

ACO/ICO/CPCI: What do these initiatives have in common? How are they different?

Feature	Commonalities	Differences
Goal	All seek to <u>coordinate</u> care	<p>The degree to which care is <u>integrated</u> across payer and service type:</p> <ul style="list-style-type: none"> • ACO is exclusive to Medicare and Medicare-covered services • ICO seeks to integrate Medicare and Medicaid and the full range of services (primary, preventative, acute, behavioral, pharmacy, LTC) • CPCI seeks to be multi-payer and while it focuses on Medicare services can include Medicaid and commercially-covered primary care services
Aspects of Primary Care Practice Transformation	<p>All seek to achieve primary care practice transformation, with these common attributes:</p> <ul style="list-style-type: none"> • person-centeredness • coordination of care • attention to care transitions • collaboration • emphasis on preventative care interventions • achievement of health outcomes • patient engagement • use of electronic health records • use of data to improve practice performance and achieve health outcomes 	<p>The structure/means through which primary care practice transformation is expected to occur:</p> <ul style="list-style-type: none"> • ACOs must be recognized as legal entities. This may be satisfied either by incorporating a new entity or under certain circumstances using an existing incorporation or other organizational structure. • ICOs would not be required to be recognized as separate legal entities. They may be structured along a continuum from being loosely configured affiliates to arrangements that parallel the requirements established by the ACO Final Rule. • CPCI will work directly with individual primary care practices. Under this model, primary care practices will not be required to affiliate with one another, but may benefit from organizing through some common means of administration (e.g. an Administrative Services Organization, ASO) and/or providing intensive care management (ICM) (e.g. purchasing the service from a centralized entity such as an ASO).
Providers Standards/ Scope of Provider Involvement	All seek to engage primary care providers.	<p>ACO Rule provides extensive standards. ICO standards are not yet established. CPCI focuses upon identified “comprehensive primary care functions”. The degree to which the medical neighborhood will be involved varies:</p> <ul style="list-style-type: none"> • ACO brings together under one structure physicians, APRNs, hospitals, and other providers involved in patient care. • ICO proposes to use as hubs primary care centers or small group practices that are connected to APRNs, specialists, hospitals, pharmacists, behavioral health practitioners, and providers of community-based services and supports (e.g. long-term care) • CPCI focuses on primary care practices but references connections to the medical neighborhood.

Feature	Commonalities	Differences
Means of financing practice transformation (e.g. costs of EHR, expanded hours, care management)	All will continue to utilize Fee-for-Service (FFS) reimbursement. ¹	Use of up-front payments varies: <ul style="list-style-type: none"> • Under ACO, there are only limited up-front payments. • Under ICO, there could be some up-front per member per month (PMPM) payments to providers for costs of care management. The State would be eligible for federal “health home” match (90% Federal Medical Assistance Payment or FMAP) for MMEs who qualify.² • Under CPCI, primary care practices would receive risk adjusted PMPM Medicare payments (expected to be on average, \$20, and initially expected to range from \$8 to \$40) and also if applicable Medicaid payments (reducing on a graduated basis over time).
Means of sharing savings	All seek to share some proportion of savings achieved.	<ul style="list-style-type: none"> • ACOs will enter into agreements with CMS on either a one-sided (shared savings only) or two-sided (both savings and risk are shared) shared savings basis. ACOs will receive payments based on achieving specified results on 33 designated practice measures relating to patient/caregiver experience, care coordination/patient safety, preventative health and at-risk populations. CMS will receive 50 or 40% of total Medicare savings, and ACO share depends on the model. Under the one-sided model, the ACO would be eligible to receive up to a cap of 50% of savings. Under the two-sided model, the ACO would be eligible to receive up to a cap of 60% of savings. Savings would be shared between CMS and ACOs with no savings to State. • Under a FFS-based ICO-type model serving MMEs, CMS proposes to provide the States with retrospective performance payments based on Medicare savings, net of any increases in the federal portion of Medicaid expenditure. The State could then share these savings, net of its up-front care management costs, with providers. • Under CPCI, primary care practices would receive a portion of the Medicare (but not Medicaid) savings that are achieved. Savings would be shared between CMS and the primary care practices based on market-level calculations with no savings to the State.

¹ Note: CMS in its July 8, 2011 letter to State Medicaid Directors referenced two models, one capitated (e.g. PACE, Special Needs Plans), the other FFS-based. Based on low participation in its SNPs, Connecticut has elected through its MME planning process to focus on the FFS-based model.

² To qualify for “health home” FMAP, an individual must have 1) two chronic conditions; 2) one chronic condition and be at risk of developing a second; or 3) a serious and persistent mental health condition. Chronic conditions are defined by Section 1945(h)(2) of the Act to include a mental health condition, a substance use disorder, asthma, diabetes, heart disease or being overweight. CMS has the discretion to expand this list.

