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CCH National Learning Community & Health Equity Learning Collaborative
Pre-Learning Session
Case Study

A Medicare Shared Savings ACO (AnyWhere ACO) has participated in the MSSP program as a one-sided risk model. Beginning in CY2024, the MSSP must move to a two-sided risk model. For the first four years of participation, the MSSP ACO has not generated any shared savings. There are 7,245 Medicare beneficiaries in the MSSP ACO. The ACO is a high-revenue ACO with two participating hospitals in the ACO provider list.

The ACO executive reviewed their prior year's performance and noted the following key data elements:

ACO Patient Population Demographics		
ACO Population	**Age Distribution**	**Race**
• Total Medicare Beneficiaries: 7,324 • ESRD: 160 • Non-Duals: 5,953 • Duals: 1,211 (18.7%)	• 0 – 64: 925 • 65 – 74: 4,562 • 75 – 84: 1,334 • 85+ - 503	• Black - 2,152 • White – 4,196 • Asian – 976
ACO Clinical Quality Measure Outcomes		
• 30-Day Readmission Rate 16.2% • All Unplanned admissions for patients with multiple chronic conditions: 41.23 • Screening for Depression: 91.02 • Remission for depression within 12 months: 0.0% • Diabetes poor control: 15.24 (A1c >9.0%) • Controlling High Blood Pressure 64.32		

After three years of participating in the MSSP ACO program, the ACO leadership recognized that they must do something different to generate shared savings now that they are moving to a two-sided risk model.

The ACO Executive implemented a pilot for health-related social needs (HRSN) screening. The pilot identified that many ACO patients were impacted by the following HRSNs:

- Medication Access
- Food Insecurity
- Transportation
- Housing Insecurity

Medication access and food insecurity were the most prevalent HRSN impacting the ACO population.

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The ACO leadership reviewed Star rating data from the Medicare Advantage program to determine what interventions worked for MA plans. The ACO leadership found a CMS analysis titled, Examining the Potential Effects of Socioeconomic Factors on Star Ratings.

The study found that the following clinical measures have a statistically significant negative effect of being LIS/DE or Disabled:

- Medication Adherence for Diabetes
- Medication Adherence for Hypertension
- Medication Adherence for Cholesterol
- Plan All Cause Readmissions
- Diabetes Control – Blood Sugar Controlled
- Diabetes Care – Kidney Disease monitoring
- Eye Exam
- Rheumatoid Arthritis Management
- Osteoporosis Management

The ACO Medical Director also provided data on people who are dual-eligible found in a March 2023 Fact Sheet released by the CMS Medicare-Medicaid Coordination Office (MMCO). In particular, the ACO Medical Director noted:

> *"These dually eligible individuals experience high rates of chronic illness, with many having long-term care needs and social risk factors…Twenty-seven percent of dually eligible individuals enrolled in Medicare Fee-for-Service have six or more chronic conditions, compared to 15 percent of beneficiaries with Medicare only…Over half of all beneficiaries who are eligible for an MSP are not enrolled."*

The ACO Medical Director also noted that the CMS MMCO March 2020 Fact Sheet provides the following additional information on people who are dual eligible.

> *"Forty-one percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive long-term care services and supports (LTSS), and 60 percent have multiple chronic conditions."*

After reviewing the historical data from CMS and the MMCO and comparing this with the 3-year ACO participation data with the ACO Population Health director, the ACO Medical Director recommends that the ACO leadership deploy targeted interventions to address the needs of their DE and disabled ACO patients. After further research, additional data analysis shows that there is a high percentage of dementia in the population that is 75+.

The ACO Executive and the ACO Medical Director begin participating in learning programs for ACO leaders. The ACO leaders noted that there are online training resources in the CMS 4i System. The ACO Executive participates in a CMMI Value-Based Care webinar produced by Mathematica. During the webinar, the ACO Executive views a presentation that was done by the Administration for Community Living. During the webinar, there is a MSSP ACO and an ACO REACH that contracted with

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local Community Care Hubs (CCHs) to provide services to their members. These examples reflect how providers in APMs are leveraging their relationship with a network of community-based organizations to provide targeted services to their patient population in the ACO.

Following the webinar, the ACO Executive reaches out to a local CCH that they found by emailing the ACL inbox: CommunityCareHubs@acl.hhs.gov.

They link with a CCH called the ADRC CCH. The ADRC CCH has CBO representation that includes the local Area Agency on Aging, Center for Independent Living, United Way, the local area foodbank and meals on wheels program, and other non-profits.

After having an introduction to the resources available through the CCH and completing a retrospective analysis of claims and gaps in care data for ACO members, the ACO leadership identifies the following target populations that they want to work with the CCH to address their needs (based on retrospective analysis of utilization, ACO clinical quality measures, and HEDIS gaps in care data).

They identify LIS/DE/Disabled patients with the following diagnoses:

- Diabetes/Prediabetes
- Heart Failure (All patients regardless of DE status)
- Falls (All patients regardless of DE status)
- Dementia (All patients regardless of DE status)
- Behavioral Health/SUD

The following conditions are identified because of the higher per capita costs for patients with one or more of these conditions:

- Heart Failure
- Falls
- Dementia