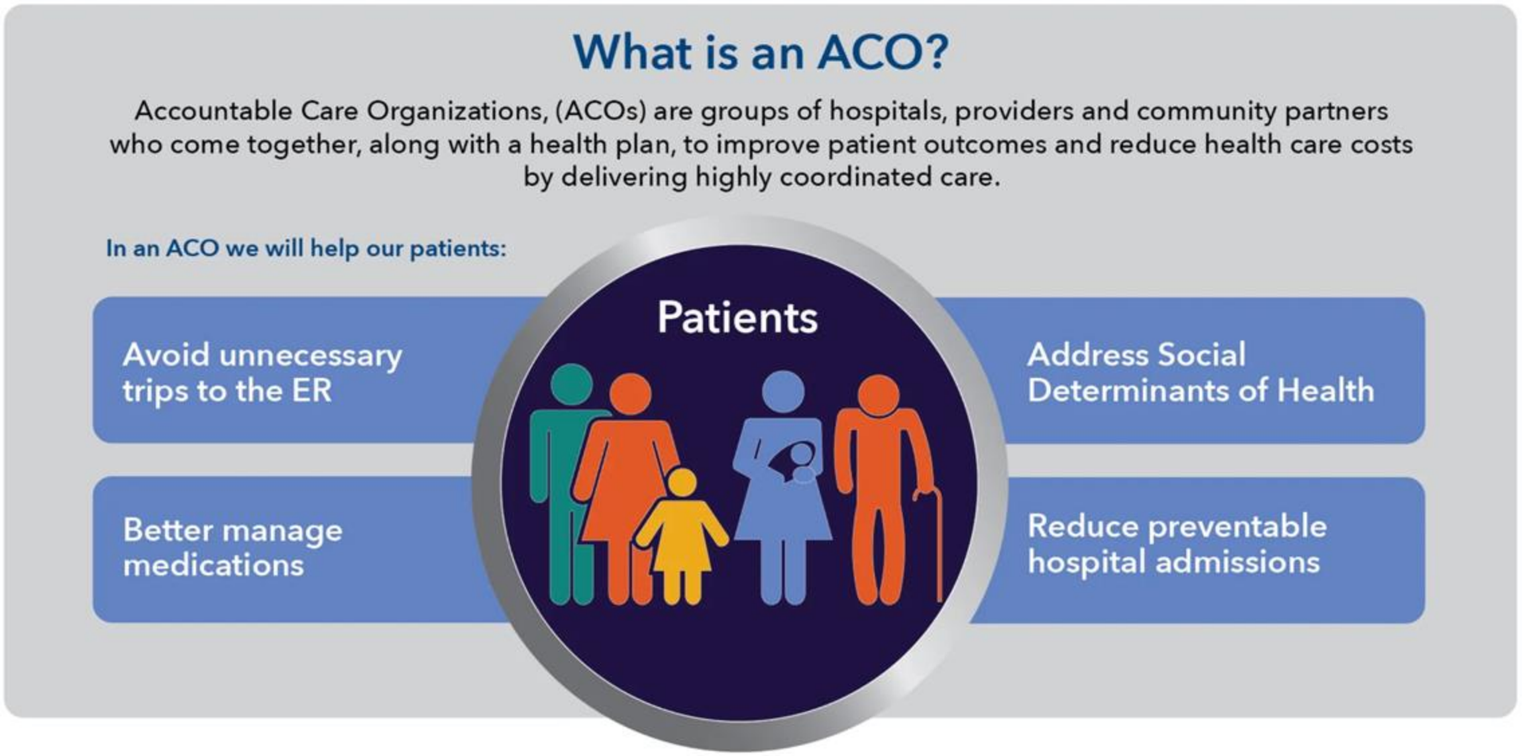
Carved out of managed care: Prescription drugs and certain specialized services are paid directly by MO HealthNet, individuals with disabilities, seniors, blind or visually impaired



Why It Matters to CBOs

Fee-for-service may provide direct reimbursement for certain covered services, while other CBO services may require partnerships through healthcare organizations and the CCH. In general, greater opportunities likely lie with partnering with Medicaid managed care organizations for things like value-added benefits as opposed to FFS.

Accountable Care Organizations (ACOs)



BJC Accountable Care Organization

Types of ACOs

Commercial ACOs: formed by private health plans and healthcare organizations for non-Medicare patients.

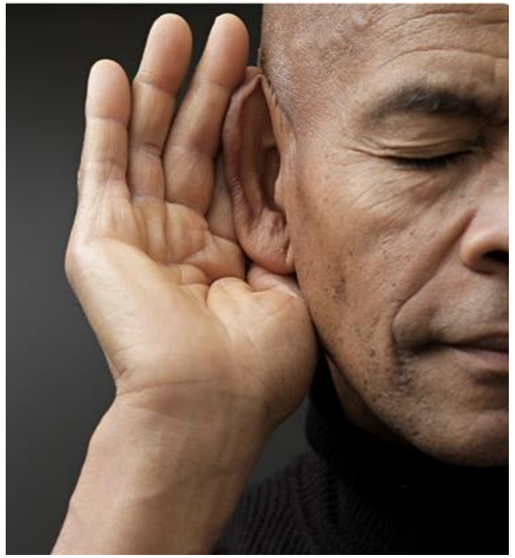
Medicaid ACOs: some states have created ACOs to improve outcomes for Medicaid enrollees and control costs for the Medicaid program.

Medicare ACOs: operate under the Medicare Shared Savings Program (MSSP) or other Medicare initiatives.

Other Healthcare Partners

Healthcare partner	Examples	Areas of opportunity for CBOs
Hospitals and health systems	Mercy, SSM Health, BJC Health System	Community benefit investments, discharge support, care transitions, referrals, and population-health contracts
Federally Qualified Health Centers	Affinia Healthcare, Betty Jean Kerr People's Health Centers, FamilyCare Health Centers	Referrals, navigation, outreach, and integrated care partnerships
Value-based provider groups	Physician groups, clinically integrated networks, and risk-bearing provider organizations Oak St. Health	May purchase CBO services when responsible for healthcare quality and total cost of care

Five Terms You'll Hear Again



Value-Based Care

Paying for outcomes and value—not simply volume of services.

Member Engagement

Helping health plan members participate in their healthcare and benefits.

Social drivers (determinants) of health

Social and economic needs that can affect health.

Preventable Utilization

Healthcare use that potentially could have been avoided through earlier or better intervention.

Risk Reduction

Strategies that help reduce the likelihood of poor or costly health outcomes.

Translate What You Do Into the Outcomes You Create







Your Organization Does	A Healthcare Partner May Hear
Provides transportation →	Improves access to care
Delivers nutritious meals →	Supports chronic disease management
Offers exercise programs →	Supports prevention and healthy aging
Provides social activities →	Reduces social isolation
Provides health education →	Improves self-management
Connects people to resources →	Addresses health-related social needs







<u>Important to CBOs!</u>

Translate your value – don't medicalize your mission. Speaking the language of healthcare can open doors to partnerships while preserving the community-based identity and purpose of your services.

From Community Service to Healthcare Partnership:
Start With the Work You Already Do



Community Expertise

↓

Identify the Population You Serve

↓

Define the Outcome Your Service Creates

↓

Identify Potential Healthcare Alignment via CCH

↓

Relationship Building with Healthcare Partners via CCH

↓

CCH Partnership Opportunities

<u>Important to CBOs!</u>

Payers don't purchase community services simply because they're good services. They invest when the service helps solve a problem they are experiencing. Lean into the CCH and utilize it to help support your journey.

Addressing the Elephant in the Room:
Perceptions Can Get in the Way of Partnership

What CBOs May Think About Healthcare Partners

"It's all about the bottom line."
"They don't understand our communities."
"They expect too much from small organizations."
"Healthcare dollars are difficult to access."

What Healthcare Partners May Think About CBOs

"Can they operate at the scale we need?"
"Can they demonstrate outcomes?"
"Can they meet data and reporting requirements?"
"Are they ready for healthcare contracting?"

The Opportunity: Work Through The Community Care Hub

By working through the CCH, healthcare payers and CBOs can address gaps in trust, communication, capacity, contracting, data, and reporting – without expecting individual CBOs to navigate these challenges alone.

When CCH partnerships work well, everyone can benefit.



What's Your Experience With Healthcare Partnerships?

Discussion Question:

Has your organization ever contracted with a healthcare provider or payer?

If yes:

What was the experience like? What worked well? What was challenging?

If no:

What questions or concerns would you have about entering into a healthcare partnership?

Creating a Bridge Between Two Different Worlds

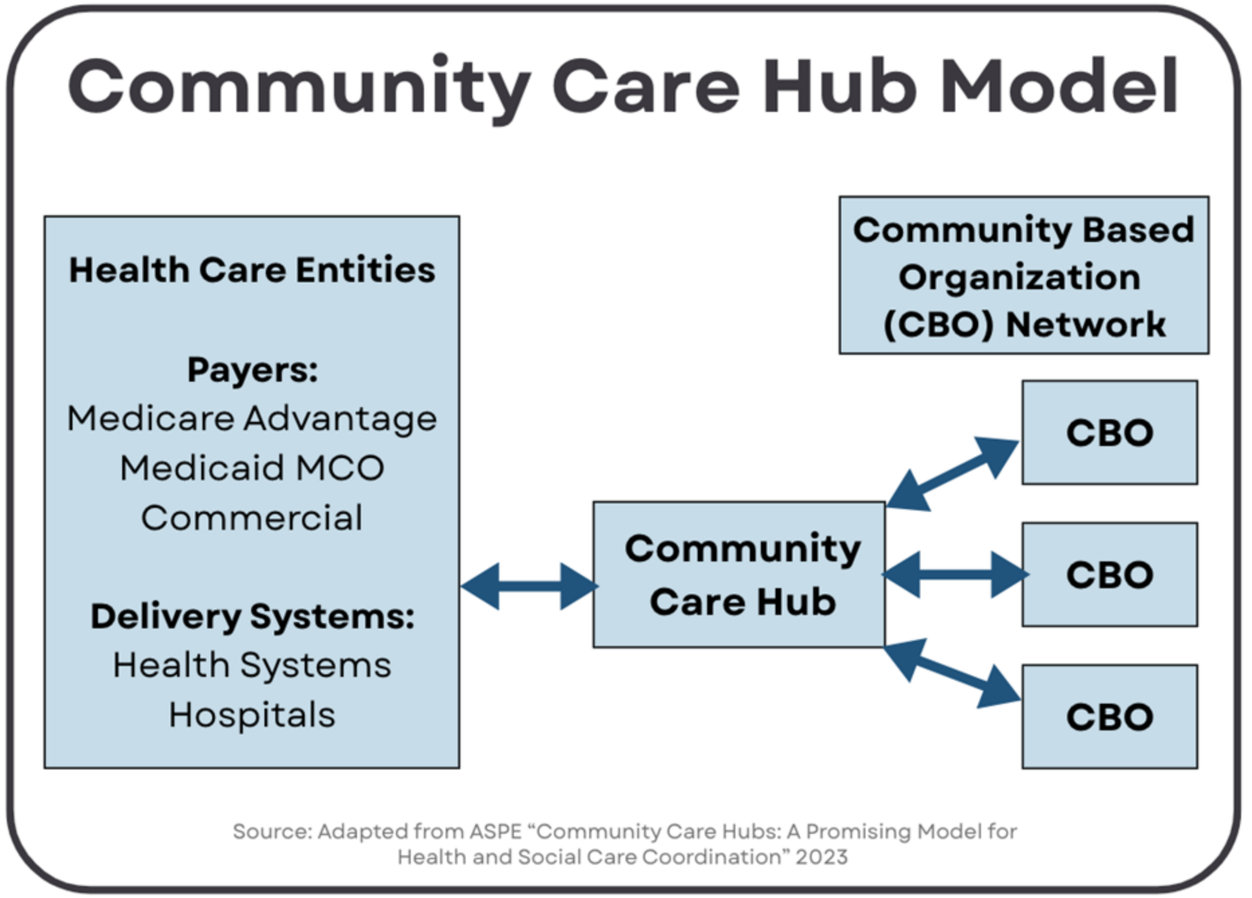
Healthcare Partners Need:

- Trusted community partners
- Reliable services
- Defined outcomes
- Data and reporting
- Scalable networks

Community Organizations Need:

- Access to healthcare partners
- Clear expectations
- Contracting support
- Sustainable funding
- Infrastructure and technical assistance

The Community Care Hub bridges the needs of healthcare partners with CBOs to improve health outcomes.



Next Stop – Seeing It In Action

Community Care Hubs in Action

Learn from an established Community Care Hub and how it:

- Built its community provider network
- Developed healthcare partnerships
- Coordinates referrals
- Supports participating organizations
- Navigates contracting and implementation

MARC
MID-AMERICA REGIONAL COUNCIL

https://www.marc.org/aging/community-support-network

Three Things to Remember

Your Takeaways

1. Know Your Value

Community services can contribute directly to outcomes healthcare organizations care about.

2. Know Your Population

The strongest partnerships happen when the people you serve, the outcomes you create, and a healthcare partner's priorities align.

3. Know The Priorities

Different healthcare payers serve different populations with differing plans, operating under different incentives.

How to Stay Engaged

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1. Sign up to continue to receive information, including notices of future webinars, on this opportunity as it evolves: HERE

2. Reach out directly to me to discuss in more detail: bwinfrey@stlouisihn.org

3. Review our website with previous webinars, additional materials, and more: https://stlouisihn.org/our-work/organizational-capacity-building/community-care-hub/

THANK YOU!

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