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Pioneer Accountable Care Organizations (ACOs): Slowed Health Spending, Improved Quality and More Drop Outs?

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The **Centers for Medicare and Medicaid Services (CMS) recently released second year results** on its **Pioneer Accountable Care Organization (ACO) program**. [1][2] The Pioneer ACO program is CMS' ambitious foray into the ACO space and a predecessor to the broader Medicare Shared Savings Program (MSSP) that has resulted in the formation of hundreds of new ACOs nationwide. CMS originally selected 32 provider organizations with a proven ability to coordinate care for their patients with the goal of transitioning the providers in those organizations from a fee-for-service payment model, to a shared savings model and finally to a population based payment model. The Pioneer ACO program kicked off in 2012 and was intended to (1) improve quality and health outcomes for patients served by each Pioneer ACO, (2) achieve cost savings for the Medicare program and (3) reward providers who were able to achieve the dual goals of cost savings and improved quality. Furthermore, Pioneer ACOs are eligible for higher levels of shared savings and subject to greater downside risk than MSSP ACOs. So, how have the Pioneer ACOs performed during their first two years?

Some have succeeded splendidly, while others have suffered severe losses and dropped out of the program. From a financial perspective, some Pioneer ACOs were able to slow health spending by approximately 7% in the first year while others allowed spending to accelerate by as much as 5%. Second year results were similar with spending being slowed or increased by approximately 5% depending on the ACO.[3] Several ACOs which failed to control health care spending will be required to repay millions to the Medicare program.

The quality results have also been a mixed bag. As mentioned above, CMS released performance data for the Pioneer ACOs second year performance in early October. The data shows that many ACOs were able to meet the requisite quality metrics while others struggled. Even some organizations which met quality thresholds chose to leave the program because they did not receive sufficient payments under the program to defray costs of participation and make ongoing participation financially viable.

The departure of 13 ACOs from the Pioneer ACO program has not gone unnoticed. The CMS Innovation Center has acknowledged that there are issues but insists that the program is on an

"upward trajectory."[4] Other stakeholders have not been so generous and criticized the formulas used by Medicare as favoring organizations in markets where health spending is above average and therefore more opportunities exists for reducing costs.[5]

Notwithstanding any criticism of the program, there are several important lessons to be learned from the Pioneer ACO initiative, not only for CMS and MSSP ACOs, but also for providers and payors who are engaging in commercial or Medicaid ACOs. First, providers need to be sure that they have adequate technical, administrative and clinical capabilities to meet the requirements of population health / value based programs. Second, losses are a real possibility and providers need to ensure that they can absorb a year or two of losses caused by 'growing pains' when they begin to engage in population health management before they can adequately manage both cost savings and quality improvement. The points above apply equally to State Medicaid programs and private payors when selecting appropriate provider partners for ACO activities. Third, all parties involved in an ACO project should craft quality, cost saving and other metrics based on realistic and achievable goals.

The guideposts detailed above may be utilized by all parties in a commercial/government ACO arrangement to value the potential for success or failure. Detailed financial modeling and examination of capabilities on all sides is critical to determine if an accountable care program stands a chance at achieving its goals or is more likely to result in severe financial loss. Nevertheless, the ACO model is of great potential benefit to payors, providers and ultimately patients. When the model works, payors can achieve cost savings and providers can share in profit and provide better quality care to patients. Patients also benefit from care that is more focused on preventative medicine. The lessons and data available from the Pioneer ACO program are highly valuable to entities contemplating an ACO payment model and current ACO participants, whether federal, state or commercial, should analyze the potential impact on their own organizations.

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[1] CMS Innovation Center, *"Pioneer ACO performance year 2 quality results.'*October 2014.

[2] CMS Innovation Center, *"Medicare Pioneer ACO Model Performance Year 1 and Performance Year 2 Financial Result.'* October 2014.

[3] Melanie Evans, *"CMS posts long-awaited ACO quality and financial results."* *Modern Healthcare*, October 8, 2014.

[4] Melanie Evans, *"Medicare's Pioneer Program Down To 19 Acos After Three More Exit."* *Modern Healthcare*, September 25, 2014.

[5] Id.

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