The Pioneer Accountable Care Organization Model
Improving Quality and Lowering Costs

The Pioneer accountable care organization (ACO) model was one of the earliest models sponsored by the Centers for Medicare & Medicaid Services (CMS) Innovation Center and has arrived at a critical juncture in its evolution. In 2012, CMS implemented the Pioneer model with 32 experienced health care organizations of diverse structures from 18 states and engaged them in demonstrating what is possible in reducing fee-for-service Medicare spending through care improvement.

Under the ACO construct, clinicians and hospitals participating in the ACO have financial incentives to lower the total costs of care and improve clinical quality and patient experience outcomes as they take systematic approaches to managing care for a given population. The demonstration was designed as part of a broader CMS strategy on accountable care that currently also includes the Medicare Shared Savings Program, the Advance Payment model, and the Comprehensive End Stage Renal Disease Care Initiative (eTable in the Supplement). The Pioneer model complements and will inform refinements to the Shared Savings Program by offering payment arrangements with higher levels of risk and reward and by testing key design elements for the future of ACOs.

Since Pioneer ACOs were selected in late 2011, CMS has developed a collaborative partnership with Pioneer ACOs that is data-driven, based on open and direct communication, and committed to continuous improvement. The CMS achieved key milestones, including establishing a rich system for shared learning, refining the expenditure benchmark methods, generating sophisticated financial reports, and helping Pioneer ACOs use Medicare data to understand their populations’ needs.

A preliminary, independent evaluation1 found that in the first performance year (2012), the Pioneer model generated $147 million in total program savings, which exceeded CMS’ actuarial calculation of total savings ($87 million in the first year), and that the majority of ACOs outperformed rates in Medicare fee-for-service models for all 15 quality metrics for which comparable data were available. The participating programs included 669 135 Medicare beneficiaries in year 1. Not all ACOs generated savings or found the model to be a sustainable fit for their organization; to date, 9 ACOs have since transitioned to the Shared Savings Program and 3 have withdrawn altogether.

In the second performance year, ACOs pivoted from “start-up” priorities—analyzing data to understand their patient populations, engaging physicians, hiring new staff, identifying priority areas for care improvement, and acclimating to program requirements and processes including the reporting of quality measures—to the tasks of implementing and scaling specific care management strategies with a particular focus on postacute care and high-cost patients and deeper engagement of clinicians, patients, and communities in improvement efforts. CMS and Pioneer ACOs also developed greater appreciation for the challenges of managing care of a fee-for-service Medicare population, including the relatively high rate of turnover in claims-attributed populations from year to year, the broader question of which care strategies yield the greatest improvement in patient outcomes and returns on investment, and the lack of some tools available in managed care settings. Equally important, ACOs took different approaches to developing their networks of physicians and facilities and learned that growing too quickly as an organization could come at the cost of strategic engagement of physicians who could effectively manage their patients.

In recognition of the need for more tools to help ACOs improve care and accountability, specific program refinements were developed. A process for Pioneer ACOs to access a waiver of the 3-day hospitalization rule before a beneficiary becomes eligible for skilled nursing facility services was crafted, and shared learning activities focused on improving postacute care delivery and staffing were enlarged. Receiving feedback from Pioneer ACOs about their need to accurately track costs they incur in transforming care and the returns on those costs through the Pioneer model, CMS engaged ACOs in an “innovation pod,” a research and development sprint of several months in which they developed standardized cost accounting templates to more transparently track input costs for their care management efforts and calculate return on investment. CMS is collaborating with Pioneer ACOs on a randomized trial of a process for voluntary alignment of patients that would supersede claims attribution based on patients voluntarily attesting that the clinicians they consider their main health care professionals are in the ACO.

Pioneer ACOs engaged their private payers in earnest, driven in part by a requirement in the model that by the end of the second year, they have committed to deriving the majority of their clinical service revenues from “outcomes-based” contracts with private payers, similar to the Pioneer arrangements, in which they are accountable for financial, clinical quality, and patient experience outcomes. CMS is now conducting a systematic review of the commercial contracts and/or Medicaid contracts that Pioneer ACOs have entered.

CMS recently announced results for the second Pioneer performance year, which included 607 945 Medicare beneficiaries (Table). In aggregate, Pioneer ACOs improved their performance in all dimensions of

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the 3-part aim—higher quality, better patient experience, and lower Medicare spending. Pioneer ACOs had a mean overall quality score of 84.0% in 2013 compared with 70.8% in 2012. The mean performance score of all Pioneer ACOs improved in 28 of 33 quality measures. The mean improvement across all quality measures was 14.8%. In addition, their mean performance score improved in 6 of 7 patient/caregiver experience ratings. Pioneer ACOs generated more total program savings in the second performance year than the first ($96 million vs $87 million). Seventeen of 23 ACOs (75%) had positive or neutral financial performance, with 11 earning shared savings above their minimum savings rate, 6 generating savings but not exceeding their minimum savings rate, and 6 generating any losses. The average amount of shared savings per ACO increased from $2.7 million to $4.2 million, with a range of shared savings for each organization from $1.2 million to $13.0 million in 2013. In unadjusted analyses, ACOs with the highest savings percentages experienced decreases in spending for skilled nursing, Medicare Part A services, and durable medical equipment compared with increases in those spending categories for ACOs with the highest loss percentages. No relationship between savings/loss performance and whether the ACO included hospitals was observed. Neither did there appear to be a relationship between the reference expenditure trend used to set an ACO’s target and the ACO’s savings/loss performance.

Now in its third year, the Pioneer model is adding key features designed to give ACOs more tools and flexibility for care management. Two ACOs opted to have a portion of their fee-for-service reimbursements converted to a monthly population-based payment, which offers them revenue flexibility to reallocate resources for care management. More organizations are expected to opt for this payment flow in subsequent years. In addition, the majority of ACOs have been approved for the waiver of the 3-day hospitalization rule. Pioneer ACOs can now directly admit clinically stable, qualified patients to a skilled nursing facility without prior hospitalization. CMS is testing “voluntary alignment,” which gives beneficiaries an opportunity to attest to the identity of their primary clinician, and if that primary clinician is participating in a Pioneer ACO, CMS would consider that beneficiary to be aligned with the ACO regardless of the results of claims analyses.

Predictably, the work has proved challenging for both CMS and ACOs, even those with extensive experience in population care management. While the withdrawal of any participant is concerning and needs to be better understood, individual organizations must make decisions most appropriate for their particular market and strategic circumstances, and the majority of those leaving the model have or plan to transition to the other Medicare ACO program (the Medicare Shared Savings Program). The Pioneer model continues to mature, fueled by rapid cycles of measurement, reporting, learning, and refinement made possible by the close collaboration CMS has formed with participating ACOs. Performance is on an upward trajectory in a manner aligned with original expectations, as ACOs become more strategic and effective in implementing care strategies and as CMS becomes more effective at facilitating their work. Looking forward, CMS will apply lessons learned about the clinical and technical sophistication, and the persistent and sustained approach that ACOs need to maintain care transformation, to the development of new models such as those that engage ACOs in global payment arrangements that offer ACOs more tools for directly engaging patients in care improvement. CMS will evaluate whether these Pioneer ACO results warrant expansion nationally. Early success in the Pioneer model suggests that in the long term, accountable care will offer patients the improved outcomes they deserve and ACOs the sustainable business model they need to stay focused on delivering high-value care.

### Table. Early Performance in the Pioneer Accountable Care Organization (ACO) Model, 2012-2013a

<table>
<thead>
<tr>
<th>Year</th>
<th>2012b</th>
<th>2013b</th>
<th>2012c</th>
<th>2013c</th>
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<tr>
<td>Total program savings, millions, $^d</td>
<td>87</td>
<td>96</td>
<td>128</td>
<td>96</td>
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<tr>
<td>Mean clinical quality score, %</td>
<td>70.8</td>
<td>84.0</td>
<td>73.0</td>
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<tr>
<td>Mean patient experience score, %</td>
<td>86.3</td>
<td>88.0</td>
<td>86.7</td>
<td>88.0</td>
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</tbody>
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* Results for 23 Pioneer ACOs participating in 2012 and 23 Pioneer ACOs participating in 2013.

* Results for 23 Pioneer ACOs participating in both 2012 and 2013.

* All savings minus all losses generated by the model.

**REFERENCES**
