Pioneer ACO Model Saves $384 Million

HHS Evaluation Report for Performance Years 1-2 and Certification Memo

On May 4, 2015 the Department of Health and Human Services (“HHS”) released an independent evaluation report demonstrating that a payment model created as a pilot project by the Affordable Care Act generated significant savings to Medicare over a two year period. Additionally, the Office of the Actuary in the Centers for Medicare & Medicaid Services (“CMS”) has certified that this patient care model is the first to meet the strict statutory criteria for expansion to a larger population of Medicare beneficiaries.

I. Background

Currently, Accountable Care Organizations can participate in the Medicare Shared Savings Program (“MSSP”). The Affordable Care Act directed CMS to implement the MSSP Accountable Care Organization (“ACO”) program to create incentives for providers to improve the quality and cost of care delivered to Medicare fee-for-service beneficiaries. The MSSP contains two tracks: track 1 is a sharing-only arrangement, while track 2 puts providers at risk for increased costs. Congress also established the Center for Medicare and Medicaid Innovation (“CMMI”) within CMS to test innovative payment techniques and service delivery models. CMMI consequently developed the Pioneer ACO Model to test whether alternative design elements might enhance ACO effectiveness and ultimately inform policy changes to improve the MSSP by means of future rulemaking. The Pioneer ACO Model began on January 1, 2012 and is currently authorized through 2016.

Under Medicare’s payment rules for the Pioneer ACO Model, providers continue to be paid Medicare fee-for-service rates for providing services. The Pioneer ACO can earn payments for achieving savings or may have to pay money back to Medicare if it experiences losses outside of a specified corridor. Savings and losses under the payment formula are calculated with the goal of establishing an incentive to reduce spending compared to a benchmark.

According to HHS, the Pioneer ACO Model offers providers a greater transfer of risk than MSSP track 2 because it includes factors that will allow those provider organizations to be reimbursed a
greater share of the savings generated by the ACOs in transforming their delivery and payment methods.1 These methods do not involve any prescribed set of activities or interventions. Instead, they involve a financial arrangement wherein provider organizations attempt to reduce expenditures below a set target while maintaining high quality metrics in exchange for bearing risk for reducing expenditures. The Pioneer ACO Model essentially creates a structured laboratory in which Pioneer ACOs design and implement methods for cost containment and quality improvement.

II. Two Year Evaluation

HHS indicated that the independent evaluation conducted for CMS determined that the Pioneer ACO Model generated more than $384 million in savings to Medicare over its first two years - an average of some $300 per participating beneficiary per year - while continuing to deliver high-quality patient care. Pioneer ACOs generated Medicare savings of $279.7 million in 2012 and $104.5 million in 2013. To date, actuarial analyses show that ACOs in the Pioneer ACO Model and the Medicare Shared Savings Program have generated over $417 million in total program savings for Medicare.

The Actuary’s certification that expansion of Pioneer ACOs would reduce net Medicare spending, together with Secretary Sylvia Mathews Burwell’s determination that expansion would maintain or improve patient care without limiting coverage or benefits, means that HHS will consider ways to scale the Pioneer ACO Model into other Medicare programs.

The Pioneer ACO Model is currently serving more than 600,000 Medicare beneficiaries. As described in the report, compared to their counterparts in regular fee-for-service or Medicare Advantage plans, Medicare beneficiaries who are in Pioneer ACOs, on average:

- Report more timely care and better communication with their providers;
- Use inpatient hospital services less and have fewer tests and procedures; and
- Have more follow-up visits from their providers after hospital discharge.

Earlier this year, HHS announced its goal of tying 30 percent of Medicare payments to quality and value through alternative payment models by 2016 and 50 percent of payments by 2018. More than

1 See http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/ for more information regarding the contractual arrangements and incentives of Pioneer ACOs.
3,600 payers, providers, employers, patients, states, consumer groups, consumers and other partners have registered to participate in the Health Care Payment Learning and Action Network, which was launched to help the entire healthcare system reach these goals.


This Committee Update provides general information and not legal advice or opinions on specific facts.