Oak St. Health

The Gold Standard of Advanced Primary Care for Medicare Beneficiaries

Our patients are our north star, and our mission charts our course for rebuilding healthcare as it should be.

Key Takeaways

- Oak Street Health serves more than 350,000 patients in over 230 centers across 27 states, providing high-quality primary care to people who need it most.
- Oak Street Health's advanced primary care model integrates physical, behavioral and social care to improve health outcomes for Medicare beneficiaries, particularly in underserved communities.
- Oak Street Health's approach led to a 44% reduction in hospital admissions compared to Medicare benchmarks[1] and enhanced patient satisfaction.
- Oak Street Health's model emphasizes prevention-based care, strong patient-provider relationships and a multidisciplinary team, including primary care providers, behavioral health specialists, community health workers and medical social workers.
- Oak Street Health's value-based business model is a potential blueprint for public policy initiatives aimed at improving primary care access and quality for vulnerable populations.
- Medicare Advantage is the vehicle that enables Oak Street Health to thrive, and its flexible reimbursement structure is foundational to Oak Street's robust patient-centered, value-based care model.

[1]Based on our hospital admission rates per thousand patients of 171 as of September 30, 2024, compared to the Medicare benchmark of 303.

Who We Are

Oak Street Health began with a simple, yet ambitious, mission of Rebuilding Healthcare as it Should Be: personal, equitable and accountable. We now have a decade-plus track record of providing better care to people who need it the most. Since opening our first center on the north side of Chicago in 2013, Oak Street has continued to embed centers in communities where patients lack access to primary care. Oak Street has since expanded to over 230 centers across 27 states, serving approximately 350,000 patients. We employ over 8,500 individuals, including nearly 900 primary care providers.

Advanced primary care is associated with improved health outcomes, improved patient experience and satisfaction, and a reduction in disparities. That's why we are excited to continue scaling our impact as we open more centers in underserved communities, cultivating settings where primary care providers can thrive and building long-term sustainability.

Oak Street is demonstrating real-world results in tackling our nation's most vexing healthcare challenges by bringing high-quality integrated care to communities with complex needs.

- **Improving access:** Two-thirds (67%) of our centers are located in Medically Underserved Areas or Health Professional Shortage Areas.
- **Driving better outcomes:** Oak Street has reduced patient hospital admissions by 44% compared to Medicare benchmarks.[1]
- **Building organizational well-being:** We have been recognized as a Great Place to Work and received the designation of Joy in Medicine, reflecting a concerted effort to create a workplace where Oak Street Health employees (Oakies) feel included, empowered and appreciated.

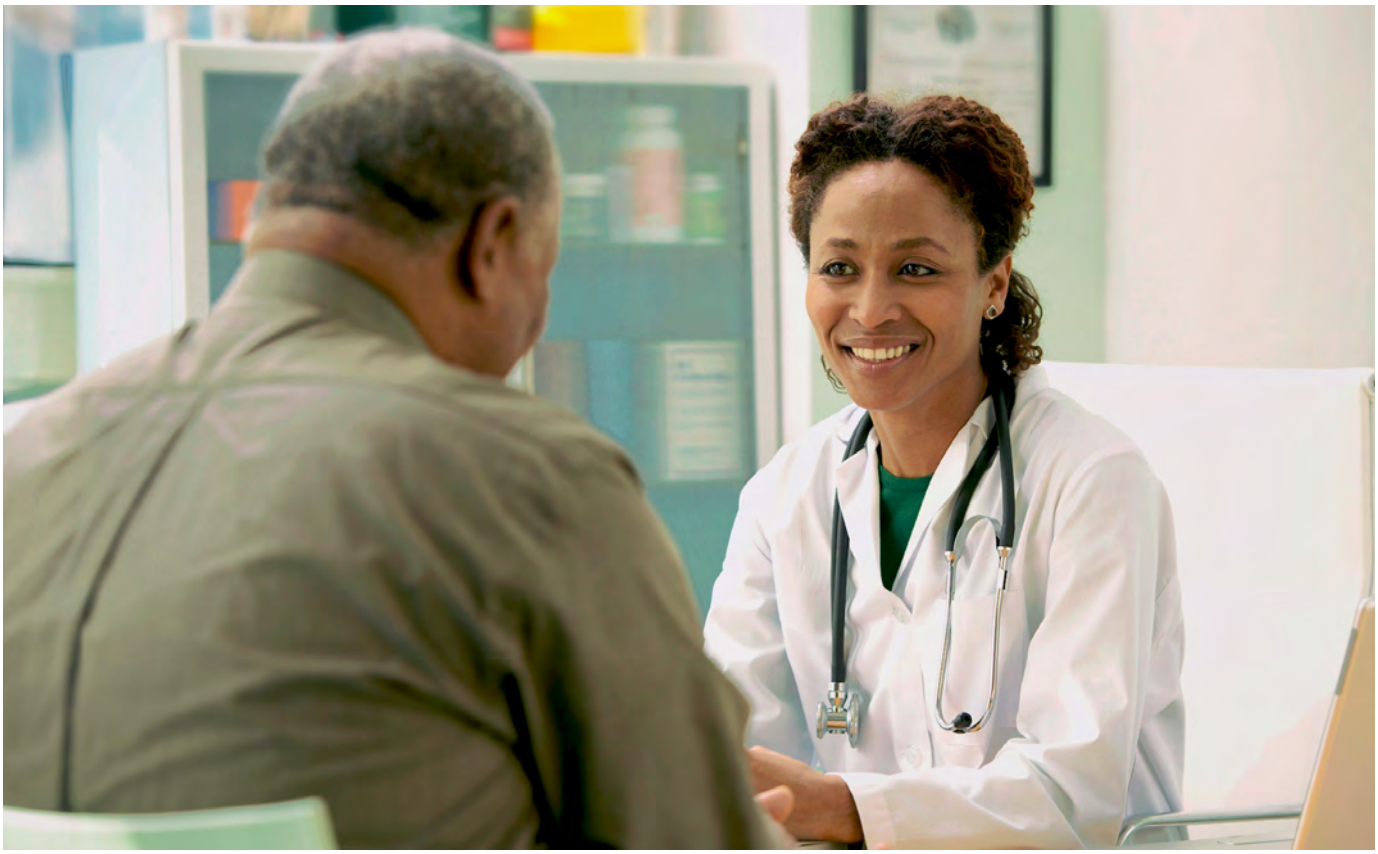
[1]Based on our hospital admission rates per thousand patients of 171 as of September 30, 2024, compared to the Medicare benchmark of 303.

Who We Serve

Oak Street serves an older, at-risk patient population where the average patient is 69 years old and takes eight medications.

- **55%** of our patients have two or more chronic conditions.
- **36%** of patients have been diagnosed with a behavioral health condition.
- **45%** have a risk factor such as housing instability, food insecurity or social isolation – which may impact their ability to engage with health systems and achieve their best health.
- **48%** of our patients are dually eligible for Medicare and Medicaid – a population that tends to be sicker and have higher healthcare costs compared with Medicare-only beneficiaries.
- The average Oak Street patient income is less than **$17,000 per year.**
- Most Oak Street centers **(85%)** are in communities where the average annual income is 300% of the federal poverty level ($43,740 in 2023) or below.
- **A majority** of our patients live in areas with an Area Deprivation Index (ADI) percentile of 60% and above, indicating significant social disadvantage and deprivation.

Oak Street serves a racially and ethnically diverse population, with a majority (69%) of the patient population identifying as Black/African American, Hispanic/Latino, Asian, American Indian/Alaskan Native, Native Hawaiian/Pacific Islander, Middle Eastern/ North African or multi-racial and speaking 78 different languages.



Our Care Model

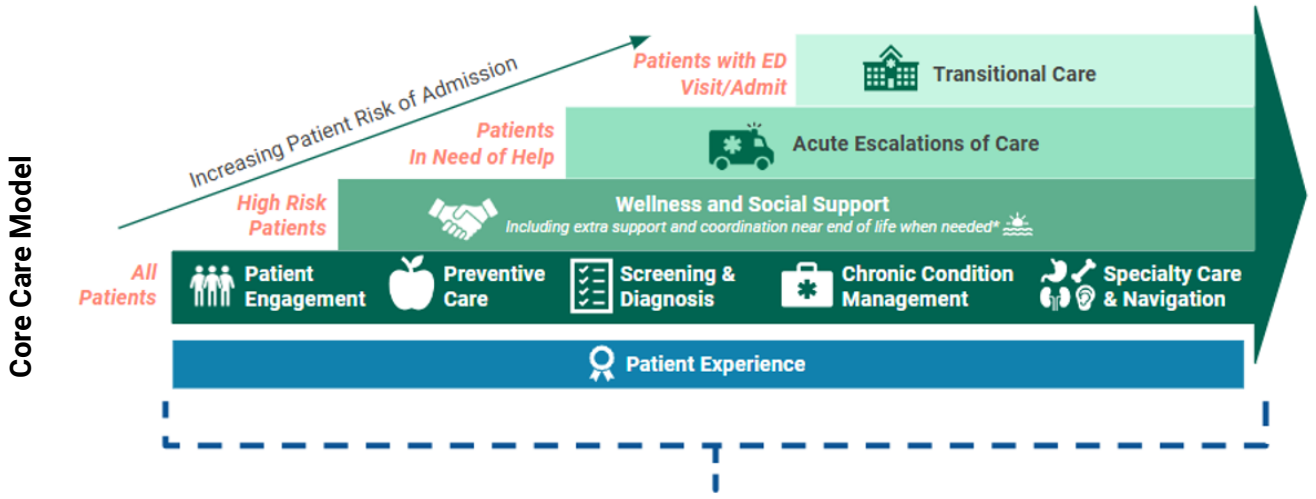
With an emphasis on prevention-based care, our model differs from a more traditional care model that tends to focus on providing treatment only when a problem arises. Oak Street's innovative model integrates physical, behavioral and social care designed to provide our patients with personalized support and services to keep them happy, healthy and out of the hospital. Using a multidisciplinary, evidence-based approach with a significant emphasis on strong patient–provider relationships, our value-based structure is inextricably linked to the prospect that the longer a patient stays with us, the healthier they become.

Care delivery at Oak Street involves robust care teams, including primary care providers, clinical informatics specialists (also known as scribes), behavioral health specialists, community health workers and social workers. Over a quarter of the provider's time is set aside to coordinate care, proactively plan and close any care gaps; through frequent touchpoints and care management, we are able to proactively provide the care that our patients require.

This work is guided by best practices enabled by our tech-platform built by providers and designed specifically for Oak Street.

1. To uphold this goal of keeping patients healthy, happy and out of the hospital, we need to understand the health conditions they are experiencing – we do this by **screening and diagnosing conditions**.
2. We develop **care plans** to help patients manage their health and medications.
3. Care plans **improve quality** and help prevent avoidable admissions and readmissions.

The Oak Street Health Care Model is designed to keep patients happy, healthy and out of the hospital.



The Care Model is made up of **patient-centered services and support across various levels of admission risk and needs.**

To further support our prevention-based care model, our medical social workers (MSWs) and community health workers (CHWs) work longitudinally to address barriers to care plan execution and take care of individual patient needs, serving as an extra layer of support to preventable hospital admissions. When a patient does get admitted, our Transitional Care team works across sites of care to support patients during and after their acute and post-acute stays to assist with safe discharges, ensure seamless transitions of care and prevent avoidable readmissions.

Community Health Workers (CHWs) perform several functions (care coordination, social support, navigation and advocacy) and do so in homes and community settings as well as in our Oak Street Health centers. CHWs are trusted members of their communities, using lived experience to more effectively partner with patients to address barriers to care.

Medical Social Workers (MSWs) specialize in providing longitudinal, proactive and relationship-based support for our highest-need patients, with an aim to address and mitigate underlying social drivers of poor health outcomes.

PATIENT ONBOARDING

Each new patient meets with a patient relations manager (PRM), who is responsible for understanding and educating patients on their insurance benefits and how to get the most out of their plan. For example, a PRM might encounter a patient facing gaps in transportation access to get to appointments. In this scenario, a PRM may be able to help the patient identify covered transportation benefits through their existing insurance.

We also offer transportation to and from doctor's appointments for eligible patients at no cost to the patient. This removes a common barrier to accessing care. We also use e-consults for our primary care teams to access specialist expertise, which can be particularly helpful for patients who cannot or will not go to see a specialist at a different location. Other times, PRMs may encounter a patient struggling financially, and the PRM can support the patient in applying for Medicaid and accessing a greater pool of social support.

As an example of our integrated care model, behavioral health specialists are incorporated into the care team based on results of universal depression screening from our Patient Health Questionnaire (PHQ-9), patient endorsed stressors or provider concerns for behavioral health. As of July 2024, 17,000 patients have enrolled in our Behavioral Health services. Fifty-five percent of early engaged patients dropped five points or greater in PHQ-9 score within the first six weeks of engagement, and 51% of engaged patients achieved 50% or greater improvement in PHQ-9 within 24 weeks. This evidence-based approach positively impacts health and adherence to physical and mental health plans. We see patients who have managed their chronic behavioral health conditions are better able to attend appointments, make decisions clearly, and put themselves first, which then allows them to also care for others. This increases both functioning and quality of life. By doing so, we create a greater impact on the community with thriving healthy older adults.

COMMUNITY

Recognizing that social isolation poses health risks as deadly as smoking up to 15 cigarettes a day, each center has a team of welcome coordinators, community health workers, medical social workers, population health coordinators, patient relations manager and an outreach team to engage with the community through in-center and out-of-center events. In-center events, which are open to all members of the community, are held in a large community room, offering patients and others access to the internet, educational sessions and social activities – including bingo, lotería, chair yoga and line dancing – to help combat loneliness.

We have a deep commitment to reflecting the communities we serve. Our provider demographics reflect the racial and ethnic demographics of our patients, and we strive for patients to see a provider who speaks their language and understands their cultural background. We know this strengthens the important connection between the patient and the care team.

Risk Stratification

With a central goal of improving patient care delivery and outcomes, Oak Street has developed a four-tiered patient risk stratification model that allows us to engage patients based on acuity level. Risk stratification enables Oak Street to appropriately allocate care management resources – such as care teams dedicating time on a weekly basis to discuss their highest risk patients – and ensure patients receive the appropriate touchpoints so that no one slips through the cracks. Assignments to risk categories are routinely refreshed to reflect rising-risk or improved health status through provider gestalt with the assistance of augmented intelligence to help our providers make clinical decisions on the bases of the medical, behavioral and social needs of each patient.

This collaborative system successfully projects 30% of acute events in the next 30 days within the top 5% of our highest risk patients. This combination of data and patient engagement helps us proactively identify patients' risk factors and prospective needs highlighting the comparatively high performance of our risk stratification system. In our view, this system works better than a claims-based risk stratification system that has more limited information and is less timely.

The Patient Journey

An older adult male patient at our Memphis location best represents how we deliver comprehensive, whole-person care within our model. John's first appointment was an annual wellness visit with his care team. As a result of our comprehensive screening approach, the team learned John was previously diagnosed with anxiety and depression. Our PHQ-9, which evaluates patients for depression symptoms, demonstrated his symptoms were significant, particularly his challenges with sleep. Here, the team learned that John did not have his current psychiatric medications and had been living in his car after being evicted from his home. The functional assessment by the team further showed that John had strong social support via previous neighbors who were looking out for his safety and nutrition. This clinically robust early inquiry into John's current experience provided relevant information to our care team to act quickly.

John's primary care provider engaged our behavioral health specialist on the same day of his first appointment and consulted with psychiatry to initiate medications. John was then enrolled in therapeutic counseling and received proactive follow-up to ensure symptoms were resolved and sustained.

After enrolling John in behavioral health services, our team introduced him to another care team resource, a MSW who met with John to address his lack of stable housing. Through further inquiry, the team learned access to shelters had been problematic because his dog was unable to join him at temporary shelters. This challenge was demoralizing, and he feared losing his dog, who had been in his care for more than 10 years. Together, the care team, alongside John, identified a plan to seek transitional housing for him and his dog, allowing him to focus his attention on his health. The MSW helped John access supplemental Medicare benefits he had not been utilizing, which helped offset financial burdens. One example included the patient assistant program (PAP) for medications. These benefits allowed John to save on and comply with important medications to manage chronic conditions and plan for sustainable housing. In the meantime, they worked together on subsidized living options.

In this patient's journey, each team member played a critical role supported by our standard screening process, tech-enabled care management platform, and action plan – with the patient at the center at every step of the way – to influence longitudinal improvements.

Benefits for the Provider

The Oak Street model offers many positives for the provider, as well. It addresses key drivers associated with primary care burnout, including administrative burden, a high volume of patients, lack of meaningful patient relationships and reduced autonomy. Its robust and supportive structure enables each care team member to practice at the top of their license and spend more time with patients because the priority is quality rather than the number of appointments.

Recognizing pipeline and training challenges facing the primary care workforce, we created fellowship programs for nurse practitioners, behavioral health specialists, and emerging leaders in healthcare to develop expertise in value-based care models. We also developed a year-long onboarding program where new providers meet on a monthly basis to learn more about the care model and build a community with other new providers.

Typical primary care providers have a patient panel size of 2,500, whereas primary care providers at Oak Street have a panel size of 500 patients, allowing them to spend more time with their patients. The provider is supported by scribes taking notes, placing orders and writing referrals; medical assistants ordering durable medical equipment and answering phone calls; nurses triaging calls and refilling medications; and patient relations managers navigating health insurance.

To provide continuous learning opportunities, we established a Clinical Excellence Series for providers to keep up to date and dig deeper into the nuanced and complicated care of our patients with complex medical conditions.

Oak Street implemented various programs to support the emotional well-being of our care teams and foster a sense of belonging. These include peer support teams and workshops for team building and stress injury to manage the emotional challenges of caring for patients together as a team.

Our Business Model

The Oak Street care model works because our business model aligns our success with better patient outcomes. We are responsible for total cost of healthcare for our patients, including both the primary care delivered at Oak Street and the care delivered outside of our centers such as specialty, acute and post-acute care. We receive an upfront, predetermined payment per patient that is expected to cover the assumed cost of care.

This predictable monthly revenue stream in the form of capitated payments from Medicare Advantage plans versus fee-for-service payments based on offices visits or procedures, allows us to focus on what our patients need, not on what is reimbursable. This funding structure also enables Oak Street to invest in enhancements to the care model, including data infrastructure, hiring staff, opening new clinics, and other operational and clinical improvements, which would be difficult to afford otherwise.

However, investing and building this type of care model takes time and is costly. Our physicians spend 3x longer with patients than most doctors' offices. Our most complex patients are seen 14 times per year, on average – or more than once per month. Medical costs for our new patients typically exceed the amount of revenue we collect in their first year with us as we spend time understanding their health needs and developing appropriate care plans. It takes time to implement care plans and ultimately reduce medical costs. This means new centers typically operate at a loss for their first few years as patient panels are built out. This does not include other costs associated with running the Oak Street model.

Due to the significant investment required to open a new center, it typically takes a few years for a center to be profitable and several years until it reaches maturity. Maturity occurs once we have a large enough and stable patient base. Given these dynamics, even a small percent change in revenue can have a significant impact on growth and operations. A good example of this is when CMS rolled out the changes to the Medicare Advantage risk adjustment model from V.24 to V.28. In the end it was helpful that Centers for Medicare & Medicaid Services (CMS) decided to phase-in the changes over 3 years vs. 1 year as initially proposed. While we have the ability to quickly adapt to change, the additional time was extremely helpful.

Policy Implications

MEDICARE ADVANTAGE

Medicare Advantage is the vehicle that enables Oak Street's model to thrive. Oak Street enters into contractual relationships with multiple health plans to serve the Medicare Advantage population. Unlike traditional Medicare, in which providers are reimbursed for each visit or service they provide, Medicare Advantage offers Oak Street the opportunity to receive an upfront monthly payment for each patient by contracting with health plans. This creates the flexible reimbursement structure that is foundational to Oak Street's robust patient-centered care model. Critically, Medicare Advantage 's payment structure is based on a beneficiary's health status and predicted medical expenses, which enables a provider like Oak Street to have the resources necessary to serve a sicker, more vulnerable population. The arrangement also means that Medicare Advantage policy changes extend beyond health plans and can impact providers, alongside the plan and ultimately impact the patient. A reduction in Medicare Advantage payments to health plans results in the plan passing along reductions in payment to the provider because we are paid a pre-determined payment tied to the percentage of the Medicare Advantage plan's payment from CMS.

An example of how this plays out are CMS Final Rate Notices for Plan Years 2024 and 2025. CMS implemented two years of payment cuts, including a new risk adjustment model and much lower growth rates and normalization factors, which thereby result in less revenue to value-based care providers, including Oak Street. As a result of these policy changes, value-based care entities faced steep payment cuts and have been facing financial challenges. This dynamic has resulted in an unsustainable environment for some healthcare entities and has led to closures in some cases.

ACO REALIZING EQUITY, ACCESS AND COMMUNITY HEALTH (REACH) MODEL

Oak Street also serves more than 10,000 traditional Medicare beneficiaries through the CMS Innovation Center's ACO REACH model, which enables participants to assume full financial risk and receive upfront payments to take accountability for the outcomes of their Medicare fee-for-service (FFS) population. ACO REACH is a time-limited model, currently scheduled to end on Dec. 31, 2026. It is critical there is a glide path developed that allows primary care providers to continue delivering advanced primary care to FFS beneficiaries. Continuity and stability are important for provider organizations to make long-term investments needed to improve patient health.

Conclusion

Oak Street Health has developed and successfully implemented the gold standard in advanced primary care structure for managing Medicare beneficiaries. We have been investing heavily in underserved communities since 2013, redesigning how patients are cared for and engaging them thoughtfully to achieve their goals. Oak Street Health's dedicated and passionate team of providers, clinicians and support staff empower patients to take control of their health. We show them the healthcare system can be their partner in health, not just illness.

About Oak Street Health

Oak Street Health, part of CVS Health, is a network of value-based primary care centers for older adults. With a mission of rebuilding healthcare as it should be, the Company operates an innovative healthcare model focused on quality of care over volume of services, and assumes the full financial risk of its patients. Oak Street Health currently operates more than 230 centers across 27 states and is the only primary care provider to carry the AARP name. To learn more about Oak Street Health's proven approach to care, visit oakstreethealth.com.