

Resource Guide

A Health Plan's Guide to Paying CBOs for Social Care

Introduction

Payment is a critical element of any contract. When negotiating the payment aspects of a contract between a health care entity and a community-based organization (CBO) or community care hub (CCH), both the amount of the payment and the payment methodology need to be considered. CBOs should keep in mind that there is no single “best” payment methodology that is appropriate in all situations. Rather, it’s important to match the various features that define the payment methodology with the nature of the services, relationship between the parties and the goals of the contract.

Over the last decade, the health care entities, driven largely by the Centers for Medicare & Medicaid Services (CMS), have been moving away from their traditional reliance on fee-for-service (FFS) payment and moving toward alternative payment models (APMs). APMs are payment methodologies that create direct financial incentives for providers to improve the quality of care while controlling costs. APMs are intended to be a departure from the volume driven incentive structures in FFS.ⁱ APMs, such as bundled payments, capitation and shared savings, can include risk sharing and quality incentives at the service, individual or population level. The goal of APMs is to align the incentives of providers and payers to produce the triple aim of improved population health, better experience of care and lower cost.



While much of the U.S. health care system is still centered on FFS payments, the growth of APMs has created new opportunities for partnership and contracting between health care entities and CBOs. Greater financial accountability and incentives can spur health care entities to invest in addressing health-related social needs (HRSNs), which can improve health outcomes and reduce overall spending. Moreover, as health care payments to CBOs accelerate, it’s important to leverage the lessons of health care’s overreliance on FFS to ensure that CBOs are compensated in ways that generate value for all involved.

Nationally, payment methodologies vary in CBO contracts with health care. Some states have begun introducing fee schedules for defined social care services covered by Medicaid, often with the caveat that they are a floor and not a ceiling and that parties are encouraged to negotiate alternate arrangements.^{ii, iii} Capitated payment, where the CBO or CCH receives a per member per month fee to cover eligible individuals within the population, is also becoming more common. The 2021 Aging and Disability Business Institute CBO–Health Care Contracting Survey showed that the percentage of CBOs with contracts being paid on a capitated basis in at least one contract had increased to 30 percent in 2021 from seven percent in 2020.^{iv}

As with the contract overall, the goal of the payment model is to align the parties around shared goals and to produce additional value for each party. For CBOs, the payment structure should advance the CBO's mission and cover at *minimum* the costs to provide the service plus relevant overhead (including the administrative and development costs). For health care entities, the value achieved extends beyond financial, to include improved health outcomes, member/patient engagement, equity and learning.

No payment model can guarantee perfectly aligned value, but different payment models create different incentives and require different inputs and activities, which can either promote or detract from the goal of creating value for the CBO, the payer and ultimately for the individuals being served. Moreover, payment provisions work in concert with other elements of the contract, including data reporting, quality measurements and eligible population to help produce that value.

Special Payment Considerations for CBOs

Contracts with CBOs to provide social care services should reflect several ways in which most CBOs differ from the health care sector:

- **Coding/Billing Standards:** Unlike the health care sector, which has well-established and comprehensive procedure codes that are applicable to nearly all health care services, procedure codes for many social care services frequently do not exist or are not standardized. While there are national efforts to develop social care codes, code-based billing for social care services is in early development^v and often requires contracting parties to independently define the service being provided. Additionally, certain codes can only be documented by certain providers which could create limitations in workflows and staffing for services provided.
- **Medical Loss Ratio (MLR):** Most health plans are required to spend at least 85 percent of premium revenues on medical services and quality improvement activities. Most social care services are not currently recognized as part of medical spending and therefore come out of a limited administrative budget, which can limit the health plan's ability to spend on those activities. Social care spending is increasingly covered as part of medical spend, including, for example assessments for health-related social needs (HSRNs), care management, social care benefits under Medicaid 1115 waivers, and services that have been approved as in lieu of services (ILOS)^{vi}; however, 1115 waivers and ILOS focused on addressing social needs are not widespread across all states. Regulatory requirements may dictate certain coding or other activities to count CBO-contract spending as part of medical loss, which can be administratively burdensome for both the CBO and the health plan.
- **Customary Payment Structures:** Historically, CBOs have often been paid through grants or contracts that reimburse them on a cost basis and do not require them to bill for individual services. Therefore, when entering contract negotiations, CBOs may be less likely to have determined the "fully loaded" unit cost and value of their services. It is vital for health plans and CBOs to work together to determine fair unit costs and pricing so that CBOs can sustain their services with sufficient reimbursement.
- **Risk Tolerance:** While risk-based contracting strategies like APMs are increasingly common in health care, CBOs and CCHs are newer to APMs and may be less able than traditional health care payers or providers to take on downside risk due to smaller organizational budgets, limited reserves, and tighter finances. Carrying risk also must be based on sufficient volume of service population in order to safely spread the risk.

- **Evolving Payment Methodology:** The payment model used in a particular health care–CBO contract may evolve over time. In the initial pilot phase, there may be insufficient information and experience to warrant a sophisticated APM or even FFS. Moreover, if a CBO doesn't have experience submitting claims, it can be helpful to allow the CBO to submit for payment via invoice rather than individualized claims by member because of the risk of denied claims and extended reimbursement cycles. The health plan can then work with the CBO to mature its operations and revenue cycle to enable it to operate under a claims model. Over time as experience, financial stability and trust increases, other payment methods can be established.

Major Payment Models

The following section details common payment models that CBOs can use in contracts with health care. There are several factors that health care organizations and CBOs should consider when determining which payment approach is most appropriate for their specific partnership goals, including:

- The level of financial certainty (expected revenue and cost) for both the CBO and the payer.
- The incentives to the CBO.
- The financial risk for both parties.
- The amount of data/experience required to support the payment model.
- The cost and administrative burden of billing under the model.

1. Fixed-price contract: The contract sets a fixed amount as the total payment for the activities and services contained in the contract, regardless of utilization. The contract may set volume targets or requirements. This payment model is predictable for both sides in terms of cost/revenue and administratively simple, but is not dynamic or responsive to the need or demand for services. It typically does not include financial incentives for volume or quality, though nothing precludes bonus/penalty arrangements that do so.

Fixed Price Contract Example

The Camden Coalition launched a new partnership with a NJ-based Medicaid managed care plan (MCP) using a fixed-price contract. The covered services included engagement and intensive care management of up to 30 high risk members with complex health and social needs, as well as providing social determinants of health (SDOH) screening services to members at participating emergency departments and primary care sites. The MCP also enlisted the Coalition to facilitate relationship building and deepening of their network in the region by hosting two site visits and including the MCP in a wide range of community meetings, programming and training. A fixed-price contract enabled the Coalition to dedicate a certain number of resources to managing the new relationship, was easy to administer, and could be easily budgeted by the health plan. The parties anticipate that they would develop a new contract that might have different payment features based on the learning and results of the initial pilot.

When to use:

Fixed price contracts are particularly well-suited to pilot projects or grant-funded projects. Pilots are often focused on creating a proof of concept and learning how the parties should work together. Much of the time and cost of a pilot is in up-front infrastructure development (e.g., establishing the partnership, developing and standing up workflows and technology interfaces, recruiting and training new staff, etc.), which is hard to recoup in a volume-based arrangement (FFS or bundled payment). The fixed price also provides certainty to the CBO to allow them to dedicate staff to this new program. In negotiating a fixed-price contract, the parties should collaborate to ensure that the funding and expectations in the Scope of Work (SOW) are well aligned, including adequate resources for staffing, and standing up new infrastructure so that the project can be successful.

2. Fee-for-service: In a fee-for-service (FFS) model, service providers submit claims to payers for each service rendered, regardless of service outcome.^{vii} Each service is typically defined in a narrow and discrete fashion, and in a unit size that can be delivered in a single encounter. It is not uncommon to deliver more than one service in a single encounter.

The health care system is largely moving away from FFS because it incentivizes providers to deliver more services without regard to the value or quality of those services. Nevertheless, it remains the dominant payment model in health care, and as new social care services are introduced, it is often the default payment model. FFS can entail significant administrative costs, particularly for CBOs that aren't used to billing for services. On the other hand, FFS allows for the amount of care (and resources) provided to fluctuate according to need/demand and ensures that the provider receives additional compensation for every client served. It's important that the health plan and CBO work together to develop equitable FFS rates that adequately cover overhead costs in addition to direct service costs.

As with health care services, the concern about incentivizing providers to oversupply a service without regard to its value is relevant in the social care context. For CBOs, FFS also contains the opposite risk—insufficient volume of individuals to serve. Low volume can harm CBOs by not generating enough revenue to support the infrastructure and staffing they've invested in to serve the payer. Some contractual ways to mitigate volume risks for CBOs and health plans include:

- Specification of a minimum service volume;
- Narrow (or broadened) eligibility criteria for the contracted service; and
- Setting a maximum volume of the service that can be provided.

Fee-for-Service - Phased Implementation

Mid-America Regional Council (MARC) Aging and Adult Services, an Area Agency on Aging in Kansas City, MO, operates a community care hub (CCH) called Community Support Network. The hub contracted with Blue Cross Blue Shield of Kansas City (BlueKC) health plan to deliver meals, educational courses and other social health interventions to individuals with complex social and medical needs under both commercial and Medicare Advantage plans. The parties chose a FFS payment model, but MARC did not have extensive experience submitting health care claims. In the first phase, MARC submitted invoices with a stated number of services, rather than individualized claims by member, to avoid the potential for denied claims and extended reimbursement cycles. In the later phase, the parties transitioned the contract to require MARC to submit individual member claims. This flexibility made for a smoother launch of the program, which

Health plans will need to consider scalability and sustainability of services in this model, particularly if these services are not considered “medical expenses” under MLR, since there is still limited evidence as to the appropriate intensity of service (e.g., how many medically tailored meals per day/week) and the duration of service (e.g., medically tailored meals offered for how many weeks/months) for specific social needs. Health plans can use pilots to better understand the costs for different intensity and duration of services to appropriately plan expenses to scale and sustain services. As the field continues to develop more evidence on the appropriate populations and best dose of different social care interventions, the parties will be better able to define member eligibility and the intensity and duration to ensure that the service is both cost-effective and sustainable over time.

When to use:

FFS may be appropriate for a standardized service that can be produced at volume, such as a medically tailored meal. Such services can be readily defined for the purposes of a standard service code and have a fairly standard cost to produce and deliver, which makes price negotiation easier.

- 3. Bundled payment:** The bundled payment model provides a single payment as reimbursement for an entire suite of services included in a person’s care, often described as an episode of care.^{viii} It is designed to create accountability in one provider for all of the services needed by the patient for a particular condition during a particular length of time, and generally includes quality/outcome metrics that are tied to the payment. It gives the provider flexibility and incentivizes delivering a combination of services as efficiently and cost-effectively as possible without regard for maximizing FFS revenue volume but does put the CBO at risk if the cost of properly serving the client exceeds the payment amount.

Designing equitable bundled payment amounts will require adequate data and experience on the part of both parties. In a bundled payment, the parties need to define:

- The beginning and end of a given episode of care,
- Which beneficiaries are eligible for the episode,
- Which services are included in the bundled payment, and
- Which services will continue to be paid for separately.

Bundled Payment Example

MARC’s Community Support Network used multiple payment models in its contract with BlueKC health plan. In addition to paying for meals, courses and other distinct services through a FFS rate, the parties chose a case rate (bundled payment) for the case management services for up to three months, with an option for approved renewal periods. The bundled payment offers more efficient billing for a range of different case management services than submitting separate claims for every contact.



When to use:

Bundled payments may be appropriate for complex services with multiple components delivered over an extended period of time (e.g., care management services, housing support services and care transitions services). In such situations, bundled payment is less administratively burdensome than FFS because each discrete service doesn’t need to be separately submitted; it also allows the CBO greater financial flexibility to provide whatever combination of services is most appropriate for the particular client and encourages greater integration and efficiency.

- 4. Capitation:** The capitated payment model is structured as a fixed payment given to a provider to cover the costs of care per covered individual per unit of time (e.g., per member, per month [PMPM]).^{ix}

Capitation creates financial certainty for both parties but involves a high level of risk around the volume of services. If volume is low, the health plan gets less value; if volume is high, the CBO incurs additional costs. Capitation incentivizes the CBO to provide service as efficiently as possible. Payers may want to incorporate quality measures or other checks to ensure that the CBO serves all qualified individuals with the full service.

Capitation is relatively easy to administer from a payment standpoint (it does not require individualized billing like FFS or bundled payment) but requires data and experience for both parties to understand the likely volume, cost and value of the services.

Capitation and Shared Loss Example

In Virginia, BayAging, a community care hub, contracted with a Medicaid managed care plan to provide fully delegated care management for Medicaid enrollees. Bay Aging is paid on a PMPM basis. The parties also agreed to a value-based arrangement in which the CCH would share penalties if they failed to achieve state-required metrics and compliance elements. The penalties, which would be imposed by the state Medicaid agency, started at \$1,000 for the first occurrence and increased in 5 percent increments for subsequent occurrences.

BayAging was responsible for achieving state-directed measures, including care plan development, documentation of discussion of person-centered care goals, reduction in all-cause hospital readmissions and vaccine administration.

When to use:

Capitation may be appropriate when the CBO provides a service (or services) that can be delivered at scale for the attributed population, and when both parties have sufficient information to price appropriately. It requires the CBO to have or create the capacity to serve all potential clients, and has the benefit of financial certainty that enables the CBO to invest in additional staff or other capacity.

Pay for Performance

In addition to the four major payment models, contracting parties can include pay for performance features to better align incentives between the payer and CBO or CCH. These financial incentives can operate as both rewards and penalties. The incentives can also be awarded in addition to the underlying payment model or can be “net” of the underlying payment (i.e., the payments already made are subtracted from the shared savings).



Hybrid FFS/Capitation Example

Western New York Integrated Care Collaborative (WNYICC) has established a hybrid FFS/capitated arrangement with Independent Health Medicare Advantage plan. The plan pays a lump sum upfront capitated payment to WNYICC to provide two weeks’ worth of home-delivered meals that are delivered to any member who is discharged from the hospital with at least one overnight stay and accepts the service. The plan also pays WNYICC a per meal amount for each day of meals (two meals per day) served per member. The FFS payments are calculated monthly, and if they are less than the capitation payment, no additional FFS payment is made. If, however, the FFS payments exceed the capitation payment, the plan pays the balance as a supplemental payment. WNYICC subcontracts the meal delivery to nine local CBO home-delivered meals partners. This arrangement ensures that WNYICC has adequate cash on hand to pay subcontractors and guarantees sufficient revenue to cover fixed costs. The plan appreciates having a community care hub manage all post-discharge meals at a predictable cost for the year and having one contract to reach all of their beneficiaries throughout an eight-county region.

Shared Savings

Shared savings is a form of bonus often used in Contracts with Accountable Care Organizations (ACOs) and other providers in which the provider receives additional financial payments for achieving reduced overall costs for the population served while maintaining or improving quality measures. Shared savings can involve complex methodologies, since they typically require the parties to calculate actual total costs as well as a counterfactual projected cost. Shared savings are more appropriate if the service is expected to have a significant impact on the population's total cost (e.g., supportive housing, care coordination, etc.), but may be less appropriate if the type of service provided is expected to have a relatively small impact on total cost. A challenge of shared savings and shared losses is to tease out the impact of social needs from other health care factors and interventions.

Shared Savings Example

United Healthcare (UHC) and the Camden Coalition (Coalition) have had a series of partnerships in which the Coalition provided intensive care management for members with a history of high health care utilization as well as practice-based care coordination activities for less complex members through seven primary care practices that work with the Coalition. The contract provided a guaranteed fixed annual payment that covered the care management services as well as a shared savings arrangement that incentivized improved quality and reduced cost. At the end of each year, the Coalition and UHC together calculated the total cost of care for the attributed population (those living in certain zip codes and attributed to the practices that work with the Coalition) and compared it to the projected spend. The Coalition would earn a bonus of 40-50 percent of the calculated savings (after netting out the guaranteed payment). The exact percentage of savings earned was based on seven quality metrics, including patient satisfaction, post-hospitalization follow-up visits, initiation of prenatal care and cancer screenings.

Shared Losses

Downside risk involves the provider sharing in losses or forfeiting part of their payment if they do not achieve certain goals (financial or quality). This can take the form of shared losses if expenses exceed a predetermined benchmark amount. In other contracts, a portion of the compensation will be at risk if a provider doesn't achieve certain quality or outcome measures. Shared losses have the same challenges as shared savings regarding sufficient size of impact and attributing causality. Moreover, many CBOs do not have the financial capacity to bear downside risk, but these provisions may become more common among CBOs who provide services with a clear financial ROI and the level of capital needed to manage downside risk over time.

Outcome-Based Payment

An outcome-based payment involves paying a negotiated amount for each client who reaches a defined outcome. For example, the standard contract for a Pathways Community HUB involves payments for sustainably addressing a health or social risk factor by closing a health/social need gap (e.g., food security, safe and stable housing, obtaining a medical home, etc.). The relative amount of each outcome-based payment has been developed based on experience with mitigating individually modifiable risk factors and extensive evidence of the financial value of addressing that social need.^{x, xi} Outcome-based payments provide significant incentive to ensure outcomes but also presents financial risk to CBOs, particularly if it is the only form of compensation, because CBOs incur costs even in situations when the outcome isn't achieved despite the best effort of the CBO. Outcome-based payments can also be used in combination with up-front capital in programs like pay for success.^{xii}

Outcome-Based Payment Example

In Ohio, Buckeye Health Plan (a division of Centene) contracted with the Northwest Ohio Pathways Community HUB (HUB) for care coordination provided by community health workers in 13 agencies contracted through the HUB to address health and social risk factors. Payment in the Pathways Community HUB Institute® (PCHI®) Model is attached to confirmed engagement (i.e., home visit) and addressing personally modifiable health and social risk factors defined by the 21 Standard Pathways (i.e., housing, social service referral, medical home, etc.). PCHI® has assigned each Pathway a standard number of outcome-based units (OBU), weighted based on the average time and complexity it takes to complete a Pathway. The HUB received 50 percent of its payment for performing engagement activities (home visit) and the remaining 50 percent based on completing one or more Pathways. The HUB and health plan negotiated a financial rate for each OBU. Buckeye calculated that the HUB reduced overall spending by \$2.36 for every \$1.00 spent on the HUB. For more information on the Pathways HUB payment model, see [Our Model | Pathways Community HUB Institute | PCHI | United States \(pchi-hub.org\)](#).

Performance Bonuses

To incentivize certain quality measures or other goals, the parties can create a performance bonus tied to certain quality or outcome measures, without having to undertake the complex data analysis of a shared saving calculation. Shared savings can also be calculated in a constructed manner, based on average cost savings from performing certain interventions or achieving certain outcomes, rather than analyzing the actual costs of the particular population.

The following metrics were the most common cited in the 2021 Aging and Disability Business Institute CBO–Health Care Contracting Survey:

- Number of clients served or service units provided (70 percent),
- Accuracy of documentation (44 percent),
- Submission of data reporting (i.e., pay for reporting) (39 percent),
- Timeliness output measures (time to initiate service, time to reassessment, etc.) (33 percent),
- Program/member engagement rate (14 percent).^{xiii}
- Parties may want to consider other metrics such as member satisfaction with services, outcome measures, etc.

Flexible Funds

Separate from the way in which the CBO is compensated for its service, health plans often enable CBOs to serve as intermediaries to provide resources directly to members to address crisis needs. Many health plans provide a flexible member needs fund that CBOs can use to provide a gift card or directly purchase goods for the member, such as food, utilities, gas or a taxi voucher. By allocating a per member amount, the health plan and CBO can collaborate to provide short term financial assistance to members outside of the plan's normal procurement process or government's bureaucratic public benefit processes to address a crisis situation and hopefully avoid an Emergency Department visit or other poor outcome.

Payment Model Summary

Feature	Fixed price contract	Fee-for-service	Bundled payment	Capitation	Pay for performance
Financial risk to CBO	Low	Low	Medium	High	Medium
Financial risk to payer	Low	High	Medium	Low	Medium
Complexity for parties to establish price	Low-Medium	Medium	High	High	Medium-High
Cost/complexity of billing	Low	High	Medium	Low	Medium-High
Incentive for CBO to maximize volume	Low	High	Medium	Low	Low
Incentive for efficiency	Medium	Low	High	High	High
Incentive for quality	Low-Medium	Low	Medium	Medium	High

Conclusion

When selecting a payment methodology, there are many considerations that need to be prioritized and balanced to achieve something that is fair, efficient and incentivizes the shared goals of both parties. The parties should consider what is realistic based on their respective ability to take risks and their level of knowledge/confidence about cost, value and volume. For example, while capitation may ultimately be the best payment model for a particular contract, the parties may need to start with a fixed payment or bundled payment structure in order for the parties to gain greater understanding and data before an appropriate capitation arrangement can be developed. Similarly, the parties can use other parts of the contract, including eligibility criteria, approval authority, quality measurement and evaluation to mitigate concerns about excess volume and achieve quality goals.



About the Aging and Disability Business Institute

This publication was produced for the Aging and Disability Business Institute via a collaboration of Partners in Care Foundation, stakeholders of the Partnership to Align Social Care and was authored by the Camden Coalition. Led by USAging in partnership with the most experienced and respected organizations in the aging and disability networks, the mission of the Aging and Disability Business Institute is to build and strengthen partnerships between aging and disability community-based organizations and the health care system. Funded by The John A. Hartford Foundation, The SCAN Foundation and the U.S. Administration for Community Living, the Aging and Disability Business Institute provides community-based organizations with the tools and resources to successfully adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Learn more at www.aginganddisabilitybusinessinstitute.org.

Partnership to Align Social Care

A National Learning & Action Network

About the Partnership to Align Social Care

The **Partnership to Align Social Care, A National Learning and Action Network^{xiv}** (Partnership) aims to address social care challenges at a national level by bringing together essential sector stakeholders (health providers, plans and government with consumers) to co-design multi-faceted strategies to facilitate successful partnerships between healthcare organizations and community care networks. The Partnership is a unique national effort to elevate, expand, and support a network-based approach to sustainably addressing individual and community health-related social needs. Learn more at www.partnership2asc.org.



About the Camden Coalition

The Camden Coalition is a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. We work to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being. Supported by robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver care to the most vulnerable individuals in Camden and regionally. Through our National Center for Complex Health and Social Needs (National Center), the Camden Coalition works to build the field of complex care by inspiring people to join the complex care community, connecting complex care practitioners with each other, and supporting the field with tools and resources that move the field of complex care forward. Learn more at www.camdenhealth.org.

October 2023

Endnotes

- i Value-Based Payment as a Tool to Address Excess U.S. Healthcare Spending, Health Affairs (December 2022), available at <https://www.healthaffairs.org/doi/10.1377/hpb20221014.526546/>.
- ii The Cal-AIM initiative supports contracting partnerships between payers and social care providers for health-related in lieu of services (ILOS) such as housing, home modifications, food and nutrition, etc. To support these new relationships, the Department of Health Care Services (DHCS) encourages and provides guidance on non-binding pricing for ILOS. Non-binding pricing is suggested as rate variations are influenced by program structure, staffing ratios, facility size, geography and payment models. More information on rate variations is available at <https://www.dhcs.ca.gov/Documents/MCQMD/ILOS-Pricing-Guidance-Updated-8-5-2021.pdf#:~:text=The%20Cal-AIM%20initiative%20and%2C%20in%20particular%2C%20the%20introduction,it%20offers%20information%20on%20potential%20rates%20for%20each>
- iii The North Carolina Healthy Opportunities pilot provides a fee schedule for services as guidance for participating organizations. The fee schedule structure accounts for frequency, duration, setting and minimum eligibility criteria for each service. More information on rates is available at <https://www.ncdhhs.gov/media/14071/open>.
- iv Scripps Gerontology Center, *Advancing Partnerships: Contracting between Community-Based Organizations and Health Care Entities*, January 2022, <https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf>.
- v The Gravity Project is a national public collaborative focused on developing health and social care interoperability data standards for social determinants of health (SDOH). The collaborative’s goal is to facilitate data sharing and payment for care across organizations and providers. More information available at [Gravity Project \(thegravityproject.net\)](https://www.gravityproject.net).
- vi On January 4, 2023, CMS issued guidance on coverage and treatment of non-medical services “in lieu of” medical services. [SMD 23-001 - ILOS \(medicaid.gov\)](https://www.medicare.gov/smd-23-001-ilos).
- vii www.healthcare.gov/glossary/fee-for-service/#:~:text=Apercent20methodpercent20inpercent20whichpercent20doctors,paidpercent20forpercent20eachpercent20servicepercent20performed.
- viii Bundled Payment, American Hospital Association, www.aha.org/bundled-payment/bundled-payment.
- ix <https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/understanding-capitation>.
- x Agency for Healthcare Research and Quality, *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes*, January 2016, www.ahrq.gov/sites/default/files/wysiwyg/innovations/CommunityHubManual.pdf.
- xi Association of Maternal and Child Health Programs, *Pathways Community HUB*, www.amchp.org/wp-content/uploads/2021/05/Pathways-Community-HUB.pdf.
- xii What is Pay for Success? Social Finance, www.socialfinance.org/what-is-pay-for-success.
- xiii Scripps Gerontology Center, *Advancing Partnerships: Contracting between Community-Based Organizations and Health Care Entities*, January 2022, www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf.
- xiv Partnership to Align Social Care: A National Learning & Action Network, Partnership to Align Social Care (Partnership), September 2022, www.partnership2asc.org/wp-content/uploads/2022/09/P2ASC_Overview_Slides_September_2022.pdf.