DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Room 352-G
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Washington, DC 20201

Center for Medicare and Medicaid Innovation

Pioneer Accountable Care Organization (ACO) Model
Request for Application

I. Background

A. Goals and Objectives – The Centers for Medicare & Medicaid Services (CMS) is committed to achieving the three-part aim of better care for individuals, better health for populations, and reduced expenditures for Medicare, Medicaid, and Children's Health Insurance Program beneficiaries. One potential mechanism for achieving this goal is for CMS to partner with groups of health care providers in an Accountable Care Organization (ACO) who accept joint responsibility for the cost and quality of care outcomes for a specified group of patients. CMS will pursue such partnerships through two complementary efforts – the Medicare Shared Savings Program and initiatives undertaken by the Center for Medicare & Medicaid Innovation (CMMI, Innovation Center) within CMS. Several objectives underlie CMMI's overall approach to testing accountable care organizations:

- Promote changes in the delivery of care from fragmented care to coordinated care systems as part of broader efforts to improve care integration, such as initiatives on medical homes and bundled payments
- Promote effective engagement with, and protections for, beneficiaries
- Protect the Medicare Trust Funds while finding new ways of delivering care that will decrease expenditures over time
- Learn what it takes for ACOs to most effectively deliver the three-part aim of better care for individuals, better health for populations, and lower growth in expenditures for the Medicare fee-for-service population
- Develop close working partnerships with providers, and
- Encourage a diverse group of ACOs to commit to delivering the three-part aim

The proposed Medicare Shared Savings Program, under section 1899 of the Social Security Act, would offer ACOs incentives to produce improvements in three-part aim outcomes for their Medicare fee-for-service patients. The Shared

Savings Program proposed regulations describe two payment arrangements, one that would begin with a one-sided shared savings model that transitions to two-sided shared savings model with performance-based risk by the third year, and a second arrangement comprised of the two-sided shared savings model for all three years.

Under Section 1115A of the Social Security Act, the Innovation Center is authorized to test new payment and service delivery models that have the potential to reduce Medicare expenditures while maintaining or improving the quality of care for beneficiaries. Through the Pioneer ACO Model described in this request for applications, the Innovation Center will use its authority to test alternative models that incorporate innovations in payment, technical support to ACOs, new means of engaging and protecting beneficiaries; and methods for learning and diffusing best practices. One purpose of the Pioneer ACO Model is to inform potential future changes to the Shared Savings Program. ACOs may participate in either the Shared Savings Program or in the Pioneer ACO Model, but not both concurrently.

B. General Approach of the Pioneer ACO Model – The Innovation Center seeks to support vanguard organizations in the transformation of their business and care delivery model from one reliant on fee-for-service volume to one focused on optimizing outcomes of care. We are interested in testing alternative payment models that (1) include escalating levels of financial accountability through successive performance periods during the Participation Agreement; (2) provide a transition from fee-for-service to population- based payment by the third performance period, and (3) generate Medicare savings. Applicants are expected to have extensive experience with systematic care improvement efforts, and either already have, or be prepared to enter payment arrangements that include financial accountability and performance incentives. Core elements of the Pioneer ACO Model include:

1. Respect for Medicare fee-for-service beneficiaries' freedom to continue to seek the services and providers of their choice
2. Selection of a diverse group of experienced organizations willing to commit to transformation of their business and care delivery models
3. Payment arrangements that, over time, escalate the degree of financial accountability for Pioneer ACOs, and that are flexible to accommodate the specific organizational and market contexts in which ACOs work

4. Appropriate consistency in quality performance metrics and other parameters across arrangements with Pioneer ACOs to allow assessment of the scalability of these models and for rigorous evaluation of their effectiveness
5. Expectations that Pioneer ACOs will engage with other purchasers, including commercial purchasers and state Medicaid agencies, in committing to derive the majority of their revenues from outcomes-based payment arrangements (defined in Section II.I).
6. Technical assistance to all Pioneer ACOs including monthly and quarterly data reports to support care improvement
7. Engagement of Pioneer ACOs in shared learning activities
8. Strong beneficiary protections and comprehensive program monitoring
9. Continuous and comprehensive evaluation

C. Letter of Intent – Interested organizations should submit a letter of intent (LOI) no later than June 10, 2011. Letters of intent will be used only for planning purposes, and will not be binding. Applicants should include in the letter of intent the name and contact information for the executive responsible for data integrity and stewardship. Applicants should use the LOI template on the CMMI website at: http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco, and submit the required form regarding their data systems to PioneerACO@cms.hhs.gov, by June 10, 2011. ***Applications from organizations that do not submit a Letter of Intent will not be considered.***

D. Application Deadline – Applications must be submitted by mail as described on the CMMI website and postmarked no later than July 18, 2011. CMS reserves the right to request additional information from applicants in order to assess their applications. Applications may be accessed at: http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco

E. Limitation on Number of Selected Pioneer ACOs – Our goal is to enter participation Agreements with up to 30 organizations. CMS will select eligible applicants using the criteria described in Section IV. CMS may make more than 30 awards if resources are available and a compelling reason exists such as the opportunity to evaluate outcomes-based payment arrangements with ACOs in communities with distinctive characteristics. CMS requires ACOs to have a minimum of 15,000 aligned Medicare beneficiaries (except ACOs that have the majority of their member clinicians located in rural areas, which must have at

least 5,000 Medicare beneficiaries) but may adjust resources applied to the Model and/or the number of organizations selected based on the actual number of aligned Medicare beneficiaries.

F. Requests to Withdraw a Pending Application or a Provider – Applicant organizations seeking to withdraw an entire application or to withdraw specific National Provider Identifier (NPI) numbers from a pending application should submit a written request on the organization's letterhead that is signed by an authorized corporate official. Note that withdrawal of individual provider NPIs from an application will require CMS to reassess the applicant's eligibility in terms of its number of aligned beneficiaries.

To submit a withdrawal request, send the request in PDF format by mail as for the Application.

The following information must be included:

- Applicant Organization's Legal Name
- Full and Correct Address and Point of Contact information
- Exact Description of the Nature of the Withdrawal:
    - E.g., Withdrawal of entire application or individual providers

II. Description of the Pioneer Model's Components

Several key components of the Pioneer ACO Model differ substantially from their analogs in the Shared Savings Program, while other components are similar across the two initiatives. We describe these distinctions in the following sections, and summarize them in Appendix A. Some parameters used to determine an organization's eligibility for the Pioneer Model mirror the analogous parameter in the Shared Savings Program *proposed* rule, while some other parameters (not used to determine eligibility) will mirror those in the Shared Savings Program *final* rule, which will be released later this year. ***After selection into the Pioneer Model, a Pioneer ACO may opt to withdraw from the Model and its Participation Agreement with CMS if the ACO finds unacceptable any conditions in the Shared Savings Program final rule that would apply to the Pioneer ACO Model. Such withdrawals must take place before January 1, 2012.***

A. Beneficiary Alignment – ***The Pioneer ACO Model may include either prospective or retrospective alignment. Programmatic procedures described in this Request for Applications are consistent with prospective alignment. A Pioneer ACO may instead choose retrospective alignment. CMS will use the retrospective alignment processes of the Shared Savings Program with changes as necessary to reflect differences in related design criteria between the two models.***

Under prospective alignment, CMS will identify the population of Medicare beneficiaries for whom an ACO is accountable through analysis of the prior three years of fee-for-service claims data (or for the amount of data available for other beneficiaries with at least twelve months of available claims), with the most recent year weighted most (60%, 30%, 10%). That is, all of the eligible services from the most recent year for a given beneficiary will be weighted by a factor of 0.6, those from the middle year by 0.3 and those from the most distant year by 0.1. Then a determination will be made of the group of providers that billed for the plurality of the pooled services from all three years. (Under retrospective alignment, CMS would use claims data for the performance period, and may include claims data from prior years as well).

In the first alignment step, beneficiaries will be aligned with the *group* of primary care providers who billed for the plurality of their primary care allowed charges during the combined three year period. CMS expects each primary care provider to be exclusively affiliated with one ACO, given the importance of a central

primary care relationship for patients. A "group" of providers will include either all eligible National Provider Identifier (NPI) numbers affiliated with an applicant ACO's Tax Identification Number (TIN), versus all eligible NPIs affiliated with non-applicant TINs (that is, an ACO would "compete" with other TINs in the alignment algorithm). Eligible primary care allowed charges will have the meaning as set forth in the proposed regulations for the Shared Savings Program. Primary care provider is similarly defined as in proposed regulations for the Shared Savings Program, but with the addition of nurse practitioners and physician assistants.

For beneficiaries who had 10% or less of their evaluation and management allowed charges billed by primary care providers, the second alignment step will identify the *group* of eligible specialist physicians who billed for the plurality of evaluation and management allowed charges with that beneficiary. Eligible specialties are nephrology, oncology, rheumatology, endocrinology, pulmonology, neurology, and cardiology.

Pioneer ACOs that select prospective alignment will be accountable for the cost and quality outcomes of all their prospectively aligned beneficiaries at each end-of-period reconciliation, with certain exceptions. CMS will consider beneficiaries as no longer being in the ACO's designated patient population for purposes of performance measurement and expenditure calculations if they: (1) have any months of Medicare Advantage enrollment or enrollment in only Part A or only Part B at any point during the performance period, (2) transfer their Medicare address to a Core Based Statistical Area (CBSA) or rural county that is not adjacent to that of the ACO's location (where the majority of its clinicians are located), or (3) receive more than 50% of their evaluation and management allowed charges in non-adjacent CBSAs or rural counties during the performance period.

Beneficiaries who newly enroll in Medicare or who disenroll from a Medicare Advantage plan may also be aligned with ACOs through an affirmative attestation on behalf of the beneficiary that a specific ACO is his or her primary provider. These beneficiaries will be included in the financial calculations for the ACO in the first performance year after they have accrued 12 months of fee-for-service experience. Beneficiaries who already have 12 or more months of fee-for-service experience may attest at any time, but will not be included in the ACO's expenditure calculations until the subsequent performance period. For

example, a 65 year old who becomes eligible for Medicare in the last month of the first performance period will be eligible for alignment and expenditure calculations at the beginning of the third performance period. The intent of procedures for beneficiary attestation is to allow patients and providers to align based on mutually acknowledged care relationships rather than claims-based algorithms. CMS does not intend for attestation to result in ACOs selecting some types of beneficiaries more than others for inclusion in their expenditure baseline and benchmark, and may revise this provision from the Pioneer ACO Model if program monitoring reveals differences between attesting patients and those patients treated by the ACO who do not attest.

At all times, Medicare beneficiaries will remain free to select the providers and services of their choice. This Model does not include any restrictions on or changes to Medicare fee-for-service benefits, nor does it include provisions for beneficiaries to opt out of alignment with a Pioneer ACO for purposes of expenditure calculations and quality performance measurement. Any future possible provisions for beneficiaries to opt out of expenditure calculations and quality measurement will mirror those in the final regulations for the Shared Savings Program.

B. Length of Agreement – Pioneer ACO Model Agreements will consist of three performance periods. The first performance period will last from the start date of the initiative (anticipated to be the third or fourth quarter of 2011) until December 31, 2012. Subsequent performance periods will each last 12 months. CMS may use its discretion to offer Pioneer ACOs an extension of their Agreement for an additional two performance periods for a total of five performance periods. CMS may not offer the additional two performance periods if the ACO does not generate program savings and/or meet performance standards or other program requirements during the first two performance periods.

C. Payment Arrangement – CMS is interested in testing alternative payment arrangements that: (1) include escalating levels of financial accountability through successive performance periods during the Agreement; (2) provide a transition from fee-for-service to population- based payment by the third performance period, and (3) are projected by CMS to generate Medicare savings.

Table 1 describes one payment arrangement that CMS intends to pursue for the Pioneer ACO Model. ***However, applicant organizations are strongly encouraged***

to propose alternative payment models. CMS will synthesize the suggestions and distill the most promising of them to offer a second, Alternative Payment Arrangement from which all Pioneer ACOs may choose (as will be reflected in the final Agreement). Together, the alternative payment arrangement and the core payment arrangement must result in projected savings equivalent or greater than those currently estimated by the Office of the Actuary for the Pioneer ACO Model.

CMS will offer variations in the shared savings, shared loss, and savings and loss maximums, in the core payment arrangement to accommodate the needs of a given Pioneer ACO. Table 2 describes Options A and B. A Pioneer ACO may choose the core payment arrangement, Core Option A, or Core Option B. There may also be Options offered for the Alternative Payment Arrangement.

Table 1. Core Payment Arrangement for Pioneer ACOs[1]

Performance Period	Core Payment Arrangement
1	Up to 60% shared savings and shared losses. The Pioneer ACO's share of savings or losses is subject to a maximum of 10% of total projected Medicare Part A and B expenditures for the ACO's aligned patients[1]
2	Up to 70% shared savings and shared losses. The Pioneer ACO's share of savings or losses is subject to a maximum of 15% of total projected Medicare Part A and B expenditures for ACO's aligned patients
3	If ACO generates a minimum average annual savings (defined below) over periods 1 and 2, the ACO's payment will transition to population-based payment in period 3. Population-based payment is a per-beneficiary per month payment amount intended to replace a significant portion of the ACO's FFS payment with a prospective payment. The minimum average annual savings amount will be no greater than 5% (for ACOs in states with the lowest historical Medicare expenditure levels) and no less than 1% (for ACOs in states with the highest historical Medicare expenditure levels), and will vary inversely with the relative Medicare expenditure level in the state where the ACO is located. For ACOs located in more than one state, CMS will set the minimum average annual savings amount based on the state where

[1] The actual shared savings percentage will be based on the ACO's quality performance score as determined using the method described in Section II of the proposed regulations for the Medicare Shared Savings Program, which will be adjusted to be consistent with the final regulations for the Medicare Shared Savings Program.

	the plurality of the ACO's aligned beneficiaries resides. CMS will make a provisional determination of whether an ACO qualifies for population- based payment at the end of the second performance period. Payment for the third performance period will begin based on this provisional assessment, and then adjusted, if necessary, based on CMS' final assessment after three months of claims run-out. The ACO's providers and suppliers will receive fee-for-service payments at 50% of fee-for-service payment rates on submitted claims for services delivered to aligned beneficiaries. CMS will provide a monthly population-based payment that will equal *the remainder of the ACO's projected FFS revenue* for its aligned Medicare patients as a per-beneficiary-per-month payment (PBPM). Appendix B details several examples of this form of population-based payment. Upon end-of-period reconciliation, the ACO will *still* receive up to 70% shared savings and losses, subject to the quality performance adjustments as described in the footnote to Table 1. Appendix B details several examples of this form of population-based payment. ***The goal of population- based payment is to allow Pioneer ACOs the revenue flexibility to provide services not currently paid for under FFS, and to invest in infrastructure to support care coordination. This particular approach to population- based payment exposes the Pioneer ACO to the same level of financial risk as in the payment arrangement in the second performance period. The Innovation Center is open to testing a different form of population- based payment in the Alternative Payment Arrangement that would offer the Pioneer ACO greater levels of financial risk and reward.*** Section 3022 of the Affordable Care Act requires ACOs to have a legal structure that would allow the organization to receive and distribute payments for shared savings to their participating providers and suppliers. CMS therefore expects Pioneer ACOs to have or develop the capability to distribute population- based payments as the ACO deems appropriate to its providers and suppliers. If the ACO does not generate the minimum average amount of savings over periods 1 and 2, the ACO will not transition to population- based payment in period 3. Instead, the period 3 arrangement will revert to the period 1 arrangement and the ACO's Agreement will conclude at the end of three years.
4 (optional)	Same as Period 3, except that the ACO's expenditure baseline will be reset to reflect average Medicare spending for its aligned beneficiaries in years 2011, 2012, and 2013.
5 (optional)	Same as Period 4 (without additional resetting of the expenditure baseline)

Table 2. Optional Variations on the Core Payment Arrangement Available to Pioneer ACOs

	Performance Period 1	Performance Period 2	Performance Periods 3, 4, 5
Core Arrangement, OR	Up to 60% shared savings and shared losses 10% maximum	Up to 70% shared savings and shared losses 15% maximum	Population-based payment, with up to 70% shared savings and shared losses 15% maximum
Option A, OR	Up to 50% shared savings and shared losses 5% maximum	Up to 60% shared savings and shared losses 10% maximum	Population-based payments as in Core Payment Arrangement
Option B	Up to 70% shared savings and shared losses 15% maximum	Up to 75% shared savings and shared losses 15% maximum	Population-based, up to 75% shared savings and shared losses 15% maximum

The Pioneer ACO Model seeks to reward higher quality performance even in the case of an ACO being responsible for shared losses. The quality-adjustment methodology applied in the Shared Savings Program results in an asymmetry in the shared loss potential compared to shared savings. The Pioneer ACO Model will seek to be consistent with the Shared Savings Program's methodology but will implement as part of the contracting process mechanisms to reduce the asymmetry and appropriately reflect higher levels of risk that should accompany higher levels of potential shared savings.

D. Calculation of Expenditure Baseline – For ACOs electing prospective alignment, the expenditure baseline for each ACO will be calculated as the weighted, prior three-year average of *actual* expenditures for each of their aligned beneficiaries, with the most recent year weighted most heavily (60%, 30%,10%) and with each of the first two years trended forward to the most recent year. For beneficiaries with less than three years of expenditure data, CMS will use the data available (with a minimum requirement of 12 months of fee-for-service data). The baseline will be calculated once at the beginning of the first performance period, and recalculated at the beginning of the fourth performance period. That is, while an ACO's patient population will be redefined at the beginning of each performance period, the ACO's expenditure baseline for performance periods 1, 2, and 3 will be based on 2010, 2009, and 2008 data for aligned beneficiaries for all three initial performance periods. The expenditures will be adjusted to

account for the national growth rate for matched cohorts of beneficiaries (see Section II.D below) in per-capita claims observed between the experience year and the beginning of the performance period. The baseline will then reset to be based on 2013, 2012, and 2011 data for beneficiaries aligned with the ACO in each of the subsequent performance periods. The reset baseline will include an adjustment to the expenditures to account for the national growth rate in per-capita claims for matched cohorts observed from the experience year through 2014.

The ACO's expenditure baseline will be compared to that for a national reference population. The total national Medicare population for baseline and performance periods comprise three subpopulations: (1) beneficiaries present in both the baseline and the performance periods (continuing Medicare enrollees); (2) beneficiaries present only in the baseline period (those who died or entered a Medicare Advantage plan before the performance period); and (3) beneficiaries present only in the performance period (those who become new enrollees or leave Medicare Advantage plans during the performance period).
The ACO aligned population is analogous to the national subpopulation (1), therefore, in trending baseline expenditures to create performance period benchmarks, CMS will use national subpopulation (a). Thus, the national reference population will be based on a similarly "matched cohort" including the following beneficiaries:

- Beneficiaries must be Medicare FFS enrollees in both baseline and performance periods;
- Beneficiaries who died or entered a Medicare Advantage plan in the baseline period are excluded (but those that die in the performance period are included);
- Beneficiaries who become newly eligible or leave a Medicare Advantage plan in the performance period are excluded

Furthermore, the matched cohort will be further restricted to include only beneficiaries with at least one evaluation and management visit during the baseline period (otherwise they could not have been aligned), and adjusted for age and gender distribution, because expenditure growth rates vary significantly across these characteristics. The growth in per-capita FFS costs experienced by the national matched cohort will be used to update the expenditure baseline for the determination of the performance year expenditure benchmark as specified in section II.E. A separate methodology will be developed for the appropriate

trending of historical expenditures for new beneficiaries who attest or are aligned after 12 months of eligibility.

E. Calculation of Performance Period Expenditure Benchmark – The expenditure benchmark for each ACO will be calculated as its expenditure baseline inflated by a factor that equally represents the national average *percentage* growth rate in Medicare per-capita expenditures, and the *absolute dollar equivalent* of that growth rate (50% each) for the appropriate matched reference population (see above). For example, assume that national average expenditures are $10,000 per beneficiary and the national average increase for the matched cohort is 10%. For an ACO with average expenditures of $12,000 per beneficiary per year, the benchmark would include 50% of the flat dollar increase of $1000 ($10,000 * .10) and 50% of the percentage increase of $1,200 ($12,000 * .10). Therefore, the increase in the ACO's expected expenditures would be $1,100 ($500 + $600) and its benchmark would be $13,100.

CMS will project the national expenditure growth rate at the beginning of each performance period but correct for the actual national growth rate at end-of-period reconciliation. Calculations of benchmark and actual expenditures for the first performance period will be adjusted to account for the fact that it lasts more than 12 months.

While the benchmark is set prospectively, CMS will make subsequent adjustments, both up and down, as appropriate, to account for changes in law or regulation that, after the benchmark is established, would increase or decrease the national average growth rate in Medicare per-capita expenditures. We believe that this adjustment is necessary because changes in law and regulation will be reflected in actual expenditures. Without an adjustment, ACOs could receive shared savings, even if their care coordination activities were unsuccessful, because actual expenditures would be lower than what they would be if the change in law or regulation had not occurred. Similarly, without an adjustment, ACOs might not receive shared savings, even if their care coordination activities were successful, because actual expenditures would be higher than what they would be if the change in law or regulation had not occurred. And, in the case just described, because ACOs would have downside risk, an ACO could be liable for payment to Medicare even if their care coordination activities were successful.

F. Minimum Savings and Loss Percentages in Excess of Expenditure Benchmarks – To allow for statistical fluctuations in expenditures, shared savings and shared loss percentages will apply only if the ACO generates at least 1% in savings or losses relative to an ACO's expenditure benchmark. The Pioneer ACO will then share savings or losses on the full difference between the benchmark and actual expenditures (that is, the ACO will share first dollar savings or losses).

G. Limits on Financial Risk – CMS aims to encourage Pioneer ACO participation by avoiding arrangements that put Pioneer ACOs at excessive financial risk. At the beginning of each performance period, Pioneer ACOs may opt to have CMS subtract from the expenditure baseline, the expenditure benchmark, and the actual Medicare expenditures for their aligned beneficiaries, any claims above the 99th percentile for national per-capita expenditures. In this case, the matched cohort used for benchmark expenditure calculations for the ACO will be adjusted accordingly. Alternatively, the ACO may purchase equivalent coverage from the private sector.

H. Calculation of Expenditure Benchmarks and Risk Adjustment – Under prospective alignment, CMS will perform risk adjustment through use of the actual historical expenditures for each of an ACO's aligned beneficiaries as described in Section II.F, rather than using clinical diagnoses to adjust from an average expenditure for a geographically defined or other general population.

I. Participation of Other Purchasers – ***Pioneer ACOs must commit to entering outcomes-based contracts with other purchasers (private health plans, state Medicaid agencies, and/or self-insured employers) such that the majority of the ACO's total revenues[2] (including from Medicare) will be derived from such arrangements, by the end of the second performance period in December 2013***. Outcomes-based contracts are defined as those that include financial accountability (shared savings and/or financial risk), evaluate patient experiences of care, and include substantial quality performance incentives. For example, contracts that make shared savings contingent on the ACO meeting minimum quality thresholds, or those that link a meaningful percentage of the ACO's revenues from that purchaser to quality performance scores would be considered substantial quality incentives. Failure to enter such arrangements by the end of the second performance period may result in CMS terminating its Agreement with the ACO.

[2] The sum total of the revenues for the ACO's member organizations

CMS particularly encourages state Medicaid agencies to enter into outcomes-based contracts with Pioneer ACOs. We plan to work with states to determine if states could benefit from technical assistance to help them pursue such arrangements with Pioneer ACOs. We are particularly interested in seeking proposals with respect to structuring contracts with Medicaid for full dual eligible individuals (individuals with both Medicare and Medicaid) to assure seamless coordination of care and alignment of financial incentives across programs.

J. Data Sharing – Under appropriate data use agreements and upon the ACO's request, CMS will provide Pioneer ACOs with several types of Medicare data to support care improvement efforts, consistent with all relevant laws and regulations to protect beneficiary privacy. In particular, CMS will provide beneficiary identifiable data to ACOs unless the beneficiary affirmatively objects, within 30 days, to such data sharing.

1. In the first performance period – Detailed, standard (not customized), historical (three baseline years) claims data on their aligned beneficiaries. Pioneer ACOs may opt to receive historical data that is de-identified in accordance with HIPAA (45 CFR 164.514(b)) at the beginning of the initiative, or to receive historical claims data with beneficiary identifiers after they have notified their aligned beneficiaries regarding their right to opt out of data-sharing, as described below

2. On a monthly basis – Standard beneficiary-level claims feeds, which will include beneficiary identifiers, and services delivered by providers outside of the ACO

3. On a monthly basis – Standard monthly financial reports on the most recent and cumulative expenditures for the Pioneer ACO's aligned beneficiaries

4. On a quarterly basis – Standard, aggregated reports at the ACO and community level on the utilization and non-utilization of key services, as well as total per-capita expenditures

5. On an annual basis – Standard, ACO specific reports on per-capita expenditures and performance on quality of care measures

6. On a negotiated basis – Under appropriate data use agreements, CMS may make available beneficiary-level data that is de-identified in accordance with HIPAA (45 CFR 164.514(b)) to Pioneer ACOs for the express purpose of submitting such data to approved local multi-purchaser databases in order to support comprehensive assessment of performance by the ACO or its member providers

At any time, beneficiaries may opt out of having their identifiable data shared with the Pioneer ACO. At the beginning of each performance period, beneficiaries will receive written notification from Pioneer ACOs and CMS regarding data sharing. If CMS does not receive within 30 days any electronic, telephone, or written notice that the beneficiary wishes to opt-out of data sharing, then the Pioneer ACO may request that CMS begin to release that beneficiary's data (including their historical claims data) in a secure manner to approved users at the Pioneer ACO. Beneficiaries may thereafter opt out of data sharing at any point during the performance period. Pioneer ACOs must make available to beneficiaries, upon their request, an explanation of which ACO providers will have access to the beneficiary's data. Beneficiaries may opt-out via a telephone hotline 1-800-Medicare, or through various modes of communication with their ACO provider. In the latter case, the ACO provider will be responsible for submitting information in a timely manner (within 30 days) to the CMS implementation contractor on beneficiaries who have opted out of data sharing.

K. Program Monitoring – Pioneer ACOs should not restrict access to necessary care. To safeguard against reductions of necessary care, CMS will routinely analyze data on service utilization, and may investigate utilization patterns through comparison surveys of beneficiaries aligned with the ACO and those in the general beneficiary population, through medical record audits, or other means. In addition, CMS plans to conduct surveys of certain subpopulations of ACO-aligned beneficiaries who may be in particular need of expensive but effective services (such as newly diagnosed cancer patients), or beneficiaries whom the ACO might consider poorly adherent (such as patients with major depression), in order to ascertain any differences in their care experiences or health status relative to similar beneficiaries who are not aligned with a Medicare ACO. CMS will also determine whether there are systematic differences in health status or other characteristics between patients who remain aligned with a given ACO over the life of the Agreement, and those who do not.

L. Beneficiary Protections – CMS expects Pioneer ACOs to submit materials for communicating with and marketing to beneficiaries regarding the Model to CMS for approval prior to their use.

Pioneer ACOs should notify beneficiaries that they can call 1-800-Medicare with questions and concerns regarding care from the ACO in particular or about the initiative in general. CMS may investigate the practices of ACOs that generate beneficiary complaints. Investigations may include medical record reviews and beneficiary interviews or surveys, or other means. If warranted, such reviews may result in termination of the ACO's Agreement, and/or corrective actions for an ACO or the design of the Model as a whole.

CMS will publicly report the performance of Pioneer ACOs on quality (including patient experience metrics) on its website. ACOs will be required to survey their aligned beneficiaries on an annual basis, using an approved vendor and an amended version of the CAHPS Clinician and Group Survey, as discussed further below in the quality performance measures section.

It is also important that patients and their advocates be meaningful partners with ACOs in improving care delivery. Pioneer ACOs are expected to include both patient representatives and consumer advocates on their governing body (See section III.C) in the absence of extenuating circumstances such as existing legal restrictions on their governance structure.

Pioneer ACOs should also have a compliance plan. We recognize that the specific design and structure of an effective compliance plan may vary depending on the size and business structure of the ACO. A compliance plan should include at least the following elements: a designated compliance official who is not legal counsel and who has the ability to report directly to the ACO's governing body; mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance; a method for employees or contractors of the ACO or ACO members to report suspected problems related to the ACO; compliance training of the ACO's employees and contractors; and a requirement to report suspected violations of law, including fraud and abuse laws, to an appropriate enforcement agency. The ACO may want to coordinate its compliance efforts with the compliance functions of its members. CMS

reserves the right to audit Pioneer ACOs' compliance plans and their effectiveness, including through program integrity safeguards.

M. Quality Performance Measures – Performance measures will mirror those in the *final regulations* for the Shared Savings Program. As proposed, these include claims based measures, a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, data from Electronic Health Record Incentive Programs, electronic prescribing incentive programs, the Centers for Disease Control and Prevention National Healthcare Safety Network, Hospital Compare, and those reported by each ACO through use of the Group Practice Reporting Option (GPRO), a reporting tool developed by CMS. As part of the Pioneer Model, CMS may test the use of software for automatic extraction of quality measures from an ACO's electronic health record. A detailed list of the proposed measures can be found in Section II of the proposed regulations for the Shared Savings Program (http://www.cms.gov/sharedsavingsprogram/).

CMS will calculate a Pioneer ACO's quality score based on that ACO's quality performance including patient experiences of care as described in Section II.C of the RFA.

Both performance measures and quality incentive calculations will be updated to be consistent with the final regulations for the Shared Savings Program, with the exception that a Pioneer ACOs' loss percentages in excess of expenditure benchmarks will be subject to a minimum percentage when the shared savings/loss percentage exceeds 60%. The precise parameters for performance measures and incentive calculations will not be finalized until after publication of the final regulations for the Shared Savings Program. ***Applicants to the Pioneer Model are encouraged to submit comments regarding performance measures and methods for performance adjustments to the Shared Savings Program proposed regulations since these regulations, once final, will be applied to the Pioneer ACO Model. Pioneer ACOs may also withdraw (by January 2012) from the Pioneer ACO Model if they find applicable terms in the final SSP regulations to be unacceptable.***

In the first performance period of the Pioneer Model, performance scores would reflect *reporting rates* on the selected measures (pay for reporting). Starting in the second performance period, scores would reflect performance rates on measures relative to the appropriate baseline.

It is important to note that, aside from quality performance, there will <u>not</u> be adjustments made to shared savings and loss percentages for Pioneer ACOs for any other behaviors described in such adjustments for the Shared Savings Program, such as for collaborating with Federally Qualified Health Centers. The Pioneer ACO Model explicitly encourages the participation of FQHCs and prioritizes applicants that collaborate with FQHCs and/or serve disadvantaged populations.

N. <u>Shared Learning Activities</u> – CMS will support Pioneer ACOs in accelerating their progress by providing them with opportunities to learn how care delivery organizations can achieve performance improvements quickly and effectively, and opportunities to share their experiences with one another and with participants in other Innovation Center initiatives. The Innovation Center will test various approaches to group learning and exchange, helping program participants to effectively share their experiences, track their progress and rapidly adopt new ways of achieving improvements in quality, efficiency and population health for Medicare, Medicaid and CHIP beneficiaries. CMS therefore expects Pioneer ACOs to actively participate in these shared learning opportunities.

O. <u>Termination of Pioneer Agreements</u> – CMS reserves the right to review the status of a Pioneer ACO and terminate its Agreement for the following reasons, or if otherwise required under section 1115A(b)(3)(B) of the Social Security Act. The Pioneer Agreement may detail additional reasons for termination.
    1. If the Pioneer ACO's number of aligned beneficiaries falls below the required minimum for more than one performance period
    2. If the Pioneer ACO does not meet quality performance thresholds in either of the first two performance periods
    3. If the Pioneer ACO fails to enter outcomes-based contracts with non-Medicare purchasers such that the majority of its revenues are derived from such contracts by the end of the second performance period
    4. If the Pioneer ACO fails to comply with the physician self-referral prohibition, civil monetary penalties (CMP) law, Anti-kickback statute, other antifraud law, or any other applicable Medicare laws, rules, or regulations that are relevant to Pioneer ACO operations.
    5. If the Pioneer ACO restricts access to necessary care.

III. Eligibility Criteria

A. Legal Status – To be eligible, an organization must be recognized as a single legal entity by the state where it is incorporated, and must have a unique Tax Identification Number (TIN) designated to receive shared savings and population-based payments. The organization must have a governing body capable of entering into a Participation Agreement with CMS on behalf of their member providers and suppliers.

B. Eligible Providers – Applicants must be providers and/or suppliers of services structured as:

- ACO professionals in group practice arrangements
- Networks of individual practices of ACO professionals
- Hospitals employing ACO professionals
- Partnerships or joint venture arrangements between hospitals and ACO professionals, or
- Federally Qualified Health Centers

For purposes of the Pioneer ACO Model, an ACO professional is a doctor of medicine or osteopathy, or a practitioner who is a physician assistant, nurse practitioner, or clinical nurse specialist. A hospital is an acute care hospital paid under the inpatient prospective payment system (IPPS), or certain non-IPPS hospitals including cancer hospitals, children's hospitals, and critical access hospitals. ***The definition of ACO hospital differs from the statutory definition of hospital in the Shared Savings Program.***

CMS encourages applications from ACOs led by Federally Qualified Health Centers (FQHCs), but notes that the Innovation Center also intends to pursue related initiatives on coordinated care systems serving indigent communities, and Medicare/Medicaid dually eligible beneficiaries. For the purposes of this RFA, dual eligibles are individuals who are fully eligible for full benefits in both Medicaid and Medicare. CMS would negotiate methods for expenditure baseline and benchmark calculations based on available Medicare data, and methods of patient alignment, with FQHCs that are selected for the Pioneer ACO Model.

CMS encourages applications from ACOs that choose to partner with Medicare Part D drug plans. Upon selection into the Model, CMS would welcome discussions with such organizations on appropriate adjustments to parameters within the Model, such as joint tracking of adherence to drug formularies or additional topics in beneficiary surveys.

C. Governance Structure – The applicant organization must demonstrate that the composition of its governing body is reflective of the member groups of providers and suppliers that form the ACO, and includes meaningful representation from consumer advocates *and* patients. Applications should also include information on other ways in which patients in general, and Medicare beneficiaries in particular are or will be involved in ACO governance.

D. Attestation of Accountability – Applicant organizations must attest that their members are willing to become accountable for the quality, cost, and overall care of Medicare beneficiaries aligned with the ACO as part of the Pioneer ACO contract. The attestation must be made by an executive who has the ability to legally bind the member providers and suppliers of the ACO.

E. Health Information Technology – By the end of 2012, Pioneer ACOs must attest and CMS will confirm that at least 50% of the ACO's primary care providers have met requirements for meaningful use of certified electronic health records (EHR) for receipt of payments through the Medicare and Medicaid EHR Incentive Programs. CMS recognizes that meeting this requirement is not sufficient for performing at the level expected of Pioneer ACOs, and will give preference in selection to those organizations with advanced EHR capabilities. (See Section IV.B)

F. Other Data Systems – Letters of intent should include on the name and contact information for the ACO officer responsible for data maintenance and stewardship (this officer will be responsible for meeting authentication requirements in accessing CMS data feedback reports and ensuring that these reports are accessible only by authorized members of the ACO).

G. Patient Centeredness Capabilities – Applications must include narrative descriptions of how the organization will ensure that the care it delivers takes into account the needs and preferences of individual patients as detailed in the application.

H. Minimum Number of Aligned Medicare Beneficiaries – Applicants must have a minimum of 15,000 beneficiaries unless located in a rural county, in which case a minimum of 5,000 beneficiaries is required.[3] Applications must include the ACO TIN, the TIN for all member organizations, and the National Provider Identifier (NPI) for all member providers, in order for CMS to verify the size of the aligned beneficiary population, as well as the CMS Certification Number (CCN) for each institutional provider in the ACO.

I. Participation of Other Purchasers – CMS believes that Pioneer ACOs will be more effective in producing improvements in three part aim outcomes if they fully commit to an outcomes-based business model. CMS therefore expects Pioneer ACOs to enter similar outcomes-based contracts with other purchasers. Applications should include a letter of verification and support from each commercial purchaser or state Medicaid agency with which the applicant either has an existing outcomes-based contract, or a commitment to enter such a contract within the first two performance periods of the Pioneer Model. Such commitments should account, in aggregate (including Medicare and non-Medicare purchasers), for at least 50% of the applicant organization's total revenues. For existing contracts, applicants should submit a description of the payment arrangement, including the design of parameters similar to those listed in Sections IIA-E, such as well as the maximum financial risk the ACO is exposed to, shared savings and risk percentages, and how expenditure baselines and benchmarks are calculated, the design of quality performance incentives, and a list of the quality metrics used (including patient experience metrics). If the contract has been active for more than one year, the application and the purchaser's verification letter should also include a summary of the expenditure and quality performance of the applicant organization to date under the contract.

J. Commitment to Ensuring Competitive Markets – Competition in the marketplace promotes quality of care for Medicare beneficiaries and protects access to a variety of providers. All of these benefits to Medicare patients would be reduced or eliminated if CMS facilitates the creation of ACOs with significant

[3] All counties that are not designated as parts of Metropolitan Areas (MAs) by the Office of Management and Budget (OMB) are considered rural. Large parts of many "urban" counties may be rural in nature. Therefore, census tracts with Rural Urban Commuting Area Codes (RUCA) 4 through 10 will be considered rural, and micropolitan areas will be considered rural for the purposes of the Pioneer Model. See: http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/.

market power. Please refer to the discussion on competition in the proposed regulations for the Shared Savings Program.

To maintain ACO competition for the benefit of Medicare beneficiaries and to promote the long-term goal of redesigning health care processes that avoid antitrust concerns, we have worked closely with antitrust agencies to reduce the potential for the creation of ACOs with market power. In particular, the antitrust agencies have issued a proposed 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. Notably, the proposed Antitrust Policy Statement makes clear that analytical principles underlying the Antitrust Policy Statement would also apply to Pioneer ACOs.[4] The Antitrust Policy Statement outlines a methodology by which ACOs can calculate their shares of common services (i.e., services provided by two or more ACO participants) provided to patients from the same primary services area (PSA). The common services consist of physician specialties, "major diagnostic categories" for in-patient settings, and "outpatient categories" for out-patient settings. We will make public the information and guidelines necessary to designate common services and to calculate PSA shares at: http://www.cms.gov/apps/files/aco/application-zipcodes.zip.

Calculating PSA shares for common services will guide applicants on when they might present competitive problems. Unless the ACO qualifies for the rural exception articulated in the Antitrust Policy Statement, the antitrust agencies believe that any ACO with a PSA share of above 50 percent for any common service that two or more ACO participants provide to patients from the same PSA should receive closer antitrust scrutiny to determine whether the Pioneer ACO applicant in fact poses significant competitive concerns or may be pro-competitive. Accordingly, the Innovation Center will work closely with the antitrust agencies in reviewing any ACO applicant that exceeds the 50 percent threshold and will not approve for purposes of the Pioneer ACO Model any applicant that will present significant competitive problems.

The establishment of a 50 percent mandatory review threshold seeks to prevent the creation of an ACO with market power and to ensure that there are sufficient providers to allow the formation of competing ACOs to serve Medicare

[4] www.ftc.gov/os/fedreg/2011/03/110331acofrn.pdf

beneficiaries. However, we recognize that, in rural areas, there may be only one or two physicians in certain specialties or few Sole Community or Critical Access Hospitals. As the antitrust agencies have indicated in their Antitrust Policy Statement, these circumstances will be taken into account in evaluating an ACO's likely competitive effects.

Nothing in these regulations shall be construed to modify, impair, or supersede the applicability of any of the antitrust laws. For further antitrust guidance, ACOs should review the Antitrust Policy Statement: http://www.ftc.gov/os/fedreg/2011/03/110331acofrn.pdf and http://www.justice.gov/atr/public/guidelines/269155.pdf.

In addition, CMS will prioritize applications that include an explanation of how the applicant organization's activities will support competitive markets.

K. Risk Bearing Capability – Applications must include either an attestation that the organization has been licensed by the state in which it is located as a risk-bearing entity, or that it is exempt from such licensure or other related licensure requirements. Applications must also include a letter of commitment to ensure its ability to reimburse Medicare for any shared losses incurred in the Pioneer ACO Model, and to repay any care coordination payments it receives in excess of its earned shared savings. ***CMS will enter into Agreements with Pioneer ACOs only if they provide enforceable assurances that they can reimburse Medicare for all potential losses. This assurance could take the form of an irrevocable letter of credit for the full amount of risk undertaken or any similarly enforceable mechanism that covers the full amount of risk. As stated in Section II, ACOs may propose different levels of risk-sharing that would have direct bearing on the amount of potential losses that must be guaranteed by the ACO.***

IV. Scoring of Applications and Selection Process

A. CMS will only consider applications from organizations that have submitted a letter of intent by June 10, 2011. CMS will screen applications to determine completeness and eligibility, including whether the organization meets the minimum requirement for the number of aligned Medicare beneficiaries. Applicants will have one week after receipt of notice of incompleteness to make corrections.

Each complete and eligible application will be reviewed by a panel of experts from the Department of Health and Human Services as well as other organizations, with expertise in the areas of provider payment policy, care improvement and coordination, primary care, and care of vulnerable populations. Reviewed applications will be scored based on the criteria listed in Table 3. CMS will normalize scores across review panels, and prioritize applications based on both scores and other considerations described below to select finalists.

We ask that applicants be prepared to travel at their own expense to CMS headquarters in Baltimore, MD within 1-2 months after the application deadline for interviews, if they are selected as semi-finalists. CMS encourages key members of the ACO's leadership team to participate in these interviews, to help CMS further assess the rigor of the ACO's care improvement plan and the commitment and capabilities of its leadership. We recommend including at a minimum the chief executive officer, chief financial officer, chair of the governing body, and chief executive for clinical improvement.

Final selection of Pioneer ACOs will be made by CMS based upon the results of application reviews and interviews.

B. Review panels will weigh the following factors, which are mapped in the table to the relevant section in the application:

Table 3. Pioneer ACO Selection Criteria and Scoring

Selection Domain	Selection Factors	Maximum Score
Patient Centeredness Application Sections E.28, E.29, F.38	1. Patient centeredness capability – during the care experience, transitions in care and outside the health care system 2. Provisions to ensure patient access to care 3. Patient engagement and activation To achieve the full 10 points, the applicant should: Have established mechanisms to conduct patient outreach and education on the necessity and benefits of care coordination Demonstrate the ability to engage patients in shared decision making taking into account patient preferences Demonstrate the ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, e.g., medication lists; care plans co-developed with the patient and embedded in the EHR; case manager follow up Demonstrate the ability to engage and activate patients at home (through such modes as home visits or tele-monitoring) to improve self-management Have mechanisms to evaluate patient satisfaction with the access (including choice of providers) and quality of their care	10
Leadership & management Application Section B.16 to B.18, E.34, F.35, F.36, F.39	1. Strength of executive credentials and capabilities 2. Commitment of leadership and governing body 3. Management and staff resources to support implementation To achieve the full 20 points, the applicant should: Have a multi-stakeholder board comprised of well qualified individuals that adequately and collectively represent the interests of patients and providers Demonstrate an executive and governing body level commitment to the three-part aim Demonstrate an effective governance model including a governing body and/or organizational mechanisms to make decisions, distribute payment, and obtain resources necessary	20

	to achieve the three-part aim Have indentified executives and lead staff throughout the organization with responsibility for clinical, financial, management, HIT, and quality improvement functions. Demonstrates experienced, strong project leadership and a project management structure and design that will enable accountability for a patient population	
Financial Application Section C.22, F.41, F.42, F.43	Experience with financial risk sharing[5] 1. Total number and percentage of patients in risk sharing arrangements for the prior three years 2. % of patient revenues in risk sharing arrangements 3. Degree of financial risk in Applicant's two largest contracts as a percentage of the ACO's revenues (or those of its largest member organization) 4. Success in achieving medical expenditure benchmarks in such contracts In outcomes-based contracts with other purchasers 5. Percentage of Applicant's revenues derived from outcomes-based contracts in 2010 6. The analogous percentage for contemplated outcomes-based contracts to begin within the first two performance periods 7. Financial stability To achieve the full 25 points, the applicant should: Demonstrate at least 3 years of experience with risk sharing arrangements with payers for a minimum of 10,000 lives Document reductions in medical expenditures achieved through previous risk based contracts	25
Performance capabilities Application Section B.11, B.12, E.26, E.28, E.29, E.31 to E.38	1. Primary care capability 2. HIT Infrastructure and functions on a provider and population/community level 3. Third party assessments of high performance[6] 4. Demonstrated experience in successfully implementing systematic improvements in clinical, administrative processes 5. Strength of community relationships and support	20

[5] Financial risk sharing is one key component of outcomes-based contracts

[6] Acceptable third party assessments would come from organizations such as the National Committee for Quality Assurance

	To achieve the full 20 points, the applicant should: Demonstrate the primary care capacity to coordinate care through an appropriate case manager to patient ratio, # of practices engaged in becoming patient centered medical homes, and ratio of participating PCPs to beneficiaries served Provide evidence of historical or baseline indicators of high performance Demonstrate ability for a majority of ACO primary care providers to meet EHR meaningful use criteria Have population-based management tools and functions, e.g. registry/ability to aggregate and analyze clinical data Have the ability to electronically exchange patient summary records across providers who are members of the Pioneer ACO and other providers in the community to ensure continuity of care Have access to multi-payer claims data and performance reports and the ability to share performance feedback on a timely basis with participating providers Enable beneficiary access to electronic health information, e.g., a patient portal to a provider EHR Demonstrate ability to coordinate care across full continuum of care Demonstrate a history of collaboration among major stakeholders (such as major purchasers) in the community being served Demonstrate a commitment from relevant community stakeholders to achieve seamless care Demonstrate the ability to coordinate and incorporate relevant social services in care plans and management	
Implementation Plan: Potential for producing three-part aim	1. Understanding of the program's principles, goals and objectives 2. Proposed care improvement plan including specific interventions and milestones for first two performance periods	20

Application Section B.11, B.12, D.25, D.26, E.27, E.32,E.36, F.39, F.40, F.41	3. Potential for cost savings and corresponding interventions 4. Potential for quality improvement and corresponding interventions 5. Potential for improving population health and corresponding interventions 6. Understanding of baseline per-capita costs 7. An overall plan that demonstrates the inter-dependencies of interventions, evaluation, and ongoing collaboration and learning to realize three-part aims To achieve the full 20 points, the applicant should: Demonstrate that the care improvement plans proposed by the applicant are important, specific and measurable and meet(s) the objectives of the Pioneer ACO program as outlined in this RFA Demonstrate excellence in the area of quality improvement and care coordination, as evidenced by the success of previous and/or existing care coordination, pay for performance, patient centered medical home, quality improvement, and/or health outcomes improvement initiatives Present a strong, credible, coordinated and feasible plan to use population-based care management, care coordination, clinical decision support, quality measurement and feedback, patient engagement and supporting HIT infrastructure and other interventions to realize the three part aims during both performance periods	
Vulnerable populations Application Section A.4, B.12, C.20, C.21,	1. Collaboration with safety net providers, behavioral and mental health providers 2. Serve beneficiaries who are dually eligible for Medicare and Medicaid To achieve the full 5 points, the applicant should: Include a diverse group of providers and care settings (e.g., small practice, community health center, rural health clinic, behavioral health centers) along established patterns of care Include safety net providers that care for indigent populations Include a high percentage of aligned beneficiaries who are dually eligible for Medicare and Medicaid	5
	TOTAL POINTS	**100**

Appendix A: Summary Comparison of Shared Savings Program and Pioneer Model Design Parameters

The following table summarizes design parameters in the Pioneer ACO Model relative to the Shared Savings Program. In a number of areas (such as eligibility requirements), the intent is to have the design of the Pioneer Model be consistent with the proposed regulations for the Shared Savings Program. In other areas (such as performance measurement), the intent is to have the design of the Pioneer Model be consistent with the *final* regulations for the Shared Savings Program. Since Agreements with Pioneer ACOs will be executed before the Shared Savings Program regulations are finalized, Pioneer Agreements will include a clause which amends these components of the Agreement based on the final Shared Savings Program regulations. If the changes are unacceptable to a Pioneer ACO, it would have the option to terminate its Agreement.

Parameter	SHARED SAVINGS PROGRAM (As proposed in the NPRM, subject to change in the final rule)	Pioneer Model
Requirement for participation of other purchasers	Not proposed at this time	Require ACOs to have at least 50% of their total revenues derived from outcomes-based contracts by the end of the second performance period
Expenditure benchmark calculation	Benchmark established using per capita Parts A and B FFS expenditures for beneficiaries historically assigned to the ACO in each of the 3 baseline years, risk adjusted using the prospective HCC model. Benchmark is updated annually by the projected absolute amount of growth in national per capita expenditures for parts A and B services.	Expenditure baseline will be trended forward using a hybrid inflationary factor (50% percentage national average growth, 50% absolute dollar growth).
Expenditure baseline calculation	Establishing the benchmark includes weighting the 3 years of the	Similar to Shared Savings Program NPRM – Except that Pioneer ACOs will have additional months of lag between

	benchmark: BY3 at 60%, BY2 at 30%, BY1 at 10%	the most recent baseline year of 2010 and the start of the first performance period (anticipated to be in the third or fourth quarter of 2011)
Length of agreement	3-yr agreement	Minimum of three performance periods (slightly longer than 3 years), with two one-year optional extensions
Core payment arrangement	Track 1: One-sided model for Yr 1 and Yr 2 automatically transitions to two-sided model in Yr 3 Track 2 - Two sided model for all 3 years	One arrangement with escalating shared savings and shared losses then transition to population- based payment in Yr 3.[7] Solicit suggestions of alternatives from applicants. Synthesize and distill suggestions. Offer all Pioneers choice of 2 final arrangements.
Timing of alignment	Retrospective using claims from the performance year, with prospective sharing of population data	Prospective or retrospective. Prospective using 3 yr prior claims (with time lag only for the first performance period), or retrospective using claims from the performance period and potentially claims from prior years
Minimum number of aligned beneficiaries	5,000	15,000 (5,000 for rural)
Beneficiary attestation	Not proposed at this time	Alignment of beneficiaries who attest ACO as their primary care coordinator and who are newly eligible for Medicare or newly disenrolled from a Medicare

[7] Over the next year, we intend to investigate how beneficiary co-insurance would work under a population-based payment arrangement.

		Advantage plan after accrual of at least 12 months of FFS experience in the preceding calendar year, or newly relocated to the ACO's market who already have at least 12 months of FFS experience (but added to expenditure calculations only in the subsequent performance period)
Beneficiary choice regarding sharing beneficiary identifiable data	Beneficiaries may decline sharing of identifiable claims data after notification during an office visit with a primary care physician in the ACO	Beneficiaries would have 30 days for opt-out before data sharing begins; can opt out to stop data sharing at any point thereafter. Process repeats with each performance period
ACO legal status requirements	Requires ACO to be a legal entity with its own TIN, recognized and authorized under state law.	Identical to Shared Savings Program NPRM
Alignment algorithm	Plurality of allowed charges for primary care physicians (internal medicine, general practice, family practice, and geriatric medicine) participating in the ACO	Pioneer Model would allow non-MD PCPs, allow alignment with certain specialists if beneficiary has PCP services totaling <10% of all evaluation and management services
Rapid data feedback	Monthly minimum necessary beneficiary identifiable data, quarterly and annual aggregated reports, baseline ACO spending performance and utilization data	Pioneer Model will offer monthly financial reports, historical claims data, and may develop additional reports based on input from Pioneer ACOs, but will provide similar quarterly and annual aggregate reports to ACOs
Legal and regulatory guidance	Separate guidance issued by FTC, DOJ, and IRS. OIG and CMS issued	Pioneer ACO Model will apply rules consistent with the guidance issued by

	joint guidance on the application of antifraud laws.	FTC, DOJ and IRS. On fraud and abuse issues, OIG and CMS expect to apply consistent principles to the consideration of fraud and abuse waiver designs for all ACO programs and models in the Medicare program.
Minimum Savings Rate/overspending percentages	MSR based on number of assigned beneficiaries under the one-sided model. Flat rate of 2% under the two-sided model	Flat rate of 1%
Governance structure requirements	Legal entity, shared governance, governance body with representative membership, where ACO participants have at least 75% control, and includes patient representation	Similar to Shared Savings Program with an additional requirement that the board include a consumer advocate.
Required HIT capabilities	By the second performance year 50 % of an ACO's PCPs are meaningfully using certified EHR technology as defined in the HITECH Act and subsequent Medicare regulations by start of the second performance year	Identical to Shared Savings Program NPRM.
Patient centeredness criteria	Eligibility criteria & beneficiary experience of care survey	Identical to Shared Savings Program NPRM
Performance metrics	65 measures, developed with input	Identical to final Shared Savings

	from experts & stakeholders, aligned with CMS and HHS quality initiatives and private sector efforts, set a high bar for quality performance and performance on patient experience measures	Program regulation
Primary care capability	Sufficient to assign at least 5,000 beneficiaries	Similar, except to be consistent with 15,000 beneficiary minimum (minus the beneficiaries who may be aligned through specialists)
Linkage between quality score and shared savings/loss percentages (including pay for reporting in the first performance period)	Increased savings for higher quality performance; decreased losses for higher quality	Similar to proposed Shared Savings Program regulation for the two-sided model except that shared losses will be subject to a minimum in certain cases.

Appendix B. Examples of Population-based Based Payments in the Core Payment Arrangement

The following examples assume, for illustrative purposes, that the Pioneer ACO is responsible for an aligned Medicare beneficiary whose expenditures for the performance period are projected to be $1,000 (that is, the beneficiary will contribute $1,000 to the ACO's expenditure benchmark). It also assumes that the Pioneer ACO is eligible, for illustrative purposes, for 70% of shared savings or losses and a quality score of 90% for a shared savings percentage of 63% (.90*.70)and a shared loss percentage of 40% (the actual calculation of (1-63%) generates a result lower than the applicable minimum shared loss percentage). In all cases, Pioneer ACO providers/suppliers will receive 100% FFS payment for services delivered to non-aligned beneficiaries, and providers/suppliers not affiliated with the Pioneer ACO will receive 100% FFS payment for all the services they deliver to any beneficiary. However, Pioneer ACO providers/suppliers will receive 50% of the usual FFS payment for services they deliver to the aligned beneficiary. Note that for physician-only Pioneer ACOs, CMS may offer population-based payments that exceed 50% of the expected amount that ACO is expected to bill in FFS for the beneficiary. For illustrative purposes, the examples also assume that the rate of "leakage" of services delivered to the beneficiary by non-ACO providers remains constant under the payment incentive.

	Example A: Beneficiary's expenditures are less than the benchmark	Example B: Beneficiary's expenditures are greater than the benchmark
Benchmark expenditures	$1,000 per month (PM)	$1,000 PM
CMS' estimate of the percentage of the beneficiary's services that will be delivered by the Pioneer ACO	75%	75%
Amount CMS retains to pay non-ACO providers	$250 PM	$250 PM
Amount CMS retains to pay ACO providers	$375 PM	$375 PM

Amount paid as a population-based payment	$375 PM ($1,000 - $250 -$375)	$375 PM
Beneficiary's actual expenditures	$800 PM	$1,200 PM
Amount received by Pioneer ACO in FFS payments	$300 PM ([$800*0.75]*0.5 FFS rate)	$450 PM($1200*.75)*0.5
Total amount received by Pioneer ACO	**$675PM ($375 + $300)**	**$825 PM ($450 + $375)**
Amount Pioneer ACO would have received under normal FFS	**$600 PM ($800 * 0.75)**	**$900 PM ($1200*.75)**
Amount earned by Pioneer ACO in shared savings or losses	+$126 PM ([$1,000 -$800]*0.63)	-$80 PM ([$1200-$1000]*.40)
Total amount that Pioneer ACO has earned	**$726 PM ($600 + $126)**	**$820PM ($900-$80)**
Amount transferred at reconciliation	**CMS pays ACO $51PM ($726 - $675)**	**Pioneer ACO pays CMS $5 PM ($820-$825)**