Key Insights Summary

One Member, Five Open Gaps: How Leading Medicare Advantage Plans Are Coordinating Member Action

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Executive Summary

Medicare Advantage plans have become increasingly sophisticated at identifying care gaps, risk opportunities, pharmacy needs, and quality priorities. The harder challenge is deciding what should happen when several of those priorities belong to the same member at the same time.

Leaders from Drips, Independent Health, myPlace Health, Johns Hopkins Health Plans, and MMM Holdings shared how they are approaching that problem from different parts of the enterprise.

Their strategies point toward a different operating model for member engagement: prioritize across the enterprise, understand why a member has not acted, use real-time context to determine what matters now, and give the person interacting with the member enough information and flexibility to act on it.

The common thread was not more outreach. It was better orchestration: using data, technology, providers, frontline teams, and member conversations to determine the right next action and improve the likelihood that it actually happens.

Guests:

- Kathleen Faulk, Chief Strategy Officer, Drips
- Brendan Generelli, Director, Medicare Stars & Quality, Johns Hopkins Health Plans
- Nilda González, VP Quality Management & Stars, MMM Holdings, LLC
- Rob Schreiber, MD, Vice President and National Medical Director of Care Model Strategy, myPlace Health (part of SCAN Group)
- Amin Serehali, SVP, Chief Data and Analytics Officer, Independent Health
- Eric Glazer, CEO, Bright Spots Ventures; Executive Producer & Host, Bright Spots in Healthcare (Moderator)

Bright Spots & Strategies

1. Prioritize for Enterprise Impact, Not One Measure at a Time

When multiple departments own different objectives for the same member, the campaign already in the market should not automatically determine what gets prioritized.

Kathleen Faulk described an approach that looks beyond the Stars weighting of an individual measure and considers its broader impact on **quality, claims cost, and revenue/documentation**. An action that affects several enterprise objectives may deserve greater priority than its individual measure weight suggests.

The larger opportunity is organizational: give teams a common framework for understanding the value of an action beyond their own department.

Takeaway: Plans do not necessarily need a sophisticated orchestration engine to begin. Start by establishing common enterprise-level prioritization logic across teams.

2. Determine Whether the Member Needs a Nudge, Barrier Resolution, or Clinical Support

Independent Health starts with three questions when a member appears to be struggling:

Why is the member struggling? How urgent is the situation? Is the member ready and able to act?

Amin Serehali emphasized that an open gap identifies what has not happened, but not why. The member may simply need a reminder, may face a specific barrier such as transportation or health literacy, or may have a more significant clinical issue requiring intensive support.

Independent Health combines clinical information, social-needs data, vulnerability indicators, and clinician-defined program hierarchies to help determine the appropriate response.

Takeaway: Before adding outreach, determine what kind of intervention the member actually needs. Reserve higher-intensity resources for situations where they can change the outcome.

3. Build One Care Plan Around What Matters to the Member

myPlace Health's PACE model offers a useful lesson for traditional Medicare Advantage plans managing members with overlapping clinical, functional, and social needs.

Rather than beginning with the care team's highest clinical priority, the interdisciplinary team first identifies what matters most to the participant. That could be mobility, food, housing, dentures, family needs, or another immediate concern. The team then builds a coordinated 180-day care plan around that goal.

Rob Schreiber emphasized that coordination also requires disciplined execution: someone owns the follow-through, responsibilities are clear, and checkpoints ensure the team does what it said it would do.

Takeaway: One member should have one coordinated roadmap, not multiple teams pursuing competing priorities. Define the goal, assign ownership, and operationalize the follow-through.

BRIGHT SPOTS VENTURES

4. Give Frontline Teams Permission to Respond to the Person, Not Just the Campaign

Johns Hopkins Health Plans is loosening rigid scripts and checklists in some outreach to give frontline teams greater room to listen and respond to what is happening in a member's life.

Brendan Generelli shared the example of a member whose partner had died three weeks before an outreach call. Her partner had managed the couple's healthcare logistics and transportation. Rather than continue through the intended checklist, the representative spent approximately 30 minutes listening.

The conversation did not immediately close the original care gap, but it surfaced transportation and health-literacy needs and established a relationship that could support future action.

Takeaway: The objective of an interaction can change once the conversation begins. Give frontline teams enough autonomy to recognize when another need should take precedence.

5. Put a Usable Member View in Front of the People Expected to Act

Both Independent Health and MMM Holdings are tackling a common problem: critical member information exists, but the person interacting with the member often has to hunt for it.

At Independent Health, nurses and member-engagement teams previously navigated roughly **12 applications** to understand one member. Its Member 360 capability now organizes clinical conditions, medications, labs, utilization, programs, risk, and other information around the individual, with LLM-generated summaries tailored to different users.

MMM has taken a similar approach with independent physician practices in Puerto Rico. Its **INNOV-A MD Smart Profile** consolidates relevant member information into an actionable view. MMM then extends the model through its **Office Advantage Quality Program**, educating and engaging nurses, front-desk personnel, and other office staff who often play an important role in moving members to action.

Takeaway: Aggregating data is only half the job. Deliver the right information, in a usable form, to the person who can act on it, including the broader provider-office team.

6. Let Member Context and Timing Change the Priority

Prioritization cannot remain static when something meaningful changes in a member's life.

Faulk described a Drips example involving a member with several existing gaps whose emergency department visit created a new, time-sensitive priority. Instead of allowing the existing outreach sequence to continue unchanged, the plan reprioritized around the event and used that moment to address other relevant actions.

In the example shared, addressing care gaps during this “moment of influence” generated **five to seven times more member action** than addressing the follow-up and regular care gaps independently.

Johns Hopkins applies a related principle to resource allocation. Rather than applying the same intervention to everyone with an open gap, it uses historical behavior to identify members who are likely to complete an action themselves versus those who may benefit from additional intervention. Generelli described one targeted approach that increased attributable gap closure from roughly **10% to 25%** among the members targeted.

Takeaway: Use real-time events and historical behavior to decide both **what to ask next and how much effort to invest**. The same open gap does not require the same intervention for every member.

What Health Plan Leaders Can Take Back

The discussion surfaced five practical questions health plans can use to pressure-test their own member-engagement model:

1. **Prioritization:** When one member has several open needs, who decides what should happen first, and are they optimizing for the enterprise or one department?
2. **Diagnosis:** Do we understand *why* the member has not acted before choosing the intervention?
3. **Context:** Can a meaningful change in the member's life alter our outreach priorities in real time?
4. **Enablement:** Does the person interacting with the member have a usable view of what matters, and permission to act on it?
5. **Follow-through:** Once the next action is identified, is someone clearly accountable for making sure it happens?

Bottom Line

The opportunity is not simply to close more gaps. It is to create an operating model capable of deciding **which action matters now, for this member, and what will make that action more likely to happen.**

For Medicare Advantage plans, that means moving from disconnected campaigns toward coordinated decisions: connecting enterprise priorities with member context, timing, and clear operational ownership.

Key Points Made by Each Guest

Kathleen Faulk, Chief Strategy Officer, Drips

- **Prioritize beyond the individual measure.** Evaluate potential actions across Stars, claims impact, and revenue/documentation so departmental priorities do not determine the member journey by default.
- **Let real-time events change the priority.** An ED visit or other meaningful event can create a "moment of influence" when a member is more willing to act; in one example, this approach generated **5–7x more member action on care gaps** than addressing the gaps independently.
- **Build prioritization around "high-potency impact."** Combine what the plan knows about the member with what is happening in the member's life to sequence actions based on enterprise value, relevance, and readiness rather than relying on a static list.

Amin Serehali, SVP & Chief Data and Analytics Officer, Independent Health

- **A gap tells you what happened, not why.** Determine whether the member needs a simple nudge, help overcoming a barrier, or more intensive clinical support before deciding what intervention to deploy.
- **Put the member, rather than the system, at the center of the data.** Independent Health moved from teams navigating roughly **12 applications** to a Member 360 view bringing clinical, pharmacy, utilization, risk, and other information together around the individual.
- **Make the information actionable for different users.** LLM-generated summaries tailor the member picture to the person using it, while clinical input helps prioritize populations based on factors including risk, impactability, and actionability.

Rob Schreiber, MD, VP & National Medical Director of Care Model Strategy, myPlace Health

- **Start with what matters to the member.** In the PACE model, the participant's most important goal, whether clinical, functional, or social, becomes the organizing point for a coordinated 180-day care plan.
- **Make multiple disciplines operate as one team.** Rather than different functions independently pursuing their own objectives, an interdisciplinary team aligns around one participant-centered roadmap.
- **Operationalize the promise.** Coordination requires clear responsibility and checkpoints: if the organization tells a member it will do something, someone must own making sure it actually happens.

Brendan Generelli, Director, Medicare Stars & Quality, Johns Hopkins Health Plans

- **Give frontline teams permission to listen.** Loosening scripts and checklists allows a representative to respond to what is actually happening in a member's life rather than forcing every conversation toward the campaign objective.
- **Invest differently across members with the same gap.** Historical behavior can help identify who is likely to act independently, who may need a nudge, and where higher-intensity intervention is worth the investment.
- **Targeting can materially improve efficiency.** In one example, narrowing outreach to members more likely to benefit increased attributable gap closure from roughly **10% to 25%** among those targeted.

Nilda González, VP Quality Management & Stars, MMM Holdings

- **Make the PCP relationship part of the operating model.** With a largely dual-eligible population and care delivered heavily through independent practices, MMM relies on strong connectivity between the plan, PCPs, and other providers.
- **Give providers a simple, actionable member picture.** INNOV-A MD and its Smart Profile bring relevant information together so practices can quickly understand the member without adding more complexity to already crowded workflows.
- **Don't stop at the physician.** MMM's Office Advantage Quality Program educates and engages nurses, front-desk personnel, and other office staff who often become the critical link between the health plan, physician, and member.