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Advancing Health in America

2025

AMERICAN HOSPITAL ASSOCIATION

LEADERSHIP SUMMIT

JULY 20-22, 2025 • NASHVILLE, TN

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LEADERSHIP SUMMIT

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How Provider-Led Health Plans Can Benefit Communities: Opportunities for Integrated Strategies

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ATI Advisory

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Mass General Brigham

Agenda

01 **The Context:**
How are Health Systems thinking about Health Plan assets differently in today's environment?

02 **The Background:** What are the Options to Better Serve Communities with Provider-Sponsored Health Plan Programs?

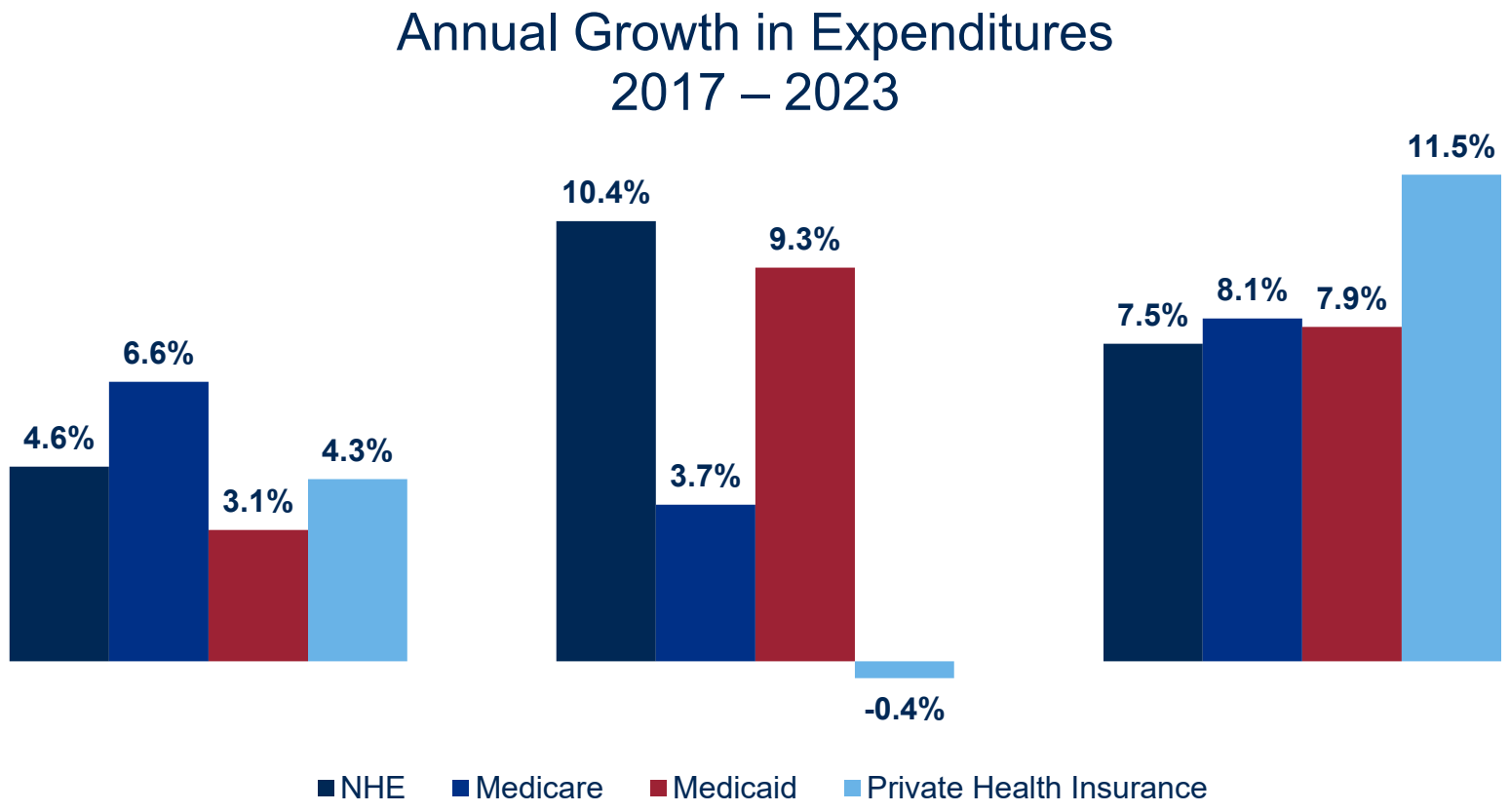
03 **Lessons from the Field:** MGBHP Case Study: Integrated Strategy to better serve Dual Eligibles

04 **Discussion / Q&A**

01 The Context:

How are Health Systems thinking about Health Plan assets differently in today’s environment?

Growth in Healthcare Spending Accelerated in 2023 Across All Major Payer Categories



- Overall healthcare spending topped $**4.9 trillion, a 17.4% share of the economy** with 92.5% of the population insured.
- Hospital spending increased 10.4% in 2023 (compared to 3.2% in 2022), the highest growth since 1990.
- Experts struggling to understand what is going on, **although 75+ and 85+ growing 9x and 6x more rapidly than 65+.**
- An integrated strategy to serve communities via comprehensive value-based care & payment remains **a compelling solution**.

Source: National Health Expenditures In 2023: Faster Growth As Insurance Coverage And Utilization Increased

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Hospital Discharge Delays Consistently Documented Around the U.S.

Oregon

- Hospital discharge volume decreased by 10% from 2017 to 2022, while average length of stay **(ALOS) and total patient hospital days steadily increased** in the same time (ALOS: +27%; total patient hospital days: +20%) [1]

Minnesota

- Study by MN Hospital Association estimated **65,555 additional days of unnecessary patient stays** between June and October 2023.[3]

New York

- **992 patients across 50 hospitals** experienced discharge delays of over two weeks between April 1 and June 30, 2022. Over half of these patients faced delays exceeding 30 day.[4]

California

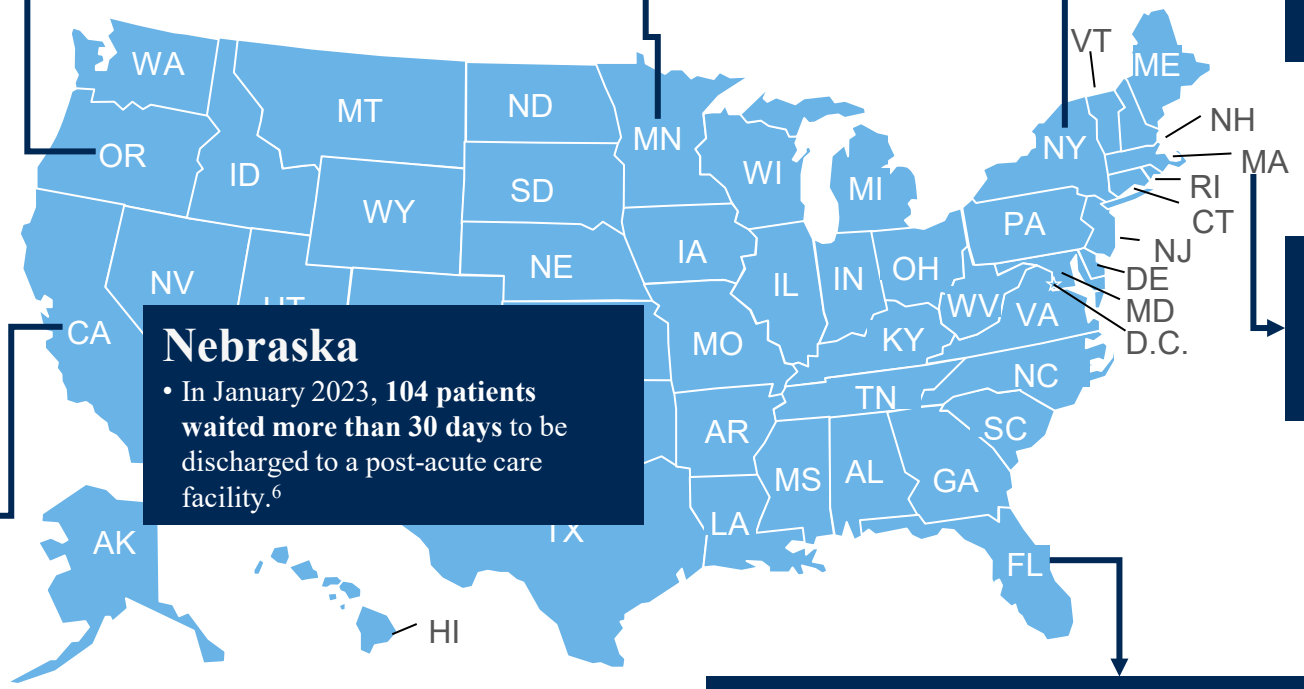
- An estimated **4,500 patients boarding in California hospitals and emergency rooms** despite being medically cleared for discharge[2]
- Every year in California, an estimated **300,000 hospital patients (9% of all patients) face discharge delays of at least three** days after medical clearance, adding 14 days to their hospital stays on average[2]

Nebraska

- In January 2023, **104 patients waited more than 30 days** to be discharged to a post-acute care facility.[6]

Massachusetts

- **Nearly 1 in 7** med-surg beds currently occupied by a patient who **no longer needs acute hospital care.**[5]



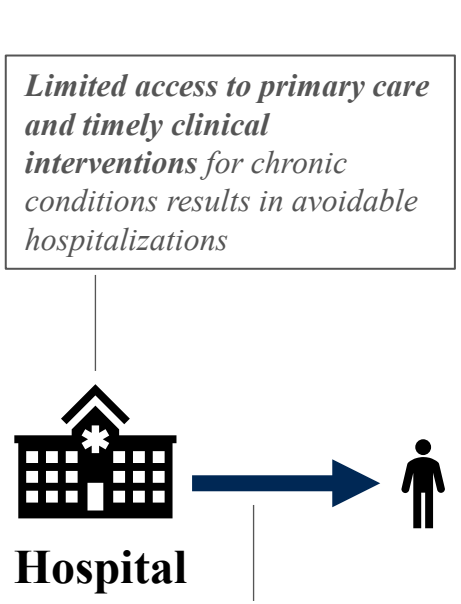
Florida

- Hospitals spent **an estimated $540 million* in unpaid care** due to patients awaiting discharge and placement.[7]

Sources: **1**. ATI analysis of Oregon All-Payer All-Claims data, 2017-2022 **2**. California Hospital Association, 2024 **3**. Minnesota Hospital Association, 2023. **4.** Healthcare Association of New York State, 2023. **5**. Massachusetts Health and Hospital Association, 2023. **6**. Nebraska Hospital Association, 2023. **7.** Florida Hospital Association, 2024.

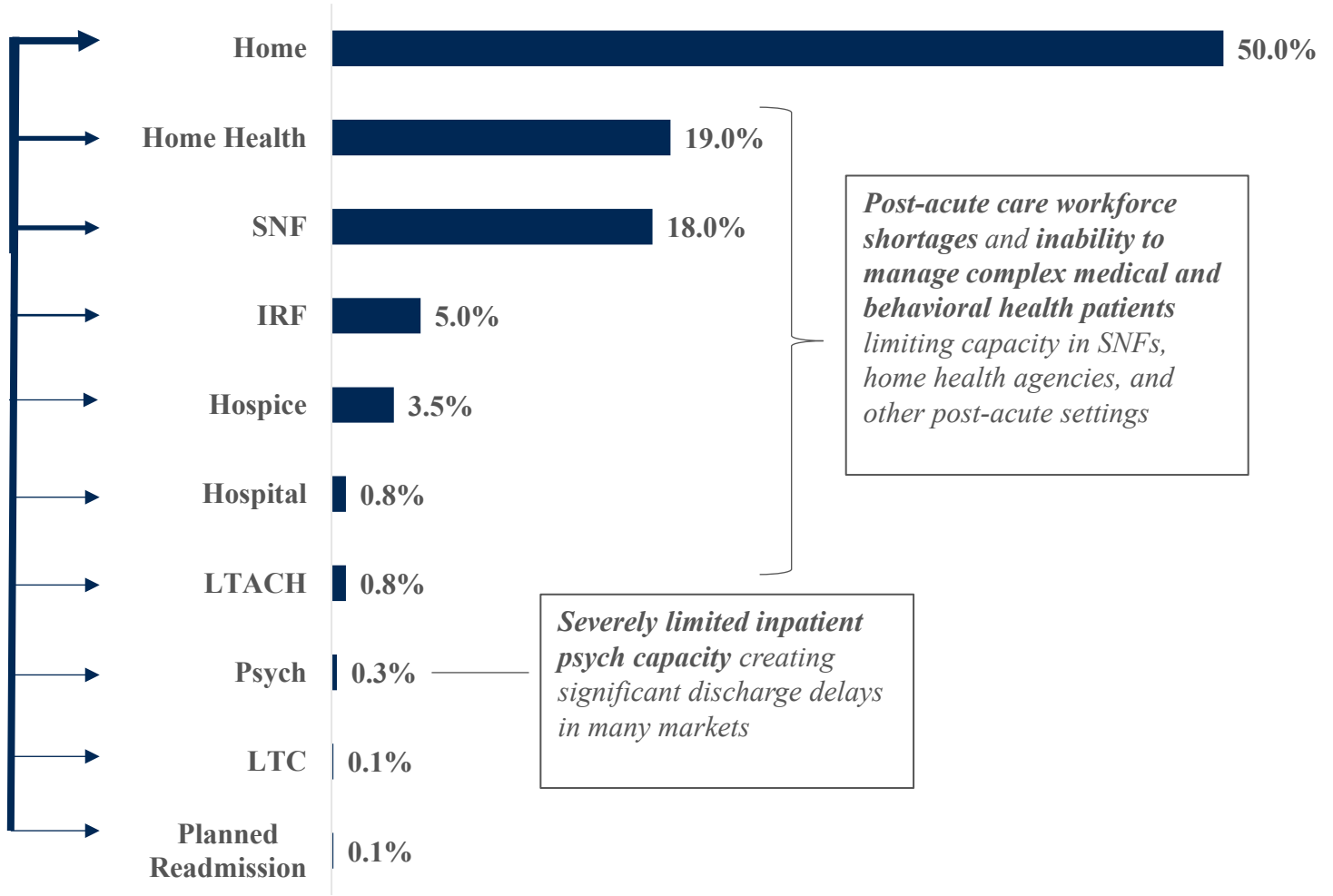
Confluence of Factors Leading to Hospital Discharge Crisis

Share of Medicare FFS Discharges by Post-Discharge Destination



Limited access to primary care and timely clinical interventions *for chronic conditions results in avoidable hospitalizations*

Prior auth requirements *and* ***Medicaid eligibility determination*** *processes delay discharges*



Hospitals delaying discharges for ***patients facing unstable housing situations****, especially those with behavioral health challenges*

Post-acute care workforce shortages *and* ***inability to manage complex medical and behavioral health patients*** *limiting capacity in SNFs, home health agencies, and other post-acute settings*

Severely limited inpatient psych capacity *creating significant discharge delays in many markets*

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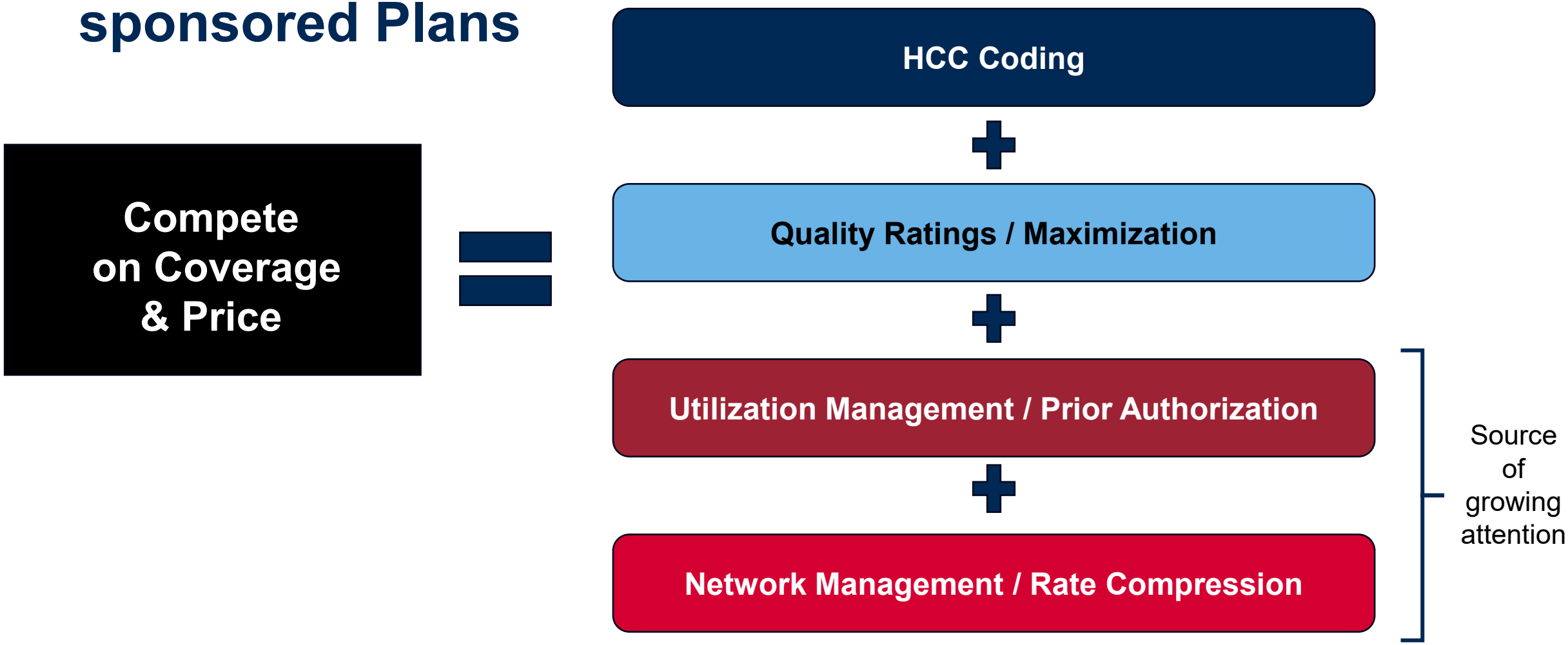
U.S. Healthcare Executives are Facing Unprecedented Headwinds Operating Within an Increasingly Fragile Healthcare System

- Although hospital and health systems' financial performance improved in 2024, many providers continue to struggle, and despite positive margins for the industry on average, there is considerable variability in providers' financial health.
- The traditional hospital business model has historically supported health systems' margins and adequately served communities, which is no longer sustainable or sufficient.

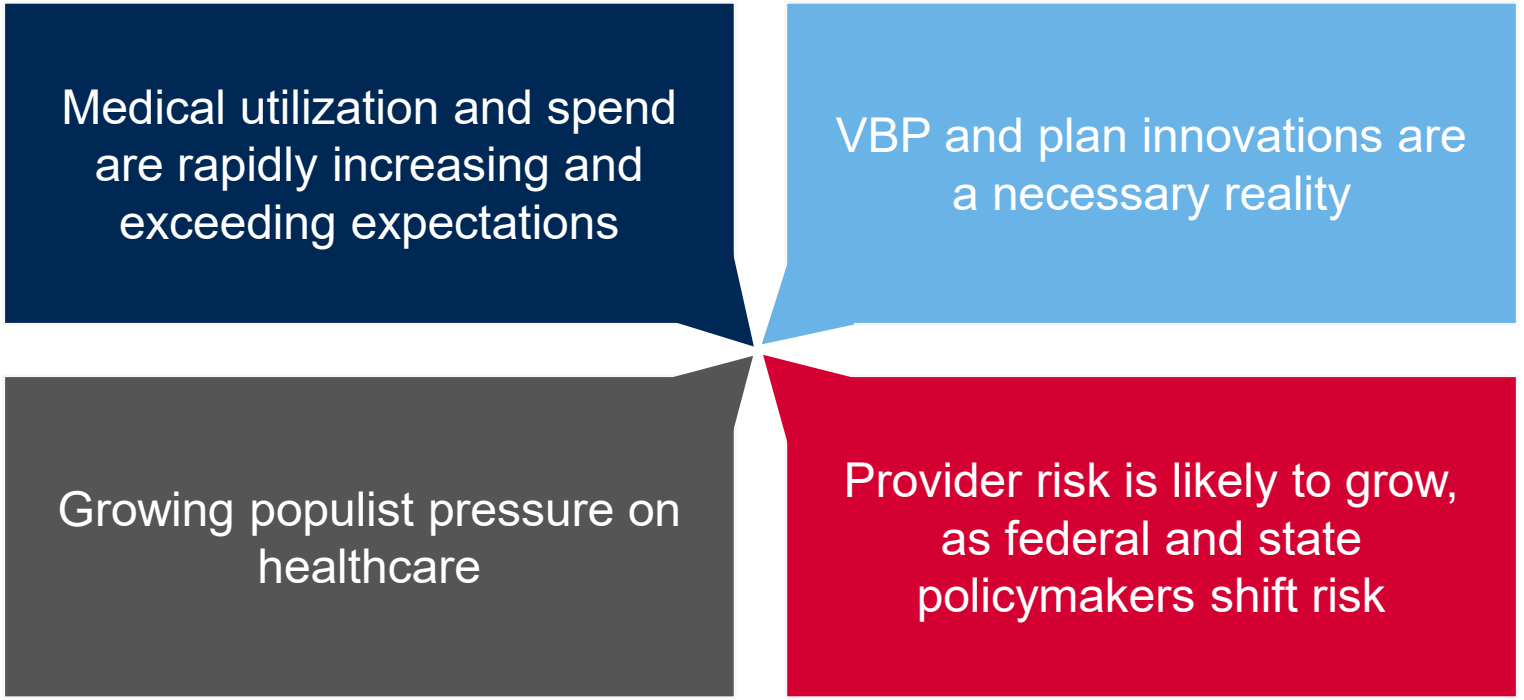
40% Hospitals operating in the red (with negative margins) in 2024	**Workforce shortages** and high turnover rates are impeding productivity and driving up labor expense	**Demographic and site-of-care optimization** are increasing the medical complexity & throughput of hospital patients	**Rising tariffs and potential supply chain disruptions** are escalating costs and impacting care delivery
-2% Projected shortfall in operating cash margin compared to pre-pandemic	Investment **market downturns** are contributing to **decreased cash reserves** and putting additional pressure on margins	Care delivery **shifts outward**, driving the need for **care team redesign** and investments in network adequacy	Legislative & regulatory activity, and the growth in Medicare Advantage, will continue to **impact reimbursement**

Sources: Advisory Board research; Kaufman Hall; Marsh McLennan healthcare labor market projections; NAHRI.

Old Insurance Tools No Longer Sufficient to Effectively Manage Care and Costs, Creating Stronger Opportunity For Value Creation by Provider-sponsored Plans

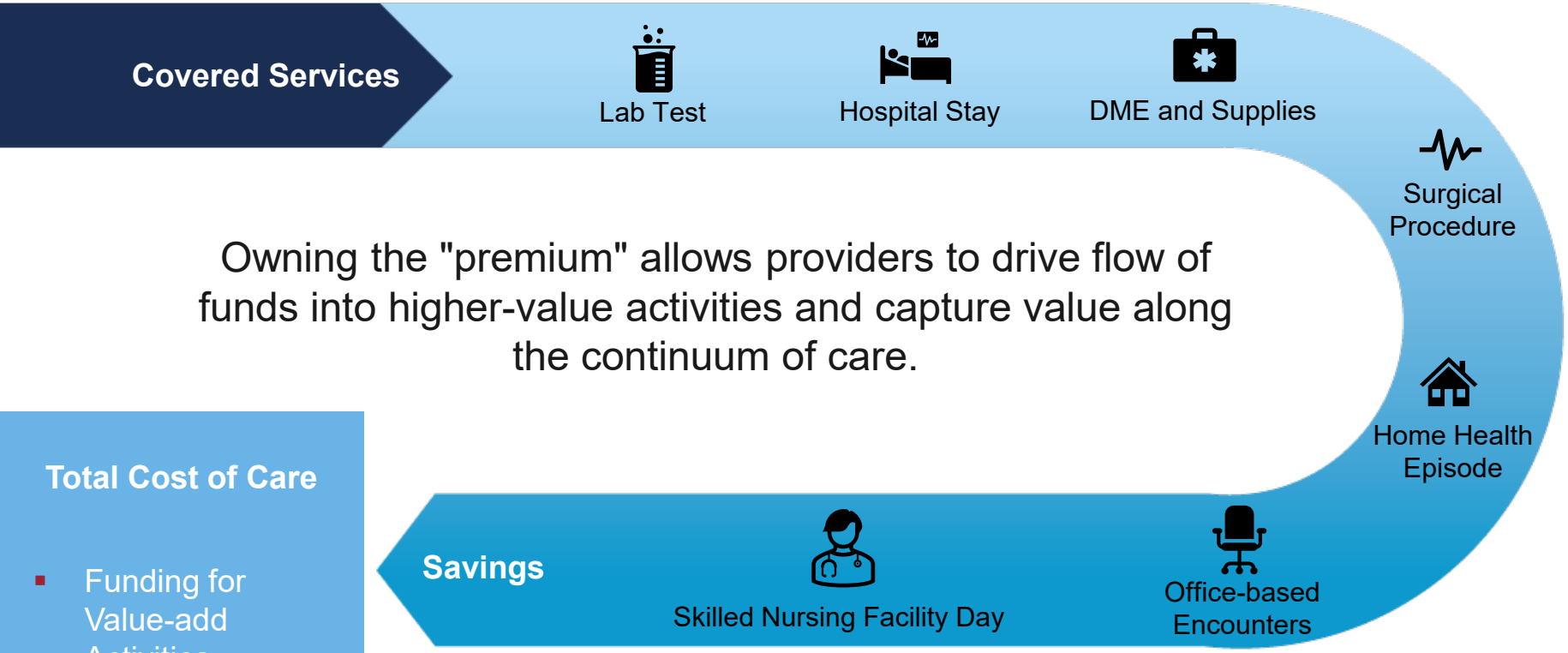


Today's Environment Creates Confluence of Factors That Will Require Different Approaches to Complex and Vulnerable Populations



- ✓ VBP is a necessary healthcare policy solution amplified by fiscal realities and bi-partisan support.

Health Plan Programs Enable Provider Access to Greater Share of Premium While Forging Closer Alignment With Their Delivery System

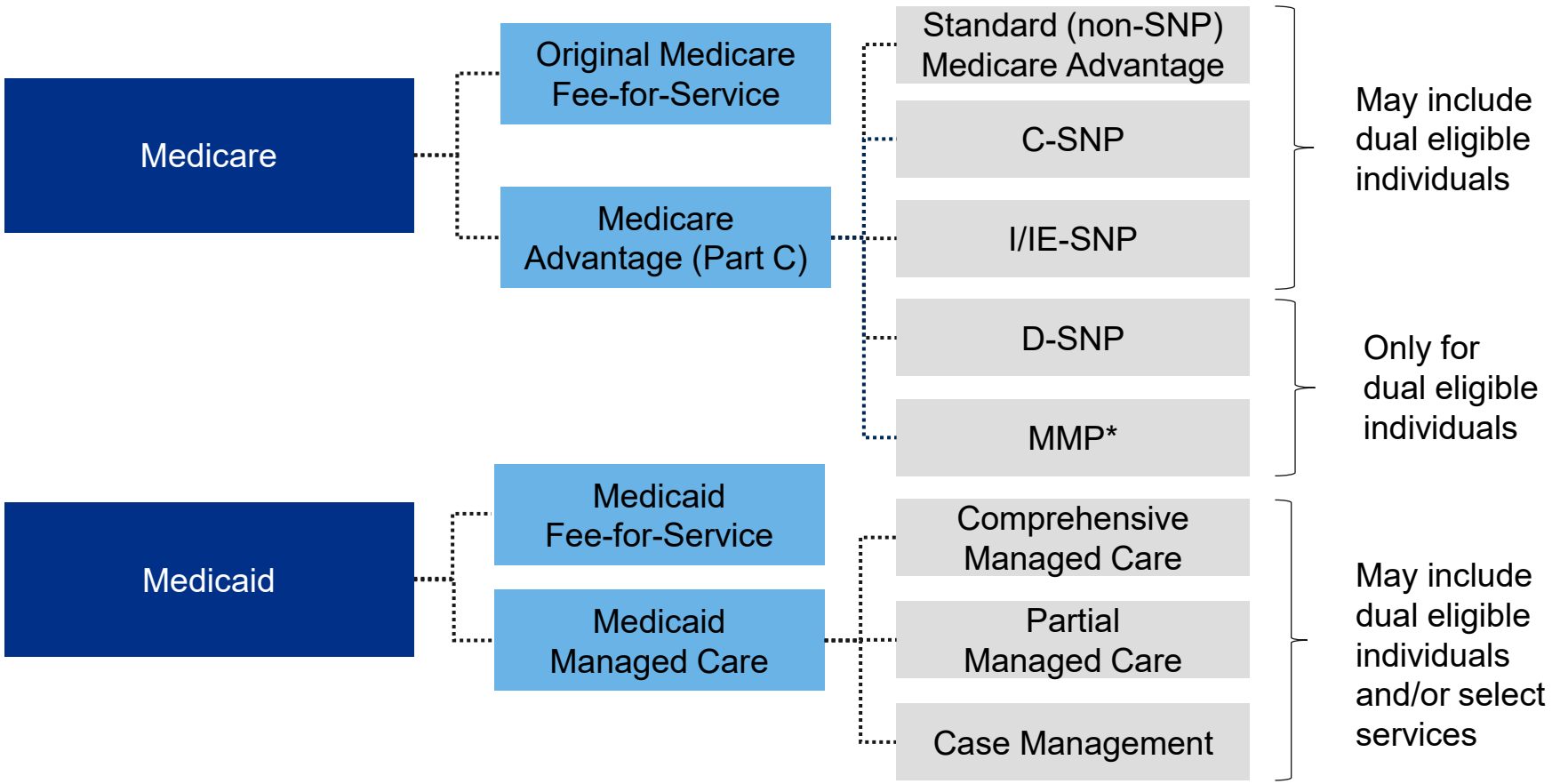


Owning the "premium" allows providers to drive flow of funds into higher-value activities and capture value along the continuum of care.

Healthcare organizations want to enable or move up the “premium” dollar.

02 **The Background:** What are the Options to Better Serve Communities with Provider-Sponsored Health Plan Programs?

Health Systems Have a Number of Paths and Programs to Evaluate to Grow into Medicare and/or Medicaid

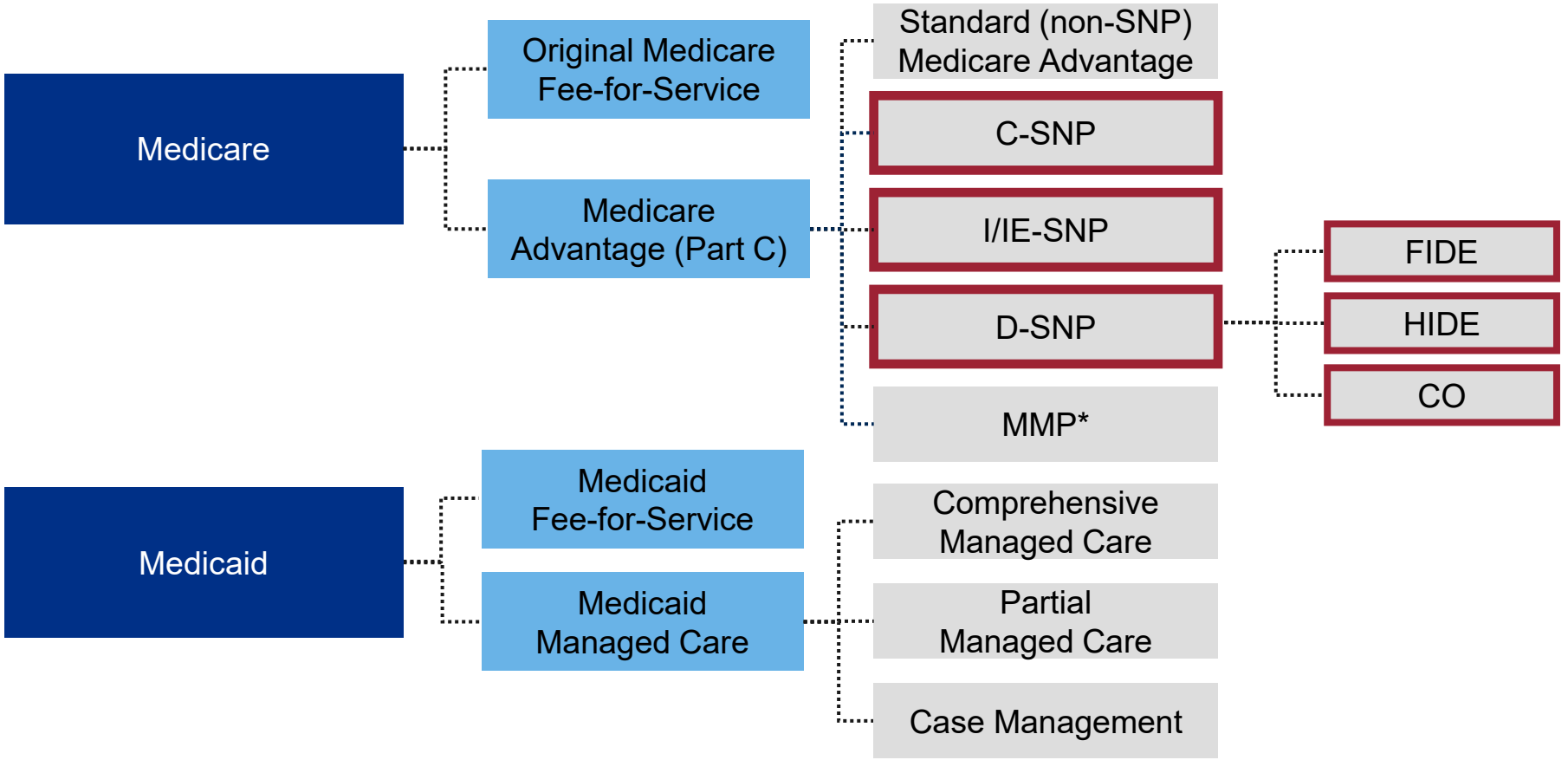


Medicare Advantage is a private insurance alternative to Original Fee-For-Service Medicare. Individuals can enroll if they:

- ✓ Are 65+ or be under 65 years old with certain disability (SSDI) or end-stage renal disease (ESRD)
- ✓ Have Medicare Part A and Part B
- ✓ Live in the plan's service area
- ✓ Are a U.S. citizen or lawfully present in the U.S.

C-SNP = Chronic Condition Special Needs Plan; I/IE-SNP = Institutional/Institutional Equivalent Special Needs Plan; D-SNP = Dual Eligible Special Needs Plan; MMP = Medicare-Medicaid Plan
*Sunsets in 2025

Special Needs Plans Have Significant Alignment with Hospital Systems' Delivery Networks & Existing Patients



Special Needs Plans are a subset of Medicare Advantage:

- ✓ C-SNPs are plans targeted to beneficiaries with specific chronic conditions
- ✓ There are also I/IE-SNPs targeted to individuals in institutional settings and D-SNPs targeted to dual eligible individuals
- ✓ Within D-SNPs, there are varying levels of integration between Medicare and Medicaid across FIDE SNPs, HIDE SNPs, and CO SNPs

C-SNP = Chronic Condition Special Needs Plan; I/IE-SNP = Institutional/Institutional Equivalent Special Needs Plan; D-SNP = Dual Eligible Special Needs Plan; MMP = Medicare-Medicaid Plan
*Sunsets in 2025

Special Needs Plans (SNPS) are a Type of Medicare Advantage Product Limited to Beneficiaries with Specific Needs

All SNPs

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	Chronic Condition Special Needs Plans (C-SNPs)	Dual Eligible Special Needs Plans (D-SNPs)	Institutional & Institutional Equivalent Special Needs Plans (I-SNPs and IE-SNPs)
Eligible Medicare Population	▪ Medicare beneficiaries with specific chronic conditions (e.g., Alzheimer's, cardiac conditions) ▪ Does not have to be dually eligible	▪ Medicare beneficiaries who are also eligible for Medicaid ▪ States can further limit which dual eligible people are eligible for D-SNP	▪ Medicare beneficiaries who meet the state definition for institutional-level care ▪ May reside in an institution or community ▪ Does not have to be dually eligible
Largest Carriers	Risant Health™ Sentara UHS	Banner Health Corewell Health KAISER PERMANENTE® UPMC LIFE CHANGING MEDICINE	SANFORD HEALTH
Plan Requirements	▪ Standard Medicare Advantage rules largely apply to SNPs ▪ CMS requires SNPs to submit and follow an approved Model of Care ▪ D-SNPs must have a State Medicaid Agency Contract (SMAC) with their state		

All SNPs

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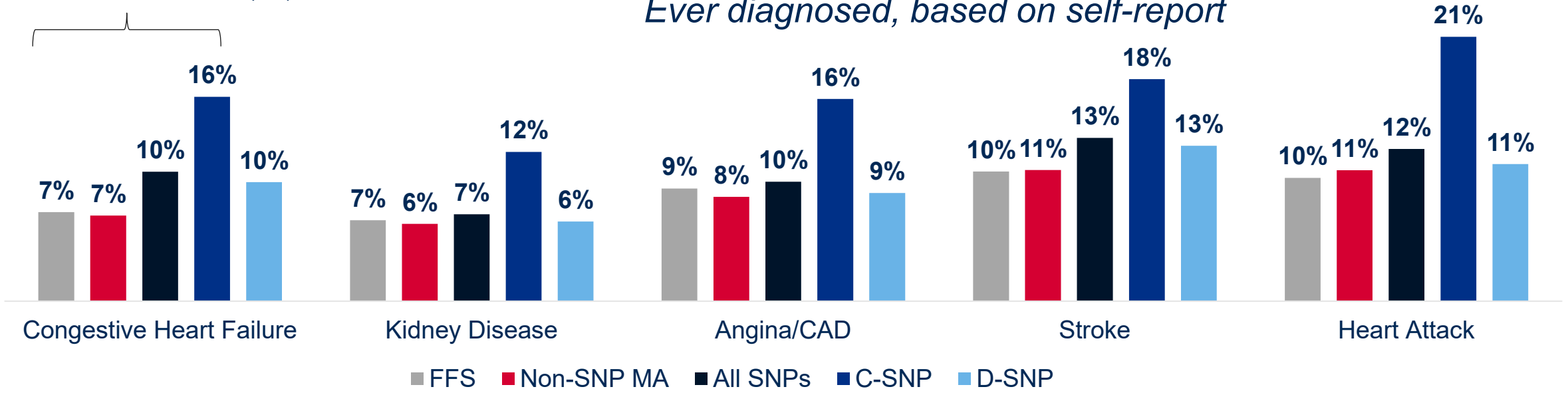
Special Needs Plans Serve Beneficiaries with Complex Medical Needs, Aligning with Common Delivery System Services Lines & Centers of Excellence

16% of C-SNP enrollees report having had heart failure, double the prevalence for non-SNP MA enrollees (7%)

Prevalence of Conditions Among Community-Dwelling Medicare Beneficiaries by Program and SNP Type

Ever diagnosed, based on self-report



Source: ATI analysis of the 2017-2022 Medicare Current Beneficiary Survey, representing the community-dwelling Medicare population nationwide, based on self-report of having ever had or been diagnosed with the condition. The analysis shown has not undergone statistical significance testing or interval estimation.

C-SNP and D-SNP Enrollment is Increasing Since Permanent Authorization in 2018, Making Them a More Stable VBP Strategy Than Many Other Programs/Models

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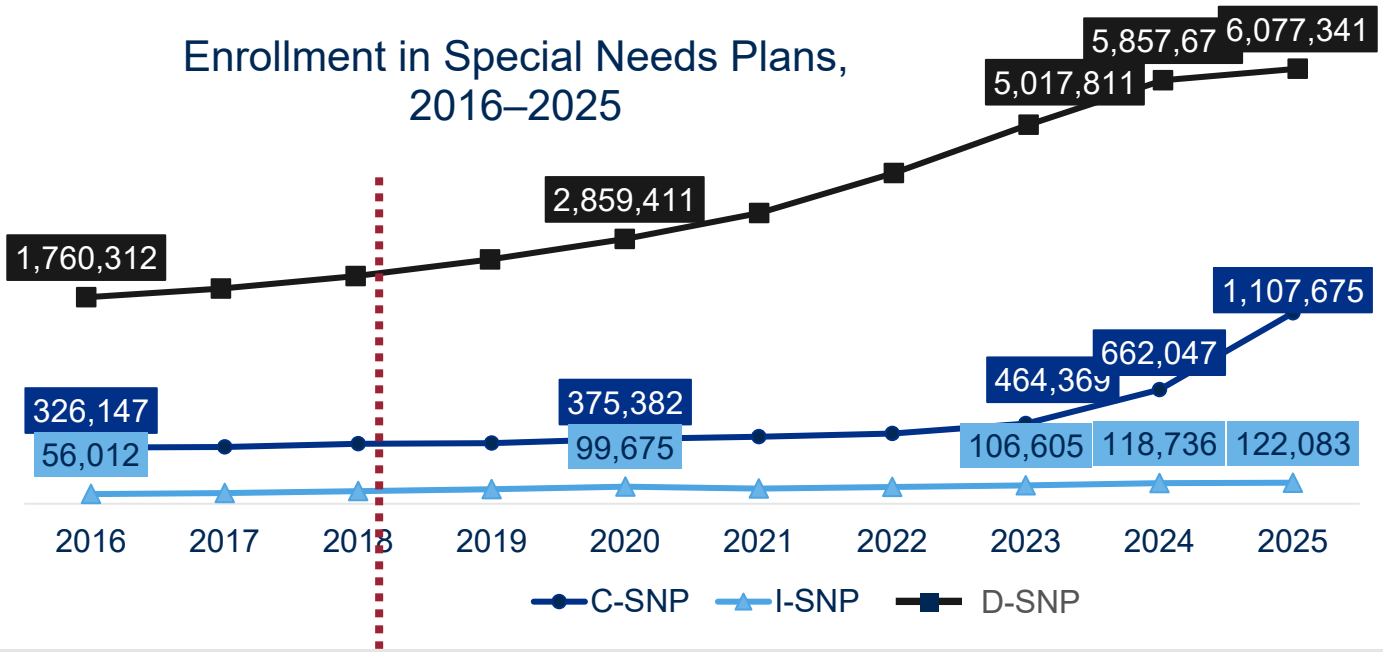
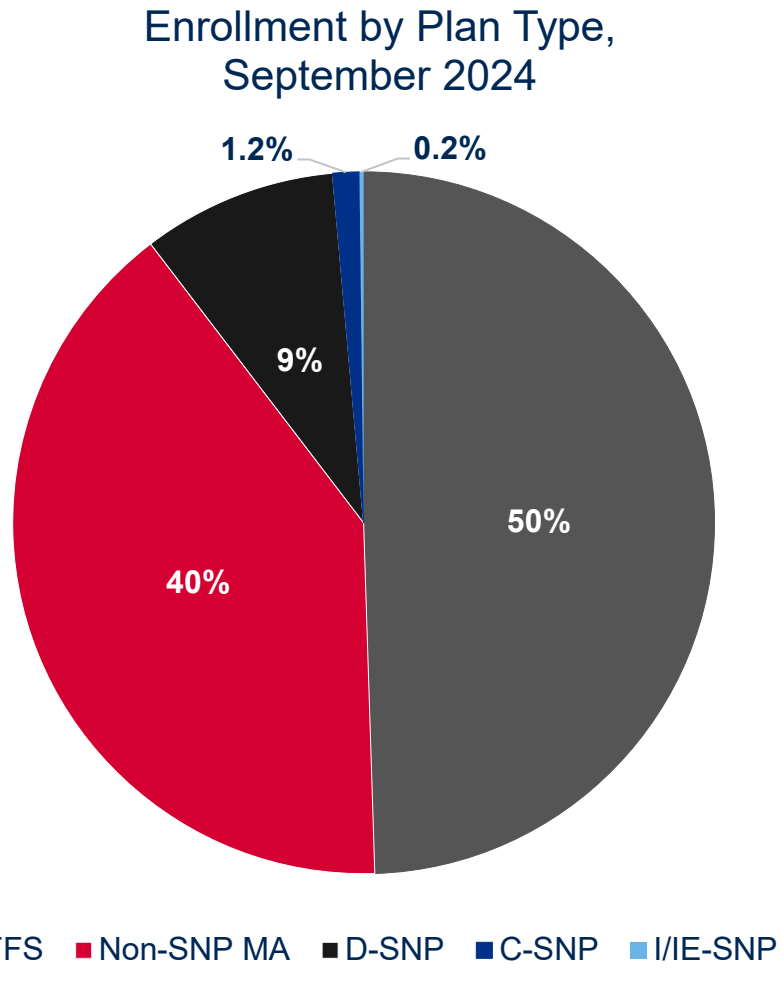


In 2018, SNPs were permanently authorized through the Bipartisan Budget Act (BBA)



Source: ATI Advisory analysis of CMS' SNP Comprehensive Reports for February 2016-2025. Includes enrollment includes all beneficiaries, including those enrolled in Part A or Part B only, in the 50 states, Washington DC, and Puerto Rico. Excludes cost and demo plan types, and enrollment in plans with fewer than 11 enrollees, which accounts for fewer than 500 enrollees per year.
Source: ATI Advisory analysis of the 2023 & 2024 MBSF and 2023 Q2 & 2024 Q1 PBP files. Notes: 1) Only MA enrollees residing in their plan's service area and in the 50 states and DC are included in the analysis; 2) "Dual eligible" refers to both full and partial benefit dual eligible individuals. SNP: Special Needs Plan; I-SNP: Institutional SNP; C-SNP: Chronic Condition SNP; D-SNP: Dual Eligible SNP.

Enrollment in Hospital / Health System MA Plans Has Grown Steadily Since 2020, with Enrollment Growth Primarily Driven By Non-SNP MA Plans

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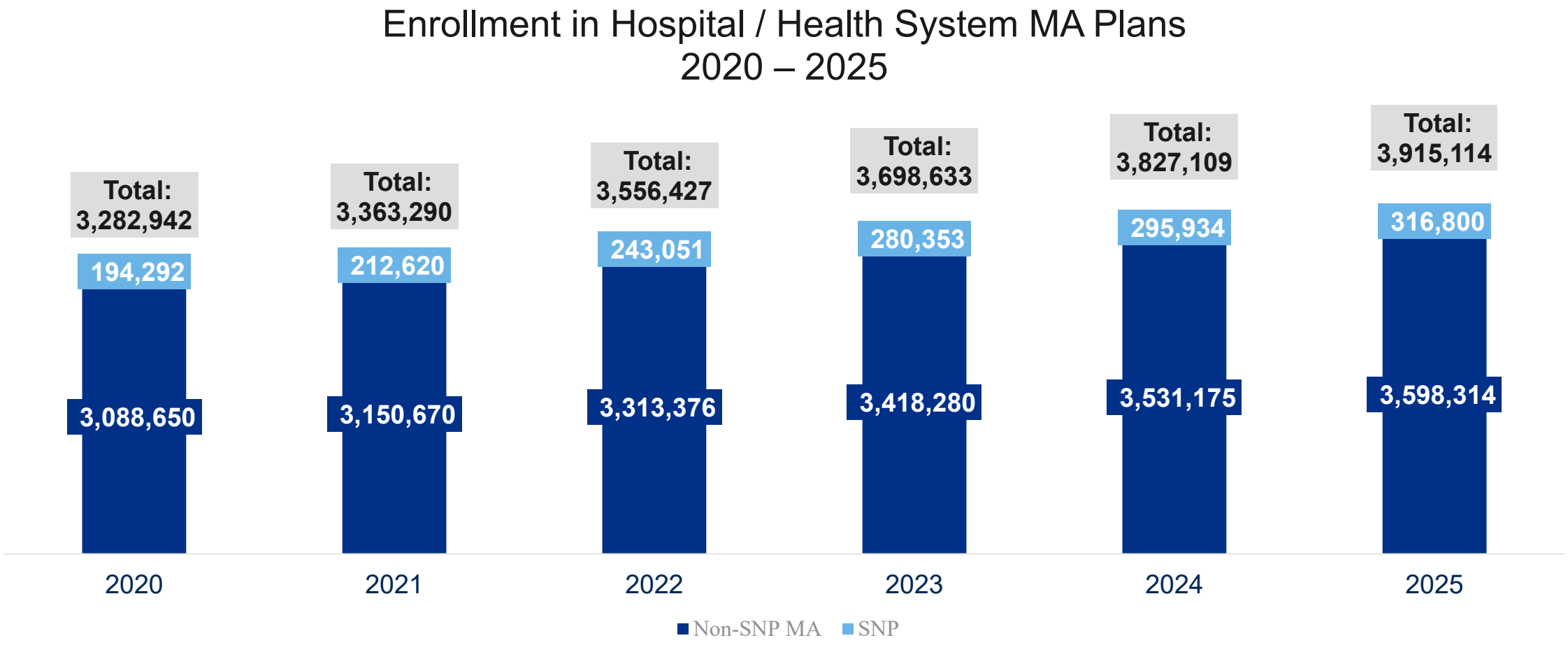

Source: ATI Advisory analysis of CMS SNP Comprehensive Reports and Contract/Plan/State/County (CPSC) enrollment files.

Growth in Provider-Sponsored D-SNP and C-SNP Enrollment Mirrors National Trends, With a Lot of Untapped Market Growth Potential

All SNPs

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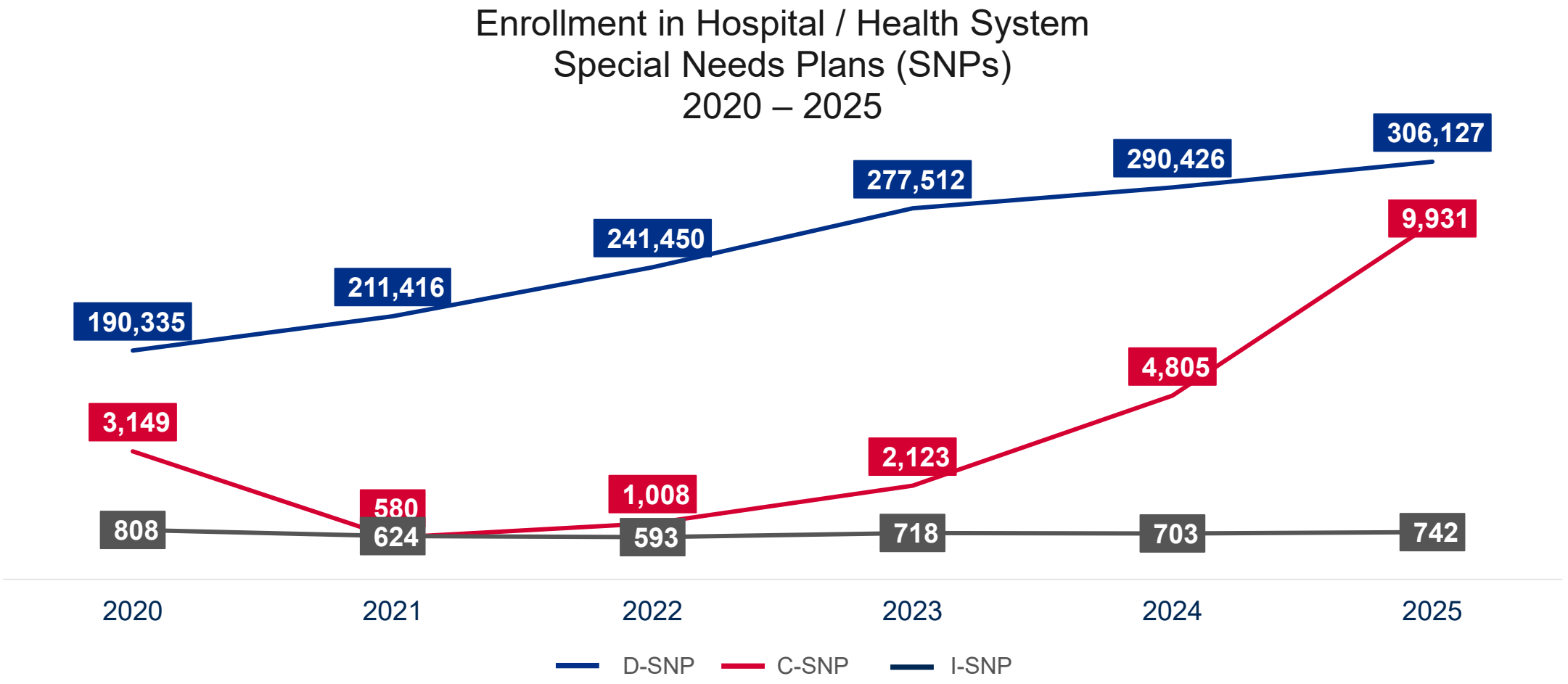

Source: ATI Advisory analysis of CMS SNP Comprehensive Reports and Contract/Plan/State/County (CPSC) enrollment files.

Plan Margins Have Dropped Since 2020, But SNP Margins are Still Higher than Average MA-PD Plan Margins, Creating Opportunities to Reinvest in Underserved Communities

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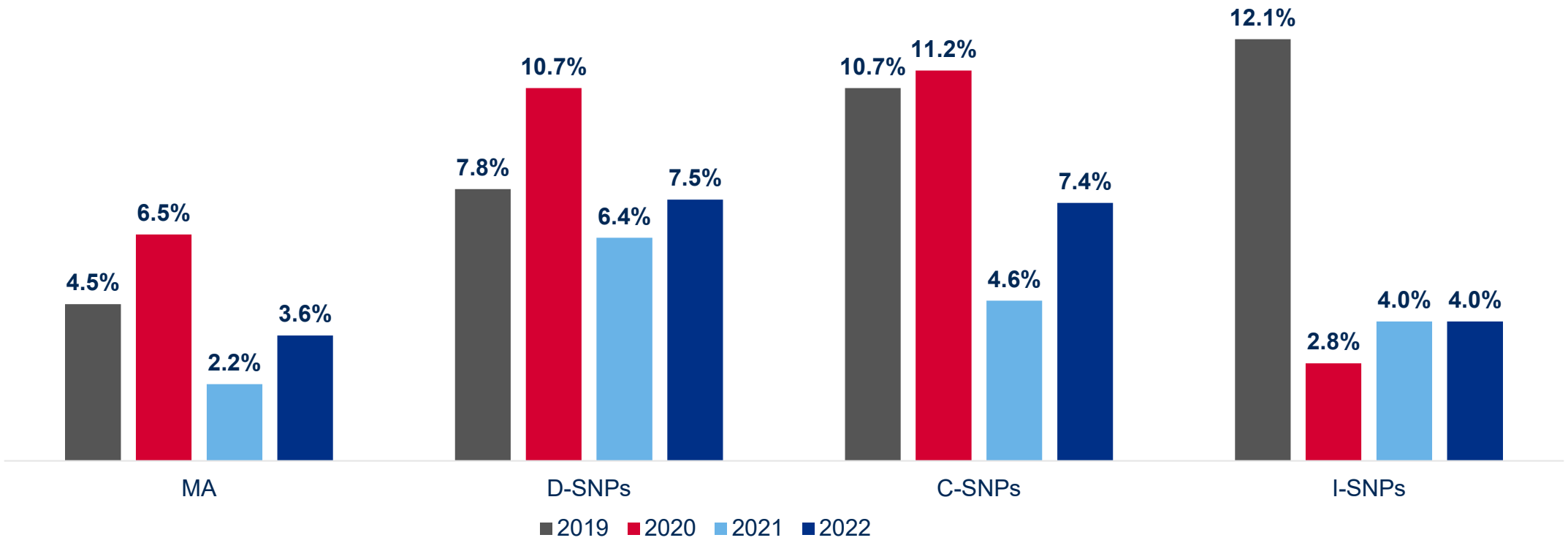
Average Margins by Plan Type, 2019-2022



Sources: MedPAC, "Report to the Congress: Medicare Payment Policy," 2021-2024.

Note: MedPAC acknowledges the decrease in 2021 margins is likely due to lower-than-expected MA revenues from MA risk scores, which were based on beneficiary diagnoses in 2020.

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CMS Sets Three Different Types of D-SNPs Based on Underlying State Medicaid Program Design

The level of integration that a member experiences in a D-SNP varies by the type of D-SNP they are enrolled in, with FIDE SNPs providing the most integrated experiences to members.

Less Integrated

Coordination-only (CO) D-SNP
D-SNP that does not bear Medicaid risk for behavioral health or LTSS in the same service area; must share data with the state to facilitate transitions of care.

Highly Integrated D-SNP (HIDE SNP)
D-SNP that includes **Medicaid risk for behavioral health or LTSS** in the same service area.

Fully Integrated D-SNP (FIDE SNP)
D-SNP that includes **Medicaid risk for behavioral health and LTSS** in the same service area.

More Integrated

> **"Longer term, for dually eligible individuals who are in Medicare and Medicaid managed care, we believe that we should continue to drive toward increasing aligned enrollment until it is the normative, if not only, managed care enrollment scenario."**
>
> — CMS CY2025 Medicare Advantage Final Rule

Coordination Only D-SNPs are the Most Common D-SNPs Offered by Hospitals and Health Systems, Although Highly Integrated D-SNPs Have Grown Substantially

D-SNPs

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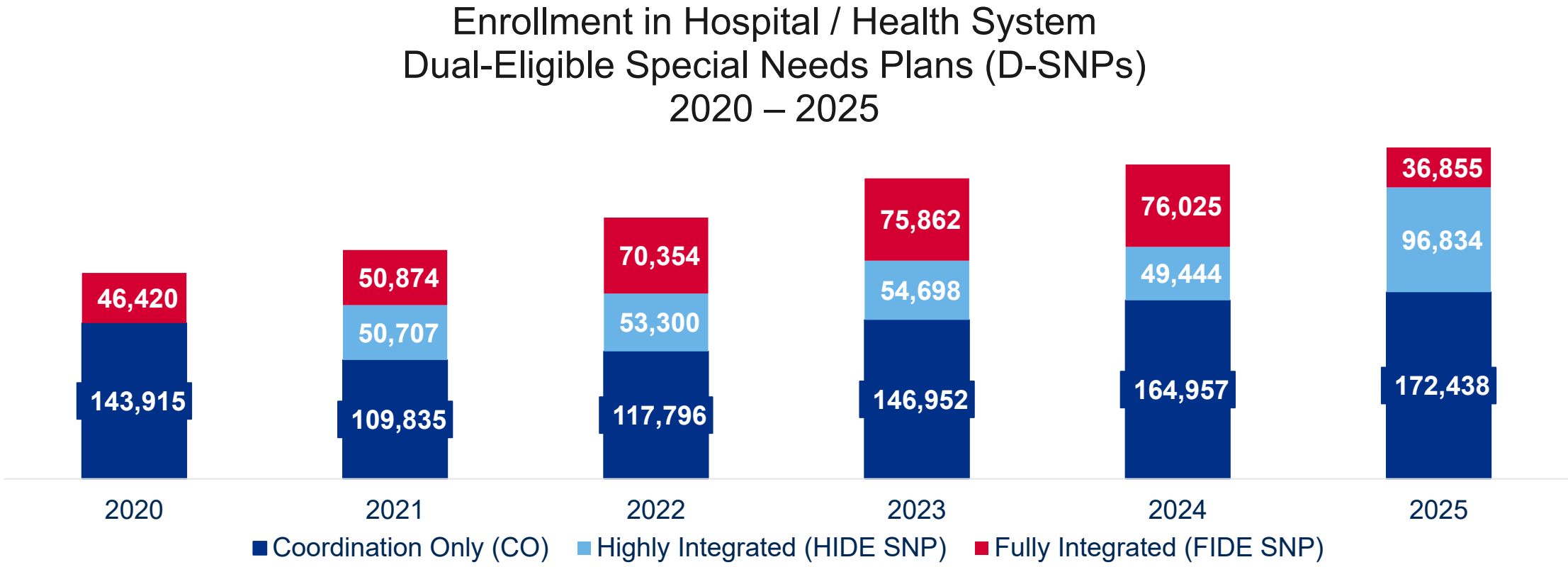

Source: ATI Advisory analysis of CMS SNP Comprehensive Reports and Contract/Plan/State/County (CPSC) enrollment files. FIDE-SNPs are D-SNPs that provide and coordinate Medicare and Medicaid coverage under a single legal entity. HIDE-SNPs are D-SNPs that provide coverage of Medicaid benefits (through the D-SNP or an affiliated Medicaid managed care plan) and include coverage of LTSS, behavioral health benefits, or both, under a capitated contract with the state Medicaid agency. Coordination Only D-DNPs are D-SNPs that do not qualify as either HIDE- or FIDE-SNPs.

CMS Sets the Approved Chronic Condition Categories for C-SNPs

C-SNPs

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Chronic alcohol and other drug dependence	**Autoimmune disorders**: • Polyarteritis nodosa • Polymyalgia rheumatica • Polymyositis • Rheumatoid arthritis • Systemic lupus erythematosus	**Cancer** • **excluding pre-cancer conditions or** • **in-situ status**	**Cardiovascular disorders**: • Cardiac arrhythmias • Coronary artery disease • Peripheral vascular disease • Chronic venous thromboemolic disorder	**Congestive Heart Failure**
Dementia	**Diabetes mellitus**	**End-stage liver disease**	**End-stage renal disease (ESRD) requiring dialysis**	**Severe hematologic disorders**: • Apastic aneima • Hemophilia • Immune thrombocytopenic purpura • Myelodysplatic syndrome • Sickle-cell disease (excluding sickle-cell trait)
HIV/AIDS	**Chronic lung disorders:** • Asthma • Chronic bronchitis • Emphysema • Pulmonary fibrosis • Pulmonary hypertension	**Chronic and disabling mental health conditions**: • Bipolar disorders • Major depressive disorders • Paranoid disorder • Schizophrenia • Schizoaffective disorder	**Neurologic disorders:** • ALS • Epilepsy • Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) • Huntington's disease • Multiple sclerosis • Parkinson's disease • Polyneuropathy • Spinal stenosis • Stroke-related neurologic deficit	**Stroke**

MAOs may apply to offer a C-SNP that targets any one of the following:

- A single CMS-approved chronic condition (selected from the list here),
- A CMS-approved group of commonly comorbid and clinically linked conditions, or
- An MAO-customized group of multiple chronic conditions

C-SNPs

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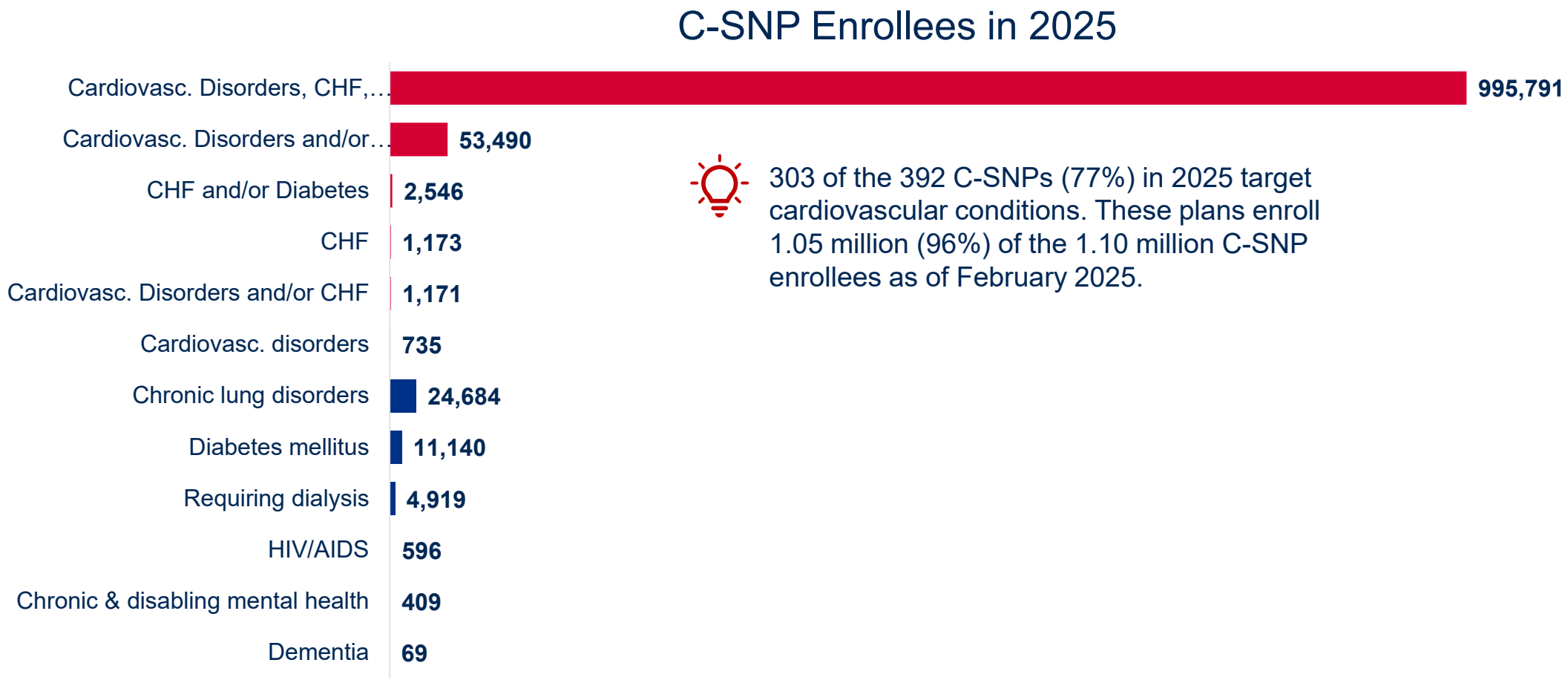
Majority Of C-SNP Enrollment is in C-SNPs Focused on Cardiovascular Conditions



303 of the 392 C-SNPs (77%) in 2025 target cardiovascular conditions. These plans enroll 1.05 million (96%) of the 1.10 million C-SNP enrollees as of February 2025.

Note: Total enrollment does not include enrollment in plans with less than 11 enrollees.
Source(s): ATI Advisory analysis of MA Contract Plan State County Enrollment Data, February 2025.

In Line with National Trends, Multi-Condition C-SNPs Comprise the Bulk of C-SNP Enrollment In Provider-Sponsored Plans

C-SNPs

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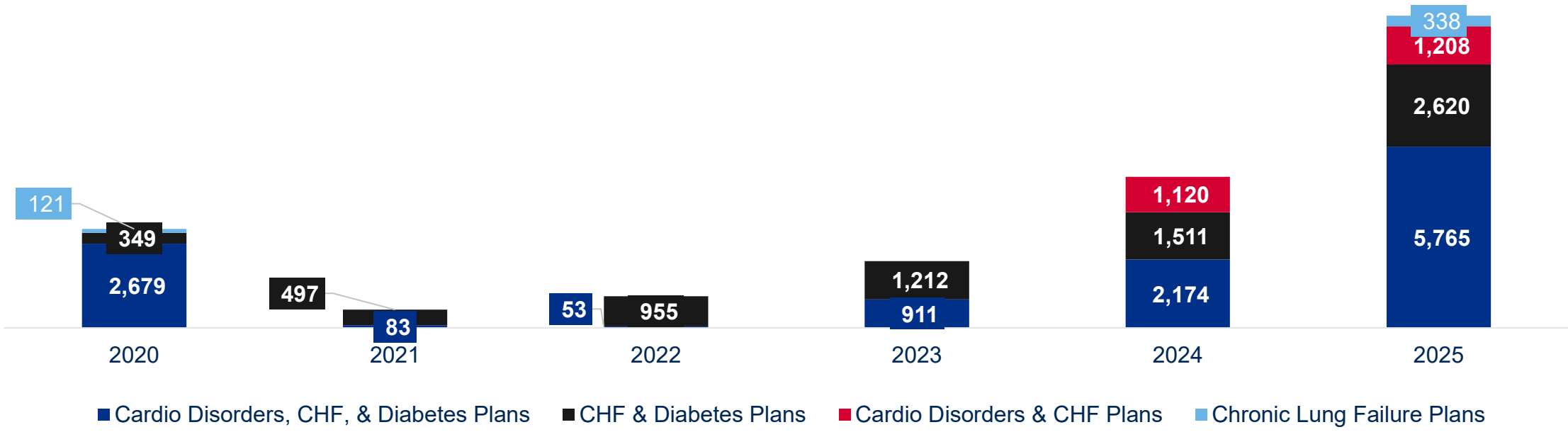
Enrollment in Hospital / Health System
Chronic Special Needs Plans (C-SNPs)
2020 – 2025



All SNPs Must Implement a Robust Model of Care (MOC) Across Four Specific NCQA Scoring Measures Which are Closely Aligned with Delivery System Capabilities

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Description of SNP Population

- Identify and create a comprehensive description of the SNP-specific population
- Population description should address the full continuum of care of current and potential SNP enrollees
- Provide information about local target population in the service areas covered under the contract
- Include a complete description of the most vulnerable enrollees that differentiates between the general SNP population and the most vulnerable enrollees
- Describe services tailored for enrollees considered especially vulnerable
- Data cannot be more than a couple years old

Care Coordination

- All SNPs must coordinate delivery of care and measure the effectiveness of the MOC delivery of care coordination
- Six elements must comprehensively address the SNP's care coordination activities:
- SNP Staff structure
- Health Risk Assessment (HRA)
- Face-to-Face Encounter
- Individualized Care Plan (ICP)
- Interdisciplinary Care Team (ICT)
- Care Transition Protocols

Provider Network

- The SNP is responsible for a network description that must include relevant facilities and practitioners necessary to address the unique or specialized health care needs of the target population
- The SNP must provide oversight information for all its network types
- SNPs must ensure their MOC identifies and describes and implements the following for their provider networks:
- Specialized expertise
- Use of clinical practice guidelines and care transition protocols
- MOC training for the provider network

Quality Measurement and Performance Improvement

- All SNPs must conduct a quality improvement program that measures the effectiveness of its MOC
- The leadership, managers and governing body of a SNP organization must have a comprehensive quality improvement program in place to measure its current level of performance and determine if organizational systems and processes must be modified, based on performance results.

Source: NCQA CY 2026 Scoring Guidelines

03 | **Lessons from the Field:** MGBHP Case Study: Integrated Strategy to better serve Dual Eligibles

About Mass General Brigham

- Mass General Brigham is an **integrated academic healthcare system**, uniting great minds in medicine to make a life-changing impact on patients in our communities and people around the world.
- Mass General Brigham connects a **full continuum of care** across a system of academic medical centers, community and specialty hospitals, a health insurance plan, physician networks, community health centers, home care, and long-term care services.

Affiliate institutions include:

- Brigham and Women's Hospital
- Massachusetts General Hospital
- Mass General Brigham Health Plan
- Brigham and Women's Faulkner Hospital
- Community Physicians Organization
- Cooley Dickenson Hospital
- Martha's Vineyard Hospital
- Mass Eye & Ear
- Mass General Brigham Home Care
- MGH Institute of Health Professions
- McLean Hospital
- Nantucket Cottage Hospital
- Newton-Wellesley Hospital
- Salem Hospital
- Spaulding Rehabilitation Network
- Wentworth-Douglass Hospital

About Mass General Brigham

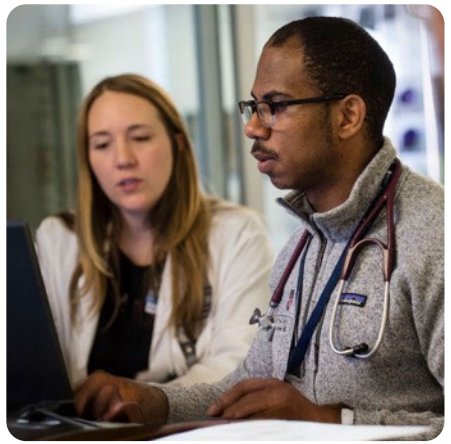
Mass General Brigham is committed to serving the community. We are dedicated to enhancing patient care, teaching and research, and taking a leadership role as an integrated health care system. We recognize that increasing value and continuously improving quality are essential to maintaining excellence.

Patient care

From routine care to the most complex cases, we offer comprehensive, full-circle clinical care to our patients, starting and ending at home.

Research and discovery

Because we are built on a legacy of medical discovery, our researchers push the boundaries of knowledge and advance medicine in new and innovative ways.



Education

We have over 100 accredited physician residency and fellowship programs, and over 2,000 trainees preparing to be the healers of tomorrow.

Community

We have five licensed and 15 affiliated community health centers. We have diverse community partnerships to support our local residents.

Mass General Brigham's commitment

- Mass General Brigham Health Plan serves over 400,000 commercial, Medicare Advantage, and Medicaid members with plans to serve the dual-eligible population.
- For nearly 40 years, Mass General Brigham Health Plan has been committed to delivering exceptional customer experiences.
- As part of Mass General Brigham, we are advancing innovative solutions through value-based care models that center on the health needs of our members to enable seamless and affordable care.

Our history as a locally-focused, integrated health plan

Our legacy of integration, innovation, and growth drives us forward

1986

- Neighborhood Health Plan was founded by the Massachusetts League of Community Health Centers and the Greater Boston Forum for Health Action.

2012

- Joined the world-renowned Partners HealthCare system.

2023

- **Became Mass General Brigham Health Plan** to advance our system's brand (rebranded from AllWays Health Partners).
- Entered the Medicare Advantage market.
- Launched the Mass General Brigham Accountable Care Organization (ACO).

2024

- Ranked #1 in member satisfaction among commercial health plans by J.D. Power, for two years in a row.
- Recognized as an "ACO to Know" by Becker's Healthcare.

2026

- Anticipated start date for our Dual-Eligible Special Needs Plans (D-SNP).

The health plan's enhanced offerings through Mass General Brigham system integration

Health Plan

>245,000 fully insured members
Commercial 34%, Medicaid 65%, Medicare Advantage 1%

4.5 out of 5 for Commercial and Medicaid health plan ratings in 2023 by the NCQA

Differentiated strengths and capabilities

- Seamless, coordinated care
- Tailored programs and services
- Innovative clinical care models

Serving members where they are
Providing care to homeless individuals at the Mass General Boston Health Care for the Homeless clinic

Creating paths to lifestyle change
Helping at-risk patients delay or prevent type II diabetes

Understanding the unique health needs of the dual-eligible population

Understanding the dual-eligible population

- In the United States, there are over 11.9 million dual-eligible individuals, or people who are eligible for both Medicare and Medicaid coverage.
- Dual-eligible individuals face a number of barriers in accessing care, including:

Health system barriers: Fragmented care coordination, complex eligibility and coverage requirements, difficulty navigating within the system	**Functional health status barriers:** Mobility challenges, behavioral health needs, disability status	**Social risk factors:** Health and digital literacy, social isolation, housing insecurity, food insecurity, limited financial resources, no or unreliable transportation	**Health disparities:** Racial inequities, gender or sexual orientation-based inequities

Addressing these barriers to care through D-SNP

- A **Dual Eligible Special Needs Plans (D-SNP)** is designed to support and coordinate care for individuals who are eligible for both Medicare and Medicaid through:

Coordinated care
- Integrated services
- Dedicated single point of contact
- Integrated care team structure

Cost savings
- No premiums
- No co-pays

Focus on preventative care
- Health promotion
- Wellness services

Personalized support
- Care management and individualized care plan
- Chronic disease management
- Behavioral healthcare management

Comprehensive and streamlined access to services
- Medical and long-term care
- Prescription drugs
- Long term services and supports (LTSS)

Simplified processes
- Minimizes administrative burden
- One plan, one card

State snapshot: Dual eligible population and programs

State landscape

- Over **340,000 Massachusetts residents** are eligible for both Medicare and Medicaid.
- D-SNPs provide extra benefits at no cost to this population.

Two primary D-SNPs in MA:

Massachusetts is the only state with two D-SNPs that address these two distinctive populations:

- **One Care**, which mainly serves disabled adults aged 21 to 64.
  - Provides extensive community-based support services like transportation or housing assistance.
- **Senior Care Options (SCO)**, which mainly serves adults aged 65+, some of whom are disabled.
  - Provides management of complex long-term care needs, including assistance with bathing, dressing.

The difference of an integrated healthcare system

Our “why” for serving the Duals population

As an integrated healthcare system, we:

Already serve the dual-eligible population and deeply understand their holistic needs due to the personal nature of provider relationships and our existing community presence

- Have more touchpoints with dual-eligible individuals (as both members and patients) than other health plans, to meet them where they are and prevent disruption to healthcare services
- Are a not-for-profit organization that is accountable to the community it serves
- Understand the needs of providers working with the dual-eligible population, and strive to eliminate the administrative burden for providers that comes with a standard insurance organization
- Have world-renowned clinical leadership and researchers, including scholars focused on learning and identifying the best methods to address the needs of dual-eligible individuals

Our unique benefits for providers as an integrated system

Anecdotally, providers capture higher reimbursement with Duals plans as compared to fee-for-service

Opportunity: Expand access to the state's D-SNP benefits and supports for ~20K dual-eligible members currently in a fee-for-service model

Approach: Combine comprehensive coverage with clinical expertise and expansive on-the-ground networks

Administrative simplification

- Providers bill only one plan instead of both Medicare and Medicaid separately
- One insurance card for the patient and one point of contact for providers
- No additional regulatory requirements for providers

Improved coordination of care and expanded supports

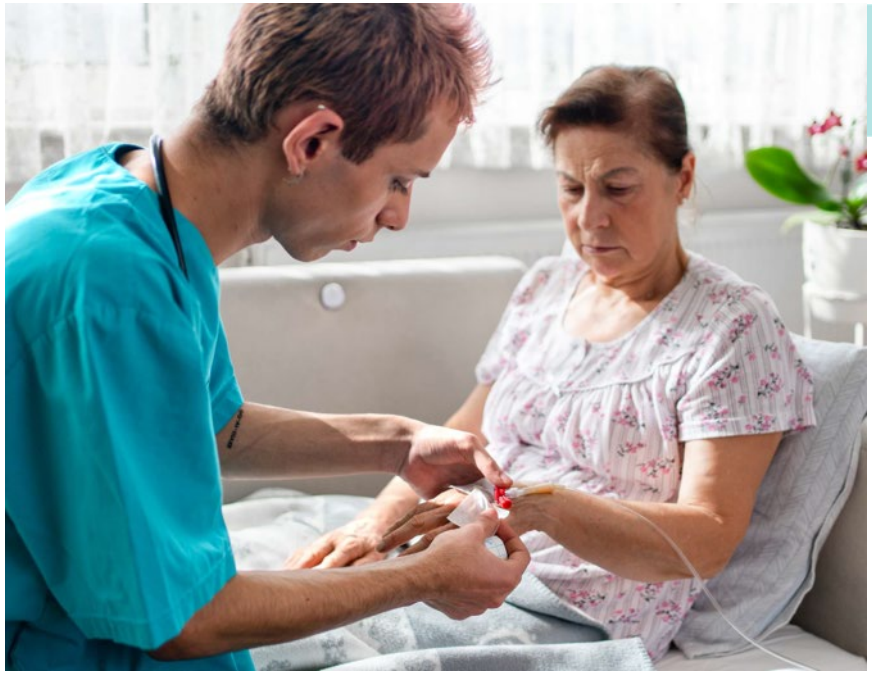
- Wrap-around care team to manage complicated healthcare needs
- Benefits that support preventative care (e.g. transportation to medical appointments) and help members adhere to clinical guidance

Enhanced efficiency and system integration

- Integrated care management platform to allow for direct care team engagement and integration into clinical workflows

We will bring world-class care solutions to our Dual Eligible members

Caring for patients who meet inpatient admission eligibility criteria in the comfort of their home. **We plan to leverage our Home Hospital program across our membership, which will also expand access for Massachusetts' island communities (Dukes and Nantucket counties).**



Mass General Brigham + BEST BUY Health

3,000+ Patients served through MGB Home Hospital since 2020

15,000+ Avoided hospital inpatient days

"…the clinical team has a greater ability to educate and act on the **social determinants of health that we see in the home**. For example, we can discuss a person's diet right in the kitchen or link a person with resources when we see the cupboards are bare."

– Dr. Michael Levine, clinical director for research and development for Healthcare at Home

We continue to expand and innovate in our Home Hospital offerings and are currently testing a short-term skilled nursing service in the home.

Expanding network access for remote communities

Dual-Eligible Enrollees in Dukes/Nantucket Experience*	
Housing instability	25%
Living alone	35%
Long Term Supports and Services (LTSS) -like disability	12%

We will be the first health plan to offer D-SNP programs in Dukes and Nantucket counties in Massachusetts.

With Mass General Brigham and our community partners, we can deliver innovative solutions to ensure the highest level of care and coordination, through:

- Telehealth/telemedicine
- Transportation innovations
- Mobile clinics
- Home Hospital services

* Source: American Community Survey 2017-2022 5-year estimates (Individual Public Use Microdata Series, IPUMS). Housing instability defined as those who rent and have household incomes below 200% federal poverty limit. LTSS-like disability is defined as having difficulty with self-care, difficulty with independent living, and ambulatory or cognitive difficulty.

We partner with local organizations to address challenges of dual-eligible population

We have established several workforce pipeline initiatives to recruit, train, and retain much-needed local healthcare professionals, like nurses and behavioral health providers.

\+ MGH INSTITUTE OF HEALTH PROFESSIONS = **$6M** for Nursing Expansion Grant Program

UMass Boston + Mass General Brigham = **$10M** for Clinical Leadership Collaborative for Diversity in Nursing

Massachusetts League of Community Health Centers + Mass General Brigham = Behavioral Health Internship Pipeline Program

"These are people who need what we can provide more than anyone else in Massachusetts. Operating in the Duals space, in many ways, is operating at the highest level of our capabilities and at the pinnacle of our mission."

Steve Tringale

President, Mass General Brigham Health Plan

04 Discussion / Q&A