

Applying Successful VBC Strategies across Dual Populations

Chair: Franke Elliott, Bloom Healthcare



Thomas Jefferson University

200+
Graduate and undergraduate programs

77,000+
Alumni

17 NCAA Division II teams

8,300+
Students (full/part time)

Over **\$200 million** In applied, basic, clinical and scholarly research

1,000+ Patents for new drugs, software innovations, medical devices and diagnostic tools

Data is FY24 - updated January 2025



Jefferson Health

4,350
Employed physicians

32 Hospital campuses

700+
Sites of care

13,600+
Nurses (full/part time)

4 Magnet® designated locations

4 Pathway to Excellence® designations

2,500+
Advanced Practice Clinicians

8.8+ million Outpatient visits (hospital and physician)

Data is FY24 - updated April 2025



Jefferson Health Plans

362,000+
Total members

40+ Years of service

316,000+
Medicaid members

750
Employees

13,000+
Medicare members

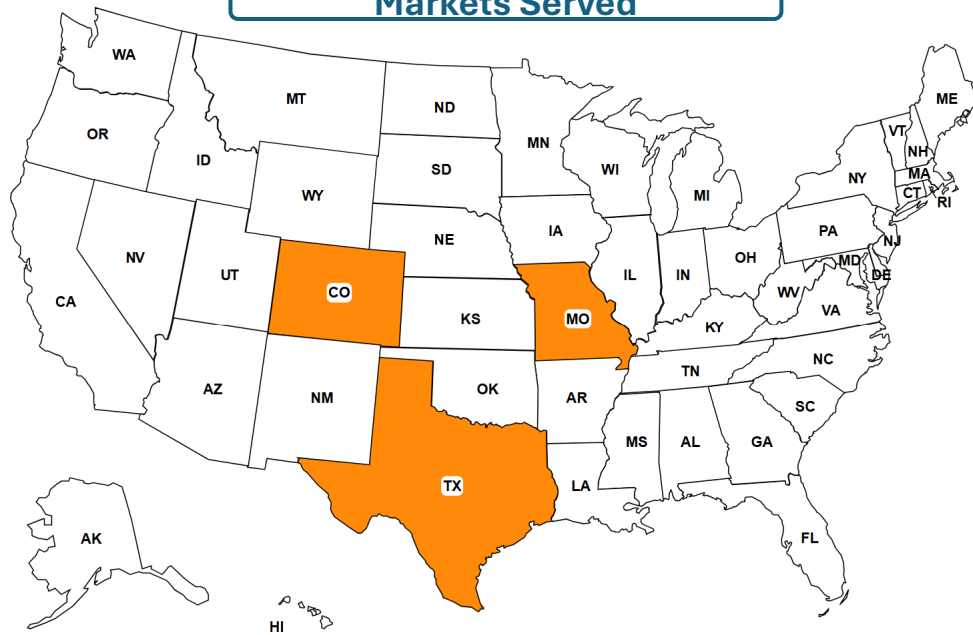
20,000+
CHIP members

13,000+ Individual and family plans


Data is 12/24 - updated January 2025


Bloom Healthcare is an industry leading provider of home-based primary care and hospice services, caring for an elderly, medically complex, homebound population through end of life

Markets Served





We work with industry leading senior living operators...























15k Primary Care and 2,100 Hospice patients served annually




100+ Employed Primary Care Providers & 250+ licensed care team members



400+ Senior Living partners



Serve private home patients



Industry-leading Quality & Financial Results

- Reducing Utilization & Cost
- Increasing Days at Home
- Increasing Patient Satisfaction



Introduction to CareConnectMD

Applying Successful VBC Strategies
Across Duals Populations

Bringing Dignity to Fragility

CareConnectMD Overview

Dedicated to caring for patients with complex medical and social needs for over 20 years

COMPANY OVERVIEW

CARECONNECTMD is a convener of Value-Based Care programs, serving high-risk and medically complex populations in their home settings.

VALUE BASED CARE PROGRAMS:

Participating in MSSP and ACO REACH, designated by CMS to coordinate Value-Based Care delivery for high-risk, original Medicare patients.

EXPERTS IN REDUCING HOSPITALIZATION

Our clinical model, grounded in patient-centered care, reduces unnecessary hospitalizations and service utilization while consistently maintaining high-quality outcomes.

MANAGEMENT TEAM:

Management Team has significant Value-Based Care experience through roles at UnitedHealth Group, CareMore, and PacifiCare.

LEADING PERFORMANCE

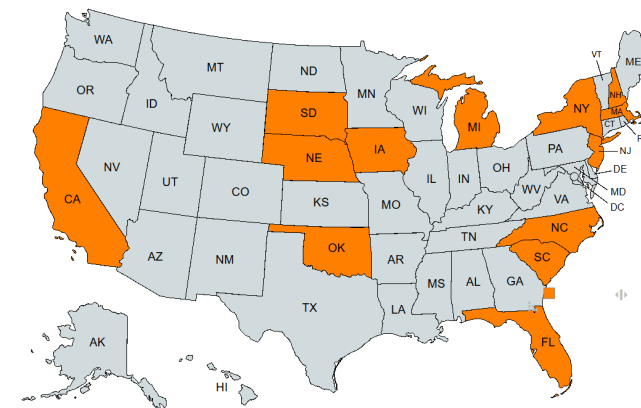
Top Performing High Needs ACO REACH since 2021 across the nation with gross savings 20 -30%.

Approx. \$15k - \$20k per beneficiary per year in medical cost

500+
Skilled Nursing Facilities

12+
States Covered
Licensed in 45 states

GEOGRAPHIC FOOTPRINT



Duals Population

The dual population utilization and costs are significantly higher compared to non-duals. Fragmented delivery of care and conflicting incentives are resulting in poor outcomes



CareConnectMD Value -Based Strategy

By applying value-based strategies to our ACO population, around 90% whom are duals and reside in the long-term care facilities, CareConnectMD has been able to reduce utilization including readmissions, ER visits, skilled days, while lowering unnecessary medical costs.

What we do best:

- Purpose-built, data-driven clinical model designed to succeed in value-based care.
- Proactive, prevention-focused approach that reduces total cost of care by avoiding unnecessary hospitalizations and utilization
- High-touch, coordinated care model integrating providers, facility staff, and families to improve outcomes for high-acuity patients
- Scalable infrastructure supported by interventional analytics and integrated virtual and on-site teams



The Local Orchestration Beneath the Human Moment

Genevieve Caruncho-Simpson

CEO and Co-Founder, Dyad Health



Payer, Advocate, Builder — Why I See the Dual-Eligible Gap Others Miss

1

As a Payer

Former CEO, UnitedHealthcare WA | CVS Aetna | Ascension Health | Humana

\$4B+ P&L, D-SNP operations at scale — saw firsthand why PCP attribution fails dual-eligible members with complex needs, and what it costs when caregivers become the de facto care coordinators.

2

As an Advocate

Former Senior Advisor, Family Caregiver Alliance

Embedded with the 53 million unpaid caregivers absorbing the friction the system creates. When they burn out, utilization spikes and care plans collapse — the invisible cost driver neither Medicare nor Medicaid is structured to see.

3

As a Builder

Co-Founder & CEO, Dyad Health

Spinning out of FCA to build what neither side could alone — community-based dyadic care that ACOs can contract for, not build from scratch.



Beyond PCP Attribution: What Dual-Eligible Care Coordination Actually Requires



The Problem We're Solving

Dual-eligible individuals living with dementia are among the highest-cost, most fragmented beneficiaries in both programs. Their unpaid caregiver — invisible to both Medicare and Medicaid — is the system's most relied-upon and least supported asset.

Why Now

Three policy forces converging by 2027 — MSSP's expanding accountability for dual-eligible outcomes, D-SNP exclusively aligned enrollment growth, and LEAD's Medicare-Medicaid integration planning phase — create the first reimbursement environment where the dyadic model is not just clinically right but financially viable.

What We Solve for Your Submission

We staff your LEAD integration plan and D-SNP partnership strategy with community-based care coordination — ready to deploy, not just documented.

What Dyad Health Does

We deploy as your community-based dyadic care partner — place-based teams + FHIR-native platform — plugging into your existing network, not replacing it. Mapped to the elements your reviewers are scoring:

- ▶ **Care Coordination / ICT:** In-home dyadic assessments, HRA completion at scale, caregiver-inclusive care plans
- ▶ **LTSS & SDOH:** Community navigation, respite coordination, closed-loop referrals tied to outcomes
- ▶ **Quality & Outcomes:** Prior auth documentation, medical necessity feeds, caregiver-reported measures
- ▶ **Interoperability:** FHIR-native EHR connecting your network, plans, and community partners

Evidence-based: Dyadic models demonstrate 15–20% reductions in acute utilization.* Dyad Health is operationalizing this for D-SNP and LEAD populations in California and select other markets.

**Peer-reviewed evidence from dyadic intervention trials.*