

ACOs, HNs and Health Homes: 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 • HNs will seek to integrate Medicare and Medicaid and the full range of services (primary, preventative, acute, behavioral, pharmacy, long-term services and supports) for all Medicare-Medicaid enrollees age 18+ • Health Homes will seek to integrate Medicaid primary and behavioral health care, and social services, for identified individuals with Serious and Persistent Mental Illness (SPMI)
Aspects of Primary Care Practice Transformation	<p>All seek to support primary care practice transformation, with these common attributes:</p> <ul style="list-style-type: none"> • person-centeredness • coordination of care • attention to care transitions • emphasis on preventative care interventions • achievement of health outcomes • patient engagement • use of electronic health records • use of data to improve practice performance 	<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. • HNs will not be required to be recognized as separate legal entities. Providers will be connected by care coordination contract. • As conceptualized, the Connecticut Health Home model will focus upon existing Local Mental Health Agencies (LMHA) as lead providers.
Providers Standards/ Scope of Provider Involvement	Both ACOs and HNs seek to engage primary care providers.	<p>The ACO Rule provides extensive standards. HNs will require that providers be enrolled in Medicaid and meet standards identified by contract. The degree to which the medical neighborhood is 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. • HNs will use as hubs primary care centers or small group practices that are connected to a broad range of providers, including but not limited specialists, hospitals, pharmacists, behavioral health practitioners, and providers of community-based services and supports (e.g. long-term services and supports). • Health Homes will focus upon incorporating medical supports within the LMHA model.

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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	<p>Use of up-front payments varies:</p> <ul style="list-style-type: none"> • Under the Medicare ACO Shared Savings initiative, there are only limited up-front payments. • Under the Demonstration to Integrate Care for Medicare-Medicaid Enrollees, the State plans to make advance payments to HNs to support formation, and to make PMPM payments for care coordination (the APM II payment). • Under the Health Home model, the State plans to make PMPM payments for care coordination.
Means of sharing savings	Both ACOs and HNs seek to share a 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 the Demonstration, CMS will make retrospective performance payments to participating based on Medicare savings, net of any increases in the federal portion of Medicaid expenditure. The State is proposing to share a portion of these savings, net of its up-front care management costs, with HN providers that achieve identified benchmarks on Demonstration-related performance measures. • The Health Home model does not include a shared savings component.

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. Connecticut has elected through its MME planning process to focus on the FFS-based model.