Innovation Center's Pioneer Accountable Care Organization (ACO) Program

Overview

Last summer, the Innovation Center announced the creation of the Pioneer ACO Program. This model was designed for healthcare organizations that already have experience in coordinating care for patients across care settings. The Pioneer ACO Program is separate from, but parallel to, the Medicare Shared Savings Program (MSSP).

Although the Pioneer ACO Program is separate from the MSSP, the two programs share some common elements. The chart below compares elements of the Medicare Shared Savings Program to the Pioneer ACO Program.

Program Element	MSSP	Pioneer ACO
Eligible Participants	The following ACO participants or combinations of ACO participants are eligible to form an ACO: (1) ACO professionals in group practice arrangements; (2) Networks of individual practices of ACO professionals; (3) Partnerships or joint venture arrangements between hospitals and ACO professionals; (4) Hospitals employing ACO professionals; (5) Critical Access Hospitals that bill under Method II; (6) Rural Health Clinics (RHC); and (7) Federally Qualified Health Centers (FQHCs).[1] In addition, any Medicare enrolled entity can	On December 19, 2011, the Innovation Center announced the selection of 32 Pioneer ACO participants.

[1] ACO Final Rule, Eligible Providers and Suppliers, 42 C.F.R. § 425.102(a).

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	participate as an ACO participant by joining an ACO formed by one of the entities listed above.[2] For purposes of the MSSP, a hospital is a subsection (d) - i.e., prospective payment system (PPS) - hospital.[3]	
Length of Agreement	In general, in order to participate, an ACO must enter into a participation agreement for at least three years.[4] For applications that are approved, the start date will be one of the following: (1) April 1, 2012 (term of the agreement is 3 years and 9 months); (2) July 1, 2012 (term of the agreement is 3 years and 6 months); and (3) January 1 of 2013 and subsequent years (term of agreement is 3 years).	Three one-year performance periods, beginning January 1, 2012.[5] CMS may use its discretion to offer Pioneer ACOs an extension of their agreement for two additional performance periods.[6]
Timing of Beneficiary Assignment	Preliminary prospective assignment. Under this model, CMS will create a list of beneficiaries likely to receive care from the ACO based on primary care utilization during the most recent periods for which adequate data are available and will provide this list to the ACO. During the performance year, CMS will update this list	Prospective assignment. Under this model, beneficiaries that are aligned with a Pioneer ACO are identified prior to the start of a performance year on the basis of their historical utilization. In general, a beneficiary is aligned with a Pioneer ACO if the beneficiary received the largest amount of primary care services (or in certain

[2] ACO Final Rule, Eligible Providers and Suppliers, 42 C.F.R. § 425.102(b).

[3] Affordable Care Act, § 3022(h)(2).

[4] ACO Final Rule, Agreement with CMS, 42 C.F.R. § 425.200(a).

[5] CMS Innovation Center, Alternative Payment Arrangements for the Pioneer ACO Model, *available at* http://innovations.cms.gov/documents/pdf/PioneerACO-AlternativePaymentArrangements_12_19_11.pdf (accessed Jan. 13, 2012).

[6] CMS Innovation Center, Alternative Payment Arrangements for the Pioneer ACO Model, *available at* http://innovations.cms.gov/documents/pdf/PioneerACO-AlternativePaymentArrangements_12_19_11.pdf (accessed Jan. 13, 2012).

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	periodically on a rolling basis to allow the ACO to adjust to changes in its assigned population. At the end of each performance year, CMS will reconcile the list to reflect beneficiaries who actually meet the criteria for assignment to the ACO during the performance year. Determinations of savings and losses will be based on this final, reconciled population.[7]	circumstances, specialty care services) from physicians and other practitioners that are affiliated with the Pioneer ACO compared to other providers.[8]
Minimum Number of Beneficiaries	The ACO must have at least 5,000 assigned beneficiaries.[9]	In general, Pioneer ACOs must have a minimum of 15,000 assigned beneficiaries.[10]
Definition of PCP	In the definitions section, the final rule defines primary care providers (PCP) as physicians with a specialty designation of internal medicine, general practice, family practice, or geriatric medicine.[11] For services furnished in an FQHC or RHC, a primary care provider is defined as a physician who directly provides primary care services in a FQHC or RHC that is an ACO participant and/or ACO provider/supplier and is included in an attestation by an ACO that includes an FQHC or RHC.[12]	The definition of PCP in this program mirrors that of the MSSP, but is expanded to include nurse practitioners and physician assistants.[13]
Payment	Two payment model tracks. Track One permits ACOs	CMS has indicated that it is interested in testing

[7] ACO Final Rule, Prospective vs. Retrospective Beneficiary Assignment to Calculate Eligibility for Shared Savings, at 233-34.

[8] CMS Innovation Center, Pioneer ACO Alignment and Financial Reconciliation Methods, at 4 (Nov. 21, 2011).

[9] ACO Final Rule, Number of ACO Professionals and Beneficiaries, 42 C.F.R. § 425.110(a)(1).

[10] Pioneer ACO RFA, at 21.

[11] ACO Final Rule, Definitions, 42 C.F.R. § 425.20.

[12] ACO Final Rule, Special assignment conditions for ACOs including FQHCs and RHCs, 42 C.F.R. § 425.404; Definitions, § 425.20.

[13] Pioneer ACO RFA, at 6.

Program Element	MSSP	Pioneer ACO
Methodologies	to share in the savings they achieve but would not hold ACOs responsible for losses (spending in excess of the ACO's established benchmark). Track Two allows ACOs to share in the savings they achieve but also includes a "downside risk" component that holds ACOs accountable for failing to achieve savings as compared to their benchmarks.[14] In Track One, the ACO may share in up to 50 percent of the savings, based upon quality performance. In Track Two, the ACO may share in up to 60 percent based on quality performance. Track Two ACOs may share in losses equal to one minus the final shared savings rate applied to first dollar savings once the minimum loss rate is exceeded. Shared losses may not exceed 60 percent.	alternative payment arrangements that: include escalating levels of financial accountability through successive performance periods; provide a transition from fee-for-service to population-based payment (partially capitated or capitated payment); and is projected to generate savings for Medicare. The specific payment arrangement for a Pioneer ACO will be negotiated in the ACO's contract with CMS.[15]
Repaying Losses	An ACO must have the ability to repay losses for which it may be liable.[16] As part of the application for the ACO program, certain ACOs with April or July start dates and Track Two ACOs regardless of start date will be required to submit information to CMS for approval documenting that they are capable of repaying losses or other monies determined to be owed.[17] The documentation must support the adequacy of the mechanism for repaying losses or other monies equal to at least one percent of the ACO's total per capita Medicare Parts A and B FFS expenditures for its	Pioneer applicants must include a letter for commitment to ensure that the Pioneer ACO is able to reimburse Medicare for shared losses incurred and to repay any payments it may receive in excess of shared savings it earns. The Pioneer ACO is required to provide "enforceable assurances" that it can reimburse Medicare for all potential losses. ACOs are permitted to propose different levels of risk sharing that would determine the amount of potential losses that must be guaranteed by the ACO.[20]

[14] ACO Final Rule, at 67,805.

[15] Pioneer ACO RFA, at 7-10.

[16] ACO Final Rule, Content of the Application, 42 C.F.R. § 425.204(f).

[17] ACO Final Rule, Content of the Application, 42 C.F.R. § 425.204(f)(1)(i).

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	assigned beneficiaries based on expenditures for the most recent performance year or expenditures used to establish the ACO's benchmark.[18] An ACO may demonstrate its ability to repay losses by obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing a line of credit, or establishing another appropriate repayment mechanism that will ensure its ability to repay the Medicare program.[19]	
Requirements Relating to other Payers	None at this time.	CMS states that Pioneer ACOs must commit to entering outcomes-based contracts with other purchasers. The majority of the ACO's total revenues must be derived from such arrangements by the end of the second performance period (December 2013). Outcomes-based contracts are described as those that: (1) include financial accountability (shared savings and/or financial risk); (2) evaluate patient experiences of care; and (3) include substantial quality performance incentives.
Quality Measures	CMS establishes quality performance measures to assess the quality of care furnished by the ACO.[21] The final rule contains 33 quality measures, grouped into four quality domains:	Quality performance measures mirror the final regulations implementing the MSSP.[25]

[20] Pioneer ACO RFA, at 23.

[18] ACO Final Rule, Content of the Application, 42 C.F.R. § 425.204(f)(1)(ii).

[19] ACO Final Rule, Content of the Application, 42 C.F.R. § 425.204(f)(2).

[21] ACO Final Rule, Measures to Assess the Quality of Care Furnished by an ACO, 42 C.F.R. § 425.500(a).

[25] Pioneer ACO RFA, at 17-18.

Program Element	MSSP	Pioneer ACO
	• Patient/Caregiver Experience • Care Coordination/Patient Safety • Preventive Health • At Risk Populations (diabetes, hypertension, ischemic vascular disease, heart failure and coronary artery disease) The complete set of final measures appears in Table 1 of the rule.[22] In the preamble, the agency states that this measure set will be the starting point for ACO measures as those in future reporting cycles will be modified to reflect changes in practice and quality of care improvement and to continue aligning the measures with other Medicare quality programs.[23] Failure to report quality measure data accurately, completely, and timely may result in sanctions against the ACO, including termination from the program.[24]	

[22] ACO Final Rule, Quality and Other Reporting Requirements, at 324-326.

[23] ACO Final Rule, Quality and Other Reporting Requirements, at 327.

[24] ACO Final Rule, Measures to assess the quality of care furnished by an ACO, 42 C.F.R. § 425.500(f).