DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OFFICE OF THE ACTUARY

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FROM: Paul Spitalnic, ASA, MAAA
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SUBJECT: Certification of Pioneer Model Savings

Certification

Section 1115A of the Social Security Act established the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare & Medicaid Services (CMS) to test innovative payment techniques and service delivery models. For successful models, the law states that "the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested…to the extent determined appropriate by the Secretary, if—

(1) The Secretary determines that such expansion is expected to—
  (A) reduce spending under the applicable title without reducing the quality of care; or
  (B) improve the quality of patient care without increasing spending;
(2) The Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce (or would not result in any increase in) net program spending under the applicable titles; and
(3) The Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under the applicable title for applicable individuals."

A certification was requested for a potential expansion of the Pioneer Accountable Care Organization (ACO) Model. Currently, ACOs may participate in the Medicare Shared Savings Program (MSSP), also known as the Pioneer Model. The MSSP program contains two tracks: track 1 is a sharing-only arrangement, while track 2 puts providers at risk for increased costs. Under the current MSSP program, all ACOs—whether participating in track 1 or track 2—will have to assume risk by the second agreement period. The Pioneer Model is currently authorized through 2016 and offers an even greater transfer of risk than track 2 of MSSP. The expansion of the Pioneer Model would create an additional option for ACOs that would also require providers to accept risk.

Based on historical evidence from the formal evaluation of the Pioneer ACO Model as well as independent internal analysis of financial impacts, and compared to the current cost baseline, I certify that expansion of the Pioneer Model would reduce net program spending under the applicable titles. The remainder of this memorandum summarizes the analysis supporting this certification.

Overview

The Affordable Care Act directed CMS to implement the MSSP ACO program to create incentives for providers to improve the quality and cost of care delivered to Medicare fee-for-service (FFS) beneficiaries. CMMI developed the Pioneer ACO Model to test whether alternative design elements might enhance ACO effectiveness and ultimately inform policy changes to improve the MSSP by means of future rulemaking. In contrast with the MSSP, the Pioneer Model offered experienced providers a more aggressive transfer of financial risk as well as greater customization in other aspects of the ACO arrangement.

The Pioneer Model began on January 1, 2012. It featured 32 Pioneer ACOs choosing 3-year agreements, with optional 2-year extensions, under one of five financial tracks that offered varying sequential pathways to an elevated transfer of financial risk for the cost of Part A and B claims and reported quality-of-care measures for annually aligned FFS beneficiaries. Of those 32 ACOs, 23 remained in the Model through the conclusion of the second performance year (2013), and 19 continue to participate as of the first quarter of the fourth performance year (2015). Eight of the 13 no longer participating in the Pioneer Model have since transitioned into MSSP.

The MSSP began soon after the Pioneer Model, with 27 and 87 ACOs entering agreements that began on April 1, 2012 and July 1, 2012, respectively, and that run through December 31, 2015. On average, the number of ACOs in the MSSP has grown by over 100 new participants each year since 2012 to reach 401 organizations by January 1, 2015. Unlike ACOs in the Pioneer Model, the MSSP ACOs were offered participation in a sharing-only arrangement (track 1), although current regulation requires all MSSP ACOs to transition to risk under track 2 in their second agreement period. As of January 1, 2015, 398 ACOs are enrolled in track 1, while only three are enrolled in track 2. The Pioneer expansion was evaluated relative to a current baseline that requires all Medicare FFS ACOs to ultimately participate in MSSP track 2.

Office of the Actuary Analysis

To determine the financial impact of the expansion of the Pioneer ACO Model, the baseline projection that includes the MSSP was compared to the expansion scenario that would create an additional track under the MSSP, thereby giving ACOs the option of selecting the Pioneer Model. A basic assumption is that ACOs participating in MSSP track 2 or the Pioneer Model, given that they are at risk for additional costs, are more likely to make significant improvements in the efficiency of care delivery in exchange for being offered a greater share of potential savings; therefore, additional ACO participation is expected to result in Medicare savings. The relative cost profile of ACOs participating in MSSP track 2 or the Pioneer Model must also be evaluated. Summarized below is an analysis of the expansion's impact on both the future number of beneficiaries attributed to ACOs and the per capita cost for those beneficiaries.

Enrollment Impact

The enrollment impact was assessed by examining the key policy differences between the Pioneer Model and MSSP track 2. Those differences include the following:

- Beneficiaries are prospectively aligned to the Pioneer Model but retrospectively assigned to the MSSP.
- Pioneer historical benchmarks are derived from the decedent-adjusted historical cost of the prospectively aligned cohort, whereas the MSSP uses historical base-year assignment symmetric to performance-year assignment to build up historical costs for distinct populations comparably served by the ACO during each base year.
- Pioneer applies segmented national reference trends to account for heterogeneity in aligned population age, gender, and eligibility risk factors, whereas the MSSP relies on Hierarchical Condition Categories (HCC) and demographic risk scores to adjust historical benchmark expenditures to a performance-year risk basis.
- Pioneer base-year historical trending is defined at a state level, whereas the MSSP applies national trends within updating historical base-year expenditures.
- To update benchmarks for expected growth through each performance year, Pioneer applies an equal blend between the percentage and absolute amount of national average growth in per capita cost, whereas the MSSP applies only the absolute amount of growth.
- Pioneers may use Tax Identification Number (TIN) and National Provider Identifier (NPI) combinations to define their provider roster, whereas the MSSP defines ACOs only at a TIN level.
- The more frequently selected Pioneer risk tracks employ maximum sharing percentages of up to 75 percent, and a minimum savings rate/minimum loss rate (MSR/MLR) of 1 percent, whereas MSSP track 2 employs a maximum sharing percentage of 60 percent and a MSR/MLR of 2 percent.
- The Pioneer Model features additional waivers (such as the 3-day minimum hospital stay requirement to receive skilled nursing care) and prospective "population-based" payments.

The Pioneer Model offers providers a greater transfer of risk than MSSP track 2 because it includes a higher savings percentage with a lower MSR/MLR, factors that will allow those providers to be reimbursed a greater share of the savings generated by the ACOs. In addition, the prospective alignment of beneficiaries enables ACOs to generate reports and implement adjustments in a more timely manner,[1] and it offers greater certainty to ACOs that they will benefit financially from deploying care management and actively attempting to prevent future adverse events for beneficiaries aligned to them.[2,3] The additional waivers—such as the 3-day

[1] Pantely, Susan. "Whose Patient Is It? Patient Attribution in ACOs," accessible at http://www.reliancecg.com/uploads/5_2011_whose-patient-is-it.pdf; Milliman, 2011.

[2] The preamble to the MSSP final rule from November 2011 at http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf states that "commenters were overwhelmingly in favor of prospective assignment" (page 67862, accessed on March 16, 2015); a more recent argument for prospective assignment was made by McClellan *et al.* in a June 2014 paper at http://www.brookings.edu/~/media/research/files/papers/2014/06/16-medicare-aco-challenges-and-alternatives/2-mcclellan-et-al--medicare-aco-program-62014.pdf (page 4, accessed on March 16, 2015).

minimum hospital stay required to receive skilled nursing facility care—and population-based payments further add to the appeal of the Pioneer Model relative to MSSP track 2. Finally, flexibility in defining TIN and NPI combinations may allow ACOs to attain increased provider membership and beneficiary alignment while improving their ability to effectively manage care with engaged provider members.

Evidence from the experience to date also indicates a preference for the Pioneer Model. Although early entrants to the MSSP in 2012 were more likely to demonstrate the baseline capabilities and experience exhibited by Pioneer ACOs, only four out of 114 ACOs in that group chose downside risk via track 2 (half of whom have since dropped out). These results suggest that the track 2 ratio of potential reward to risk may not be sufficient to attract significant ongoing participation. By contrast, the Pioneer Model, featuring greater sharing percentages with lower loss-sharing percentages (assuming an ACO achieves a reasonable overall quality score), clearly offers a stronger financial incentive for effective organizations to participate.

Based on the comparison of the two models and the evidence from program participation, we believe that the addition of the Pioneer track would increase the overall participation in ACOs relative to the baseline and that the majority of participants would choose the Pioneer Model.

Per Capita Cost Impact

To assess the impact of spending per beneficiary in the Pioneer Model compared to MSSP track 2, we analyzed information from a number of sources. We first compared evidence from the historical shared savings calculations from both the Pioneer ACOs and the MSSP ACOs. While this is only a comparison of actual spending to a benchmark and not an evaluation of the true savings generated by the ACOs, it is useful for comparing the two programs. We also reviewed the formal evaluation of the Pioneer ACO Model prepared by L&M Policy Research, LLC. The evaluation results were supplemented with our own analysis of market-level trends.

1) Evidence from Historical Benchmark Calculations

Total benchmark savings calculations appear to indicate that the Pioneer Model generated greater initial efficiency gains than the MSSP. Total Pioneer aligned FFS Part A and Part B claims costs were approximately 1.2 percent below the combined expenditure benchmark in 2012 and 1.3 percent below benchmark in 2013; these results exceeded the combined shared savings payments (net of shared losses) of approximately 1.0 percent of benchmark in 2012 and 0.8 percent in 2013. By comparison, the MSSP beneficiaries in the program's first performance period (covering April 2012 through calendar year 2013) exhibited total spending that was only 0.5 percent below the combined benchmark, or slightly less than the offsetting cost of resulting shared savings payments (net of shared losses) that represented about 0.7 percent of the combined benchmark.

It is likely, however, that historical differences in performance are at least partly driven by the characteristics of those organizations that select to participate in either program. Pioneer ACOs include many organizations that are experienced with accepting financial risk and associated care management for a defined population. At the same time, within the MSSP ACOs there is a subset

[3] Lieberman, Steven M., and Bertko, John. "Building Regulatory And Operational Flexibility Into Accountable Care Organizations And 'Shared Savings,'" accessible at http://content.healthaffairs.org/content/30/1/23.full; 2015.

that may be less comparable to Pioneer ACOs due to significant funding received under the Advance Payment Model.[4] Accordingly, the MSSP benchmark results were also examined to find a more comparable subset of 94 ACOs that had not received Advance Payment funding and that had joined the program in the first two enrollment cycles (April or July of 2012), thereby demonstrating immediate interest in an ACO arrangement and likely a greater baseline level of experience in care management than those ACOs waiting until 2013 or later to organize and enroll. This more comparable subset of MSSP ACOs exhibited combined expenditures that were approximately 1.0 percent below benchmark and were offset by combined resulting net shared savings payments of 0.9 percent of benchmark. The subset demonstrated improved results relative to the MSSP in total, but the outcomes only partly closed the gap relative to the Pioneer combined benchmark results summarized above.

The benchmark calculations are the product of two distinct prospectively defined formulas that transparently determine savings and loss outcomes for individual ACOs in each program. While both benchmark methodologies are generally considered unbiased estimators of cost savings relative to the national trend (except to the extent that ACO savings and/or "spillover" savings affect the national trend used to update ACO benchmarks), they differ in key features, such as in how the populations are aligned and how the historical baselines are constructed, risk adjusted, and updated by national trends. Even setting aside these systematic differences, the benchmark savings calculated for the mix of ACOs in each program are influenced by variation in extraneous factors, including market-level changes in beneficiary characteristics, changes in unit cost, and variation in underlying utilization trends. Therefore, a more confident assessment of the historical impacts of ACOs requires consideration of alternative methods for estimating programmatic impacts. Two such methods are the formal Pioneer Model evaluation report provided by CMMI and an internal evaluation of market-level trends provided by the Office of the Actuary.

2) Evidence from the Pioneer Formal Evaluation Report

The formal evaluation of the Pioneer Model identified an average gross savings on expected claims cost of between 3.7 percent and 4.8 percent in year one (2012) and of 1.1 percent to 1.8 percent in year two (2013), differentiated by whether each ACO's counterfactual trend was estimated using a comparable "alignable" population from the same ("near") market or from a ("far") market at some distance from the ACO. The majority of Pioneer ACOs were estimated to have produced statistically significant savings in the first performance year (19 ACOs relative to a near-market comparison and 22 relative to a far-market comparison), whereas only 11 (near-market) or 12 (far-market) ACOs were estimated to have shown statistically significant savings in year two. A different pair of ACOs under near- and far-market comparisons were estimated to have exhibited statistically significant increases in cost in year two.

A near-market comparison may lead to an understated savings measurement because ACOs' effects may "spill over," affecting the cost of care for beneficiaries who are not technically

[4] The Advance Payment Model is an initiative within CMMI that is a subset of MSSP ACOs. It provides monthly funding to assist certain ACOs in undergoing the process of improving efficiency. The initiative largely involves smaller and rural ACOs that were perceived as having fewer resources to invest in and create care improvement processes at the start of the program, and it is intended to test the effects of this monthly funding on the ACOs' quality and cost improvement.

attributed to the ACOs.[5] This hypothesis is supported by the fact that the far-market comparisons produced a larger average combined savings measurement than the respective average near-market comparisons in year one and again in year two.[6] In addition to spillover, savings measurements are also potentially confounded by increasing MSSP enrollment in both the near and far markets.

Examination of the specific markets utilized in the evaluation report confirms that a majority of chosen comparison populations were significantly affected by new MSSP ACO formation in mid-2012 and, to a greater extent, in 2013 and beyond. This outcome is potentially related to the markedly lower average savings estimated by the evaluation for the second performance year under both near- and far-market comparisons.[7] Notwithstanding the reduction from year one savings, the overall far-market estimate for year two still indicates that actual Model savings would have materially exceeded the offsetting cost of net shared savings payments to providers and that the resulting net savings would have been significantly greater, correspondingly, than indicated by the combined benchmark calculation.

Evaluation report results therefore appear to indicate that Pioneer ACOs generated real savings in 2012 and 2013 and that such savings were likely greater on average than strictly estimated by the benchmark formula. Moreover, these findings are not inconsistent with the hypotheses that (1) ACOs have some level of spillover effect on the cost of care for non-aligned beneficiaries, and (2) Pioneer savings observed in year two could be partly obscured by significant growth in savings from increasing MSSP ACO activity in 2013. A limitation of the evaluation report is that, since the analysis was not similarly applied to comparable MSSP ACOs, it does not address the relative performance between the Pioneer Model and the MSSP. This comparison was therefore attempted through an analysis of market-level trends.

3) Analysis of Market-Level Trends

An alternative method for estimating ACO impacts at an aggregate level stems from the observation that growth in ACO participation has been heterogeneous at the market level. Beneficiary attribution data from both the MSSP and the Pioneer Model were used to estimate the proportion of beneficiaries from each Hospital Referral Region (HRR) who were assigned each year to a Pioneer or MSSP ACO. Markets were grouped according to the estimated proportion of ACO assignment, a classification that made possible a broad comparison of per capita cost and utilization trends that ultimately supported the evaluation report findings for significant Pioneer savings and, importantly for this exercise, provided a comparable estimate indicating somewhat lower relative savings impacts for the MSSP.

[5] http://www.ncbi.nlm.nih.gov/pubmed/23982369

[6] The Pioneer evaluation authors attempted, but were ultimately unable, to identify explicit evidence for spillover by analyzing ACO-level changes in the gap between near- and far-market savings measurements from year one to year two; however, we note that attempting to make inferences on such comparisons is likely confounded by a lack of control for the impact of ongoing MSSP ACO formation after 2012 in the near- and far-comparison markets chosen for the evaluation.

[7] It is also possible that other CMMI models could have a disproportionate effect on the efficiency of care for non-ACO populations to the extent that they are targeted at non-ACO providers and beneficiaries, thus potentially reducing the portion of true savings that could be observed relative to non-ACO comparison groups.

Unlike savings estimates calculated on explicitly assigned ACO populations—a common feature of both the benchmark calculations and the Pioneer evaluation estimates alike—an overall market analysis implicitly assumes that if ACOs are responsible for reducing FFS expenditures, then significant ACO activity within a market (measured by the proportion of an HRR's beneficiaries assigned to an ACO) would be correlated to lower market overall per capita spending growth. Two advantages of this complementary approach are (1) a protection against mistaking cost shifts within a market as savings and (2) an ability to capture spillover savings effects from ACOs to neighboring providers and populations.

HRR claims and enrollment data for years 2007-2013 were obtained from CMS public use files on geographic variation.[8] In the interest of comparability, these public data were calculated using non-end-stage renal disease (ESRD) beneficiaries with Medicare FFS enrollment in both Part A and Part B. The key statistic analyzed—total Part A and Part B per capita spending—was normalized by the average HCC risk score for each HRR and standardized across a national average payment schedule. This process improved the likelihood that adjusted differences in expenditure trends were attributable to the independent variable—ACO assignment—rather than to extraneous confounding factors like price changes or shifts in population risk. Supplemental HRR-level data were obtained from the CMS Integrated Data Repository (IDR) through calendar year 2014. Similar to the public use data, IDR claims were limited to non-ESRD FFS beneficiaries with both Part A and Part B coverage. Although HCC risk scores and price standardization were not available for 2014 data, raw trends were still compared for the purpose of observing more recent incremental ACO effects on cost, under the assumption that our market groupings did not encounter materially heterogeneous overall impacts on baseline trend from price changes or beneficiary risk changes experienced that year.

To further reduce the potential for extraneous factors to confound the observed differences in expenditure trend, each comparison was made on as broad a grouping as possible to maintain large sample sizes. In first constructing a grouping of non-ACO markets against which Pioneer and MSSP market trends could be compared, a dividing line of 10-percent ACO assignment was chosen such that roughly half of the 2013 FFS population resided in 171 HRRs, with each HRR exhibiting less than a 10-percent proportion of Pioneer and MSSP ACO assignment combined. For these non-ACO markets, the combined average assignment ratio to any ACO (MSSP or Pioneer) was only 3 percent in 2013. In addition, a baseline comparison trend for 2014 was constructed from the 111 HRRs that remained after the same maximum ACO assignment criteria had been applied to 2014 assignment data. These 111 HRRs combined to account for just over one-fourth of FFS beneficiaries nationally, and they continued to exhibit minimal average ACO assignment of 3 percent in 2014. ACO market groupings were made using the inverse of these criteria—specifically whether at least 10 percent of beneficiaries were assigned to an ACO in the given program in the particular year.[9]

[8] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html

[9] Thirteen HRRs exhibited greater than 10-percent assignment in both MSSP and Pioneer ACOs in 2013. Nine of these markets demonstrated similar levels of assignment in the two programs that year and remained in both the MSSP 2013 and the Pioneer 2012 and 2014 groupings. One HRR showed significantly greater MSSP assignment and was included in only the MSSP 2013 grouping. Three HRRs exhibited significantly greater assignment for Pioneer ACOs and were included in only the Pioneer 2012 and 2014 groupings. For the same reason, one of the three HRRs would have also appeared in the MSSP 2012 grouping but was excluded.

The table below shows baseline characteristics and combined average per capita cost trends for the HRR market groupings compared in the analysis. ACO markets were first sorted on the basis of 2012 assignment data and then were resorted using subsequent such data to better capture evolving ACO participation. ACO markets tended to have higher baseline costs, although these differences were largely mitigated by price standardization and risk adjustment. Pioneer HRRs exhibited higher average baseline Medicare Advantage enrollment rates, perhaps related to the expectation that ACOs in the Pioneer Model would have more experience with managed care in their marketplaces. Annual historical trends (adjusted for risk and standardized for price) were very consistent across the four ACO HRR groupings, with increases of approximately 3.0 percent per year from 2007 to 2011. Average adjusted trend increases for the low-ACO market groupings were slightly lower by about 0.3 percent to 0.4 percent annually over the same historical period. The consistency in the historical adjusted trends provides some assurance that the ACO activity used to create the market groupings may be causally related to the divergence in trends after the start of the ACO programs.[10]

Summary of Combined HRR Market Trend Analysis

Criteria for Grouping HRRs→	HRRs with ACO Activity				Non-ACO HRRs	
	>10% MSSP 2012	>10% MSSP 2013	>10% Pioneer 2012	>10% Pioneer 2014	<10% Comb'd 2013	<10% Comb'd 2014
Baseline Characteristics						
Number of HRRs	48	113	26	21	171	111
HHR Percent of Total FFS Population	18%	43%	12%	7%	49%	27%
Medicare Advantage Penetration (2013)	29%	31%	42%	37%	29%	29%
Percent FFS Assigned to MSSP	17%	18%	4%	14%	3%	3%
Percent FFS Assigned to Pioneer	1%	2%	18%	22%	0%	0%
A&B FFS Per Capita Cost (Nominal 2011)	$10,012	$10,054	$10,507	$9,972	$9,094	$8,739
Risk Adjusted and Price Standardized	$9,340	$9,283	$8,947	$8,971	$9,189	$9,064
2007-2011 Avg Cost Trend (Adj & Std)	3.1%	3.0%	3.0%	3.0%	2.7%	2.6%
Comparison from Final Base Year Prior to Pioneer and MSSP (2011)						
Combined Adj Trend '11→'12	2.0%	2.2%	2.1%	1.9%	2.5%	2.6%
Combined Adj Trend '12→'13	−0.5%	−0.5%	−0.8%	−0.8%	−0.5%	−0.4%
Combined Raw Trend '13→'14	0.5%	0.3%	−0.3%	0.0%	0.7%	0.9%
Total Change 2011→2014	1.9%	2.0%	1.0%	1.2%	2.7%	3.1%
Difference from "<10% 2014" HRRs	*−1.2%*	*−1.1%*	*−2.1%*	*−1.9%*	*−0.3%*	—

[10] The following published studies provide further evidence that providers that are similar to ACOs have been associated with greater efficiency:

- "The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending And Improved Quality," accessible at http://content.healthaffairs.org/content/31/8/1885.full.html
- "Spending Differences Associated With the Medicare Physician Group Practice Demonstration," accessible at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3484377/pdf/nihms408048.pdf
- "Higher Health Care Quality And Bigger Savings Found At Large Multispecialty Medical Groups," accessible at http://content.healthaffairs.org/content/29/5/991.long

Annual cost trends for MSSP and Pioneer HRR groupings are generally equal to or below those for the comparison markets for each of the 3 years since the two programs began. The full difference in partially adjusted average cost trends from 2011 to 2014 is shown in the final row of the table. Regardless of the assignment data used to construct each ACO grouping, the overall 2014 gross claims savings implied by the comparison amount to just over 1 percent for MSSP markets and approximately 2 percent for Pioneer markets.

In the context of the Pioneer evaluation results and relative benchmark savings calculations, the divergence in market trend impacts implies that while both programs appear likely to be generating significantly greater gross savings than necessary to offset the respective cost of net shared savings payments, the relative savings impact from Pioneer ACOs appears to be greater on average over the first 3 years of both programs.

4) Overall Assessment

Based on the evidence from the formal evaluation of the Pioneer Model and our analysis of the market-level trends, Pioneer ACOs have been shown to reduce Medicare spending relative to the fee-for-service program. The market trend impacts and the historical benchmark calculation indicate that, although MSSP ACOs were also shown to reduce spending, Pioneer ACOs were likely to have generated greater relative savings than MSSP ACOs in the first 3 years of the two programs.

The difference in performance is likely related to multiple factors. One key factor is the greater incentive represented by downside risk and greater potential sharing of savings in Pioneer risk tracks. Since both MSSP track 2 and the Pioneer Model put the ACO at risk, this factor would not be expected to have an effect on the expansion of the Pioneer Model. An additional factor is selective Pioneer participation from organizations with the experience and resources necessary to materially improve the efficiency of beneficiary care. This selection effect would not exist under the expansion, as all ACOs would be in the MSSP.

Other notable Pioneer policies contribute to the expectation that an ACO would generally achieve greater savings under Pioneer than under MSSP track 2. Prospective alignment of beneficiaries could allow ACOs to more efficiently focus their care management techniques. In addition, the 3-day stay waiver and population-based payment could, in theory, result in greater efficiency by alleviating incentives for volume in a fee-for-service system. Finally, more favorable sharing of savings and a narrower MSR/MLR threshold are features that are more likely to lead to increased efforts towards generating efficiency than the weaker financial incentives in track 2.

These factors would likely generate a small amount of savings for the Pioneer Model relative to the MSSP. The savings would be offset by the more favorable sharing of savings. Since more of the savings would be shared with the ACOs, less would be retained by the Medicare program. The overall effect could be either a cost or a savings to Medicare, but the impact is likely negligible in size.

Conclusion

Because several of the design aspects of the Pioneer Model are more attractive to the ACOs, we expect that many ACOs that would have otherwise participated in track 2 would instead opt for the Pioneer track if it were offered as an additional track under the MSSP. In addition, we believe that the existence of the Pioneer track would lead to an overall increase in beneficiary enrollment in ACOs relative to the current-law baseline.

The difference between the expected per capita savings generated by MSSP track 2 and the Pioneer Model is likely negligible. Accordingly, for those ACOs that would be expected to participate in MSSP track 2 under current law but instead choose the Pioneer track under the expansion, the total financial impact on the Medicare program would be minimal.

Both the Pioneer and MSSP ACOs have been shown to produce savings relative to fee-for-service Medicare. As a result, the additional ACOs that are expected to be gained by the expansion would generate further savings to the Medicare program. Since the cost impact of those ACOs switching from MSSP to Pioneer is expected to be minimal, we have concluded that the additional savings that would be achieved from increased ACO enrollment would lead to an overall reduction in Medicare costs for the expansion of the Pioneer ACO Model.