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Health Policy Brief

Medicare accountable care organizations: Balancing risk and opportunity

Produced by the Deloitte Center for Health Solutions
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Executive summary

As the US health care system's payment models shift from a focus on volume to value, the US Centers for Medicare & Medicaid Services (CMS) is testing ways to pay for Medicare services through its flagship accountable care organization (ACO) programs, the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model, as well as its new Next Generation Model. Between the MSSP and Next Generation programs, health systems can select one of four ACO models to test value-based care (VBC) in their Medicare service offerings. A critical question for health care organizations to consider is, "Which ACO model will best balance risk and opportunity and meet our goals for participating in VBC?"

The ACO programs are testing incentives for providers to coordinate patient care across settings and the care continuum, while reducing spending and improving quality. Some organizations may feel prepared for and confident about taking on higher levels of risk, while others may just be starting on their journey to VBC. CMS's Medicare ACO programs offer many risk arrangements, and it is up to provider organizations to select which arrangement best fits their needs and priorities.

Health care organizations that wish to establish or continue a Medicare ACO should consider several key factors before moving ahead. Among these these are how CMS tracks patients and aligns ACO performance to them; how ACOs are paid and what opportunities exist for participating organizations to share in savings; and how performance will be measured. This paper provides details about these program requirements.

Each ACO model offers benefits (e.g., lower risk or higher savings) and risks (e.g., higher shared losses and lower flexibility); the appropriate approach depends on a health system's tolerance for risk along with other program requirements. While organizations with more advanced capabilities in care management and analytics may be better-equipped to handle the higher risk-sharing models, they may not always be the best choice. CMS has strict rules around patient engagement, performance feedback, provider types, and other factors which health care organizations should consider before selecting a model.

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Are ACOs just a new type of health plan? Not really.

Medicare has three main payment approaches for health care services: FFS, Medicare Advantage, and ACOs. Under Medicare Advantage, CMS contracts with health plans, which receive a monthly fee to cover services to beneficiaries. With ACOs, CMS contracts with health care providers, which manage performance risk (i.e., cost and quality) for a specific patient population. (See Table 1 for key differences between the programs.)

Table 1: Key differences between Medicare Advantage and Medicare ACOs

	Medicare Advantage	ACOs
Participating organizations	Health plans	Health care providers
Organization risk level	Full risk for all Medicare services, including drugs	Basic payment is FFS, but all ACOs can earn bonuses; MSSP Track 2 and 3 and Next Generation ACOs are at risk for penalties as well; Part D drugs are not included
Payment methodology	Health plans receive a monthly capitated payment for each beneficiary	MSSP ACOs continue to receive FFS payments throughout the year and shared savings or losses (if applicable) are applied later; Next Generation ACOs can select one of four payment mechanisms
Beneficiary assignment	Beneficiaries are locked into the network for the plan they select during open enrollment	Beneficiaries can seek care at any provider, regardless of whether or not it is the ACO to which they are attributed
Data provided by CMS on enrollees' service use	Some information on members is available for plans to access	CMS sends claims data to provider organizations
Quality	Star ratings program rates health plan performance on up to 44 quality measures (depending on the contract); CMS uses ratings to calculate bonus payments for health plans	CMS rates ACO performance on 33 quality measures; these are used to calculate the final bonuses or penalties

Context: Medicare Shared Savings Program and Next Generation ACOs

Medicare spending accounts for 14 percent of the federal budget and 20 percent of all US health care expenditures.[1] As Medicare spending grows, the US Department of Health and Human Services (HHS) and CMS have been clear about the need to move the Medicare program toward care based on outcomes and value. Earlier this year, HHS set a goal to tie 50 percent of traditional fee-for-service (FFS) Medicare payments to alternative payment models, such as ACOs, by 2018.[2] ACOs are designed to reduce health care costs and improve quality by coordinating care, reducing unnecessary and duplicative services, transitioning services to lower-cost settings when appropriate, aligning clinicians to consistent care models, and engaging beneficiaries in their own care.

The Affordable Care Act (ACA) created the MSSP and Pioneer ACO models, and health care organizations began signing on in 2012. Eligible providers may participate in the MSSP by creating or participating in an ACO. Organizations must agree to participate in the program for three performance years.[3] As of April 2015, there are 404 MSSP organizations and 19 Pioneer ACOs. Combined, these ACOs serve nearly eight million Medicare beneficiaries.[4]

The Next Generation ACO program will begin in 2016 and is anticipated to essentially replace the Pioneer program. CMS accepted applications for the first round of Next Generation ACOs until June 1, 2015, and is expecting approximately 15 to 20 organizations to participate in the first performance period.[5] The remainder of this Issue Brief will examine the core similarities and differences of the MSSP and Next Generation ACO models.

Selecting an ACO model: Three considerations

With more than 400 organizations already participating in Medicare ACO programs, there is no shortage of interest in the different ACO models from current and potential participants. When considering the pros and cons of each, a priority for an accountable care program should be to shift the cost curve downward. (See Figure 1.) In addition, health care organizations should consider the following questions:

Which program is better for our organization – MSSP or Next Generation?

The Next Generation Model requires organizations to take on the greatest amount of financial risk. For example, the Next Generation benchmark methodology may make it more difficult to achieve savings, as the baseline is automatically discounted by at least 0.5 percent (regardless of whether or not it will be adjusted for previous years' savings). Additionally, a guaranteed shared loss rate of 80 percent or 100 percent for Next Generation organizations may make the model unattractive compared to the different MSSP tracks. However, organizations with more advanced care management models and analytics capabilities may find Next Generation to be an attractive program.

If our organization decides that the Next Generation program is too risky, which MSSP track should we choose?

As shown in Figure 1, factors in addition to financial savings and losses are important when selecting an ACO model. For example, an organization that believes it can spend below its set level may find Track 3 most attractive because it offers the greatest potential for shared savings *and* population management. However, if an organization does not think it can adopt strong care management strategies that bend the cost curve, or if the idea of potential shared losses may undermine provider relations, Track 1 may be the most conservative choice. For organizations that want to take on some risk but also limit the downside potential as much as possible, Track 2 may offer an attractive "middle ground."

If we move to greater risk sharing, does our organization have the necessary analytics, care management, and tracking capabilities to manage this risk?

This is an important question for organizations considering the Medicare ACO programs, as advanced capabilities will be critical for success under these new payment models. Many of the organizations already participating in the Medicare ACO programs have learned which capabilities are needed to begin taking on more risk. (See case studies on page 5.)

Below are more detailed considerations for health care organizations as they contemplate which ACO program and/or track fits best when mapped to their competencies and positioning.

Figure 1: Each ACO option offers health care organizations different benefits and risks

	MSSP Track 1	**MSSP** Track 2	**MSSP** Track 3	**Next Generation**
Risk arrangement: What potential for upside and downside risk exists? How strong is the financial incentive to change?	• No downside risk • With no downside risk, the financial incentive to change care management approaches may be small	• Potential for downside risk • Existence of risk could incent more proactive population management	• More potential downside risk • Existence of risk could incent more proactive population management	• Most potential downside risk • Highest potential to manage population and steer in-network (see items below)
ACO's shared %: Is the sharing percentage high enough for it to be worth the effort and/or risk?	• Smallest of all sharing percentages (up to 50%) • If historical quality results are high, there could be more opportunity to maximize gain-share with little additional effort	• Higher sharing potential than Track 1 (up to 60%) • ACO's share of losses is limited at 60%, and could be as low as 40%	• Highest sharing potential for MSSP (up to 75%) • Largest loss-sharing potential for MSSP (up to 75%, but could be 40%)	• Highest gain-share potential of all options (80% or 100%) • Loss-share percentage is not dependent on quality performance (≠ 1 – gain-share percentage)
Benchmark methodology:[1] Does the benchmark methodology make it possible to continue achieving savings year over year?	• Will be increased to include historical shared savings payments, which could lead to better opportunity for savings			• One-year benchmark is always discounted (0.5% - 4.5%), making it harder to achieve additional savings
Benefit design enhancements: What opportunities for unique population management strategies are available?	• None (no waivers to allow for true population management)		• Phased-in waivers (skilled nursing facility (SNF), possibly telehealth, etc.) to allow for better management potential	• Member bonuses; annual selection of optional waivers (three-day SNF rule, telehealth, post-discharge home visits)
Beneficiary assignment: How does the assignment methodology operate, and what strategies would be required to manage given that methodology?	• Retrospectively assigned • Could lose current beneficiaries to Track 3 or Next Generation ACOs		• Prospectively assigned[2] • Gives organization better foresight • Could go elsewhere for care but still assigned to ACO	• Prospectively assigned[2] • Voluntary alignment supersedes claims-based assignment
Other considerations	• Previous successes as a Track 1 MSSP could lead to buy-in from physicians and overall organization (i.e., highest comfort level)	• Flexibility to choose Minimum Savings/Loss Rates (MSR/MLR) • Annual loss limit is lower than Track 3 and Next Gen	• Flexibility to choose MSR/MLR • Payment limit is higher than Track 2 and Next Gen	• Beneficiaries offered Coordinated Care Reward to incent in-network utilization • No MLR means any losses shared at 80% (or 100%)

1 Some items for the benchmarks under all programs for this year and future years are under consideration.
2 Beneficiaries that are prospectively assigned to a Track 3 or Next Generation ACO cannot be reassigned to another ACO (even if more care received elsewhere).

Two MSSP organizations learned what capabilities are critical to operating under a risk-based arrangement

Case study #1: One large, major metropolitan health system has been particularly successful in the MSSP program. One of the program's more significant savings earners, it added to CMS's more than $280 million total MSSP savings in the first year.[6] Participating as a Track 1 MSSP ACO was just one part of this organization's overall strategy to take on more risk arrangements. Among key success factors has been an enterprise-level focus on VBC strategies; technology investments; strong leadership; the willingness to take on greater risk for potential greater shared savings; and high levels of physician alignment and integration into leadership roles.

The health system's MSSP program involvement has also allowed it to identify hurdles early. For example, clinical integration and disconnected data sources were a key priority coming out of the first performance period. Going forward, a focus on integrating technology systems, aligning care management strategies across the continuum, identifying areas of patient loss, and better communication across the enterprise may help to advance the health system's participation in risk-based arrangements.

Case study #2: Another health system in the South that started as a Track 1 MSSP ACO saved much less during its first year. That said, the system earned enough and had high-enough quality ratings that it was able to share in those savings. Moreover, lessons learned from that year allowed this organization to more than double savings by the next year. As was true for the other health system, participating in the Medicare ACO program was just one part of a larger strategy to adopt more risk-based arrangements.

Early preparation and ongoing monitoring was essential to success for this health care provider. The organization and its leadership faced numerous questions, such as which community-based physician groups to partner with; what infrastructure and operational investments would be required; whether its provider network had gaps; how to structure the governance and operating model; and whether the organization had the technology necessary to support care management and reporting needs. Early on, it identified hurdles that it needed to overcome to be successful in the program; among them, physician relationships. As a result, the organization worked to enhance current relationships and develop new affiliations. It also identified data collection, reporting, and analytics as essential capabilities.

This health system's learnings and subsequent success have served as a foundation for its participation in more population health arrangements with commercial health plans and large employers.

Selecting which model works best for an organization

How would our organization be paid throughout the year? How much risk is involved?

A key difference between the MSSP and Next Generation models is that the latter offers the potential for capitation payment. However, both programs have options that provide FFS payment streams. Under any of the three MSSP tracks, participants receive payments under normal Medicare FFS arrangements throughout a given year. By contrast, the Next Generation Model offers ACOs four payment options:

- **Normal FFS:** Organizations are paid through the usual FFS process
- **Normal FFS plus an additional per-member-per-month (PMPM) payment:** Organizations are paid FFS and receive an additional PMPM payment (up to $6 PMPM)
- **Population-based payments:** Organizations receive reduced FFS payments and a PMPM payment equal to the FFS reduction percentage
- **Capitation:** Starting in performance year two, organizations can be paid through capitation; CMS estimates total annual expenditures for the ACO's members and that amount is paid on a PMPM basis to the ACO[7]

Organizations participating in MSSP can select from among three risk models, and participants in the Next Generation program can choose between two. (See Appendix 1.) Each model would change an organization's payment structure and most build in the potential to earn bonuses or penalties. The models present a continuum of risk and reward – the lowest-risk model has the potential for a bonus and no risk of a penalty, but the bonus is small in comparison to the other tracks. Meanwhile, the highest-risk model offers the greatest potential bonus but also has the highest potential penalty if an organization fails to meet its targets.

Finding the patients

Another key difference between the two Medicare ACO programs that can affect health care organizations' analytics and care management strategies is how enrollees are assigned to the ACO. In the MSSP program, it is a two-stage process, while the Next Generation program offers prospective assignment. Unlike Medicare Advantage, where beneficiaries actively enroll in a health plan and generally stay within that plan's provider network, beneficiaries in the Medicare ACO programs can see whichever providers they choose, whether or not the providers are in the ACO network. To determine how well an ACO performs on quality and cost measures, CMS needed to develop a way to match patients to ACOs. This attribution process, based on which providers the beneficiary chooses, is known as beneficiary assignment.

How do we know who our beneficiaries are?

Beneficiaries must meet certain criteria to be assigned to an ACO. (See sidebar.) If a beneficiary meets these criteria, CMS assigns him/her to an ACO based on primary care practitioner use:

- A beneficiary is assigned to an ACO if he/she received at least one primary care service provided by a primary care physician (PCP) inside that ACO.
- A beneficiary that did not receive any services from a PCP either inside or outside an ACO is assigned to an ACO if he/she received primary care services from other medical professionals (e.g., nurse practitioners, physician assistants) at that ACO.[8]

Medicare beneficiaries must meet certain criteria to be assigned to an ACO:

- CMS must have enrollment information on the beneficiary
- Beneficiaries must have participated in Medicare Parts A and B for at least one month but have not enrolled in Medicare Advantage or another demonstration program
- They must be permanent US residents
- Beneficiaries must have received most of their primary care services from a PCP at a participating ACO
- Eligible beneficiaries may only participate in one Medicare ACO

In MSSP Tracks 1 and 2, CMS uses a two-stage process to determine which beneficiaries go with which ACOs. At the beginning of each year, CMS assigns beneficiaries based on their utilization patterns from previous years. At the end of the year – based on which beneficiaries used which providers in the ACO – CMS does a final or "retrospective" assignment.[9] In Track 3, CMS prospectively assigns beneficiaries to an ACO and removes ineligible individuals at the end of the year.[10] In the Next Generation Model, CMS aligns beneficiaries on a prospective basis. Starting in performance year two, beneficiaries have the option of being voluntarily assigned to an ACO.

Caution: Free-roaming beneficiaries can create measurement problems

Unlike Medicare Advantage plans where beneficiaries are locked into a provider network, CMS rules for the traditional Medicare program prohibit beneficiaries from being required to seek care at one provider organization. Many ACOs have objected to this rule; they claim it can prevent organizations from effectively coordinating patient care.[11] Ultimately, savings and losses are assessed based on the health outcomes of an ACO's assigned beneficiary population. Many organizations claim that payments may not be entirely accurate or fair if the ACOs cannot track the care their "free-roaming" beneficiaries receive. To address this potential information gap, CMS allows ACOs to request claims information about a particular patient. However, before CMS releases this information, an organization must notify the patient that it wishes to access his/her personal information. Beneficiaries may decline to have their claims information shared.[12]

Caution: Retrospective assignment can make it difficult to target services

Some ACOs have found it challenging to target services to the beneficiaries whose care they will be graded on when they are retrospectively assigned. Proponents of the policy argue that because ACOs must provide care to a masked population, it is more likely that all patients will receive a high level of coordinated care as opposed to a select few.[13] Conversely, many provider organizations argue that if they know their patient population in advance with prospective assignment, it will allow for more targeted services.[14]

ACO financial model components

How does CMS set an organization's goals and targets?

Benchmarking is the first step that CMS takes to determine a health care organization's shared savings or losses. At the end of each year, CMS compares the organization's costs to the benchmark to determine whether or not it has saved money and, as a result, will receive bonuses or penalties, as appropriate. CMS uses different approaches to set the benchmarks for the two ACO programs. It has not yet indicated its specific approach for Next Generation, but the benchmark likely will be lower.

CMS establishes MSSP benchmarks before the start of each agreement period using data from three historical years. Benchmarks are adjusted for four categories of beneficiaries to account for the significant cost differences among groups. To avoid skewing expenditures by keeping the most costly patients in the calculation, CMS excludes the top one percent of claims when it establishes benchmarks.[15] Claims are risk-adjusted at the end of each performance year.[16]

In its 2015 final rule, CMS changed the benchmark methodology to give equal weight to previous years. Whereas CMS previously weighted benchmark year one at 10 percent, year two at 30 percent, and year three at 60 percent, it now weighs all three years equally. For the second agreement period, CMS will include any savings an organization generated during its prior agreement period in the new benchmark.[17] (See Figure 2.)

CMS will use one historical baseline year to calculate the benchmark for Next Generation ACOs; however, CMS has yet to indicate what year it will use for that calculation. The Next Generation ACO benchmark will likely be lower than the MSSP benchmark because it includes a discount that rewards quality and efficiency. This could make it more difficult to achieve savings under the Next Generation Model. It is unclear what benchmarking methodology CMS will use for performance years four and five of the model.[18]

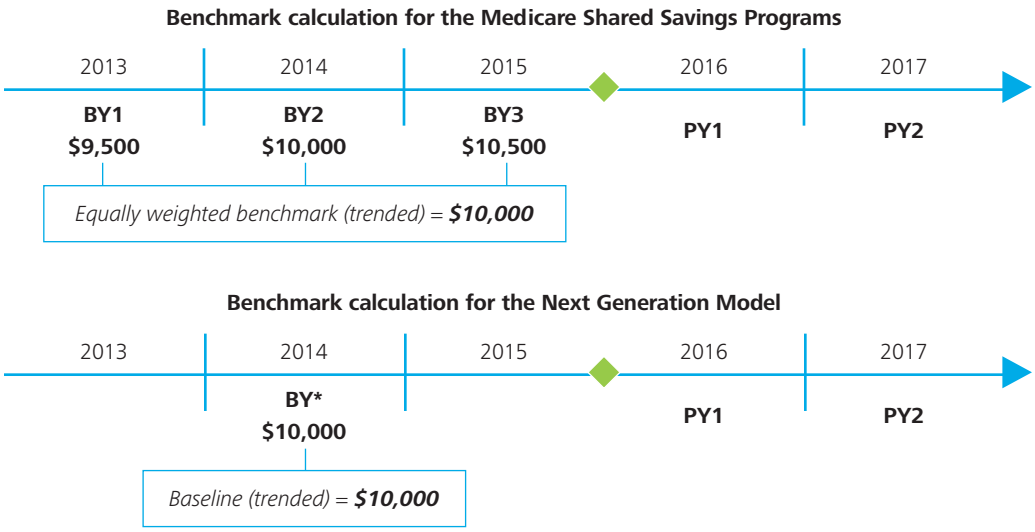
Do goals and targets change over time?

CMS updates benchmarks to account for changes in spending and beneficiary characteristics, and it plans to update the benchmarks differently in the two programs. In the MSSP, CMS trends the first two benchmark years' per-capita expenditures ahead to the third benchmark year by using the national growth rate for spending on Medicare Part A and B services. CMS also makes separate adjustments based on four categories of beneficiary characteristics.[19]

Because the MSSP methodology uses growth in average per-capita expenditures to update benchmarks, it overestimates ACO costs in low-cost and low-growth areas of the country and underestimates costs in high-cost and high-growth areas. ACOs in both areas may receive higher or lower savings depending on the estimates. Subsequently, organizations in the underestimated areas may be less inclined to form ACOs.[20]

CMS will adjust the benchmark for Next Generation ACOs differently. It will trend the baseline ahead using a trend similar to what is being used in Medicare Advantage. Regional prices will be used to apply the regional trend.

Figure 2. Differences in benchmark methodology, MSSP and Next Generation ACOs



Source: Deloitte analysis of the MSSP and Next Generation programs

*Based on current guidelines, it is unclear which year will be used as the baseline for Next Generation ACO program

BY = Benchmark year

How does CMS calculate our savings or losses? What does that mean for our final bonus or penalty?

MSSP ACOs must hit a minimum savings or loss amount to share savings or losses with CMS, whereas Next Generation ACOs will share any amount they save or lose. To calculate shared savings or losses, CMS compares an organization's performance – per-capita, risk-adjusted expenditures – with the benchmark that was set at the beginning of the performance period.[21]

This is where an MSSP ACO will see different payment based on its chosen track. In Track 1, ACOs can share in savings, but do not share in losses. Track 2 ACOs can share in (or will be required to pay back) savings (or losses) in excess of their benchmark. The new track, Track 3, sets the savings and losses bar even higher.[22]

Next Generation ACOs will have a choice between two risk arrangements that offer shared savings and losses of 80 percent or 100 percent. Organizations will neither have to meet a minimum savings rate to share in savings below the benchmark nor meet a minimum loss rate to be accountable for payments back to CMS for spending above the benchmark. (See Appendix 2.)

Calculating quality

How does quality factor into each model?

Before an ACO can share in any savings it has generated, it must demonstrate that it met quality performance standards for that year.[23] MSSP and Next Generation ACOs will be measured on quality in different ways: MSSP ACOs are held to 33 quality measures that span four equally weighted domains: patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk population.[24] Next Generation ACOs will be measured against the same quality standards, except that CMS has removed the electronic health record (EHR) measure because all of the Next Generation ACOs will be required to demonstrate EHR capabilities in their program applications.

CMS uses multiple sources to measure ACO quality: patient surveys, claims data, the EHR incentive program, and the CMS Group Practice Reporting Option (GPRO).[25] An MSSP ACO's sharing rate depends on how well it performed on quality; the higher the performance, the greater the savings.

CMS scores ACOs on quality using a sliding scale. For each measure, the performance rate is converted to quality points. CMS sums the quality points for each domain and divides that figure into the total available points for each domain to come up with an overall domain score. The four domains are then averaged together to produce an overall quality score. CMS uses the overall quality score to calculate the final sharing rate that an MSSP ACO receives.[26] In the Next Generation program, CMS will use the quality score to calculate the quality component of the benchmark discount.

CMS has already revised some of the quality measures in minor ways, but most of the benchmarks have remained relatively consistent. In the 2014 Physician Fee Schedule, CMS did not move forward with its initial proposal to increase the number of quality measures from 33 to 37. However, CMS said it would leverage claims data more to measure ACO quality.[27]

Conclusion

The two health care organizations profiled in this paper's case studies gained significant savings and learnings from their MSSP participation. However, many other organizations were unable to reach their performance goals and, as a result, did not share in savings after the first period.

Before an organization moves to a Medicare ACO risk-sharing payment model, it should balance the risk and opportunity and consider whether it has the necessary analytics, care management, and tracking capabilities to manage risk and realize savings.

Appendix 1: Key differences between MSSP Tracks 1, 2, and 3 and Next Generation ACOs

	MSSP Track 1	MSSP Track 2	MSSP Track 3	Next Generation
Shared savings	Yes	Yes	Yes	Yes
Shared losses	No	Yes	Yes	Yes
Number of participating organizations	404		TBD	TBD
Summary of risk model	This track is designed for less-experienced organizations. Participants share in savings but not losses.	More experienced organizations may bypass Track 1 and begin in Track 2. ACOs that begin in Track 1 can move to Track 2 after three years. Track 2 participants share in both savings and losses.	This track will begin in 2016 and has a higher sharing rate than Tracks 1 and 2. Organizations can share in savings up to 75 percent. They are also at risk for greater losses than organizations in Track 2.[28]	**Increased shared risk:** For periods one through three, organizations would share savings or losses up to 80 percent; for period four, the rate would increase to 85 percent. **Full performance risk:** Organizations would share 100 percent of the savings and losses.[29]

Source: Centers for Medicare & Medicaid Services, *Fast Facts: All Medicare Shared Savings Program (Shared Savings Program) ACOS and Pioneer ACOs,* April 2015, p. 1-2, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf, accessed August 14, 2015

Appendix 2. Shared savings and losses in MSSP Track 1, 2, and 3 and the Next Generation Model

	Track 1 (one-sided)	Track 2 (two-sided)	Track 3 (two-sided)	Next Generation
Shared savings rate	Up to 50 percent	Up to 60 percent	Up to 75 percent	80 percent or 100 percent depending on arrangement choice
Shared loss rate	N/A	May not be less than 40 percent or exceed 60 percent	May not be less than 40 percent or exceed 75 percent	80 percent or 100 percent depending on arrangement choice
Quality scoring	Final sharing rate conditional on quality performance			Final sharing rate not affected by quality rating
Minimum savings rate/ Minimum loss rate	Varies from 2.0-3.9 percent depending on population size; MLR not applicable to Track 1 ACOs	ACOs have the choice of symmetrical MSR and MLRs; organizations may choose among three different structures*		Applies a discount to benchmark instead of having an MSR. First dollar shared savings and losses for spending below or above the benchmark, respectively.
Maximum sharing cap	Payment capped at 10 percent of ACO's benchmark	Payment capped at 15 percent of ACO's benchmark	Payment capped at 20 percent of ACO's benchmark	Payment capped at 15 percent of ACO's benchmark

Source: http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-04.html;
*Note: The June 9, 2015, CMS Final rule on the MSSP made changes to the MSR and MLR options for Track 2 organizations. Previously, MSR and MLR were fixed at two percent for these organizations.

Endnotes

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Authors

Mark Bethke, FSA, MAAA
Director
Deloitte Consulting LLP
mbethke@deloitte.com

Jim Whisler, FSA, MAAA
Principal
Deloitte Consulting LLP
jwhisler@deloitte.com

Claire Boozer Cruse, MPH
Health Policy Specialist
Deloitte Center for Health Solutions
Deloitte Services LP
cboozer@deloitte.com

Molly Stormont
Senior Consultant
Deloitte Consulting LLP
mollystormont@deloitte.com

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