

ACO/ICO/CPCI Comparison

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Generally, CMS has evidenced intent to focus on a “three-part aim” as follows: 1) **better care for individuals**, evidenced in dimensions of safety, effectiveness, patient-centeredness, timeliness, efficiency and equity; 2) **better health for populations** through public health education on causal factors for poor health and the influence of preventative services; and 3) **lower growth in expenditures**. CMS is making available diverse funding opportunities in support of coordination of care, three of which are contrasted below.

Model	Accountable Care Organization (ACO)	Integrated Care Organization (ICO)	Comprehensive Primary Care Initiative (CPCI)
Description	<p>Under the Shared Savings Program, an ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for a minimum of 5,000 Medicare fee-for-service patients. Only individuals enrolled in original Medicare Parts A & B are permitted to be assigned to an ACO. Individuals who are enrolled in a Part C Medicare Advantage Plan and Programs for All-Inclusive Care (PACE) are not permitted to be assigned to an ACO.</p> <p>Beneficiaries will be assigned based on a preliminary <u>prospective</u> assignment methodology with final retrospective reconciliation based on utilization data demonstrating that the ACO has provided primary care during the performance year. Assignment will be based on where participants choose to receive a plurality of their primary care services during the performance year.</p>	<p>An ICO refers to a group of providers and suppliers of service that has as its hub either a primary care center or a small group practice; and also includes APRNs, specialists, hospitals, pharmacists, behavioral health practitioners, and providers of long-term care; that will work together to coordinate care for individuals who are dually eligible for Medicare and Medicaid (MME's).</p> <p>Enrollment/attribution method to be determined.</p>	<p>Expanding upon the patient-centered medical home (PCMH) concept, CPCI intends to improve the practice of primary care to Medicare beneficiaries and by extension other populations through both "practice transformation" (e.g. holistic, person-centered, integrated, preventative care; characterized by use of electronic health records, care management and access accommodations) and multi-payer payment reform.</p> <p>Beneficiaries will be aligned using a prospective methodology based on the provider from whom they have received the plurality of their primary care in the most recent 24-month period.</p>
Goal	<p>The goal of an ACO is to deliver seamless, high-quality care for Medicare beneficiaries, instead of the fragmented care that often results from a fee-for-service payment system. ACOs will be patient-centered organizations within which patients and providers are partners in care decisions.</p>	<p>Connecticut's ICO goal is to “create a person-centered system of care that enhances quality, cost-effectiveness and experience of care for dually eligible individuals in Connecticut by creating a single point of accountability for the delivery of medical and non-medical support services across the continuum of care.”</p>	<p>The CPCI "will seek to strengthen free-standing primary care capacity by testing a model for comprehensive, accountable primary care supported by multiple payers".</p>

Model	Accountable Care Organization (ACO)	Integrated Care Organization (ICO)	Comprehensive Primary Care Initiative (CPCI)
Structure	<p>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. The following may qualify: ACO professionals in group practice arrangements; networks of individual practices of ACO professionals; partnerships or joint venture arrangements between hospitals and ACO professionals; hospitals employing ACO professionals [e.g. physicians, physician assistants, nurse practitioners, or clinical nurse specialists]; and Critical Access Hospitals (CAHs) billing under method II, Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).</p>	<p>ICOs are not required to be recognized as separate legal entities. They may either:</p> <ul style="list-style-type: none"> • follow the ACO structural model; or • be loosely configured affiliates. 	<p>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 providing intensive care management (ICM).</p>
Additional Detail	<p>The Rule identifies the following elements as key to achieving a “three-part aim” of achieving better care for individuals, better health for populations and lower growth in expenditures:</p> <ul style="list-style-type: none"> • person-centeredness • coordination of care; • attentiveness to care transitions; • efficiency, waste reduction and a focus on use of internal resources and preventative interventions, • prompt and regular communication with patients; • use of data to improve care delivery and outcomes; • innovation; and • staff skill-building. 	<p>Connecticut’s stated objectives include:</p> <ul style="list-style-type: none"> • promoting practical strategies for person-centered care; • facilitating collaboration across the care continuum; • offering access to a seamless continuum of services; • leveraging health information technology/ electronic data; • focusing on achievement of medical service outcomes and the effectiveness of home and community-based services; • aligning financial incentives to promote value (quality, cost-effectiveness); and • establishing a financial model that rewards performance and incentivizes enhanced quality of care. 	<p>The CMS solicitation identifies five core functions of primary care that will be evaluated in assessing practice transformation:</p> <ul style="list-style-type: none"> • risk-stratified care management; • access and continuity; • planned care for chronic conditions and preventive care; • patient and caregiver engagement; and • coordination of care across the "medical neighborhood". <p>CMS will be looking at such factors as current use of "non-fee-for-service support" to primary care practices, past success with practice transformation, capacity for data sharing, use of common quality metrics and experience with multi-payer/multi-stakeholder initiatives.</p>

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Reimbursement Description	<ul style="list-style-type: none"> • Payments for service will continue to be made on a fee-for-service basis. • Additionally, ACOs will enter into agreements with CMS on either a one-sided or two-sided (in which risk is shared) sharing savings basis and will receive payments based on achieving specified results on practice measures relating to patient/caregiver experience, care coordination/patient safety, preventative health and at-risk populations. • Savings are shared between CMS and ACOs. 	<ul style="list-style-type: none"> • Payments for service will continue to be made on a fee-for-service basis. • ICOs will receive per member per month payments (PMPM) for some or all participants • Additionally, ICOs will enter into agreements in which they will share in net savings that will be calculated as follows: <div style="text-align: center;"> <table> <tr> <td>Medicare A&B – increased</td> <td>Medicaid = shared</td> <td></td> </tr> <tr> <td>Savings</td> <td>costs</td> <td>savings</td> </tr> </table> </div> • Savings are shared by CMS, DSS and ICOs. 	Medicare A&B – increased	Medicaid = shared		Savings	costs	savings	<ul style="list-style-type: none"> • Payments for service will continue to be made on a fee-for-service basis. • Additionally, primary care practices will receive \$8 - \$20 per member per month (PMPM) Medicare and also if applicable Medicaid payments. • Primary care practices will also receive a portion of the Medicare savings that are achieved. • Savings are shared between CMS and the primary care practices.
Medicare A&B – increased	Medicaid = shared								
Savings	costs	savings							
Shared Savings Split	<p>CMS receives 50 or 40% of total Medicare savings, and depending on model:</p> <ul style="list-style-type: none"> • One-sided model: ACO is eligible to receive up to a cap of 50% of savings • Two-sided model: ACO is eligible to receive up to a cap of 60% of savings 	<ul style="list-style-type: none"> • CMS receives 50% of the net savings and the ICO splits the remaining 50% of the net savings with DSS 	<ul style="list-style-type: none"> • Primary care practices share Medicare savings with CMS, based on market-level calculations. 						

Acronyms:

ACO Accountable Care Organization
CAHs Critical Access Hospitals
CHCs Community Health Centers
CMS Centers for Medicare & Medicaid Services
DSH Disproportionate Share Hospital
EHR Electronic Health Record
FFS Fee-for-service
FQHCs Federally Qualified Health Centers
HCAHPS Hospital Consumer Assessment of Health care Provider and Systems
HIT Health Information Technology
ICM Intensive Care Management
LTCHs Long-Term Acute Care Hospitals

MA Medicare Advantage
MAPCP Multipayer Advanced Primary Care Practice
MMEs CMS' preferred term for individuals who are dually-eligible for Medicare and Medicaid
NCQA National Committee for Quality Assurance
PACE Program of All Inclusive Care for the Elderly
PACFs Post-Acute Care Facilities
PCMH Patient Centered Medical Home
PGP Physician Group Practice
RFI Request for Information
RHCs Rural Health Clinics
SNFs Skilled Nursing Facilities
SPMI Severe and Persistent Mental Illness