The Medicare Shared Savings Program and the Pioneer Accountable Care Organizations

Promoting and evaluating accountable care organizations

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Healthcare costs have been on the rise over the last few years and there are growing concerns over the financial stability of the Medicare program. There are also concerns regarding the aging of the Baby Boomers, the increase in average age of enrollees, and an insufficient tax base to cover future funding of the Medicare program. The Patient Protection and Affordable Care Act (PPACA) signed into law on March 23, 2010, attempts to address some of these growing concerns by implementing laws and programs aimed at reducing healthcare costs. The Medicare Shared Savings Program (MSSP) as well as the Pioneer program are just two such initiatives.

The Center for Medicare and Medicaid Innovation (CMMI) was established to develop and evaluate various alternative payment models that allow for the creation of accountable care organizations (ACOs) and other cost-containment programs to be tested with regard to how well they integrate and coordinate care, improve quality, and reduce healthcare costs. To date, the CMMI has developed several demonstration projects, including the Pioneer ACO program, among others. The MSSP, enacted as part of the PPACA, will be a permanent program to encourage further development and formation of ACOs. Each of these programs encourages formation of ACOs to care for traditional Medicare fee-for-service beneficiaries, and to improve care and quality of these patients while reducing healthcare costs.

Accountable care organizations are an emerging concept whereby provider groups and hospitals join together to coordinate the care of, and achieve quality improvements and reductions in spending for, a specified population. The concept of ACOs has become increasingly recognized due to the passage of the PPACA. The goals of ACOs are to control future health care costs and increase access to affordable health insurance coverage while promoting and rewarding quality care. Providers may want to form ACOs and participate in these programs for many reasons, including the need to increase or maintain market share and the possibility to share in savings resulting from improved care coordination.

This paper compares the MSSP and Pioneer ACOs and outlines their key features in terms of six major areas: payment arrangements, beneficiary alignment, interim payment methodology, benchmark methodology, trending methodology, and calculation of shared savings/losses.

OVERVIEW

1. The MSSP is a permanent program to encourage development of ACOs, which must agree to:

- Accept risk for at least 5,000 Medicare fee-for-service beneficiaries, who will be free to choose their own healthcare providers, for a period of three years, with CMS monitoring compliance with respect to eligibility, quality performance, and data reporting requirements.

- Be held to a benchmark under which they may realize savings or losses.

2. The CMMI's Pioneer ACO program develops and evaluates alternative payment models to test how well ACOs and other cost-containment programs integrate and coordinate care, improve quality, and reduce healthcare costs.

- The ACO must agree to accept risk for at least 15,000 Medicare fee-for-service beneficiaries (5,000 in rural areas), for a period of three years or less, with CMS having the option of extending the contract an additional two performance years for compliant ACOs.

- ACOs will be paid on a fee-for-service basis for the first two performance periods and if savings are achieved and program requirements are met during the first two performance years, and the ACO will transition to population-based payments during the third and subsequent two optional performance years.

- Pioneer inherently includes more risk but also provides greater potential rewards.

- The Pioneer program includes a global payment option beginning in the third performance year.

In the Pioneer program, ACOs need to make strides toward participating in shared savings, capitation, or other risk contracts with other payers outside of Medicare, including Medicaid and private payers. CMS stipulates that 50% of a Pioneer ACO's revenue must come from these arrangements by the second performance year.

Pioneer ACOs will be liable for losses beginning in the first performance year (second year for Alternative 1), reflecting the increased level of risk that is inherent in this program.

KEY FEATURES

1. Payment arrangement options

MSSP

Participants in the MSSP have the option of participating in two tracks:

- Track 1, also known as the one-sided model, is designed for less experienced ACOs, who will share in savings but not in the losses. It is available only for the first agreement period.

- Track 2 of the program, also known as the two-sided model, is geared for more experienced ACOs or those choosing to continue to participate in the MSSP following participation in Track 1. Participants share both savings and losses.

The choice allows participants to pick a model based on their risk appetite and prevents experienced ACOs from taking advantage of the system, by forcing all participants into Track 2 in subsequent agreement periods.

Pioneer

The Pioneer program offers a Core Payment Arrangement and four alternative payment arrangement options (Option A, Option B, Alternative Option 1, and Alternative Option 2) that stipulate varying degrees of shared savings/losses and caps them across the performance years. In addition, Alternative 1 and Alternative 2 offer capitation options for Part B only or for all Medicare Part A and Part B services.

All of the Pioneer models function like the MSSP for the first two years but transition thereafter to a population-based payment approach.

2. Beneficiary alignment

MSSP

The MSSP will use prospective assignment of beneficiaries preliminarily but will finalize assignment at the end of each performance year.

- At the outset, CMS will provide the ACO with a list of prospectively assigned beneficiaries. CMS will provide quarterly updates to this list until year-end, when the final assignment list is determined, based on retrospective assignment. The list of beneficiaries will change over the course of the year.

- The assignment of beneficiaries is a two-step process, using allowed charges associated with a primary care physician (PCP) and then charges associated with a specialist/FQHC who provides primary care services in place of a PCP.

Pioneer

- Unlike the MSSP, the Pioneer program will assign beneficiaries on a prospective basis for members who have had at least 12 months of fee-for-service coverage under Medicare Parts A and B. ACOs will know whose care and quality they will be held accountable for in a given performance year.

- Like the MSSP program, the assignment of beneficiaries is essentially the same two-step process, using both allowed charges associated with a primary care doctor as well as charges associated with a specialist/FQHC providing primary care services in place of a PCP.

- A Pioneer ACO can also choose retrospective alignment, which will work the same as the MSSP process.

3. Interim payment methodology

MSSP

ACO participants continue to receive payments under the Medicare fee-for-service program at the usual allowable amounts. Savings or losses are determined by comparing fee-for-service claims costs to the benchmark, using a retrospective reconciliation at the end of each performance year.

Pioneer

Like in the MSSP, ACOs participating in the Pioneer program will continue to receive payments under the Medicare fee-for-service program for the first two years.

- Savings or losses are compared to the benchmark using a retrospective reconciliation at the end of each performance year.

- After the first two years, ACOs in the Core or Options A and B will start receiving a combination of fee-for-service reimbursement and population-based payments for their aligned beneficiaries.

  — Fee for service is paid at 50% of the usual allowable fee.

  — The population-based payment is estimated as 50% of the ACO's expected fee for service costs (at 100% allowed amounts). This payment is made to the ACO each month.

- The Pioneer ACO will still be eligible for shared savings or losses under the population-based payment approach, but CMS requires a minimum 3% reduction in costs before sharing savings.

4. Benchmark methodology

MSSP

- The benchmark is calculated using Part A and B fee-for-service expenditures for beneficiaries that would have been assigned to the ACO in any of the three preceding years of the first agreement period.

- The benchmark resets at the start of each agreement period (first agreement period is years one through three) to adequately represent newly aligned beneficiaries.

- Base year expenditures will be weighted 60%/30%/10% for the third, second, and first historical base years, respectively.

- The benchmark accommodates four separate categories of beneficiaries to account for the significant cost differences between these groups and is calculated separately for End Stage Renal Disease (ESRD), Disabled, Aged/Dual Eligible beneficiaries, and Aged/Non-Dual Eligible beneficiaries.

- To reduce variation from catastrophic claims, CMS will cap the benchmarks and performance year per beneficiary expenditures at the 99th percentile of national Medicare Part A and B expenditures. Claims costs in excess of this threshold are retained and paid by CMS.

- The MSSP adjusts for risk every performance year to reflect the changing risk profile of the ACO's assigned beneficiaries. The MSSP will use the CMS-HCC model to risk adjust the benchmark. However, so as not to incent ACOs to *upcode*, the benchmark for continuously assigned beneficiaries will be adjusted using demographic factors, unless there is a decline in the CMS-HCC risk score for this group, in which case the lower risk score will be applied. To reflect the risk profiles associated with newly assigned beneficiaries, CMS will update the benchmark using the CMS-HCC model. All of these risk adjustments are calculated separately for ESRD, Disabled, Aged/Dual Eligible beneficiaries, and Aged/Non-Dual Eligible beneficiaries.

- Lastly, the benchmark and performance year expenditures will exclude Disproportionate Share Hospital (DSH) and Indirect Medical Education (IME) payments to encourage care to be provided in the most appropriate care setting.

Pioneer

Pioneer ACOs are compared to a three-year historical claims benchmark, like in MSSP, except the benchmark calculation includes a provision that limits the benchmark increase in areas of high costs or high cost trends. This provision also increases the benchmark more rapidly in areas of low costs or low cost trends.

- The benchmark calculation is a complex formula that combines the historical expenditures for prospectively aligned beneficiaries with both the national per-capita growth in expenditures and the absolute amount of growth in expenditures (calculated from the historical and performance year expenditures for a comparable national reference population), which are blended 50%/50%. The Pioneer ACO benchmark is calculated retrospectively because expenditures for the reference population are unavailable until the end of the performance year.

- The benchmark is developed using three calendar years of base claims experience (for both the prospectively aligned and reference populations) trended forward to each performance year for the first three performance years, with the three base years set to the preceding 12 months of the first performance year.

- The benchmark is rebased (recalculated) in the fourth performance year for the remaining two years of the program.

- Unlike MSSP, the benchmark is adjusted to exclude claims for beneficiaries no longer aligned with the ACO in the performance period.

- CMS will offer Pioneer ACOs the choice between:

  — A benchmark that caps expenditures at the 99th percentile of national Medicare fee-for-service Part A and B expenditures in order to reduce variation from catastrophic claims, or

  — An uncapped benchmark and the requirement to purchase their own reinsurance. Capping of expenditures would be done separately for ESRD and non-ESRD beneficiaries.

- Unlike in the MSSP, the benchmark and performance year expenditures will include DSH and IME payments. This may inadvertently provide incentives for ACO participants to steer care away from academic medical centers and teaching hospitals.

Prospectively aligned beneficiaries

Beneficiaries are aligned with an ACO if they have received the plurality of their services from a participating ACO provider and if they have had at least 12 months of fee-for-service coverage under Medicare Parts A and B.

Beneficiaries are *prospectively aligned* if they were eligible for alignment with a participating ACO for at least 12 months, and up to 36 months, starting six months before each performance period. This approach reflects the risk mix of the ACO-aligned population in each performance year, with the most weight given to the most recently aligned beneficiaries in a given performance year. CMS will perform reconciliations three months after each performance period to remove anyone who was not alignment-eligible in that year.

Since the baseline only includes claims experience for alignment-eligible beneficiaries, decedent costs are added in to ensure that the benchmark includes costs associated with beneficiaries who may die in a given performance year.

Likewise, the benchmark is also adjusted for newly eligible prospectively aligned beneficiaries who either just became eligible for Medicare or withdrew from a Medicare Advantage plan and

thus have no relevant Medicare fee-for-service Part A and B claims experience to include in the baseline. The benchmark is adjusted by estimating costs for newly eligible beneficiaries using historical expenditures for these types of beneficiaries.

National reference population

The reference population baseline expenditures represent national, not state-specific, expenditures. To ensure that the reference population accurately represents the risk mix of the prospectively aligned beneficiaries, CMS stipulates that national expenditures be adjusted using the same age, sex, and, eligibility (aged, disabled, or ESRD) distributions as the prospectively aligned beneficiaries.

5. Trending methodology

MSSP

The MSSP uses the national growth rate for Part A and B services under fee-for-service Medicare to trend base year expenditures to the third base year.

- Since base and performance year expenditures will be developed separately for each beneficiary category, the national growth rate will also be developed and applied separately for ESRD, Disabled, Aged/Dual Eligible beneficiaries, and Aged/Non-Dual Eligible beneficiaries.

- Using a national growth rate overestimates the benchmark in low-cost/low-growth areas, providing more incentives to share in savings and underestimates the benchmark in high-cost/high-growth areas, making savings harder to achieve and possibly discouraging the formation of ACOs under the MSSP.

- In addition, an ACO's benchmark is trended to each performance year using the absolute amount of growth in national per capita expenditures for Part A and B services under fee-for-service Medicare.

- The absolute amount of growth in national per capita expenditures is also calculated and applied separately for ESRD, Disabled, Aged/Dual Eligible beneficiaries, and Aged/Non-Dual Eligible beneficiaries.

Pioneer

The Pioneer ACO uses two separate trending methodologies.

ACO-specific baseline expenditure

- The baseline claims expenditures for base year one and base year two are trended to base year three using trends for beneficiaries with similar characteristics including beneficiaries residing in the same state and having the same age, sex, and eligibility category (aged/disabled/ESRD).

- The trends are developed separately for trending base year one to base year three, and from base year two to base year three.

ACO expenditure benchmark

- This methodology trends the ACO-specific baseline expenditure to the performance year using the national growth rate and absolute amount of growth, blended 50%/50%.

As in the MSSP, using a national growth rate overestimates the benchmark in low-cost/low-growth areas and provides more incentives to share in savings, while underestimating the benchmark in high-cost/high-growth areas, making savings harder to achieve. Examples of this are illustrated in Appendix A, attached.

6. Calculation of shared savings/losses

MSSP

If an ACO's performance year expenditures are less than the applicable benchmark in a given year and quality performance metrics are met, the ACO shares in a portion of the savings if total savings are more than the minimum savings rate (MSR) (one-sided and two-sided models).

If an ACO's performance year expenditures are more than the benchmark in a given year, the ACO is required to pay back a portion of the losses if losses are greater than the minimum loss rate (MLR) (two-sided model only).

The ACO will be scored on four different quality domains, totaling 33 quality measures weighted equally so as not to inadvertently create incentives to provide one service over another.

ACOs must meet or exceed the minimum savings/loss rate (MSR/MLR) before savings are shared or losses are paid back.

- One-sided model: ACOs are subject to a sliding scale MSR based on the number of assigned beneficiaries. The idea is consistent with the law of large numbers, in that smaller ACOs will have greater fluctuation in claim costs while larger ACOs will have lower fluctuation. Therefore, under the one-sided model, participating ACOs will be subject to MSRs that are between 3.9% for smaller ACO organizations (i.e., 5,000 assigned beneficiaries) and 2.0% for larger ACO organizations (i.e., at least 60,000 assigned beneficiaries).

- Two-sided model: ACOs are subject to a flat 2.0% MSR and MLR to provide greater financial incentives for ACOs

Maximum sharing/loss rate

The MSSP also stipulates the maximum portion of savings and losses that an ACO can share in:

- One-sided model: ACOs will be allowed to share up to 50% of the savings in excess of the benchmark (i.e., first dollar savings), if 100% of the quality performance metrics are met.

- Two-sided model: ACOs will be allowed to share in (or be required to pay back) 60% of the savings (or losses) in excess of the benchmark if 100% of the quality performance metrics are met. The MSSP again provides greater financial incentives for

ACOs participating in the two-sided model. The loss rate under the two-sided model will be 60%, which is consistent with the maximum sharing rate in the two-sided model.

Payment/loss limits

ACOs participating in the MSSP can share in any savings produced from better coordination and quality of care. However, payments to ACOs are capped at a percentage of their benchmark, as are losses in the two-sided model, to protect ACOs from incurring significant losses. These caps will grade upward with each performance year.

- One-sided model: ACOs share in savings up to a maximum amount that is equal to 10% of the benchmark for a given performance year.

- Two-sided model: ACOs share in savings up to 15% of the benchmark for a given performance year (ACOs participating in the two-sided model can earn greater rewards for accepting greater risk). An ACO is liable for losses of up to 5% of the benchmark in the first performance year, 7.5% in the second performance year, and 10% in the third performance year.

Pioneer

Savings or losses are determined using a retrospective reconciliation at the end of each performance year against the Pioneer ACO's benchmark for the first two performance years.

- If performance year expenditures are less than the applicable benchmark in a given year, and quality performance metrics are met, the ACO will share in a portion of the savings.

- If performance year expenditures are more than the benchmark in a given year, the ACO will be required to pay back a portion of the losses.

The ACO will have to achieve savings and meet quality standards and other program requirements to move to population-based payment. However, CMS will determine whether participating ACOs will be able to move to population-based payment in years three through five.

The quality standards that the ACO will be held accountable for are the same as those in the MSSP.

The minimum savings/loss rate for Pioneer is set at 1%. Savings and losses are shared based on the difference to the benchmark rather than only the excess over the benchmark plus the MSR/MLR. Potential gains and losses are greater for Pioneer ACOs under all program options.

Maximum shared savings/losses for Pioneer are set at levels higher than MSSP, increasing to 15% of the benchmark by year three for all program options.

As discussed above, the Pioneer program will offer five models for ACOs to participate in: Core Payment Arrangement, and two alternative payment arrangements, Option A and Option B. For years three through five, Alternative 1 and Alternative 2 are also available and include population-based payments.

MAJOR DIFFERENCES BETWEEN THE MSSP AND PIONEER PROGRAMS:

- The Pioneer program uses a trending methodology that, all other things being equal, produces a slightly higher benchmark than the MSSP, for high-cost areas.

- IME and DSH payments are included in the Pioneer benchmark, but excluded from MSSP, which also contribute to a higher benchmark under the Pioneer program. This is also illustrated in Appendix A, attached. Appropriate shifting of care to non-academic settings can create significant savings for the ACO.

- The MSSP program uses CMS-HCCs to reflect the risk mix of the aligned beneficiaries while the Pioneer program revises the benchmark every performance year by removing claims for beneficiaries no longer aligned with the ACO or including expenditures for beneficiaries that become newly aligned with the ACO.

- The Pioneer program inherently includes more risk but also provides greater rewards (through lower minimum savings rates, higher sharing rates, and higher payment limits).

- The Pioneer program requires that 50% of the Pioneer ACOs revenues come from participating in "risk" contracts with other payers.

- The Pioneer program includes global payment mechanisms beginning in the third performance year.

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COMPARISON OF MSSP AND PIONEER ACOS

FEATURE	MSSP	PIONEER
Payment Arrangements	**Track 1**: One-Sided model (upside only for all three years) **Track 2**: Two-Sided model (upside and downside risk)	Option of Core Payment Arrangement, Option A, Option B, Alternative 1, or Alternative 2 (with varying degrees or risk among the options)
Benchmark Methodology	Developed using expenditures for beneficiaries historically aligned with ACO	Developed using expenditures for beneficiaries prospectively aligned with ACO
Trending Methodology	Baseline is trended using the absolute amount of growth in national per capita expenditures for Part A and B services under fee-for-service Medicare	Baseline trends using 50% national growth rate and 50% of absolute amount of growth in national per capita expenditures for Part A and B services under fee-for-service Medicare for the reference population
Risk/Demographic Adjustments	Benchmark is adjusted using combination of CMS-HCC model and demographic factors	Benchmark adjusted by removing claims for members no longer prospectively aligned in performance period and for new entrants and decedents
Minimum Savings/ Loss Rate	**Track 1**: 2.0% to 3.9%, depending on the number of beneficiaries assigned to ACO. **Track 2**: ±2.0%	**Core Payment Arrangement**: ±1.0% **Option A**: ±1.0% **Option B**: ±1.0% **Alternative Option 1**: Year 1: 2.0% to 2.7%, depending on the number of beneficiaries assigned to ACO; Year 2: ±1.0%; Years 3-5: Population-based payment for Part B Services **Alternative Option 2**: Years 1-2: ±1.0%; Years 3-5: Population-based payment for Part A and B Services
Maximum Sharing/ Loss Rate	**Track 1**: +50% **Track 2**: ±60% (All arrangements move to population-based payments by performance year 3)	**Core Payment Arrangement**: ±60%, ±70%, ±70% (Years 1, 2, 3-5 respectively) **Option A**: ±50%, ±60%, ±70% (Years 1, 2, 3-5 respectively) **Option B**: ±70%, ±75%, ±75% (Years 1, 2, 3-5 respectively) **Alternative Option 1**: +50%, ±70%, population-based payment for Part B services and 70% for Part A services (Years 1, 2, 3-5 respectively) **Alternative Option 2**: ±60%, ±70%, population-based payment (Years 1, 2, 3-5 respectively)
Payment/Loss Limit	**Track 1**: 10% **Track 2**: 15% on savings; 5.0%, 7.5%, and 10% on losses in years one, two, and three, respectively	**Core Payment Arrangement**: 10%, 15%, 15% (Years 1, 2, and 3-5 respectively) **Option A**: 5%, 10%, 15% (Years 1, 2, and 3-5 respectively) **Option B**: 15%, 15%, 15% (Years 1, 2, and 3-5 respectively) **Alternative Option 1**: 5%, 15%, population-based payment for Part B services and 15% for Part A services (Years 1, 2, 3-5 respectively) **Alternative Option 2**: 10%, 15%, population-based payment (Years 1, 2, 3-5 respectively)
Payment Adjustments	Exclude IME & DSH payments	Include IME & DSH payments
Length of Contract	3 years	Minimum 3 years, option for 2 additional years
Capping Expenditures	Capped at 99th percentile of Medicare fee for service Part A and B expenditures	Choice of a capped or uncapped model (at 99th percentile of Medicare fee for service Part A and B expenditures)
Other Program Requirements	N/A	50% ACO's revenue must come from *risk* contracts by the second performance year
Patient Attribution	Prospective assignment with reconciliation at year-end	Prospective or retrospective
Quality Measures	4 domains with 33 quality measures (weighted equally)	Same as MSSP
Min. Number of Beneficiaries	5,000	15,000 (5,000 if in a rural area)

REFERENCES

Centers for Medicare and Medicaid Service, Medicare; Medicare Shared Savings Program; Accountable Care Organizations Federal Register / Vol. 76, No. 212 / Wednesday, November 2, 2011/ Rules and Regulations

Center for Medicare and Medicaid Innovation, Pioneer Accountable Care Organization (ACO) Model Request for Application (downloaded on March 2, 2012 from http://innovations.cms.gov/Files/x/Pioneer-ACO-Model-Request-For-Applications-document.pdf)

Centers for Medicare and Medicaid Service, Medicare; Medicare Advantage - Rates & Statistics; FFS Data (2009 data downloaded on October 24, 2011 from https://www.cms.gov/MedicareAdvtgSpecRateStats/05_FFS_Data.asp#TopOfPage)

Related analysis can be found at:
http://publications.milliman.com/publications/healthreform/pdfs/acos-beyond-medicare.pdf

http://publications.milliman.com/publications/healthreform/pdfs/at-first-look-acos.pdf

APPENDIX A

Table 1 provides estimated benchmarks in high-cost and low-cost areas, for MSSP and Pioneer, assuming DSH and IME payments are *included* in the benchmark. In this example, we use New York as the proxy for a high-cost area and Utah as the proxy for the low-cost area. In the final regulation for both the MSSP and Pioneer, the MSSP benchmark actually excludes DSH and IME payments. This table illustrates that the trending methodology in the Pioneer program produces a slightly higher benchmark, all other things being equal in both programs (i.e., assuming DSH and IME are included), than that produced in the MSSP for high-cost areas; the opposite is true for low-cost areas.

Table 2 provides estimated benchmarks in high-cost and low-cost areas, for MSSP and Pioneer, assuming DSH and IME payments are *excluded* from the benchmark. As in the previous example, New York is treated as the high-cost area and Utah is treated as the low-cost area. In the final regulation for both the MSSP and Pioneer, the Pioneer program actually includes DSH and IME payments. This table further illustrates that the Pioneer program produces a higher benchmark than MSSP just by virtue of including DSH and IME payments in the calculation of the benchmark (comparing the $890.21 PMPM developed in Table 2 for MSSP versus the $974.74 developed for Pioneer in Table 1 for the high-cost area, as an example).

Therefore, all other things being equal, financial results are likely to be more favorable under the Pioneer than from the MSSP for an ACO that is committed to reducing healthcare costs. Some reasons include:

- The trending methodology in the Pioneer program inherently produces a higher benchmark for high-cost areas than that in MSSP, and

- Pioneer includes DSH and IME payments in the benchmark, which provide additional dollars in the benchmark against which savings can be achieved by diverting services away from high-cost institutions.

The New York, Utah, and National 2008 and 2009 Paid PMPMs in Tables 1 and 2 below were calculated using the Medicare 5% Sample for 2008 and 2009. IME and DSH payments were removed by estimating the portion of IME and DSH payments included in Part A in both New York and Utah.

TABLE 1: MSSP AND PIONEER BENCHMARK CALCULATION (INCLUDING DSH AND IME)

AREA	2008 PAID PMPM	2009 PAID PMPM[1]	GROWTH RATE (2009 OVER 2008)	ABSOLUTE GROWTH (2009 OVER 2008)	2010 MSSP BENCHMARK[2]	2010 PIONEER BENCHMARK[3]
NATIONAL	$762.42	$808.25	6.0%	$45.83	N/A	N/A
HIGH-COST	$878.50	$924.05	5.2%	$45.55	$969.88	$974.74
LOW-COST	$629.85	$664.52	5.5%	$34.66	$710.34	$707.40

TABLE 2: MSSP AND PIONEER BENCHMARK CALCULATION (EXCLUDING DSH AND IME)

AREA	2008 PAID PMPM	2009 PAID PMPM[1]	GROWTH RATE (2009 OVER 2008)	ABSOLUTE GROWTH (2009 OVER 2008)	2010 MSSP BENCHMARK[2]	2010 PIONEER BENCHMARK[3]
NATIONAL	$726.36	$770.02	6.0%	$43.66	N/A	N/A
HIGH-COST	$804.81	$846.54	5.2%	$41.73	$890.21	$893.82
LOW-COST	$606.61	$639.99	5.5%	$33.38	$683.65	$681.06

1 The 2009 Paid PMPM represents the illustrative baseline period for both the MSSP and Pioneer program.
2 MSSP Benchmark = Baseline Paid PMPM + National Absolute Dollar Growth
3 Pioneer Benchmark = [(Baseline Paid PMPM + National Absolute Dollar Growth) + (Baseline Paid PMPM x [1 + National Growth Rate])] / 2