

Fact Sheet: Medicare Shared Savings Program and the Pioneer ACO Program



The Affordable Care Act (ACA) incorporated a concept that some health reform proponents have advocated for several years: an Accountable Care Organization (ACO). An ACO is a group of health care providers, such as physicians and hospitals, that work together to manage and coordinate care for a group of patients—across the entire spectrum of care for those patients—and accept responsibility for the quality and cost of that care. The ACO structure is intended to encourage more integrated care for patients, resulting in quality improvements and reduced costs. Under some arrangements, if an ACO achieves a benchmark level of cost savings, and maintains a measurably high quality level, the ACO shares in the cost savings.

While the ACA has created interest in and opened the door for ACOs in the private sector, it specifically created a program in the public sector: the Medicare Shared Savings Program (MSSP). In addition, separate from the MSSP, the Center for Medicare & Medicaid Innovation announced the creation of the Pioneer ACO Program. This program was designed to be a slightly more advanced and flexible version of an ACO for health care organizations that already have experience in coordinating care across care settings.

These two programs together represent a focus on payment reform by encouraging the formation of ACOs. While two distinct programs, they do have many similarities, including:

- **Duration:** In the MSSP model, providers must agree to participate for at least three years. In the Pioneer Program, providers must commit to three one-year performance periods, although they may be given an extension of two years if they meet certain savings and quality criteria.
- **Assignment:** With the MSSP, beneficiaries are assigned prospectively to the ACO that provides the majority of primary care services (with a retrospective reconciliation process at the end of the first performance year). In the Pioneer Program, an ACO can choose either prospective or retrospective

assignment. A prospective assignment would be based on the prior three years of claims weighted at 60 percent (most recent), 30 percent, and 10 percent.

- **Quality measures:** Both programs have 33 quality measures in four categories: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations.

There are a number of differences between the programs as well—the most significant of which is the shared savings payment methodology:

- With the MSSP, there are two options: a shared savings only model (Track 1) and a two-sided risk model (Track 2). In the Track 1 model, ACOs achieving a specified minimum savings rate can share in up to 50 percent of savings based on quality performance, and there is no downside risk for the full three-year agreement period. For Track 2, ACOs that achieve a specified minimum savings rate can share in up to 60 percent of savings, but this model includes downside risk. ACOs not meeting the minimum savings rate will share in losses (not exceeding 60 percent).
- In the Pioneer Program, there is a core method in which an ACO that achieves a specified minimum savings rate can share in up to 60 percent of savings in the first year (70 percent in the second year) and shared savings or losses are capped at 10 percent (15 percent in the second year). Pioneer Program ACOs have two other options from which to choose: one would increase the financial risk and reward, the other would decrease the risk and reward. CMS also has published proposed alternative payment approaches that reflect a different minimum savings rate.

Actuarial Considerations for Implementing ACOs

While the ACA specifically created these programs for the public sector, it has opened the door to ACOs in the private sector as well. As entities consider designing

and implementing an ACO, there are several actuarial considerations that should be taken into account:

- How risk is correlated with various population characteristics and the potential for adverse selection resulting from how populations are enrolled in these programs.
- How random variation is recognized and considered, particularly in situations in which final results are affected by a relatively small number of enrollees.
- How to support the need for continued enhancement of measurement approaches for quality, efficiency, and resource use.
- How the various potential payment arrangements affect the financial risk borne by an ACO as well as how risk is allocated within the ACO.
- How individual physicians are incented to align with appropriate behavior and practice patterns.
- How risk adjustment can mitigate concerns that ACOs might select against unhealthy risks.

- How risk-based capital models adapt to new risk arrangements, including ACOs.
- How risk-based capital models are applied to new risk-bearing entities.
- How data are integrated and why having the ACO take responsibility for that integration may result in more comprehensive information on how the ACO delivers efficient, quality care.

Other significant issues include the creation of a level playing field between ACOs and traditional providers, the up-front costs associated with the development of a new information technology infrastructure, and a change in the approach to health care delivery.

For a more detailed discussion of these and other significant considerations, see American Academy of Actuaries' Health Care Quality Work Group issue brief, *An Actuarial Perspective on Accountable Care Organizations* (December 2012).

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