AMERICAN ACADEMY OF FAMILY PHYSICIANS

Side-by-Side Comparison of Medicare Shared Savings Program (MSSP) Tracks

Participants considering the MSSP need a broad understanding of the available tracks. The table below outlines similarities and differences of the risk and rewards associated with each.

Topic/Subject	Track 1 One-Sided Risk Model	Track 1+ Two-Sided Risk Model	Track 2 Two-Sided Risk Model	Track 3 Two-Sided Risk Model
Performance Year	A 12-month period beginning on January 1 of each year during the agreement period.	The Track 1+ application cycle will align with Tracks 1, 2, and 3; it is a 12-month period beginning on January 1 of each year during the agreement period.	A 12-month period beginning on January 1 of each year during the agreement period.	
Agreement Period	ACOs enter into an agreement to participate in the MSSP for no less than a three-year period. An eligible ACO may continue under the one-sided model for its second agreement period.	ACOs enter into a three-year agreement period. • Participation is limited to one full three-year agreement period. • ACOs that transition to Track 1+ under their existing contract during a Track 1 agreement period have the opportunity to renew for a subsequent three-year agreement period under ACO Track 1+. • Once Track 1+ is elected, the ACO cannot participate in Track 1 for subsequent agreement periods.	ACOs enter into an agreement to participate in the MSSP for no less than a three-year period. An ACO may elect Track 2 without completing a prior agreement period under the one-sided model (Track 1). Once Track 2 is elected, the ACO cannot participate in Track 1 for subsequent agreement periods.	ACOs enter into an agreement to participate in the MSSP for no less than a three-year period. An ACO may elect Track 3 without completing a prior agreement period under the one-sided model (Track 1). Once Track 3 is elected, the ACO cannot participate in Track 1 for subsequent agreement periods.

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Topic/Subject	Track 1 One-Sided Risk Model	Track 1+ Two-Sided Risk Model	Track 2 Two-Sided Risk Model	Track 3 Two-Sided Risk Model
Participation Criteria	• Each participant in an ACO that is applying to participate in the MSSP must agree to participate in and comply with the requirements of the MSSP. Agreements/contracts related to participation in the MSSP that involve the ACO, its participants, and its providers/suppliers must be completed before the ACO submits its application. • ACOs in the MSSP must maintain a population of at least 5,000 assigned beneficiaries.	• An ACO must concurrently participate in Track 1 to be eligible to participate in Track 1+. • ACOs in Tracks 2 and 3 are not eligible to participate in Track 1+. • Each participant in an ACO that is applying to participate in the MSSP must agree to participate in and comply with the requirements of the MSSP. Agreements/contracts related to participation in the MSSP that involve the ACO, its participants, and its providers/suppliers must be completed before the ACO submits its application. • ACOs in the MSSP must maintain a population of at least 5,000 assigned beneficiaries. • For Track 1+, the ACO must complete an additional application process to ensure that the ACO meets the requirements for the model and has established an adequate repayment mechanism for shared losses. • The ACO may not be owned or operated by a health plan.	• Each participant in an ACO that is applying to participate in the MSSP must agree to participate in and comply with the requirements of the MSSP. Agreements/contracts related to participation in the MSSP that involve the ACO, its participants, and its providers/suppliers must be completed before the ACO submits its application. • ACOs in the MSSP must maintain a population of at least 5,000 assigned beneficiaries.	
Beneficiary Assignment	Beneficiaries who receive at least one primary care service from a primary care physician within an ACO are assigned to an ACO in a two-step process: (1) The first step assigns the beneficiary to an ACO if he or she receives the plurality of primary care services from primary care physicians within the ACO. (2) The second step only considers beneficiaries who have not had a primary care service furnished by any primary care physician, either inside or outside the ACO. In this case, the beneficiary is assigned to an ACO if the beneficiary receives a plurality of his or her primary care services from a specialist physician and certain non-physician health care professionals (i.e., nurse practitioners, clinical nurse specialists, and physician assistants) within the ACO.			

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Topic/Subject	Track 1 One-Sided Risk Model	Track 1+ Two-Sided Risk Model	Track 2 Two-Sided Risk Model	Track 3 Two-Sided Risk Model
Reporting Beneficiary Assignment	• Preliminary prospective assignment with retrospective reconciliation. • The ACO is provided with a preliminary prospective beneficiary assignment list on a quarterly basis during the PY. The ACO is held accountable for any Medicare FFS beneficiary who chooses to receive the plurality of his or her primary care services from health care professionals billing through the TINs of ACO participants during the PY.	A prospective beneficiary assignment list is provided to the ACO at the start of the PY. This list encompasses all beneficiaries for whom the ACO will be held accountable in that PY for reports, quality reporting, and financial reconciliation.	• Preliminary prospective assignment with retrospective reconciliation. • The ACO is provided with a preliminary prospective beneficiary assignment list on a quarterly basis during the PY. The ACO is held accountable for any Medicare FFS beneficiary who chooses to receive the plurality of his or her primary care services from health care professionals billing through the TINs of ACO participants during the PY.	A prospective beneficiary assignment list is provided to the ACO at the start of the PY. This list encompasses all beneficiaries for whom the ACO will be held accountable in that PY.
Benchmarking	CMS develops benchmarks for the ACO by which performance is measured to assess generated savings or losses during the PY.			
Benchmark Rebasing	Beginning in 2017, regional FFS expenditures will be incorporated into calculations for establishing, adjusting, and updating benchmarks of ACOs that continue to participate in the MSSP after their initial three-year agreement period.			
Adjustments for Health Status and Demographic Changes	Historical benchmark expenditures are adjusted on the basis of the CMS-HCC model. The updated historical benchmark is adjusted relative to the risk profile of the PY assigned population. For the PY: • Newly assigned beneficiaries are adjusted using the CMS-HCC model. • Continuously assigned beneficiaries are adjusted using demographic factors alone, unless the CMS-HCC risk scores result in a lower risk score.			
Shared Savings	First dollar is shared once the MSR is met or exceeded. A higher MSR may be used in an ACO that has fewer assigned beneficiaries. This avoids a situation in which the payer makes a shared savings payment to a provider simply based on more random variation in spending due to a smaller pool of assigned patients.			

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Topic/Subject	MSSP Track 1 One-Sided Risk Model	MSSP Track 1+ Two-Sided Risk Model	MSSP Track 2 Two-Sided Risk Model	MSSP Track 3 Two-Sided Risk Model
Risk Associated With Quality and Cost (Performance Risk)	Under Track 1, shared savings are calculated for each PY during the term of the ACO's first agreement period. ACOs in Track 1 are not held accountable for losses. The MSR is 2.0%- to 3.9% depending on the number of assigned beneficiaries.	Under Track 1+, the options for symmetrical MSR/MLR are: (1) No MSR/MLR (2) Symmetrical MSR/MLR in 0.5% increment between 0.5% and 2% (3) Symmetrical MSR/MLR to vary based on the number of assigned beneficiaries	Under Track 2, the ACO shares in losses in return for the opportunity for a higher share of savings. ACOs that enter Track 2 choose a symmetrical MSR and MLR. The options for symmetrical MSR/MLR are: (1) No MSR/MLR (2) Symmetrical MSR/MLR in 0.5% increment between 0.5% and 2% (3) Symmetrical MSR/MLR to vary based on the number of assigned beneficiaries The ACO must make its MSR/MLR selection prior to the start of each agreement period and may not change its MSR/MLR during the course of the agreement period.	Compared with Track 2, Track 3 offers the ACO greater risk for the possibility of greater reward. It has a higher sharing rate and performance payment limit than Tracks 1 and 2. Track 3 also has a higher loss rate and loss sharing limit than Track 2. The options for symmetrical MSR/MLR are: (1) No MSR/MLR (2) Symmetrical MSR/MLR in 0.5% increment between 0.5% and 2% (3) Symmetrical MSR/MLR to vary based on the number of assigned beneficiaries The ACO must make its MSR/MLR selection prior to the start of each agreement period and may not change its MSR/MLR during the course of the agreement period.
Quality Measures, Reporting, and Performance Standards	For 2018 and 2019 reporting years, CMS will measure quality of care using 31 quality measures (29 individual measures and one composite that includes two individual component measures). Quality measures span four quality domains: Patient/Caregiver Experience, Care Coordination/Patient Safety, Preventive Health, and At-Risk Population.			
Sharing Rate	ACOs are eligible for a maximum sharing rate of 50% based on quality performance.	ACOs are eligible for a maximum sharing rate of 50% based on quality performance.	ACOs are eligible for a maximum sharing rate of 60% based on quality performance.	ACOs are eligible for a maximum sharing rate of 75% based on quality performance.

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Topic/Subject	Track 1 One-Sided Risk Model	Track 1+ Two-Sided Risk Model	Track 2 Two-Sided Risk Model	Track 3 Two-Sided Risk Model
Advantages	• Upside risk only • An ACO that completes its first agreement period under Track 1 may apply for a second agreement period under this model. This allows organizations less experienced with risk to test performance and develop infrastructure before transitioning to a two-sided risk model. • Care is coordinated for the beneficiary, with a single point of contact to provide comprehensive care.	• Qualifies as an AAPM under MACRA • Less downside risk than is currently available in Tracks 2 and 3 • Limit on the amount of shared losses is based on the ACO's participant composition and the applicable PY • ACOs in Track 1+ may apply for a waiver of the Skilled Nursing Facility 3-Day Rule. • Prospective attribution allows an ACO to know up front which patients it will be held accountable to manage.	• Less risk than Track 3 • Relies on data to make decisions at the practicing physician level • As an ACO matures in the improvement of quality and cost metrics, it can advance to higher risk contracts. • Qualifies as an AAPM under MACRA • An ACO may elect Track 2 without completing a prior agreement period under Track 1. • The two-sided risk model has reduced the burden of the repayment mechanism. • Care is coordinated for the beneficiary, with a single point of contact to provide comprehensive care.	• The greatest benefit of Track 3 is a higher sharing rate than in Tracks 1 and 2. • Relies on data to make decisions at the practicing physician level • Qualifies as an AAPM under MACRA • An ACO may elect Track 3 without completing a prior agreement period under Track 1. • The two-sided risk model has reduced the burden of the repayment mechanism. • Beginning in 2017, ACOs in Track 3 may apply for a waiver of the Skilled Nursing Facility 3-Day Rule. • Care is coordinated for the beneficiary, with a single point of contact to provide comprehensive care. • Prospective attribution allows an ACO to know up front which patients it will be held accountable to manage.
Disadvantages	• Beneficiaries retain the right to choose providers or suppliers inside or outside of the ACO. This may drive up costs since care is not coordinated within the ACO. • Does not qualify as an AAPM • Financial investment of start-up and operating costs	Beneficiaries retain the right to choose providers or suppliers inside or outside of the ACO. This may drive up costs since care is not coordinated within the ACO. Many ACOs may not be ready to take on the terms of financial risk required. ACOs are limited to one full three-year agreement period in Track 1+. Medicare ACOs that have previously participated in performance-based risk ACO initiatives (e.g., Track 2 or 3) are ineligible.	• Beneficiaries retain the right to choose providers or suppliers inside or outside of the ACO. This may drive up costs since care is not coordinated within the ACO. • Many ACOs may not be ready to take on the terms of financial risk required. • The required financial investment does not guarantee shared savings. • An ACO may be required to repay a portion of losses that exceed its MLR, based on the shared loss rate.	

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RESOURCES

The following resources are available from the Centers for Medicare and Medicaid Services:

Accountable care organization 2015 program analysis quality performance standards narrative measure specifications.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf. Accessed July 19, 2016.

Accountable care organizations: what providers need to know.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Providers_Factsheet_ICN907406.pdf. Accessed July 19, 2016.

Additional guidance for Medicare Shared Savings Program accountable care organization (ACO) applicants.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Memo_Additional_Guidance_on_ACO_Participants.pdf. Accessed July 19, 2016.

Medicare Shared Savings Program Final Rule overview.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2015-SSP-ACO-Final-Rule-Overview-6-29-15.pdf. Accessed July 19, 2016.

Medicare Shared Savings Program: managing your ACO participant list and ACO participant agreement guidance.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Tips-ACO-Developing-Participant-Agreements.pdf. Accessed July 19, 2016.

Medicare Shared Savings Program quality measure benchmarks for the 2016 and 2017 reporting years.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-QM-Benchmarks-2016.pdf. Accessed July 19, 2016.

Medicare Shared Savings Program quality measure benchmarks guidance for the 2018 and 2019 reporting years.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-and-2019-quality-benchmarks-guidance.pdf. Accessed March 7, 2018.

New Accountable Care Organization model opportunity: Medicare ACO Track 1+ Model.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/New-Accountable-Care-Organization-Model-Opportunity-Fact-Sheet.pdf. Accessed January 27, 2017.

Proposed Rule versus Final Rule for accountable care organizations (ACOs) in the Medicare Shared Savings Program.
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/Downloads/Appendix-ACO-Table.pdf. Accessed, July 19, 2016.

Shared savings program ACO spotlight newsletter. Issue 6.
http://mphca.com/LiteratureRetrieve.aspx?ID=141715. Accessed July 19, 2016.