AMERICAN ACADEMY OF FAMILY PHYSICIANS

Side-by-Side Comparison of Accountable Care Organizations (ACOs) and Clinically Integrated Networks (CINs)

ACOs and CINs allow physicians and other providers to come together to improve care and reduce cost across the medical neighborhood. These relationships promote a new approach to health care quality, finances, and delivery. The models have many similarities, but they also have notable differences.

	ACO	CIN
Definition	• An accountable care organization (ACO) is a group of health care providers who agree to share responsibility for the quality, cost, and coordination of care (with aligned incentives) for a defined population of patients. • An ACO is focused on improving care for an entire patient population.	• A clinically integrated network (CIN) is an arrangement (typically a separate legal organization) that is usually sponsored by an independent physician/practice association (IPA) or a hospital. • CINs are led by physicians seeking to assemble the resources needed to effectively manage care for defined patient populations. • The focus of a CIN is collaboration among different health care providers and sites to ensure high-quality, coordinated, efficient services for patients.
Origin of Model	• On October 20, 2011, the U.S. Department of Health and Human Services (HHS) announced two initiatives to provide new incentives for providers to work together through ACOs: the Medicare Shared Savings Program (MSSP) and the Advanced Payment Model. These initiatives were just two of several efforts to improve the quality and coordination of health care and to lower cost that were made possible by the Patient Protection and Affordable Care Act (ACA). • Additional ACO programs have been piloted through the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI), as well as by private payers. • In April 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a pathway of alternative payment models (APMs). It specifically names several ACO models that will qualify as APMs: – MSSP – Demonstrations under the Medicare Health Care Quality (MHCQ) Demonstration Programs – Other models under the CMMI, with the exception of Health Care Innovation Award recipients – Demonstration required by federal law	• From the 1980s through the mid-1990s, the health care industry undertook efforts to control cost. Two structures emerged from the health maintenance organization era: physician-hospital organizations (PHOs) and IPAs. Both entities had to worry about federal antitrust laws and lacked collective bargaining power beyond the messenger model. • Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the U.S. Department of Health and Human Services (HHS) published a final rule protecting eligible individuals and entities that provide electronic health record (EHR) items and services to eligible recipients from being subject to the anti-kickback law as long as the requirements of the "safe harbor" are satisfied. • In 2007, the Federal Trade Commission (FTC) issued a staff advisory opinion letter regarding the Greater Rochester Independent Practice Association's plan to integrate its network members to create additional efficiencies in the local health care market. The FTC found that the programs proposed by the Greater Rochester IPA were integrated and would not likely have an anticompetitive impact on the market. This ruling provided some protection from antitrust concerns. • The Patient Protection and Affordable Care Act (ACA) laid the groundwork for innovative approaches to health care delivery. This gave both federal and commercial insurers impetus to improve quality and lower cost by altering the incentives in their payment methods. • In April 2015, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a pathway of alternative payment models (APMs) that corresponds to higher levels of clinical integration in order to move to value-based payments.

continued

	ACO	CIN
Advantages	• An ACO promotes health information exchange that allows providers to communicate with other organizations that are assisting in care coordination. • Shared risk means shared responsibility that defrays cost for all members. • Joining other health care providers casts a wider net for data aggregation, which can lead to better population health. • Patients who have access to care planning liaisons receive more comprehensive care and, theoretically, receive more tailored services since providers will only be reimbursed for necessary tests and procedures. • Payers, including the federal government, continue to provide technical assistance to ACOs to improve quality of care and reduce cost. • The physician becomes a partner in the patient's health care decisions. • An ACO that meets quality performance standards is eligible to receive care management fees and/or a share of any savings it achieves (i.e., a share of the amount by which its expenditures are below the benchmark expenditure level). • For process improvement initiatives, external entities have few requirements for the practice style of the independent provider; however, there may be internal incentives or requirements.	• A CIN can provide an antitrust "safe harbor" for physicians who jointly invest in performance improvement. This is a key benefit of a CIN and the **most significant difference** between a CIN and an ACO. • A CIN can share electronic health records. • A standard set of performance and quality metrics for all participating physicians creates workflow alignment. • Care is coordinated across the medical neighborhood, with a focus on care transitions for which savings can be realized more quickly. • A CIN is information technology (IT) intensive because it uses analytic technology to identify utilization trends in services. This supports the development of evidenced-based protocols for care. • Participants receive compensation for population health management activities that are aligned with CIN initiatives. • A CIN's revenue cycle supports the introduction of new methods to help physicians comply with new rules within the Centers for Medicare & Medicaid Services (CMS) Prospective Payment System (PPS). • As a CIN evolves from basic performance management to the focus on value-based purchasing goals, risk-based contracts may be designed to meet the specific population's needs.
Disadvantages	• Legal issues surrounding the Stark law, the anti-kickback law, and antitrust laws are a greater concern for ACOs. • Information technology (IT) infrastructure required for a robust ACO is expensive. • In the MSSP model, Medicare beneficiaries are not bound to seek care within the ACO. When beneficiaries seek care outside of the ACO, cost and quality are not within the organization's control. In a commercial model, beneficiaries choose from a narrower network of providers, which may make this less of a concern. • Shared risk is also shared decision making across a network of practices, each of which has its own individual priorities and vision. • Benchmarks help provide a foundation for an ACO to deliver high-quality, cost-effective care. However, it is not always possible to anticipate regional variations that will impact spending.	• A CIN has high network development costs. • Attention to community health needs is improved, but new risks are created as physicians' roles and degree of authority change because freedom of choice is restricted. • A CIN requires collaborative working relationships and a high level of trust, so it may take time for a network to develop. • A CIN is a newer model, so it may be more difficult to find a local or regional attorney who has the expertise to set one up.
Small Practice Versus Large (System-owned) Practice	**Advantages for a small practice:** • Joining an ACO can help improve functionality and profitability. Examples of benefits include funding of the electronic health record (EHR), quality improvement resources, and care coordination from well-financed partners. **Disadvantages for a small practice:** • Many small practices do not have infrastructure or resources available. When a small practice joins an ACO, it must meet the same standards as the group's larger providers. It may be harder for small practices to realize a positive return on investment. **Advantages for a large practice:** • Joining an ACO creates a partnership with other practices that serves as the risk-bearing organization. This organization will negotiate contracts for the physician-owned practices. **Disadvantages for a large practice:** • Shared risk is also shared decision making, which may pose challenges to ensuring that shared savings are achieved.	**Advantages for a small practice:** • A CIN allows for the organization of different health care providers and sites (e.g., hospitals) to form a single network with a focus on performance improvement. Primary care physician leaders work closely with hospital administrators to craft a vision and strategy for population management. This relationship provides clear, tangible benefits for all stakeholders, particularly small practices. **Disadvantages for a small practice:** • A small practice may not have the internal staff to monitor quality and cost. Staff may be assigned to tasks and functions for which they have never been responsible. • Success will be limited without a positive relationship between the small practice and the hospital. **Advantages for a large practice:** • A large practice may have support resources available to monitor cost and quality, as well as the capability to utilize care management staff to address the needs of high-risk patients. • Physician leaders may work with internal colleagues to derive solutions for effective population health management. **Disadvantages for a large practice:** • Without strong physician leadership at all levels, success will be limited.

	ACO	CIN
Cash Flow	• An ACO within the MSSP can receive payment for meeting quality metrics and reducing cost. • In each performance year, CMS determines whether the estimated average per capita Medicare expenditures in an ACO are above or below the benchmark. A three-month claims run out with a completion factor is utilized to calculate expenditures for each performance year.	• The purpose of a CIN is to provide quality care. The network is rewarded if it demonstrates value (i.e., the highest quality at the lowest cost). The CIN can contract with payers, employers, or health systems. • If shared savings is achieved or a bonus is earned, the timing of payment varies by line of business.
Payment	• In the MSSP, CMS has developed benchmarks for each ACO against which its performance is measured to assess whether it qualifies to receive shared savings or–if it is an ACO that has elected to accept responsibility for losses–may be held accountable for losses. • Issues exist with patient attribution, risk adjustment, and year-to-year variation. • The ACO can partner with commercial payers to align care delivery with new incentives.	• With a focus on improving quality and lowering cost, a CIN can attract physicians who may be rewarded by payers through a higher physician fee schedule and/or through pay-for-performance incentives. • All issues with incentives and payment that exist in an ACO potentially exist in a CIN.

AMERICAN ACADEMY OF
FAMILY PHYSICIANS