Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OBSERVATIONS FROM OUR REVIEW OF CMS'S ADMINISTRATION OF THE FIRST PERFORMANCE YEAR OF THE PIONEER ACCOUNTABLE CARE ORGANIZATION PAYMENT MODEL

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Audit Services

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A-01-13-00509

Office of Inspector General

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

May 31, 2016

TO: Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Observations From Our Review of CMS's Administration of the First Performance Year of the Pioneer Accountable Care Organization Payment Model (A-01-13-00509)

This memorandum offers observations based on our review of the Centers for Medicare & Medicaid Services' (CMS) administration of the Pioneer Accountable Care Organization (ACO) Payment Model (Pioneer Model). Calendar year 2012 was the first performance year (PY1) and was the only completed year at the time of our data collection. Because our review was limited to the first year of one ACO model, we are making no formal recommendations, and our observations do not represent an overall assessment of CMS administration.

Our observations on CMS's administration of Pioneer Model PY1 include that CMS:

- although not required to do so, did not publicly disclose certain retroactive payment arrangement selections for PY1;
- did not have access to data needed to verify shared savings and loss calculations;
- did not promptly process and collect the only shared loss;
- performed two Pioneer ACO pilot audits and, although not required to do so, may not have communicated and resolved the results; and
- did not always maintain complete Pioneer ACO agreements and other key documentation.

BACKGROUND

Traditional Medicare Fee-for-Service

CMS administers Medicare's traditional fee-for-service program, which provides hospital insurance (Part A) and supplementary medical insurance (Part B) to eligible beneficiaries. Under the fee-for-service payment structure, providers and suppliers for a Medicare beneficiary receive Medicare payment for each service and specific item they provide. As a result, the delivery of care is often fragmented. Incentives in the fee-for-service payment structure may also contribute to the growth in health care costs in the United States because they tend to reward providers and suppliers for the volume of services delivered, rather than the quality of those services.

Medicare Accountable Care Organizations

In general, a Medicare ACO is composed of a group of health care providers and suppliers who accept joint responsibility for the cost and quality of Medicare Parts A and B for a specified group of fee-for-service beneficiaries. CMS assigns beneficiaries to each Medicare ACO on an annual basis according to each program's specifications.

The Center for Medicare and Medicaid Innovation and the Pioneer Model

The Patient Protection and Affordable Care Act (ACA)[1] established section 1115A of the Social Security Act (the Act), which authorizes CMS, through the Center for Medicare and Medicaid Innovation, to contract directly with groups of health care providers and suppliers to test innovative payment and service delivery models. This is an effort to reduce program expenditures, while preserving or enhancing the quality of care for Medicare and Medicaid beneficiaries.

Through the Pioneer Model, CMS sought to support experienced ACOs in the transformation of their business and care delivery models so that they would not be reliant on fee-for-service volume and could focus on optimizing outcomes of care. Pioneer ACOs were expected to have extensive experience with systematic care improvement efforts and either already have had or have been prepared to enter into payment arrangements that included financial accountability and performance incentives. Pioneer ACOs are responsible for the Medicare Part A and B health care expenditures of their assigned group of beneficiaries even though those beneficiaries are not limited to obtaining services within the ACOs.

Pioneer Accountable Care Organization Agreements

The Pioneer ACO agreements between CMS and each of the Pioneer ACOs establish specific requirements for the Pioneer Model. The Pioneer ACO agreements are similar but have different payment arrangements, appendixes, and amendments. Each Pioneer ACO has a payment arrangement with an expenditure goal, called a "benchmark," and a threshold percentage for

[1] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as "ACA."

savings relative to the benchmark. Four of the five payment arrangements offered in PY1 also included a shared loss provision, with the same percentage threshold used to determine shared savings. Shared savings are due from CMS to the Pioneer ACO and shared losses are due from the Pioneer ACO to CMS for any monetary amount in excess of the threshold percentage relative to the benchmark.

The Pioneer ACO agreements lasted for 3 years with an option to extend 2 more years. In the first 2 performance years, the Pioneer Model tested shared-savings and -loss payment arrangements with varying levels of reward and risk, while providers and suppliers continued to receive traditional fee-for-service payments. Each Pioneer ACO's performance relative to its benchmark, which is based on specific financial and quality-of-care targets, determines whether the Pioneer ACO generated shared savings or shared losses (or neither). The Pioneer Model provided ACOs that were successful in achieving shared savings in the first 2 years the opportunity to transition to a population-based payment in the third year, under which providers and suppliers would receive a mix of fee-for-service and per-beneficiary per-month payments.

CMS relies on contracts with outside entities to provide critical program management services for the Pioneer Model. For example, one contract provides for monitoring Pioneer ACOs' performance and auditing their compliance with Pioneer ACO agreements. Another contract provides for calculation of shared savings and losses.

Annually, CMS provides shared savings and loss information to each Pioneer ACO in a settlement report. Pioneer ACO agreements allow 30 days after a settlement report is deemed final for CMS to pay shared savings and collect shared losses.

HOW WE CONDUCTED OUR REVIEW

Our objective was to assess CMS's administration of the Pioneer Model after its first full year of operation. We limited our review to those internal controls related to CMS's administration of the Pioneer Model PY1. We did not review internal controls at the Pioneer ACOs or CMS contractors. We did not review any Medicare claims from Pioneer ACO providers or suppliers.

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations, Pioneer ACO agreements, CMS outside contracts for work under the Pioneer Model, email communications between CMS and Pioneer ACOs, CMS policies and procedures, Pioneer ACO pilot audit documentation, and documentation of the collection of the PY1 shared loss; reviewed and analyzed PY1 settlement reports of shared savings and losses for Pioneer ACOs; and interviewed officials of CMS and CMS's program analysis and monitoring contractors; and

- interviewed officials of all seven Pioneer ACOs in New England[2] to obtain their perspective of Pioneer Model administration.

We contacted CMS in Baltimore, Maryland, from March 2013 through March 2014. We performed fieldwork interviews at the offices of New England Pioneer ACOs from December 2013 through March 2014.

We conducted this audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

OBSERVATIONS

At the time of our review, CMS was continuing to develop the Pioneer Model and work with the Pioneer ACOs in the transformation of their business and care delivery models. We made observations on CMS's administration of Pioneer Model PY1 at the time of our fieldwork.

Although Not Required To Do So, CMS Did Not Publicly Disclose Certain Retroactive Payment Arrangement Selections for Performance Year 1

Pioneer ACO agreements generally provided that the selection of a payment arrangement was binding for PY1. Amendments to the agreements were generally permitted when mutually agreed upon in writing by the parties.

In April 2013, after the close of PY1 when Medicare claims data became available to determine shared savings and losses, CMS transferred five Pioneer ACOs from a two-sided risk model with potential for either shared savings or shared losses to a one-sided risk model with no risk of shared losses, retroactively effective for PY1.[3] Our analysis of settlement reports obtained from CMS showed that four of these Pioneer ACOs would have had shared losses exceeding $6.8 million, combined, under their original payment arrangements but would not incur shared losses under the one-sided arrangement into which CMS transferred them after the close of PY1. The fifth Pioneer ACO sustained a loss smaller than the agreed-upon threshold to trigger a shared loss.

[2] Pioneer Model PY1 involved 32 ACOs nationwide, including 5 in Massachusetts, 1 in New Hampshire, and 1 in Maine.

[3] The Pioneer ACO agreements required each Pioneer ACO to select one payment arrangement from among five choices. Four of the choices were two-sided and created the risk of the Pioneer ACO sharing in losses as well as the possibility of greater sharing in savings, with various percentages for triggering the sharing and for the amount of shared savings or losses. One choice was one-sided, with a possibility of the Pioneer ACO sharing in some savings but no responsibility for sharing losses.

While CMS published information about the results of Pioneer Model PY1's total shared savings and shared losses, it did not include information that five ACOs had been permitted retroactively to select a one-sided payment arrangement. The first press release of PY1 shared savings and shared losses stated, "[o]nly 2 Pioneer ACOs had shared losses totaling approximately $4.0 million."[4] Specifically, the published information did not include information about the total shared savings or shared losses that would have resulted had the four ACOs incurred shared losses under their originally selected two-sided arrangements. CMS could have explained there or in other public documentation that five ACOs were permitted to change to one-sided payment arrangements retroactively and could have collectively incurred additional shared losses totaling approximately $6.8 million had they not done so.

While CMS was not required to report specific information, more complete information would have provided a fuller picture of the Pioneer Model in PY1 and provided stakeholders with a more complete understanding of the performance of the five Pioneer ACOs—four of which left the Pioneer Model after PY1[5]—in reducing health care costs.

Instead, without more complete information from CMS, the publicly reported Pioneer Model PY1 shared savings and shared losses presented a more favorable overall outcome than would have been achieved under the payment arrangement selections actually in place during PY1.

CMS Did Not Have Access to Data Needed To Verify Shared Savings and Loss Calculations

Pioneer ACO agreements specify the methods for calculating shared savings and losses; CMS provides information about shared savings and losses annually to the Pioneer ACOs in settlement reports. CMS awarded a contract to perform these calculations. As a part of CMS's contract

[4] The press release was still available as of July 16, 2015, on the CMS Web site: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2013-Press-releases-items/2013-07-16.html. Note that one of the two Pioneer ACOs originally reported as having sustained a shared loss (of just over $2 million) was later relieved of that obligation because of its election of an optional technical adjustment. CMS later revised the amount of the other Pioneer ACO's shared loss from just under $2 million to more than $2.5 million, the collection of which was because of another technical adjustment.

[5] Three of the four that left the Pioneer Model after PY1 transferred to the lower risk Medicare Shared Savings Program and one left Medicare ACO programs entirely.

management and administration over the contractor who performed these calculations, it should ensure that best practices techniques are used, including good management practices.[6]

CMS did not verify the contractor's shared savings and loss calculations for PY1 because only the contractor had access to necessary historical Pioneer Model data. Although CMS performed some validity checks on underlying data, it had not conducted an end-to-end review of shared savings and loss calculations. The failure to conduct end-to-end testing demonstrates that CMS did not have good management practices over the contractor. Without this testing, CMS could not make sound judgments on whether the contractor was performing according to the contract terms and conditions. Good management practices indicate that when overseeing the contract administration function, CMS should have verified the contractor's calculations because, according to officials of several Pioneer ACOs, these calculations used a methodology that was not standard in the health care industry.

Because CMS did not verify the contractor's calculations, it did not have independent assurance that Pioneer Model PY1 shared savings of $65.6 million and a shared loss of $2.5 million, totaling net reported shared savings of $63.1 million, were accurate.[7]

CMS Did Not Promptly Process and Collect the Only Shared Loss

Pioneer ACO agreements grant 30 days from the date the settlement report is issued by CMS for a Pioneer ACO to notify CMS of an error in the settlement calculation. Unless the Pioneer ACO notifies CMS within the 30-day period, the settlement report is final 30 days after it is issued. In the case of a shared loss, the agreements require full payment within 30 days of the date of the final settlement report.

CMS did not promptly process and collect the only PY1 Pioneer ACO shared loss. Specifically, the settlement report for one Pioneer ACO, dated August 1, 2013, indicated a shared loss of approximately $2.5 million. Under the terms of the Pioneer ACO agreement, the settlement was

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[6] Federal Acquisition Regulation Subpart 37.5 defines "Best practices" and incorporates by reference Office of Federal Procurement Policy (OFPP) Policy Letter 93-1, paragraph 7 "Good Management Practices" subparagraph (c) "Control." That subparagraph states:

> When contracting for services, in particular for highly specialized or technical services, agencies should ensure that a sufficient number of trained and experienced officials is available within the agency to manage and oversee the contract administration function. This especially applies to such services as management and professional support, studies, analyses, and evaluations, and engineering and technical support. Agency officials need to be able to make sound judgements on what the requirements should be, the estimated costs, and whether the contractor is performing according to the contract terms and conditions. Agency officials must retain control over, and remain accountable for, policy decisions that may be based, in part, on a contractor's performance and work products. Agency officials must also provide an enhanced degree of management controls and oversight when contracting for functions that closely support the performance of inherently Governmental functions.

[7] These were the amounts in PY1 settlement reports we obtained from CMS.

final on August 31, 2013, and CMS should have promptly initiated efforts to collect the loss.[8] However, CMS did not formally record the loss as money due to the U.S. Treasury until after we inquired on November 19, 2013, as to whether the loss had been collected, and CMS did not collect the $2.5 million shared loss until December 26, 2013.[9]

As a result of delayed processing and collection of the PY1 shared loss, CMS did not comply with the Pioneer ACO agreement.

CMS Performed Two Pioneer ACO Pilot Audits and, Although Not Required To Do So, May Not Have Communicated and Resolved the Results

CMS awarded a contract to monitor Pioneer ACOs that included routine audits "to begin around June 2012."[10] The contractor performed pilot audits of two Pioneer ACOs and prepared draft reports, both dated February 2013. In the two pilot audits, the contractor found a total of 10 reportable issues of noncompliance with specific Pioneer Model requirements and 4 notable deviations from either the Pioneer ACOs' internal policies or good management practices. Examples of audit findings included the following:

- Significant discrepancies existed between the Pioneer ACO provider/supplier lists and the official CMS versions of these lists. Using complex methods, historical beneficiary claims data are matched with providers or suppliers on these lists to determine which beneficiaries are "aligned" to the Pioneer ACO. The Pioneer ACOs are then responsible for the Medicare Parts A and B costs of their aligned beneficiaries which, ultimately, determines shared savings and losses.

- Beneficiary choices regarding sharing mental health, substance abuse, or other medical data, either were not executed in writing, as required, or the documentation of those choices was not provided.

Although not required to do so, good management controls for monitoring and communications indicate that CMS should have ensured that it documented end-of-audit discussions with each

[8] CMS provided no documentation of the Pioneer ACO's notice to CMS within 30 days of any error in the settlement calculation.

[9] In a discussion on November 19, 2013, CMS officials responded to our question by stating that CMS had not set a target date for collecting the reported shared loss and had not established a CMS receivables account to record shared losses for the Pioneer Model. However, CMS issued a demand letter for the shared loss on November 27, 2013, in which the settlement report sent August 1, 2013, is referred to as "the final settlement report." We are not making a recommendation to collect the shared loss because CMS subsequently issued a demand letter and collected the shared loss.

[10] "[ACO] Compliance Oversight, Monitoring and Audit Design and Operational Support Contractor Statement of Work," Attachment 2—Statement of Work and Deliverable Schedule (Mod 1), Task Order No. HHSM-500-2011-00144G, Contract No. GS-00F-0026M, Task 8 Deliverable Summary, p. 23.

auditee, including providing each auditee with its final audit report and resolving the findings.[11] A CMS official stated on November 19, 2013, that CMS did not attempt to resolve any of the findings because the official did not consider the findings of noncompliance and other deficiencies "egregious." The official also stated that CMS sent the audit reports to, and formally discussed results with, each audited Pioneer ACO at the end of the audit.

CMS did not provide documentation of its formal end-of-audit discussions or documentation showing that the audit reports had been sent to the audited Pioneer ACOs. Furthermore, an official of one of the audited Pioneer ACOs stated on December 17, 2013, that CMS had not provided the audit report or contacted the Pioneer ACO regarding the outcome of its audit.

CMS Did Not Always Maintain Complete Pioneer Accountable Care Organization Agreements and Other Key Documentation

CMS did not always maintain complete documentation of Pioneer ACO agreements. For example, in response to our requests, CMS provided documentation for Pioneer ACO agreements that was missing individual pages (identical among the 32 Pioneer ACO agreements) and entire amendments. We requested missing amendments and CMS did not provide complete documentation.

Further, during PY1, CMS officials routinely corresponded with Pioneer ACO officials using individually assigned CMS email accounts. During 2013, more than half the Pioneer Model staff at CMS left, and CMS did not always maintain access to the terminated employees' email accounts. The problem of inaccessible documentation from terminated employees' email accounts might have been avoided if CMS officials had used a group account to communicate with Pioneer ACO officials, such as the Pioneer Model group account that CMS created later.

As a result, CMS lost much Pioneer Model documentation, including email supporting one Pioneer ACO's election of an optional technical adjustment (not a change in payment arrangement selection) that eliminated a PY1 shared loss exceeding $2 million. It was only after we requested this key email that CMS recovered a copy from an official of the affected Pioneer ACO.

CONCLUSION

We reviewed CMS's administration of the first year of operation of the Pioneer Model. Because our observations are limited to the first year of one ACO model, we are making no formal recommendations at this time. However, we encourage CMS to consider these observations as it completes its administration of the Pioneer Model and moves forward with its administration of alternate payment and service delivery models outside of the Pioneer Model.

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[11] Federal Government internal control standards include the following examples of controls regarding the current observation: (1) "Internal control monitoring should assess the quality of performance over time and ensure that the findings of audits and other reviews are promptly resolved" and (2) "In additional [sic] to internal communications, management should ensure there are adequate means of communicating with, and obtaining information from, external stakeholders that may have a significant impact on the agency achieving its goals" (*Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1, Nov. 1999, pp. 19–20).

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft memorandum, CMS stated that it recognizes the importance of internal controls and that it has strengthened processes and procedures to guide the design of other innovative models. CMS also stated that it offered retroactive payment arrangement selections for PY1 because it was unable to provide monthly claims or utilization data to the Pioneer ACOs until well into the second quarter of the first performance year. As a result of this delay, CMS stated that the ACOs "would not have full awareness of claims or utilization data" for services furnished to their beneficiaries by providers or suppliers who were not participating in the ACO. We note that under Pioneer Model opt-out provisions, substance abuse and mental health claims data are by default not available to Pioneer ACOs. Because several of the Pioneer ACOs we interviewed stated that few beneficiaries take the initiative to opt-in to allow this important data to be shared, Pioneer ACOs never have full awareness of all claims data.

CMS further commented that it decided against disclosing loss information because Pioneer ACOs would not have had opportunity to review the loss calculations under retroactive payment arrangement selections. We maintain that, for transparency, CMS should have disclosed publicly that retroactive payment arrangement selections occurred, resulting in the elimination of several shared losses. Disclosing this information would have provided stakeholders with a more complete picture of the Pioneer Model in PY1.

Finally, CMS stated that during the 30-day notification period specified by the Pioneer ACO agreement, the Pioneer ACO with a reported shared loss "had concerns with their report's calculations and CMS worked with them to resolve any questions regarding the accuracy of the calculations." Thus, CMS stated that it promptly processed the shared loss of the Pioneer ACO as required by the terms of the Pioneer ACO agreement. However, we requested and CMS did not provide any evidence of communication between CMS and the affected Pioneer ACO during the 30-day notification period.

We have included CMS's comments in the Appendix.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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APR 11 2016

To: Daniel R. Levinson
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Office of Inspector General

From: Andrew Slavitt
Administrator
Centers for Medicare & Medicaid Services

Subject: Office of the Inspector Memorandum: "Observations From Our Review of CMS's Administration of the First Performance Year of the Pioneer Accountable Care Organization Payment Model"

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) memorandum on the Pioneer Accountable Care Organization (ACO) program. CMS is committed to improving quality of care for patients and being a good steward of taxpayer dollars.

The Pioneer ACO Model is an innovative initiative that is being used to test the impact of different payment arrangements in helping organizations who already have experience operating in ACO-like arrangements achieve the goals of providing better care to patients, and reducing Medicare costs. An independent evaluation report showed that the Pioneer ACO Model generated over $384 million in savings to Medicare over its first two years – an average of approximately $300 per participating beneficiary per year – while continuing to deliver high-quality patient care. Through the use of the Pioneer ACO Model, CMS seeks to support organizations in transforming their business and care delivery models to ones more focused on quality, rather than the quantity of care they give beneficiaries.

A central focus of the Pioneer ACO Model is providing the beneficiary with a better care experience through greater care coordination and engagement with beneficiaries as compared with Medicare Fee-For-Service (FFS). ACOs that participated in the Pioneer Model for 2012 and 2013 had significantly higher quality scores for a majority of the measures in the second and third performance years.

In addition, ACOs shared in Medicare savings or losses for a specific set of beneficiaries. To track the savings to Medicare, an expenditure benchmark is used for the beneficiaries aligned to the ACO. ACOs with savings above the minimum savings percentage received a portion of the amount saved, incentivizing ACOs to improve over time and create additional savings. Those ACOs that had shared losses greater than the minimum loss percentage were held accountable to pay a portion of the losses, reducing the total cost to Medicare and in turn taxpayers.

In the first performance year, Pioneer ACOs could choose their preferred payment arrangement when completing the Pioneer ACO Model Innovation Agreement ("Pioneer Agreement") prior to

the start of the first performance year. Several arrangements were available to Pioneer ACOs, including an arrangement allowing Pioneer ACOs to participate in a "one-sided" risk track in the first performance year. This risk track did not require Pioneer ACOs to repay losses but permitted the Pioneer ACO to share in savings.

The savings and losses calculations for Pioneer ACOs include the total Medicare Part A and B expenditures for all beneficiaries aligned to the ACO, not just those services furnished by the ACO and its providers and suppliers. At the time the Pioneer ACOs chose their payment arrangement, CMS told the Pioneer ACOs that it would provide the Pioneer ACOs with Medicare data to support care coordination efforts and, in particular, information about the services beneficiaries are receiving from other providers and suppliers not participating in the Pioneer ACO.

Unfortunately, CMS was unable to provide the claims data to ACOs until well into the second quarter of the ACOs' first performance year. Although Pioneer ACOs had knowledge and awareness of claims data and utilization trends for beneficiaries who were furnished services by the ACO's providers and suppliers, the delay in obtaining monthly claims data would mean an ACO would not have full awareness of claims or utilization data for services furnished to their beneficiaries by providers or suppliers who were not participating in the ACO.

CMS recognized the impact of delays in providing claims data, particularly to Pioneer ACOs responsible for losses in the first year. As such, CMS offered the Pioneer ACOs an opportunity to change their risk track to the one-sided model for the first performance year in accordance with the terms of the Pioneer agreement. Pioneer ACOs that desired to change their risk track were required to amend the Pioneer ACO agreement before the financial calculations to determine shared losses or shared savings had been performed. Five of the thirty-two Pioneer ACOs elected to change their risk tracks to one-sided risk tracks for the first performance year according to the terms of the agreement.

Establishing the payment arrangement for the Pioneer ACO is only the first step towards determining whether an ACO shares in savings or repays losses. A reconciliation process occurs after a performance year is completed, including an opportunity for Pioneer ACOs to review their settlement report findings and raise any concerns with the calculations. As these five Pioneer ACOs changed their risk track, the calculations related to losses no longer applied to them. Thus, it would not have been appropriate for CMS to report loss calculations that the Pioneer ACOs were never able to review or dispute during the regular process. However, CMS did publicly report and promptly process and collect funds for the one Pioneer ACO that had shared losses in the first performance year, as required by the terms of the Pioneer agreement.

As OIG notes, the agreement between CMS and Pioneer ACOs grants 30 days from the date a settlement report is issued to notify CMS of an error in the settlement calculation. During that 30 day time period, the Pioneer ACO identified in the OIG report that owed shared losses to CMS had concerns with their report's calculations and CMS worked with them to resolve any questions regarding the accuracy of the calculations. Once the accuracy of the settlement calculation was confirmed, CMS deemed the report final and issued a demand letter requesting payment of the full amount of shared losses from the Pioneer ACO. The ACO then paid the full

amount of the shared losses identified in the report within 30 days of the letter's issuance in accordance with the terms of the Pioneer ACO agreement.

CMS recognizes the importance of internal controls to ensure the accuracy of the calculations used in the Pioneer ACO settlement reports and has extensive requirements in place for its contractor to both conduct calculations and perform an extensive quality assurance process on all shared savings and loss calculations. This process helps to verify the accuracy of the calculations used in the Pioneer ACO settlement reports. In addition, CMS conducts ongoing risk analysis of the contractor's performance while periodically performing validity checks of the underlying data, consistent with industry standards.

In addition, as part of CMS' oversight, CMS conducts audits of the Pioneer ACOs to ensure compliance with program requirements. CMS conducted pilot audits of two Pioneer ACOs in 2012 related to discrepancies between the provider/supplier lists posted on the ACO's web site and the provider/supplier lists maintained by CMS. As a result of these audit findings and their possible relevance to all Pioneer ACOs, CMS provided education to all Pioneer ACOs on keeping their provider/supplier lists up to date on their web site as well as the importance of updating and maintaining beneficiary data sharing opt-out documentation. This education was provided through a frequently asked questions document and a variety of learning activities.

Since the initiation of the Pioneer ACO Model program, CMS has strengthened processes and procedures, including improving documentation, and built on early successes of the program to guide the design of other innovative models. CMS is committed to the transparency of results, and has made financial and quality performance results for the Pioneer ACOs publicly available on its web site. CMS remains committed to leading delivery system reform, with an array of alternative payment models, including the Pioneer ACO Model.