“Ineffective” and “unsustainable” are two words frequently used to describe the way health care is paid for in the United States. It has long been recognized that fee for service (FFS), the dominant form of payment, encourages a “do more, get more” approach to practicing medicine, and there have been numerous attempts over more than three decades to control volume through reforms to payment systems. Within Medicare, these include the implementation of the Medicare inpatient prospective payment system (IPPS) in the early 1980s, the adoption of spending targets for physician services through the sustainable growth rate (SGR), and the development of prospective payment systems for home health and skilled nursing facilities. The Centers for Medicare & Medicaid Services (CMS) has also used its demonstration authority to test various pay-for-performance arrangements. In some of these arrangements, providers retain a portion of the “savings” that accrue to the Medicare program when quality targets are met and volume and costs are reduced. In the private sector, California insurers were early adopters of extending capitation to providers as a way to create incentives to manage service volume.

The Patient Protection and Affordable Care Act (ACA) of 2010 introduced yet another variation of payment reform aimed at reducing cost growth in Medicare by encouraging providers to form accountable care organizations (ACOs) that would be responsible for the cost and quality of care for a defined population. CMS expected that ACOs would be formed by a variety of different organizations such as integrated delivery systems (IDSs) and physician-led independent practice associations (IPAs), and also through collaborations between hospitals and groups of physicians. Two ACO programs have been implemented: the Medicare Shared Savings Program (MSSP), a permanent part of the Medicare program
under the ACA, and the Pioneer ACO Model, a demonstration conducted by the Center for Medicare & Medicaid Innovation (CMMI). The Pioneer ACO Model, which got under way first, was aimed at organizations with “experience offering coordinated, patient-centered care, and [already] operating in ACO-like arrangements.”

The goal for both ACO programs is to encourage providers to transform the organization and delivery of care in order to reduce unnecessary services, prevent avoidable hospital admissions and readmissions, and coordinate care while meeting quality benchmarks. Although the details differ, both programs allow providers to share in a portion of the savings to Medicare ostensibly made possible by transformed practice. Both programs also include the potential for sharing losses, meaning the ACO must write a check to Medicare if spending growth for attributed Medicare beneficiaries exceeds spending growth for similar Medicare beneficiaries in fee for service. Pioneer ACOs, however, are subject to higher levels of reward and risk than MSSP ACOs. A unique feature of the Pioneer program is that if a Pioneer ACO achieves shared savings in program year (PY) 1 and 2, then that ACO is eligible to move a substantial portion of its payments to a population-based or global budget model in PY3.

### KEY PROGRAM ELEMENTS OF THE PIONEER ACO MODEL

**Beneficiary attribution** — Under the Pioneer model, ACOs are responsible for a minimum of 15,000 Medicare beneficiaries in urban areas; the minimum is 5,000 for ACOs operating in rural areas. CMS prospectively assigns or attributes beneficiaries to an ACO based on “the health care providers that choose to participate.” Those beneficiaries receiving the “plurality” of their primary care services from an ACO’s participating primary care providers are attributed to that ACO. In the absence of significant use of primary care, beneficiaries can also be assigned based on their use of participating specialists. Individuals dually eligible for both Medicare and Medicaid are not excluded. Beneficiaries are notified by the ACO that their physician is participating in the program but are assured that they can still choose any doctor or hospital for their care. If beneficiaries do not want CMS to share information about their care with the ACO, they must complete a form to opt out of information sharing.

**Spending targets** — Savings are determined by comparing Medicare spending for an ACO’s population with projected spending or a benchmark. The benchmark is the baseline spending (calculated...
using data from the three years prior to the start of the program) for the ACO’s population, adjusted for growth in spending for all traditional Medicare beneficiaries from the same baseline period to the current period. The adjustment is designed as a 50-50 blend of an absolute dollar increase and a percentage growth rate. This is a middle ground to encourage participation by ACOs in both high- and low-cost areas; an adjustment based solely on an absolute dollar figure would be more favorable for ACOs in low-cost areas, while an adjustment based solely on a percentage growth rate would be more favorable for ACOs in high-cost areas.

**Quality reporting** — All Pioneer ACOs are required to report on 33 quality measures grouped into four domains: patient experience of care, care coordination/patient safety, preventive health, and at-risk populations. ACOs were eligible to receive quality bonuses in PY1 simply for reporting on quality measures; payments in PY2 and later will be tied to performance on the measures.

**Contracting** — To encourage a commitment to a “business model based on financial and performance accountability,” a Pioneer ACO is required by the end of PY2 to have at least 50 percent of its revenue derived from similar contracts with other payers, such as commercial insurers, employers, and Medicaid.

**FIRST-YEAR EXPERIENCE**

CMS announced its selection of Pioneer ACOs on December 19, 2011, with the first performance period set to begin January 1, 2012. Of the 32 organizations selected, 15 were described as an IDS; 12 were IPAs or a combination of an IPA and a medical group(s); and the remaining 5 were a partnership between a health system and an IPA or medical practices. All together, the Pioneer ACOs were responsible for about 670,000 Medicare beneficiaries.

CMS reported that 18 of the 32 ACOs lowered costs in PY1, but only 13 achieved savings that were large enough to allow them to receive a share of those savings. These 13 ACOs generated $87.6 million in total savings with a net to Medicare of about $33 million. (An independent evaluation of the Pioneer ACOs, which compared spending with local FFS comparison groups rather than a national benchmark, reported more favorable results of an estimated $146.9 million in savings to the Medicare program.) Four ACOs accounted for $57 million or 65 percent of the total savings. With quality reporting adjustments included, the Pioneer ACOs earned over $76 million in PY1.
Spending did not significantly exceed projected targets for 12 of the 14 that did not achieve savings. Only two ACOs were required to repay Medicare a share of the excess spending, to the tune of about $4 million. Even with spending exceeding the target at 14 ACOs, as a whole the Pioneer ACOs kept their overall rate of cost growth to less than half of that for similar Medicare beneficiaries not in ACOs (0.3 percent versus 0.8 percent).9

All of the ACOs reported on quality measures, and all outperformed FFS Medicare on clinical quality measures for which there are comparable data. Over three-quarters of the Pioneer ACOs had lower risk-adjusted hospital readmission rates for their aligned beneficiaries than the benchmark rate for FFS beneficiaries. The ACOs also outperformed their comparison groups on measures of blood pressure control and cholesterol control for diabetic patients.10

At the end of the first year, nine Pioneers dropped out of the program, with seven choosing to switch their participation to the MSSP.11 Two left Medicare ACO programs all together. Of those switching to the MSSP program, five were IPAs, one was an IDS and one was an alliance between a hospital system and medical groups. Of those who left Medicare ACO programs entirely, one was an IDS and the other was a health system-IPA collaboration. Although second-year results have not yet been reported, some of the remaining 23 Pioneers have already announced that they will either leave the program or switch to the MSSP.

**CHALLENGES**

Published reports and conversations with individual Pioneer ACOs suggest that there are a number of challenges these organizations face. Some center on what might be called short-term implementation issues, such as the complexity of the methodologies used to attribute beneficiaries to the ACO or create the baselines and benchmarks against which the Pioneer ACOs’ financial performance is measured.12 Concerns have been raised, for example, about the ability of efficient providers to achieve savings as baselines are recalculated in future years,13 and about data lags that make it difficult for Pioneers to closely monitor their performance.

There are also larger issues that may make it challenging for ACOs to achieve shared savings and sustain their participation in the program over the long run. Criticisms of the attribution methodology aside, there is a larger concern about the ACOs’ ability to engage
beneficiaries in ways that lead to better care and lower costs. Today, beneficiaries have no financial incentive to receive their care from the ACOs’ providers. Preserving beneficiaries’ prerogative to seek care wherever they prefer was a key element of the original design, but one that has been questioned by Pioneer ACOs and outside experts alike. Some Pioneer ACOs have noted that they would prefer an enrollment methodology and the ability to offer financial incentives, such as reduced co-payments, to encourage beneficiaries to seek care from the ACOs’ providers. Leakage—the term used to describe the amount of care received outside the ACO—is very high, with some ACOs reporting that as much as 50 percent of care is received from non-aligned providers. The problem of leakage is exacerbated by the inability of some Pioneer ACOs to track when and where their patients receive care. The absence of a health information exchange function, whether performed at the local level or by CMS, is viewed as a serious impediment to managing a patient’s care and its associated costs.

Another major question is the ability of these ACOs to generate shared savings sufficient to cover the costs of generating those savings. Developing robust information technology systems, redesigning clinical practice, and expanding intensive care management capacity, for example, are resource-intensive activities. Relatively few Pioneer ACOs are believed to have achieved a level of shared savings sufficient to cover these infrastructure costs. Pioneer ACOs are also challenged to generate enough shared savings to give participating providers rewards that are large enough to make up for the net income they lose by reducing volume and unnecessary services. This is particularly an issue for inpatient revenue, which is where utilization tends to be reduced as a result of better population health management. Primary care services, in contrast, may actually increase. Nevertheless, some worry that physicians may not be sufficiently motivated to participate, and that some who do sign up will fail to comply with time-consuming quality reporting and other requirements.

While these challenges are considerable, it should be noted that throughout the implementation process, CMMI has worked closely with the Pioneer ACOs to address their questions and concerns. Responses to a CMMI Request for Information (RFI) about the evolution of ACO initiatives, which were due March 1, 2014, are likely to provide valuable feedback from Pioneer ACOs and may form the basis for program modifications going forward. It is also important to remember that, overall, the program has been successful in achieving
savings to the Medicare program. Perhaps more importantly, the Pioneer ACO program has helped some participating organizations and systems transform their care delivery processes in ways that are likely to have positive effects on cost and quality well into the future. Some also believe that Pioneer ACOs’ experiences will give them a leg up in adapting to future payment systems that move away from FFS toward value- or population-based payment approaches.

SESSION

This Forum session featured representatives from two Pioneer ACOs: Stuart Lockman, JD, president of the Michigan Pioneer ACO in Detroit, and Susan Thompson, MS, president and chief executive officer of UnityPoint Health in Ft. Dodge, Iowa. Each spoke briefly describe the market in which their ACO operates, discussed their successes and challenges in implementing the Pioneer ACO model, and reflected on what their shared savings program experiences suggest about the journey from FFS to more population-based payment. Hoangmai Pham, MD, MPH, director of the Seamless Care Models Group at the Center for Medicare and Medicaid Innovation also provided commentary.

KEY QUESTIONS

• What are some of the major reasons organizations opt to become a Pioneer ACO?

• What types of care coordination activities did organizations have in place before becoming a Pioneer ACO? What has been added or changed since then? How significant were start-up costs to put new coordination activities into place?

• How are ACOs tracking beneficiary utilization, and what tools might they use to potentially intervene to coordinate care?

• What payers, other than Medicare, use population-based payment? Did Pioneer ACOs have experience with population-based payment from other payers prior to applying to become an ACO?

• What has been the experience obtaining physician buy-in? Do physicians typically receive a share of any savings that are accrued?

• Data lags have made it difficult for Pioneer ACOs to know how they are performing financially. Does this uncertainty jeopardize future participation?
What does the experience of the Pioneer ACOs suggest about how to move forward with population-based payment in Medicare?

ENDNOTES


6. Thresholds have been established for both savings and losses to avoid payments or repayments that likely reflect random variation in spending.


11. One of the seven switching to the MSSP program achieved shared savings as a Pioneer ACO.


