Pioneer Accountable Care Organization (ACO) Model Program
Frequently Asked Questions – Addendum
July 13, 2011

Do the later deadlines for the letter of intent and the application mean that the first performance period for the Pioneer ACO Model will be later than stated in the Request for Application (RFA)?

The Innovation Center is working to achieve the targets included in the original RFA released on May 17th, and also to ensure the Pioneer ACO Model effectively achieves the three-part aim of better health care, better health, and lowering costs through improvement. As part of the Center's commitment to partnering with the stakeholder community to develop the best possible initiatives, the Center agreed to stakeholder requests to extend the deadlines for both the letter of intent and application for the Pioneer ACO model. In accordance with the RFA, the first performance period for the Pioneer ACO Model will begin by the end of the fourth quarter, 2011.

How will the Pioneer ACO Model work with the Shared Savings Program?

Within CMS, the Center for Medicare and the Innovation Center are working closely to coordinate efforts between the programs and share resources wherever appropriate For example, as noted in the RFA, the quality measures specified in the Shared Savings Program final rule will also apply to the Pioneer ACO Model.

However, the Pioneer ACO Model is a separate and distinct program from the Shared Savings Program. Applicant organizations with unique Tax Identification Numbers (TINs) may apply to both programs but may only participate in one at any time. Providers cannot be a part of an ACO under the Pioneer ACO Model and the Shared Savings Program concurrently.

The Pioneer ACO Model is also intended to help inform future changes to the Shared Savings Program. Lessons drawn from the initiative may be used by CMS to shape future iterations of the Shared Savings Program.

Are the antitrust policy statements from the FTC, DOJ and IRS that were released for the Shared Savings Program proposed regulations applicable to the Pioneer ACO Model?

Yes. The Antitrust Policy Statement that applies to collaborations among otherwise independent providers, formed after March 23, 2010, that participate, or seek to participate, as ACOs in the Medicare Shared Savings Program will also apply to Pioneer ACOs. During the selection process, the Pioneer ACO Model will apply rules consistent with the guidance issued in March 2011 by the FTC, DOJ, and IRS.

If my organization submits a Letter of Intent before the June 30th deadline, are we then required to submit an application? What if we no longer wish to apply?

No. The Letters of Intent due on June 30th are non-binding. An applicant can withdraw from the application process at any time. Similarly, applicants may withdraw after submitting an application by notifying CMS as described in the RFA (I-F).

Will the Innovation Center consider a joint application from multiple organizations that would function as individual ACOs?

The Innovation Center expects organizations that intend to perform as separate ACOs to submit separate applications. We understand that multiple organizations within a given community may desire to participate in the Pioneer ACO Model because of the support and increased momentum for improvement that such an arrangement offers, but the primary factor CMS will consider in selecting Pioneer ACOs is the strength of individual organizations' applications based on the criteria detailed in the RFA.

How will the Pioneer ACO Model account for how an ACO's patient population might change over time?

At the start of each performance period, CMS will repeat the claims-based alignment process to identify an ACO's patient population for that year. CMS will then use the actual spending data for those aligned beneficiaries from the *baseline* time period to calculate the ACO's expenditure baseline, and then trend that baseline forward to the performance year to calculate the ACO's expenditure benchmark. This approach automatically takes into account any changes in the overall health status of an ACO's patient population over time.

Does the Pioneer ACO Model include indirect medical education or disproportionate share payments in expenditure calculations?

Yes. All services to Medicare beneficiaries for which the program makes a part A or part B payment will be included in the calculation of baseline expenses, expenditure targets, and actual performance. As payments under Part A and Part B reimbursement, indirect medical education and disproportionate share payments will be included in these calculations.

Can you tell me more about the Alternative Payment Arrangements? Can applicants propose other changes to the Pioneer ACO Model besides the payment arrangement?

CMS encourages applicants to suggest an alternative payment arrangement to the Pioneer ACO Model. That arrangement may vary the payment parameters for any or all of the five possible performance periods. Applicants are strongly encouraged to be specific and detailed in their suggestions, and to include succinct justifications/rationales so that CMS can more readily assess the merits of each proposed arrangement.

Most parameters in the Pioneer ACO Model need to remain consistent with the RFA and across all Pioneer ACOs in order to ensure operational efficiency during implementation of the model, and to allow for a valid evaluation. Besides the alternative payment arrangement, the RFA allows flexibility in such parameters as the method for the ACOs to guarantee payment of shared losses or sharing of Medicare data with multi-payer databases on the ACO's behalf. Applicants in unique circumstances or that have specific concerns about other parameters should contact the Pioneer ACO Model staff at pioneeraco@cms.hhs.gov

What happens if providers leave or enter an ACO after the program has begun?

At the start of each performance period, the Pioneer ACO will send to CMS an updated list of its member providers and suppliers, which CMS will use to conduct beneficiary alignment. Providers/suppliers may leave or enter the ACO during that performance year, but such changes *will not change* the aligned population of patients for that ACO until the next round of patient alignment is conducted at the start of the next performance period.

If an ACO loses providers/suppliers, CMS will reassess the size of its aligned patient population to ensure that it still meets the 15,000 beneficiary threshold. Pioneer ACOs with populations that fall below the threshold at any point will receive notice from CMS and will be reassessed at the next round of

alignment. Pioneer ACOs that persistently fall substantially below the threshold may not remain eligible to participate in the initiative.

The RFA states that ACOs "must commit to entering outcomes-based contracts with other purchasers … such that the majority of the ACO's total revenues…will be derived from such arrangements." What do you mean by outcomes-based contracts?

This requirement is designed to ensure that Pioneer ACOs are working with other payers beyond CMS in moving toward the three-part aim of better health care, better health, and lowering costs through improvement. The RFA defines outcomes-based contracts as "those that include financial accountability (shared savings and/or financial risk), evaluate patient experiences of care, and include substantial quality performance incentives." Financial accountability may take many forms, such as shared savings or shared risk arrangements, bonuses or tiered arrangements based on costs of care, or capitation. Quality performance accountability may similarly take diverse forms, such as performance thresholds or pay-for-performance incentives. Medicare Advantage contracts and contracts for self-insured employers, like all other commercial contracts, would be considered outcomes-based contracts if they include both financial accountability and quality performance/patient experience accountability.

Pioneer ACOs have until the end of the second performance period to develop such outcomes based contracts with other purchasers. Failing to enter into outcomes based contracts by this time is grounds for termination of contract. In assessing whether a Pioneer ACO that has not fulfilled this requirement would still be eligible to extend its agreement for the two optional years, CMS will take into account mitigating factors such as whether the Pioneer ACO has made good faith efforts to develop outcomes based contracts, the relative market leverage of its other purchasers, and whether the performance of the Pioneer ACO is generating Medicare savings and improving or sustaining the level of quality for its aligned beneficiaries.